

Litigation as TB Rights Advocacy: A New Delhi Case Study

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Abstract

One thousand people die every day in India as a result of TB, a preventable and treatable disease, even though the Constitution of India, government schemes, and international law guarantee available, accessible, acceptable, quality health care. Failure to address the spread of TB and to provide quality treatment to all affected populations constitutes a public health and human rights emergency that demands action and accountability. As part of a broader strategy, health activists in India employ Public Interest Litigation (PIL) to hold the state accountable for rights violations and to demand new legislation, standards for patient care, accountability for under-spending, improvements in services at individual facilities, and access to government entitlements in marginalized communities. Taking inspiration from right to health PIL cases (PILs), lawyers in a New Delhi-based rights organization used desk research, fact-findings, and the Right To Information Act to build a TB PIL for the Delhi High Court, *Sanjai Sharma v. NCT of Delhi and Others* (2015). The case argues that inadequate implementation of government TB schemes violates the Constitutional rights to life, health, food, and equality. Although PILs face substantial challenges, this paper concludes that litigation can be a crucial advocacy and accountability tool for people living with TB and their allies.

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Introduction

State failure to adequately treat and prevent tuberculosis (TB) constitutes a human rights violation. In India, the Constitution, Supreme Court judgments, and international law commitments uphold the fundamental rights to life, health, equality, and dignity. At the same time, policies and legislation including the Revised National Tuberculosis Control Programme (RNTCP, 2005), the National Food Security Act (2013), and the Consumer Protection Act (1986) ensure treatment, related services, and legal protections for individuals living with TB. Despite legal guarantees, data indicate that in New Delhi individuals living with TB, especially women, and TB affected people in marginalized communities, cannot access quality testing services, adequate treatment, or the minimum nutrition they require. Tuberculosis Control (TBC) India reports that 1,000 people die every day from TB across India.¹ The statistics on TB and TB-related deaths represent a fraction of TB's impact in India. For example, the 2015 World Health Organization Global TB Report shows that India accounts for 23% of the world's TB cases and for 54% of the reported multidrug resistant TB (MDR-TB) cases.² TB affects millions of Indians. As part of a broader strategy to combat TB, activists in New Delhi use the legal system to close the gap between government policy goals and obligations and realities on the ground.

This paper argues that legal advocacy is an essential component of a human rights-based approach to TB. It draws on a case study from New Delhi to outline a broad array of legal tools and arguments Indian activists use to advocate for the rights to life, health, and equality in the context of TB. The case study also highlights limitations and challenges of litigation. Part one describes how legal activists and lawyers in New Delhi use a rights-based approach to TB to document fundamental rights violations and government failures to implement schemes. Part two provides an introduction to public interest litigation (PIL) in India and outlines right to health judgments and impacts that inspired activists to use litigation in the TB context. Part three examines the legal arguments lawyers advanced in the TB PIL in New Delhi and

the outcome at the Delhi High Court. Finally, part four explores the challenges these activists faced and the broader constraints of legal advocacy in India.

Part One: Using human rights to evaluate TB policy in New Delhi

India and Nigeria alone accounted for one-third of the 1.5 million global TB deaths in 2014.³ In 2013, New Delhi reported 3,239 medically certified TB deaths, almost 10 deaths every day.⁴ For human rights activists, this represents more than a public health crisis, it constitutes a state failure to uphold basic human rights to life, health, and equality. As part of a wider strategy to hold the government accountable for ensuring the right to health, activists at the New Delhi-based Human Rights Law Network (HRLN) developed a legal strategy to improve TB treatment in the capital, culminating in a legal case at the Delhi High Court. HRLN is a collective of lawyers and social activists committed to using the law for social change and to pursuing justice for victims of fundamental rights violations.⁵ This section illustrates the first step of HRLN's legal advocacy strategy, documentation.

Documenting fundamental rights violations: desk research, field research, and right to information requests

Investigating and documenting health rights violations creates a record of key issues, improves awareness among communities and activists, and lays the foundation for further advocacy. As the first component of the TB legal advocacy strategy, researchers and lawyers in New Delhi gathered information from diverse sources to create comprehensive analysis of TB treatment and care in New Delhi.

To evaluate TB services, the legal team employed the Available, Accessible, Acceptable, and Quality framework, known as the "AAAQ" framework, outlined in the General Comment No. 14: The Right to the Highest Attainable Standard of Health by the UN Committee on Economic, Social and Cultural Rights.⁶ Availability requires functional

TB facilities, goods, and services.⁷ Accessibility demands that TB facilities, information, goods, and services are non-discriminatory, physically accessible, and affordable.⁸ Acceptable TB services, goods, and facilities respect medical ethics and culture while quality obligates states to provide scientifically and medically appropriate health facilities, goods, and services.⁹

India's RNTCP has five key components aimed at fulfilling each of the AAAQ requirements: (1) a political and administrative commitment to ending TB, (2) good quality diagnosis, (3) uninterrupted supply of good quality anti-TB drugs, (4) supervised treatment to ensure adherence to treatment, (5) systematic monitoring and accountability.¹⁰ To test and treat TB, India relies on the Directly Observed Treatment Short-Course (DOTS) strategy. Operating under the assumption that many TB patients fail to complete treatment, DOTS mandates strict observation of patients and increased outreach to communities. The government of India has established DOTS centers throughout India where health workers watch TB patients take their medication three days a week, coordinate community outreach, and perform diagnostics.¹¹ DOTS-plus centres add MDRTB diagnosis, management, and treatment.¹² To uncover specific barriers to available, accessible, acceptable, and quality TB care in Delhi, HRLN researchers and lawyers collected evidence on the RNTCP and DOTS implementation in three phases: desk research, field research, and right to information (RTI) requests.

Desk research examined publicly available material including RNTCP data, World Health Organization reports, and media reports. Frequently, government evaluations and status reports provide the richest source of data and pointed criticisms. The information collected on TB uncovered a public health and human rights crisis in Delhi. Today, 40% of the capital's population lives with a latent form of TB.¹³ Additional information from the RNTCP 2014 annual status report shows that 3% of all DOTS patients in Delhi switched to MDR-TB treatment, a substantially higher percentage than in the rest of India.¹⁴ Desk research also discovered underspending on TB budgets and evidence

that recent health budget cuts could further gut the RNTCP.¹⁵ Moreover, desk research captured important information on TB and gender discrimination, TB and nutrition, and developments in testing technology. For instance, reports of birth and death registrations show that in Delhi, the most women die from TB between the ages 15-24, whereas the most men die from TB later, between ages 45-54.¹⁶

The team used the desk research as context for field reports. Fact-finding reports featuring testimony from communities personalize statistics and expose specific barriers to available, accessible, acceptable, and quality care. HRLN social activists conducted fact-finding missions throughout Delhi to investigate DOTS centers and to interview members of TB-vulnerable communities.

The first TB fact-finding mission in 2012 evaluated four DOTS centres and found that they did not have drinking water, clean, or comfortable spaces for individuals under treatment, nor did they have adequate staff or outreach services. A DOTS provider told the team that "the government does not care about his center's situation and ... that two out of every three months the government does not pay the staff's salary."¹⁷ The 2012 fact-finding team also spoke to individuals receiving treatment about their experiences. Thirty-two-year-old Vipin suffered from TB for a year before seeking treatment because "he thought he would get better by himself."¹⁸ Another individual had undergone DOTS treatment for two years with frequent interruptions in his treatment while he took trips to visit his home village. His teenage daughter received a positive TB diagnosis on the same day that the fact-finding team interviewed him. The family could not afford to purchase adequate food and relied on the DOTS centre to reimburse his transportation to the treatment center.¹⁹ A follow-up fact-finding mission in November and December 2014 uncovered poor record keeping; unhygienic conditions at DOTS centres including sinks with "stains, spills, and dirt;" and inadequate staffing across DOTS providers.²⁰

A February 2015 fact-finding visit to the Pul Mithai slum community revealed additional state

failures to ensure the AAAQ guarantees.²¹ Even with a TB hospital across the road, Pul Mithai residents routinely succumb to TB. The following examples are drawn from a series of fact-finding missions to Pul Mithai.

The interviews highlighted within fact-finding reports show the RNTCP has failed to address key gender dynamics and cultural norms, important components of acceptable care. For example, an interview with Poonam, aged 27, revealed that women do not visit government health facilities because of their past negative maternal health experiences, the cost of travel, and limited freedom to travel outside of the community.²² Throughout visits to Pul Mithai, fact-finding teams interviewed Munita, a widow with four children who lost her husband, Khushi Ram, to TB in January 2014. He had received treatment at a government facility, but his condition did not improve.²³ In May 2014 Munita, overworked, malnourished, and without access to proper sanitation, also succumbed to TB.²⁴ Although she lived across the street from a government TB treatment center, Munita never received TB treatment.²⁵ Women in Pul Mithai believe that the TB hospital is cursed because anyone who visits inevitably dies.²⁶

Suresh's case study from the February 2015 fact-finding mission in Pul Mithai uncovers challenges even the most dedicated TB patients must overcome. Suresh received his second TB diagnosis in August 2014.²⁷ The February 2015 fact-finding mission reported that "Suresh feels weak, faint, has a constant cough, and sometimes vomits blood."²⁸ The report found that Suresh received medication from the TB hospital across the road, but with regular medicine stock-outs, he was expected to obtain the medicines at his own cost from a TB hospital near India Gate, a distance of over 6km.²⁹ Although the treatment is free at this hospital, transportation cost him a nearly impossible sum of about Rs. 1,650 (USD 25) over the six months since his diagnosis.³⁰ TB medicines make Suresh lightheaded and dizzy; after taking them in the morning he can only lie down and rest. Unable to work, Suresh and his six children rely on his elderly mother's income from selling dry fruits, sweeping, and odd jobs.³¹ His

mother also has a chronic cough, and has a severely injured foot from a road accident.³² Sometimes the effect of the medicines is so strong that Suresh forgets to take the complete dosage for the day.³³ For example, the day prior to the fact-finding visit, he had taken four of six required tablets, meaning that the remaining two tablets would be wasted.³⁴

Suresh's TB treatment experience highlights violations of the AAAQ right to health framework. For instance, the government has failed to ensure available services where Suresh's DOTS facility has frequent medicine stock-outs. The prohibitive travel cost to the India Gate TB hospital represents a violation of the right to accessible treatment. Suresh's extreme reaction to the medicine limiting his ability to work and to consume the full daily dosage indicates that the government of Delhi does not ensure Suresh's right to acceptable and quality TB care.

In addition to desk research and fact-finding missions, the team used the Right To Information Act (RTI Act, 2005) to seek additional information from the government on implementation of TB programs.³⁵ The RTI Act allows the public to submit requests to the government for information about programs and mandates that the government reply. Activists routinely use the RTI Act to investigate corruption and implementation of schemes. HRLN filed RTI requests to the State TB Officer for Delhi requesting information on DOTS centres in the state, the staff at each facility, the number of DOTS-PLUS facilities (for treating MDR-TB), the number of individuals enrolled in MDR-TB treatment, the number of individuals who completed TB treatment, the number of individuals treated at DOTS centers who died as a result of TB, and the current stock of drugs at each facility.

Replies to the RTI requests showed widespread failure to provide adequate treatment to individuals with MDR-TB, failure to ensure available drug supplies, and high numbers of DOTS patient deaths. For example, an RTI response from Guru Teg Bahadur Hospital, Dilshad Garden Chest and TB clinic reported 65 registered MDR-TB patients in 2012-2013.³⁶ The RTI reply stated that just 33 patients had completed treatment and that nine

individuals died during treatment.³⁷

Data from desk research, field visits, and the RTI requests created a strong case of government failure to adequately implement the RNTCP guarantees in violation of the fundamental rights to life, health, and equality. The team met with prominent TB activists to discuss arguments and to shape the violations and demands. The fact-finding reports and documentation constitute important legal advocacy tools themselves. HRLN lawyers and activists presented findings from their research to government representatives at meetings and consultations throughout Delhi. Activists, including the petitioner sent detailed letters to government offices outlining findings and fundamental rights violations, and requesting immediate improvements. The government never replied to any of the letters. Faced with inaction, the team began drafting a public interest petition for the Delhi High Court.

Part Two: Public interest litigation in India and the right to health

The Constitution of India contains both guaranteed Fundamental Rights as well as Directive Principles which guide the creation and implementation of state policy.³⁸ Fundamental Rights include the right to life, the right to equality before the law, the right to education, and the right to free expression.³⁹ Directive Principles of State Policy encourage the state to *inter alia*, ensure adequate working conditions, free legal services, and equal pay for men and women.⁴⁰ Directive Principles are not justiciable, but they should guide legislation. The Constitution empowers the judiciary to interpret Fundamental Rights and to adjudicate alleged violations.⁴¹

PIL allows any person or organization to approach a high court or the Supreme Court in the wake of violations of Fundamental Rights violations.⁴² Revolutionizing traditional *locus standi* norms, the petitioner does not have to be a direct victim as long as the petition advances the public good. PILs allow activists, NGOs, and individuals to access courts on behalf of dozens or millions of victims of Fundamental Rights violations. A 2010

Supreme Court judgment describes the crucial role PIL plays in increasing access to justice:

Public interest litigation is not in the nature of adversary litigation but it is a challenge and an opportunity to the government and its officers to make basic human rights meaningful to the deprived and vulnerable sections of the community and to assure them social and economic justice.... The Government and its officers must welcome public interest litigation because it would provide them an occasion to examine whether the poor and the down-trodden are getting their social and economic entitlements or whether they are continuing to remain victims of deception and exploitation at the hands of strong and powerful sections of the community and whether social and economic justice has become a meaningful reality for them or it has remained merely a teasing illusion and a promise of unreality, so that in case the complaint in the public interest litigation is found to be true, they can in discharge of their constitutional obligation root out exploitation and injustice and ensure to the weaker sections their rights and entitlements.⁴³

In the same judgment, the Court examines “abuse of PIL,” underscoring a pervasive concern that “meddlesome interlopers” file cases for personal gain which diminishes the significance of PIL.⁴⁴ The judiciary has become increasingly weary of frivolous PILs and PILs filed to score business victories, while the Government of India has become increasingly hostile toward non-governmental organizations (NGOs) who use the legal system to hold the state actors accountable.⁴⁵ At the same time, human rights activists have questioned whether PILs have a meaningful impact on poor people’s lives, whether the judiciary should issue policy directives on issues ranging from clinical trials to air pollution, and whether litigation can co-opt social movements.⁴⁶

Despite increasing ambivalence and important concerns from activists, lawyers continue to obtain strong orders and judgments through PIL. PILs play an essential role in developing the right to health in India. The Supreme Court and high courts have rooted the rights to health, nutrition, and dignity in Article 21 of the Constitution, which guarantees that “No person shall be deprived of his

life or personal liberty except according to procedure established by law.²⁴⁷ The Supreme Court has held that the right to health includes a government duty to provide “adequate medical facilities for the people”²⁴⁸ and declared that “failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment” results in a violation of the right to life guaranteed in Article 21.⁴⁹ The Supreme Court has also ordered the government to ensure adequate access to affordable medicines as a component of its right to health obligations.⁵⁰

PILs have underscored and refined state obligations under the right to health. For example, the High Court at Jabalpur, Madhya Pradesh has held that the state’s failure to ensure adequate infrastructure and “manpower” under the National Health Mission violates the rights to life and health under Article 21 of the Constitution.⁵¹ The Delhi High Court has held that “an inalienable component of the right to life is the right to health, which would include the right to access government health facilities and receive a minimum standard of care.”⁵² Drawing from this jurisprudence and international law obligations under the International Covenant on Economic Social and Cultural Rights (ICESCR), the Delhi High Court recently held that right to health “core obligations” including access to essential medicines are non-derogable forbidding the government from failing to provide treatment for diseases under any circumstances.⁵³

Internationally, litigation has made a major impact on human rights and health policy. For instance, in South Africa, litigation expanded access to a drug that prevents mother-to-child transmission of HIV,⁵⁴ and obligated the government to provide a homeless community with access to temporary shelter.⁵⁵ Nigerian courts halted gas flaring by oil companies on the grounds that it violated the Iwherkan community’s rights to life, environmental health, and dignity.⁵⁶ A PIL case in Kenya outlawed the government’s practice of imprisoning TB patients who failed to complete treatment.⁵⁷ Courts in Colombia and Brazil have heard thousands of cases on access to medicines and treatment. Creative and determined activists in almost every jurisdiction

can use the law to fight for improved TB treatment and policies.

Anchoring their arguments in these rights and legal victories, health rights activists and lawyers in India use PILs to usher in new health rights legislation, to create minimum treatment standards, to hold states accountable for inadequate health expenditures, to improve conditions at individual health facilities, and to ensure right to health entitlements for specific marginalized communities. This section uses six PILs to illustrate these outcomes while the next section shows how activists in New Delhi have taken inspiration from these cases in the context of TB. At the same time, this section will begin to highlight the key PIL challenges and shortcomings that are outlined in full in part four.

Usher in new health rights legislation: People’s Union for Civil Liberties v. Union of India and Others (PUCL)

Filed in the wake of massive starvation deaths in 2001, orders in this PIL have expanded coverage for supplementary nutrition, improved functioning of food distribution systems, and underscored the states’ obligation to ensure adequate nutrition for all under the umbrella of Article 21 of the Constitution.⁵⁸ This PIL played an essential role in shaping the National Food Security Act (2013), “an Act to provide for food and nutritional security in human life cycle approach, by ensuring access to adequate quantity of quality food at affordable prices to people to live a life with dignity and for matters connected therewith or incidental thereto.”⁵⁹

In the context of the right to health, *PUCL* illustrates that litigation contributes directly to schemes, laws, and policy across public health issues. In addition to creating and expanding nutrition schemes, the Supreme Court has issued directions ordering the state governments to implement programs for pregnant women, workers, and homeless populations. In 2011, the Court ordered the state governments to establish homeless shelters in major cities with specific provisions including mattresses, drinking water, latrines, electricity, first-aid, health care services, detox facilities, and recreation.⁶⁰

The PIL encouraged reform and created a space for accountability. For activists working on TB and the right to health, *PUCL* highlights the Court's understanding of the indivisibility of rights. The Court links the rights to nutrition, antenatal care, shelter, and health making crucial connections for addressing barriers to accessible, available, acceptable, and quality care. Additionally, *PUCL* illustrates a PIL's power to facilitate new legislation that creates obligations and mechanisms for enforcing a fundamental right. However, *PUCL* also shows that litigation can only chip away at massive injustices like starvation, homelessness, and poor maternal health policy. Starvation deaths persist throughout India; the Right to Food Campaign documents widespread failure to implement the National Food Security Act, and states have largely ignored the Court's orders on homeless shelters.⁶¹

*Create minimum treatment standards:
Ramakant Rai v. Union of India & Others*

In 2003, social activist Ramakant Rai filed a PIL on the horrific conditions in female sterilization camps throughout India.⁶² In 2005, the Supreme Court issued final orders to empanel doctors for sterilization services, to create a pre-operative checklist for each patient, to ensure completion of informed consent paperwork, to constitute Quality Assurance Committees at the district and state level, to maintain accurate data on sterilization, to hold enquiries into guideline breaches, and to create an insurance scheme for sterilization related deaths, complications, and failures.

In a new PIL on sterilization, *Devika Biswas v. Union of India and Others*, affidavits from each state show at least minimal compliance with the *Ramakant Rai* orders.⁶³ States have empaneled doctors, created quality assurance committees, and established insurance schemes. Thousands of women have received compensation for failed or botched sterilizations as a result of this judgment.⁶⁴ Moreover, in 2006 and 2008, the Ministry of Health and Family Welfare issued comprehensive Standard Operating Procedures for Male and Female Sterilization emphasizing informed consent, full counseling, patient privacy, and hygiene.⁶⁵

Health rights activists use the 2006 and 2008 Standard Operating Procedures to evaluate sterilization camps and demand improvements. For instance, the Chhattisgarh High Court, the Supreme Court, and activists have coupled the *Ramakant Rai* requirements with the Standard Operating Procedures to hold the government accountable for the 2014 Bilaspur, Chhattisgarh sterilization camp massacre.⁶⁶

While *Ramakant Rai* served as a foundation for important policy changes and created an entire government regulatory system for sterilization, implementation suffers. In fact, the Supreme Court has expressed its frustration with state governments who fail to follow orders during hearings in *Devika Biswas*.⁶⁷ In the face of state apathy, the Supreme Court has ordered the states to meet and develop a strategy for improved sterilization services.⁶⁸ This development might not represent a revolution in women's constitutional rights, but it does show that *Ramakant Rai* laid a foundation for a monitoring and accountability system for female sterilization. Broadly, this PIL illustrates that litigation can create rights-based accountability tools including guidelines, checklists, insurance policies, and monitoring bodies for specific health services.

Hold states accountable for inadequate or illegal health expenditures: Centre for Health and Resource Management v. State of Bihar and Others (CHARM)

This PIL in the High Court at Patna alleged poor implementation of the government's flagship National Rural Health Mission (NRHM) in violation the right to life, health, the right to survive pregnancy and delivery, and the right to equality. Detailing conditions at a major District Hospital, the PIL shows:

*The hospital presents an appalling lack of hygiene, construction, and operation. There appears to be no upgrading to the original structure, built in 1932. The maternity ward was inoperative, all female patients were housed in filthy rooms, with beds lacking mattresses, ceilings and walls caving inward, broken windows and open wiring throughout the room.*⁶⁹

In March 2011, the High Court at Patna demanded an affidavit from the State Health Secretary detailing expenditures under the NRHM for 2007-2012.⁷⁰ In a June 2012 order, the High Court demanded quarterly reports “with regard to medical facilities/equipments provided at Public Health Center(s) [in] all the Districts...”⁷¹ The Court evaluated every rupee spent by the state and demanded a detailed account for each failure to spend allocated resources.⁷²

CHARM serves as an important example of litigation as an accountability tool against financial corruption, under-spending, and inadequate oversight in health policy. Unfortunately, *CHARM* also shows that an individual judge can determine the scope and impact of a PIL. For years, the High Court routinely demanded answers from government lawyers on poor health indicators, inadequate infrastructure, and failure to spend health budgets. In 2015, a new Chief Justice in Patna closed the case, with the tepid “hope that the facilities would be maintained at proper level and the services would be extended to the public, without any deficiency...”⁷³ An individual judge’s religious, political, and judicial philosophy can stop a powerful PIL in a single hearing. While interim orders in *CHARM* represent a major victory for accountability, the PIL did not create sweeping change in Bihar, where rampant maternal mortality, illegal drug pricing, and “fiscal irregularities” in National Rural Health Mission spending persist.⁷⁴

Improve conditions at individual health facilities: Dinanth Wagmare v. State of Maharashtra

In 2013, health activists in Maharashtra filed a PIL in the Nagpur Bench of the Bombay High Court illustrating deplorable conditions with a special focus on fundamental rights violations at one of Asia’s largest hospitals, the District Hospital Nagpur. In February 2013, the High Court urged the government lawyer to “go pay a visit to a public hospital and take appropriate action.”⁷⁵ An October 2014 High Court order notes that “The right to health would also include the facilities to be provided by the State Government which are conducive

of maintenance of health and not detrimental to the maintenance of health.”⁷⁶ In its order, the High Court established a committee of government functionaries to make immediate recommendations for improving public health services. A 2015 follow up fact-finding visit discovered that as a result of this PIL, the government removed 300 trucks of garbage from the District Hospital courtyard and ensured improved hygiene standards throughout the facility. Additionally, interviews with the Dean of Hospital, doctors, and nurses found widespread awareness of the ongoing PIL and the need to maintain high standards of care to avoid further High Court scrutiny.⁷⁷

The PIL and fact-finding reports documented hundreds of violations regarding hygiene, gender discrimination, infrastructure, staffing, HIV/AIDS services, and worker rights.⁷⁸ However, the High Court’s orders focus almost exclusively on cleanliness at a few facilities.⁷⁹ Improvements in hygiene have dramatically changed conditions at Nagpur District Hospital, but the Court’s orders do not address key components of rights-based care including training, employee compensation, and infrastructure. On the other hand, a PIL can take decades to work its way through the Indian legal system. The quick results in *Dinanth Wagmare* prove that PILs can achieve immediate and measurable results at health facilities. Furthermore, this PIL shows how litigation can hold government health providers accountable where they know their facility is the subject of ongoing litigation.

Ensure health rights entitlements for specific marginalized communities: Shakeel Ahmad v. NCT of Delhi and Others

Housing rights activist Shakeel Ahmad filed this PIL on behalf of the 380 families living in the Pul Mithai homeless cluster in Old Delhi.⁸⁰ The community did not have access to clean water, public health facilities, or supplementary nutrition schemes for children and pregnant women. In October 2014, the High Court ordered the state government to ensure the rights to health and education in the cluster by providing potable water to residents, repairing a local school, providing

reproductive health services, conducting immunization camps, and operationalizing a center for distributing supplementary nutrition to children, adolescents, and pregnant and lactating women.⁸¹

As a result of this petition, the government established a nutrition center for children and increased community outreach in Pul Mithai, showing that a single PIL can substantially improve access to entitlements and health services in specific communities. At the same time, *Shakeel Ahmad* underscores the need for a strong movement behind each PIL. Pul Mithai residents do not have the information or resources to demand services from government officials. Accordingly, even after the Court order, outside activists visited the community on a weekly basis to monitor compliance. Ultimately, Shakeel Ahmad filed a contempt petition to demand full implementation of the Court's directions.⁸²

As the fact-finding reports in part one show, TB represents a major human rights issue for Pul Mithai residents. To ensure available, accessible, acceptable, and quality TB treatment per its Constitutional and ICESCR obligations, the government of India will have to facilitate social change, improve standards for patient services, ensure accountability for budget expenditures, launch changes at the facility level, improve access to drugs, and fully implement entitlement programs in vulnerable communities. Litigation can play a role in ensuring these changes.

Part Three: Constructing and arguing the PIL: Legal arguments, reliefs, and outcomes

As a result of persistent inaction, HRLN filed a PIL in the Delhi High Court on behalf of health activist and former TB patient Sanjai Sharma in August 2015. Drawing inspiration from the PILs outlined in part two, *Sanjai Sharma v. NCT of Delhi and Others* aims to hold the government accountable and to obligate the government to take meaningful steps to bridge the gap between constitutional rights and implementation.

Using the information summarized in

part one, lawyers for Sanjai Sharma developed arguments rooted in constitutional protections, Supreme Court PIL judgments, and international law. Lawyers shaped the legal arguments to correspond to 13 specific reliefs rooted in three fundamental rights enshrined in the Constitution of India; the right to health, the right to food, and the right to be free from discrimination.⁸³ This section provides a brief sketch of the key fundamental rights violations alleged in the petition.

The right to health

Sanjai Sharma draws on the AAAQ framework outlined in part one to argue that the Delhi government fails to provide available, accessible, acceptable, and quality TB goods, facilities, services, and information in violation of constitutional and international law.

- *Availability*: The petition outlines myriad barriers to available TB care in Delhi. For example, *Sanjai Sharma* argues that the drug stock-outs, understaffing, and outdated testing methods documented in the fact-findings and desk research render treatment unavailable. Moreover, the PIL states that the high death rate indicates the government's failure to make treatment available to thousands of people who live with TB.
- *Accessibility*: The PIL also argues that TB treatment in Delhi is inaccessible to patients who cannot physically travel to DOTS centres, who cannot afford to miss work to travel to facilities, or who cannot bare the financial burden of travel to facilities. Additionally, the PIL shows that individuals with TB and vulnerable communities do not have access to information on TB or TB treatment. Women in TB impacted communities believed they could not get TB because they did not drink, families did not understand transmission, and people undergoing DOTS treatment did not understand the need to regularly take their medication.⁸⁴
- *Acceptability*: The PIL contends that TB treatment in Delhi is unacceptable where it does not align with the realities of people living in TB vulnerable communities. Reporting to a DOTS

centre every day is impossible for individuals who work or cannot leave their homes. People in marginalized communities like Pul Mithai lack access to nutrition and government rations, making it impossible to get food they require for recovery.⁸⁵ Women feel uncomfortable in government health facilities and refuse to travel to care even when the hospital is only minutes away.

- *Quality*: Finally, the PIL uses examples of insufficient hygiene practices, inadequate record keeping, and the concerns of DOTS providers to show poor quality TB treatment in Delhi.

To respond to right to health violations, the PIL asks for the High Court to direct the state government to conduct an independent audit and quality control survey of all DOTS centres in Delhi. The PIL urges the High Court to include members of civil society in the audit process. This relief aims to make the government accountable for the quality at all DOTS centres and to create a record of the status quo that can be used as a benchmark for measuring change and impacts. Civil society experts would ensure an independent review.

Additionally, to guarantee available and accessible goods, services, facilities, and information, the PIL prays (the terminology used in the PIL) for new standard testing procedures; new DOTS PLUS centres to treat MDR-TB; improved staffing, infrastructure, and supplies at existing DOTS centres; cash payments for travel to treatment; and an employee insurance scheme. Inspired by the directions in *Ramakant Rai*, *CHARM*, and *Dinanth Wagmare*, these reliefs aim to create standards of care for patients and to improve conditions at the facility level.

If the High Court did issue these directions, ensuring implementation would be a constant struggle. Activists supporting the *Shakeel Ahmad* PIL worked for over a year to ensure full implementation of the High Court's directions. In the end, the activists filed a contempt petition to demand potable drinking water and basic services for just 380 families.⁸⁶ Additionally, even with perfect implementation, these changes will not overhaul gender dynamics, geographic isolation, and stereotypes about government

health services. Even with these difficulties, a court direction obligates the government to act where it has failed. The court order provides activists with a tool for demanding continued improvements. PILs with equally expansive right to health reliefs have resulted in massive hygiene improvements in Maharashtra, improved implementation of government schemes, and legally binding standards of care.⁸⁷

The right to food

Drawing on the fundamental right established in *PUCL*, *Sanjai Sharma* argues that failure to provide individuals with TB and their communities with supplemental nutrition violates the right to food. The PIL shows that malnutrition increases the risk of latent TB developing into active TB, that malnutrition persists in Delhi slums, that TB impacts an individual's ability to metabolize food, and that TB creates economic constraints for families, reducing nutritional intake for already vulnerable family members.⁸⁸ The PIL also uses data from WHO, Delhi Government, and fact-findings to show that inadequate access to nutrition disproportionately impacts women in violation of their right to equality enshrined in Article 15 of the Constitution.

Here, the PIL prays for a nutritionist or dietitian to provide counseling in all DOTS centres. The PIL includes an urgent interim prayer requesting the High Court to direct the Delhi government to provide supplementary nutrition to individuals with TB and their families as an emergency measure before the final judgment in the case. Given the widespread failure to enact the National Food Security Act and *PUCL* related schemes, ensuring implementation of these prayers will also be a significant challenge.

The right to be free from discrimination

The petition shows that the state's failure to provide gender sensitive TB services constitutes discrimination under the Constitution of India and international law. The petition uses the fact-finding reports and data to show that stereotypes based on sex limit women's access to quality care and prevent women from undergoing testing as they fear being rejected by prospective husbands and in-laws.⁸⁹ At

the same time, India's reproductive health schemes largely ignore TB even though uterine TB has a high prevalence rate and TB drugs may decrease the effectiveness of oral contraception.⁹⁰ In this context, women cannot access acceptable TB services and information. The government fails to ensure gender equality where women do not have access to the same services as men.

To ensure TB treatment free of discrimination and to address disproportionate impacts of TB on marginalized groups, the PIL requests the Court to direct the state to implement outreach programs in slum areas and to expand TB awareness with a focus on women, pregnancy, and MDR-TB. Furthermore, the PIL asks for employee training on TB and pregnancy, and improved links with field level health providers. PILs on women's rights have failed to create gender sensitized government policies.⁹¹ However, the success in *Shakeel Ahmad* and *Dinanth Waggmare* show that a single case can result in immediate change in specific communities.

The outcome

In November 2015, the Delhi High Court heard arguments in *Sanjai Sharma v. NCT of Delhi*. The Court's order acknowledged that the petitioner "points out many shortcomings in the functioning of DOTS centres in Delhi...and come(s) out with certain suggestions...."⁹² The government lawyer argued that Delhi had launched a program to improve accessibility to DOTS centres. The government lawyer also stated that "further suggestions if any from the petitioner for strengthening the system are welcome."⁹³ Accordingly, the High Court ordered the government to give "an audience" to the petitioner to ensure improved implementation of DOTS. Lastly, if the government does not act, the High Court allowed the petitioner "to seek revival of this petition."⁹⁴ With that, the High Court closed the case. After legal activists spent years collecting data, filing RTI requests, and drafting a 100 page petition in collaboration with TB activists, the High Court did not evaluate the specific arguments, fundamental rights violations, and/or reliefs outlined in the petitioner's case.

The order does create a space for a dialogue

between the petitioner and the government. In an individual meeting, the petitioner will have more time to develop and explain the arguments in the petition. In fact, similar meetings resulting from PILs have improved implementation of government schemes.⁹⁵ Most importantly, the order allows the petitioner to approach the High Court if the government fails to take meaningful action. While the order facilitates a crucial dialogue and allows for future legal action, the Court did not issue specific directions or demand accountability for fundamental rights violations. An unpredictable judicial system represents just one substantial challenge PILs face.

Part Four: Limitations and challenges

The cases in part two show that legal advocacy has the potential to create immense change in TB policies, treatment, and perspectives. At the same time, the outcome of *Sanjai Sharma* illustrates four key challenges right to health PILs face. *Sanjai Sharma* underscores the importance of using litigation as just one component of a multi-pronged strategy for change.

First, PILs designed to tackle systematic and widespread fundamental rights violations may fail to acknowledge nuance, to address community-specific issues, or to evolve flawed policy. The Indian judiciary has been the subject a fierce debate on judicial activism with some scholars arguing that Indian judges violate their constitutional parameters and act as legislators who create laws and policy.⁹⁶ Scholars on the other side of the debate argue that continued government failure to ensure the minimum guarantees make it necessary for "activist" judges to fill the gaps between policy and reality. Either way, even the best intentioned judges may not understand the dynamics of a specific right to health issue. For example, in *Ramakant Rai*, the Supreme Court created a standard protocol for sterilization procedures but failed to address the underlying gender and class discrimination issues inherent in India's family planning programs. In the context of TB, orders in any single PIL cannot capture or address the innumerable intersections

between class, gender, caste, geography, religion, HIV status, sexuality, and education that impact TB services. Barriers to TB treatment and definitions of acceptable care may vary widely between two communities in the same city. A high court judge may not be the best person to reshape India's TB policy.

Secondly, an incredibly overburdened judiciary and hostile government pose a perpetual threat to human rights litigation. Certain judges may have little interest in PILs. In hearings for a PIL regarding the death of a homeless woman's infant daughter, a Delhi High Court judge joked that the PIL was a "publicity interest litigation and not public interest litigation."⁹⁷ In the Supreme Court, many PILs have been delegated to the newly created Social Justice Bench, creating delays and removing important social issues from the spaces where property matters, criminal cases, and corporate litigation dominate.⁹⁸ At the same time, the Indian government has become increasingly inimical to NGOs that challenge policy or highlight fundamental rights violations in India.⁹⁹ Fortunately, progressive judges have continued to protect and promote PILs, underscored in the 2010 *Uttranchal* decision discussed in part two and highlighted in *PUCL*, *Ramakant Rai*, *CHARM*, *Dinanth Wagmare*, and *Shakeel Ahmad* orders. High courts have also upheld the rights of NGOs who have been the target of government retribution.¹⁰⁰

Sanjai Sharma may have faced ambivalence from overburdened judges. It is a positive sign that the order allows the petitioner to return to the High Court if the government fails to improve DOTS centres. In the future, another court could be more enthusiastic or could refuse to hear the case altogether. In this unpredictable and increasingly hostile environment, a PIL must represent one component of a wider human rights strategy. Although *Sanjai Sharma* did not move the Delhi High Court justices, activists continue to document violations, to advocate for change with policy makers, and to hold India accountable for poor TB indicators at the international level.

Third, even when courts issue groundbreaking orders, the government routinely fails to act.

For example, a 2014 fact-finding mission in Indore, Madhya Pradesh found zero compliance with the *PUCL* orders on homeless shelters.¹⁰¹ A 2012 Supreme Court PIL highlights state failures to fully implement the *Ramakant Rai* orders, leading to continued deaths and complications at sterilization camps across India.¹⁰² The Delhi Government failed to implement the full range of orders for the Pul Mithai residents in *Shakeel Ahmad*. Unquestionably, PILs encourage government action, but it may be limited or short lived. Poor implementation results from inadequate monitoring, insufficient accountability for failures to follow court orders, and from unclear court directions. As Mahendra Singh articulates, "a judge may talk of right to life as including right to food, education, health, shelter and a horde of social rights without exactly determining who has the duty and how such a duty to provide positive social benefits could be enforced."¹⁰³ *Sanjai Sharma* had not reached the relief stage, but the activists knew it would be almost impossible to ensure full implementation of their prayers without vigilant monitoring.

Lastly, a PIL may take years of arguments, filings, and adjournments before a court issues a substantive order. *PUCL* has been in the Supreme Court since 2001. It is important to have a petitioner and legal team with the resources and wherewithal to respond to government replies, to evaluate implementation of interim orders, and to participate in wider advocacy on a single issue. Interim prayers, narrowly tailored petitions, and progressive judges can facilitate meaningful impacts in a matter of months as evidenced by *Dinanth Wagmare* and *Shakeel Ahmad*. Even these positive outcomes generated additional work for petitioners. In both cases, the petitioners conducted follow-up fact-finding visits to measure implementation and filed additional briefs or petitions in their respective courts. Likewise, in *Sanjai Sharma*, the petitioner has to meet with government officials and continue to monitor and document fundamental rights violations for future legal advocacy.

The challenges and limitations outlined above create human rights advocacy space outside of the courtroom where activists, NGOs, government

agencies, policy makers, academics, and individuals affected by TB can fight for rights using a human rights framework. For lawyers and legal activists, the Delhi High Court's decision in *Sanjai Sharma* has paved the way for a dialogue and for future litigation. Working together, these diverse voices can ensure the right to health for all.

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References

1. Directorate General of Health Services Ministry of Health and Family Welfare, Government of India, *About RNTCP*. Available at <http://www.tbcindia.nic.in>.
2. World Health Organization, *Global tuberculosis report 2015*, (Geneva: World Health Organization, 2015), p. 2.
3. *Ibid.*, p. 24
4. Directorate General of Health Services Ministry of Health and Family Welfare, Government of India, (see note 1).
5. Human Rights Law Network, *Human Rights Law Network (HRLN)*. Available at www.hrln.org.
6. Committee on Economic Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), UN Doc E/C.12/2000/4 (2000).
7. *Ibid.*
8. *Ibid.*
9. *Ibid.*
10. Directorate General of Health Services Ministry of Health and Family Welfare, Government of India, (see note 1).
11. Ministry of Health & Family Welfare, Central TB Division, Directorate General of Health Services, *Revised National Tuberculosis Control Program, DOTS-Plus Guidelines*. Available at: <http://health.bih.nic.in/Docs/Guidelines/Guidelines-DOTS-Plus.pdf>.
12. *Ibid.*
13. TB FACTS, *TB statistics in India* (2015). Available at <http://www.tbfacts.org/tb-statistics-india/>.
14. Government of India, *TB India 2014: Revised National Control Programme annual status report* (New Delhi: Central Tuberculosis Division, March 2014), p. 73. Available at <http://www.tbcindia.nic.in/pdfs/TB%20INDIA%202014.pdf>.
15. D. C. Sharma, "Budget cuts threaten AIDS and tuberculosis control in India," *The Lancet* 386 (September 5, 2015), p. 942.
16. Directorate of Economics & Statistics & Office of the Chief Registrar (Birth & Death), Government of the National Capital Territory of Delhi, Government of National Capital Territory of Delhi report on medical certification of cause of deaths in Delhi – 2013, (November 2014), pp. 22-23.
17. Human Rights Law Network, *TB control: DOTS centres in Delhi, a fact-finding report prepared by Human Rights Law Network* (New Delhi: Human Rights Law Network, June 2012). Available at <http://www.hrln.org/hrln/images/stories/pdf/RR-fact-findings-reports-11.pdf>.
18. *Ibid.*, p. 19.
19. *Ibid.*, pp. 27-29.
20. Human Rights Law Network, *TB control: DOTS centres in Delhi, a fact-finding report prepared by Human Rights Law Network* (New Delhi: Human Rights Law Network, November-December 2014).
21. E. Heggadon, Knowledge and experience of TB and the effectiveness of DOTS centres and the public health system: Fact-finding at Pul Mithai slum (New Delhi: Human Rights Law Network, February 2015).
22. *Ibid.*, p. 11.
23. *Ibid.*, p. 6.
24. *Ibid.*, pp. 4-5.
25. *Ibid.*, p. 6.
26. *Ibid.*, p. 11.
27. *Ibid.*, pp. 7-11.
28. *Ibid.*, p. 7.
29. *Ibid.*, p. 9.
30. *Ibid.*
31. *Ibid.*
32. *Ibid.*
33. *Ibid.*
34. *Ibid.*, p. 8.
35. Government of India, Ministry of Law and Justice, Right to Information Act, 2005, Act No. 22 of 2005 (modified February 2011).
36. Guru Teg Bahadur Hospital, Dilshad Garden Chest and TB Clinic, *Right to Information Reply* (New Delhi: Guru Teg Bahadur Hospital, February-March 2015).
37. *Ibid.*
38. Constitution of India, Parts III and IV.
39. Constitution of India, Part III.
40. Constitution of India, Part IV.
41. Constitution of India, Part V, Chapter IV.
42. *Hussainara Khatoon & Others v. Home Secretary, State of Bihar* (Supreme Court of India, Writ Petition 57 of 1979, Final Judgment, March 9, 1979).
43. *State of Uttranchal v. Balwant Singh Chauhal and*

Others (Supreme Court of India, Special Leave Petition 1134 – 1135 of 2002, final judgment, January 18, 2010), para. 39.

44. *Ibid.*, paras. 46 and 163.

45. See, for example, S. Datta, “Is the Modi Govt Hounding Lawyers’ Collective?” *Catch News* (March 13, 2016). Available at <http://www.catchnews.com/india-news/is-the-modi-govt-hounding-lawyers-collective-1457880024.html>; See also, Surya Dave, “Public Interest Litigation in India: A Critical Review,” *Civil Justice Quarterly* 28/1 (2009), pp. 33-34.

46. *Ibid.*, p. 36.

47. Constitution of India, Article 21.

48. *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996), S.C.C. 37.

49. *Francis Coralie Mullin v. The Administrator, Union of India*, (1981 SCR (2) 516).

50. *Vincent Pannikulangura v. Union of India* (Supreme Court of India, 1987 2 SCC 165).

51. See *Sandesh Bansal v. Union of India and Others* (High Court at Jabalpur, Writ Petition (Civil) 9061 of 2008, order June 2, 2012), para. 22.

52. *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others* (Delhi High Court, Writ Petition (Civil) 8853 of 2008, final judgment, June 4, 2010), para. 19.

53. *Mohd. Ahmed v. Union of India & Others* (Delhi High Court, Writ Petition (Civil) 7279 of 2013), Paras 64-69.

54. *Minister of Health v. Treatment Action Campaign*, (Constitutional Court of South Africa, 2002 (5) SA 721 (cc)).

55. *Government of the Republic of South Africa v. Grootboom*, (Constitutional Court of South Africa, 2001 AS 46 (cc)).

56. *Gbemre v. Shell Petroleum Development Company Nigeria Limited and Others* (Federal High Court of Nigeria in the Benin Judicial Division, suit FHC/B/CS/53/05, 14 November 2005).

57. J. Oloka-Onyango, “Human rights and public interest litigation in East Africa: A bird’s eye view,” *The George Washington International Law Review* 47/44 (2015), p. 793.

58. *People’s Union for Civil Liberties v. Union of India and Others* (Supreme Court of India, Writ Petition (Civil) 196 of 2001).

59. *The National Food Security Act*, No. 20 of 2013, preamble, The Gazette of India (2013).

60. See *People’s Union for Civil Liberties* (see note 58, interim order dated July 18, 2011).

61. See, for example, UNICEF, *Improving Child Nutrition, The achievable imperative for global progress* (Geneva: UNICEF, 2013), p. 13; See, Right to Food Campaign, *National Food Security Act Violated*, (June 18, 2015), Available at: <http://www.sacw.net/article11302.html>; H. Mander, *Living Rough, Surviving City Streets: A Study of Homeless Populations in Delhi, Chennai, Patna, and Madurai for the Planning Commission of India* (New Delhi: Planning Commission of India, February 12, 2014).

62. *Ramakant Rai v Union of India and Others* (Supreme Court of India, Writ Petition (Civil) 209 of 2003, final judgment, March 1, 2005).

63. *Devika Biswas v. Union of India and Others* (Supreme Court of India, Writ Petition (Civil) 95 of 2012).

64. See, for example, *Pratibha D’Mello v. Government of NCT of Delhi* (Delhi High Court, Writ Petition (Civil) 10827 of 2015), petition.

65. Government of India, *Standard Operating Procedures for Sterilization Services in Camps* (New Delhi: Ministry of Health and Family Welfare, March 2008).

66. See, for example, Sama Resource Group for Women and Health, Jan Swasthya Abhiyan, and National Alliance for Maternal Health and Human Rights, *Camp of wrongs: The mourning afterwards, a fact finding report on sterilization death in Bilaspur* (New Delhi: National Alliance for Maternal Health and Human Rights, November 2014).

67. *Devika Biswas v. Union of India and Others* (Supreme Court of India, Writ Petition (Civil) 95 of 2012, orders dated January 30, 2015 and August 14, 2015).

68. *Ibid.*

69. *Centre for Health and Resource Management v. State of Bihar and Others* (Patna High Court, Writ Petition (Civil) 10724 of 2011).

70. *Ibid.*

71. *Ibid.*, (order dated June 25, 2011).

72. *Ibid.*

73. *Ibid.*, (order February 2, 2015).

74. “Fiscal irregularities in NRHM in Bihar, says CAG report,” *The Times of India* (March 18, 2016). Available at <http://timesofindia.indiatimes.com/city/patna/Fiscal-irregularities-in-NRHM-in-Bihar-says-CAG-report/articleshow/51463130.cms/>.

75. *Dinanth Waghmare v. State of Maharashtra and Others* (Bombay High Court, Writ Petition (Civil) 19303 of 2013, order dated 8 February 2013).

76. *Ibid.*, (order dated October 12, 2014), Para. 5.

77. Human Rights Law Network, Fact finding report on the implementation of NHM schemes and High Court recommendations in Waghmare v. district collector, Nagpur, Chnadrapur, and Yoetmal Districts, Maharashtra (Nagpur: Human Rights Law Network, August 6-10, 2015).

78. *Ibid.*

79. *Dinanth Waghmare v. State of Maharashtra and Others* (Bombay High Court, Writ Petition (Civil) 19303 of 2013), order dated 8 February 2013.

80. *Shakeel Ahmad v. NCT of Delhi and Others* (Delhi High Court, Writ Petition (Civil) 2840 of 2014), order dated October 15, 2014.

81. *Ibid.*

82. *Ibid.*

83. *Sanjai Sharma v. NCT of Delhi & Others* (Delhi High Court, Writ Petition (Civil) 10855 of 2015).

84. E. Heggadon, Knowledge and experience of TB and

the effectiveness of DOTS centres and the public health system: Fact-finding at Pul Mithai slum (New Delhi: Human Rights Law Network, February 2015).

85. *Ibid.*

86. *Shakeel Ahmad v. NCT of Delhi and Others* (Delhi High Court, Contempt Petition (Civil) 810/2015).

87. *Dinanth Wagmare v. State of Maharashtra and Others* (Bombay High Court, Writ Petition (Civil) 19303 of 2013), order dated 8 February 2013; *Centre for Health and Resource Management v. State of Bihar and Others* (Patna High Court, Writ Petition (Civil) 10724 of 2011); *Ramakant Rai v Union of India and Others* (Supreme Court of India, Writ Petition (Civil) 209 of 2003, final judgment, March 1, 2005).

88. *Sanjai Sharma v. NCT of Delhi & Others* (see note 83).

89. *Ibid.*

90. *Ibid.*

91. See, for example, *Laxmi Mandal v. Deen Dayal Hospital & Others* (Delhi High Court, Writ Petition (Civil) 8853/2008); *Vishaka & Others v. State of Rajasthan* ((1997) 6 SCC 241).

92. *Sanjai Sharma v. NCT of Delhi & Others*, (Delhi High Court, Writ Petition (Civil) 10855 of 2015), November 24, 2015 order.

93. *Ibid.*

94. *Ibid.*

95. See *VHAP v. Union of India & Others*, (Supreme Court of India, Writ Petition (Civil) 349/3006).

96. See M. Khosla, "Addressing judicial activism in the Indian Supreme Court: Towards an evolved debate," *Hastings International & Comparative Law Review* 32 (2008), pp. 55-56.

97. Justice Rajiv Sahai Endlaw, during oral arguments in *Priya Kale v. NCT of Delhi & Others* (Delhi High Court, Writ Petition (Civil) 641/2013), oral arguments on September 19, 2014.

98. See, for example, No author listed, "7 cases showing why SC's social justice bench has failed to close a single social justice," *Legally India* (August 29, 2015). Available at <http://www.legallyindia.com/SCOI-Reports/7-cases-showing-why-sc-s-social-justice-bench-has-failed-to-close-a-single-case-of-social-justice>.

99. See, for example, No Author listed, "Licenses of 4,470 NGOs, including those funding Supreme Court Bar Association, cancelled," *NDTV* (June 10, 2015). Available at <http://www.ndtv.com/india-news/government-cancels-licenses-of-4-470-erring-ngos-entities-barred-from-funding-supreme-court-bar-asso-770210>.

100. See, for example, Greenpeace, *Delhi HC overturns offloading, terms move undemocratic* (New Delhi: Greenpeace, 2015). Available at <http://www.greenpeace.org/india/en/Press/Victory-for-Greenpeace-activist-Priya-Pillai-Delhi-HC-overturns-offloading-terms-move-undemocratic/>.

101. B. K. Jha "HC notice to IMC over poor state of shelter homes for destitute pregnant women," *The Times of India* (March 28, 2014). Available at <http://timesofindia.indiatimes.com/city/indore/HC-notice-to-IMC-over-poor-state-of-shelter-homes-for-destitute-pregnant-women/articleshow/32855300.cms>.

102. *Devika Biswas* (see note 63).

103. S. Deva, "Public interest litigation in India: A critical review," *Civil Justice Quarterly*, 28/1 (2009), p. 33-34, citing M. Singh, "Protecting the rights of the disadvantaged groups through public interest litigation" in M. Singh, H. Goerlich and M. von Hauff (eds), *Human Rights and Basic Needs Theory and Practice*, p.322.

