MATERNAL MORTALITY IN INDIA

Using International and Constitutional Law to Promote Accountability and Change

CENTER FOR REPRODUCTIVE RIGHTS

The Center for Reproductive Rights

Our Mission

The Center for Reproductive Rights uses the law to advance the position that reproductive freedom is a fundamental right all governments are legally obligated to protect, respect and fulfill.

Our Vision

Reproductive freedom lies at the heart of the promise of human dignity, self-determination, and equality extended in both the U.S. Constitution and the Universal Declaration of Human Rights. The Center works to enshrine that promise in law in the U.S. and throughout the world. We envision a world in which all women are free to decide whether and when to have children, have access to the best reproductive healthcare available, and can exercise their choices without coercion. Simply put, we envision a world where all women participate with full dignity as equal members of society.

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Background

In 2004, the Center for Reproductive Rights launched a global initiative to promote the use of strategic litigation for the advancement of women's reproductive rights worldwide. Inspired by the use of public interest litigation in India as a tool for advancing social justice and promoting human rights, the Center organized the first ever training on reproductive rights for lawyers in India in 2006, in collaboration with Human Rights Law Network. It was at this meeting that the potential for developing constitutional litigation to address maternal mortality through the use of international norms and comparative law was discussed in great depth for the first time.

The discussions that took place at this training, and which followed later at various meetings and consultations, provide the inspiration for this report. We hope it will be used as a tool to help establish a protective legal environment based on human rights principles and norms that will enable women to exercise their right to survive pregnancy and childbirth and lead healthy and productive lives. We further hope that this report will serve as a useful resource for lawyers, judges, academics, activists, students and others who seek to challenge and dismantle discriminatory norms and practices that contribute to gender inequality in Indian society – an inequality that is continuously manifested in the huge number of preventable and foreseeable maternal deaths that occur each year.

Table of Abbreviations and Glossary

ABBREVIATION OR TERM	COMPLETE TERM OR DEFINITION
AHRC	Asian Human Rights Commission
AP	Andhra Pradesh
Anemia (Anaemia)	Condition characterized by an insufficient supply of red blood cells or hemoglobin, often caused by iron or folic acid deficiency
Anganwadi workers	Workers trained by the government to deliver basic child- and maternal-health and education services
ANM	Auxiliary Nurse Midwife
Antenatal care (ANC)	Health care given to women during pregnancy, also referred to as prenatal care
ASHA	Accredited Social Health Activist
Beijing Conference	1995 United Nations Fourth World Conference on Women: Global conference on women's human rights
Beijing Platform for Action	Beijing Declaration and Platform for Action, United Nations Fourth World Conference on Women: Consensus document adopted by nations participating in the Beijing Conference
BPL	Below poverty line
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women: International treaty codifying states' duties to eliminate discrimination against women
CEDAW Committee	Committee on the Elimination of Discrimination against Women: UN treaty monitoring body charged with monitoring states parties' implementation of the Convention on the Elimination of All Forms of Discrimination Against Women
Central Government	The governing authority of the federal Union of India, which includes all states and union territories in the country
CERD	Committee on the Elimination of Racial Discrimination
CESCR	Committee on Economic, Social and Cultural Rights: UN treaty monitoring body charged with monitoring states parties' implementation of the International Covenant on Economic, Social and Cultural Rights
Children's Rights Convention	Convention on the Rights of the Child: International treaty upholding the human rights of children
CRC	Committee on the Rights of the Child: UN treaty monitoring body charged with monitoring states parties' compliance with the Convention on the Rights of the Child
Concluding Observations	Comments and recommendations issued to the reporting state party by the respective treaty monitoring body
Constitution	The Constitution of India

CPA	Consumer Protection Act
Dalit	Member of the Scheduled Caste (SC) in India
Directive Principles of State Policy	Part IV of the Indian Constitution: non-justiciable principles that guide state administration and formulation of laws and policies
Eclampsia	An often-fatal condition of convulsions and coma during pregnancy or delivery, caused by pre-eclampsia (hypertension during pregnancy)
Fistula (Obstetric or vaginal)	Serious medical condition brought on by inadequate care during childbirth, in which a hole develops between rectum and vagina or between bladder and vagina.
Fundamental Rights	Part III of the Indian Constitution: basic human rights guaranteed as enforceable
GDP	Gross Domestic Product
General Comment	Comprehensive interpretation of a particular article of a treaty issued by the respective UN treaty monitoring body
General Recommendation	Comprehensive interpretation of a particular article of a treaty issued by the respective UN treaty monitoring body.
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HRLN	Human Rights Law Network
Human Rights Committee (HRC)	UN treaty monitoring body charged with monitoring states parties' compliance with the International Covenant on Civil and Political Rights
ICCPR	International Covenant on Civil and Political Rights: International treaty protecting individuals' civil and political human rights
ICESCR	International Covenant on Economic, Social and Cultural Rights: International treaty protecting individuals' economic, social and cultural human rights
ICPD	International Conference on Population and Development: United Nations Conference on population and development issues held in Cairo in 1994
ICPD Program (Programme) of Action	Programme of Action of the International Conference on Population and Development: Consensus document adopted by states participating in the International Conference on Population and Development
JSY	Janani Suraksha Yojana – component of NRHM entailing cash payments to BPL women who obtain certain maternal health services
Maternal morbidity	Illness or disability in women caused directly or indirectly by factors relating to pregnancy, childbirth, or the puerperal (post-delivery) period
Maternal mortality	Deaths of women caused directly or indirectly by factors relating to pregnancy, childbirth, or the puerperal (post-delivery) period

MDG	Millennium Development Goals; eight goals endorsed by governments at the United Nations Millennium Summit in 2000 that range from halving extreme poverty to promoting gender equality and improving maternal health, all by the target date of 2015
MMR	Maternal Mortality Ratio, measured in maternal deaths per 100,000 live births
NFHS	National Family Health Survey
NGO	Non-governmental organization
NHRC	National Human Rights Commission of India
NMBS	National Maternity Benefits Scheme
NRHM	National Rural Health Mission
NPP	National Population Policy
OBC	Other Backwards Class
PHC	Primary Health Center
PIL	Public Interest Litigation
Pre-eclampsia	Condition during pregnancy characterized by hypertension (high blood pressure), fluid retention, and protein in urine.
Prenatal care	Health care given to women during pregnancy, also called antenatal care
RCH–II	Reproductive and Child Health Program, Phase Two, 2005 - 2010
SAARC	South Asian Association for Regional Cooperation
SC	Scheduled Caste (sometimes known as *Dalit*)
Special Rapporteur	An individual appointed by the UN Human Rights Council to investigate, monitor, and recommend solutions to human rights problems
ST	Scheduled Tribe
State party (pl. states parties)	Government that has signed or ratified an international treaty
Suo moto (sua sponte)	On its own motion, without prompting or suggestion
TMB	United Nations treaty monitoring bodies: Committees charged with monitoring states parties' fulfillment of their obligations under the six major international human rights treaties
UN	United Nations
UNFPA	United Nations Population Fund: United Nations agency devoted to funding and supporting population and reproductive health programs in low- and middle-income countries
Universal Declaration	Universal Declaration of Human Rights: United Nations human rights instrument at the foundation of modern international human rights law
WHO	World Health Organization: UN agency devoted to researching and promoting public health worldwide

Introduction

"The challenge to human rights principles is to make the promise of safe motherhood real. The opportunity of advancement through ensuring respect for human rights has been recognized nationally and internationally, and the language of human rights has come to define the best enjoyments of life that countries can offer their populations."[1]

***IN 2005**, the estimated number of maternal deaths worldwide was 536,000.*[2]

***95%** of maternal deaths occur in Asia and Africa.*[3]

More women die due to pregnancy-related causes in India than anywhere else in the world. United Nations (UN) agencies estimate that around 117,000[4] maternal deaths occur in India each year, which make up almost one quarter of the maternal deaths that occur annually worldwide.[5]

The right to survive pregnancy and childbirth is a basic human right. Under international law, the government of India bears a legal obligation to ensure that women do not die or suffer complications as a result of preventable pregnancy-related causes. The staggering scale and continuing occurrence of maternal deaths and morbidity in India reveals the government's failure to protect women's reproductive rights, and comply with international law.

Reproductive rights "rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health." They also include the right of all "to make decisions concerning reproduction free of discrimination, coercion and violence." ***– ICPD Program of Action***[6]

The most common causes of maternal mortality and morbidity are widely known and include a range of medical, social and health system-related factors. The vulnerability of certain subgroups of women to pregnancy-related mortality and morbidity based on other health conditions, income, caste and age has been documented, making it possible to assess the risk of mortality in specific populations. Policies aimed at reducing maternal mortality have been in place for decades, but as the current situation shows, they have not had substantial impact.

The UN estimates that for every woman who dies as a result of pregnancy, approximately 30 women suffer injury, infection and disabilities.[7] Complications arising from pregnancy include anemia, infertility, pelvic pain, incontinence and obstetric fistula.[8] While there are no national data on the incidence of maternal morbidity in India, based on this global estimate it may be inferred that the incidence of maternal morbidity is very high, making it an equally pressing concern (see box – *Maternal Morbidity: Fistula, a Neglected Concern,* p. 50).

The absence of legal accountability for maternal deaths and morbidity caused by health system failures, socioeconomic disparities and discriminatory social practices is a major impediment to successfully reducing maternal mortality. Maternal deaths do not only involve a tragic loss of life, but

also cumulatively represent deeply entrenched gender discrimination and social injustice. A nation's maternal health indicators reflect its efforts to uphold and protect women's dignity and basic human rights. A high incidence of maternal mortality indicates a breach of international legal obligations to protect women's most important human rights: their rights to life, health, reproductive autonomy and equality and nondiscrimination. As the nation leading the world with respect to the number of maternal deaths, the Indian government has an immediate obligation to take meaningful steps to dramatically reduce maternal mortality by fully implementing national policies on maternal health and holding those responsible for the failure of its policies accountable.

Scope, purpose and content of the report

This report focuses primarily on maternal mortality as a human rights concern. However, since maternal morbidity can be attributed to many of the same causes that lead to maternal death, the discussion in this report can be applied to address both.

This report is intended to serve as a resource for those interested in using international and constitutional legal norms and mechanisms to establish government accountability for maternal deaths and pregnancy-related morbidity through public interest litigation (PIL) and human rights advocacy. A human right to survive pregnancy implies the need for constitutional guarantees of access to pre- and postnatal health care and emergency obstetric care for all pregnant women, as well as the need for legal protection against discrimination that puts women's physical integrity and reproductive health in jeopardy. By highlighting stories of women who have died giving birth, this report illustrates the connections between their experiences and state action or inaction. Information from studies undertaken by local non-governmental organizations (NGOs) has been used to draw attention to important trends and challenges in implementing maternal health policies. Some of these studies contain data that may be used as a basis for public interest litigation. Finally, this report showcases a few important legal initiatives being undertaken in parts of India that seek accountability for maternal deaths and morbidity in order to inspire further action.

Structure of the report

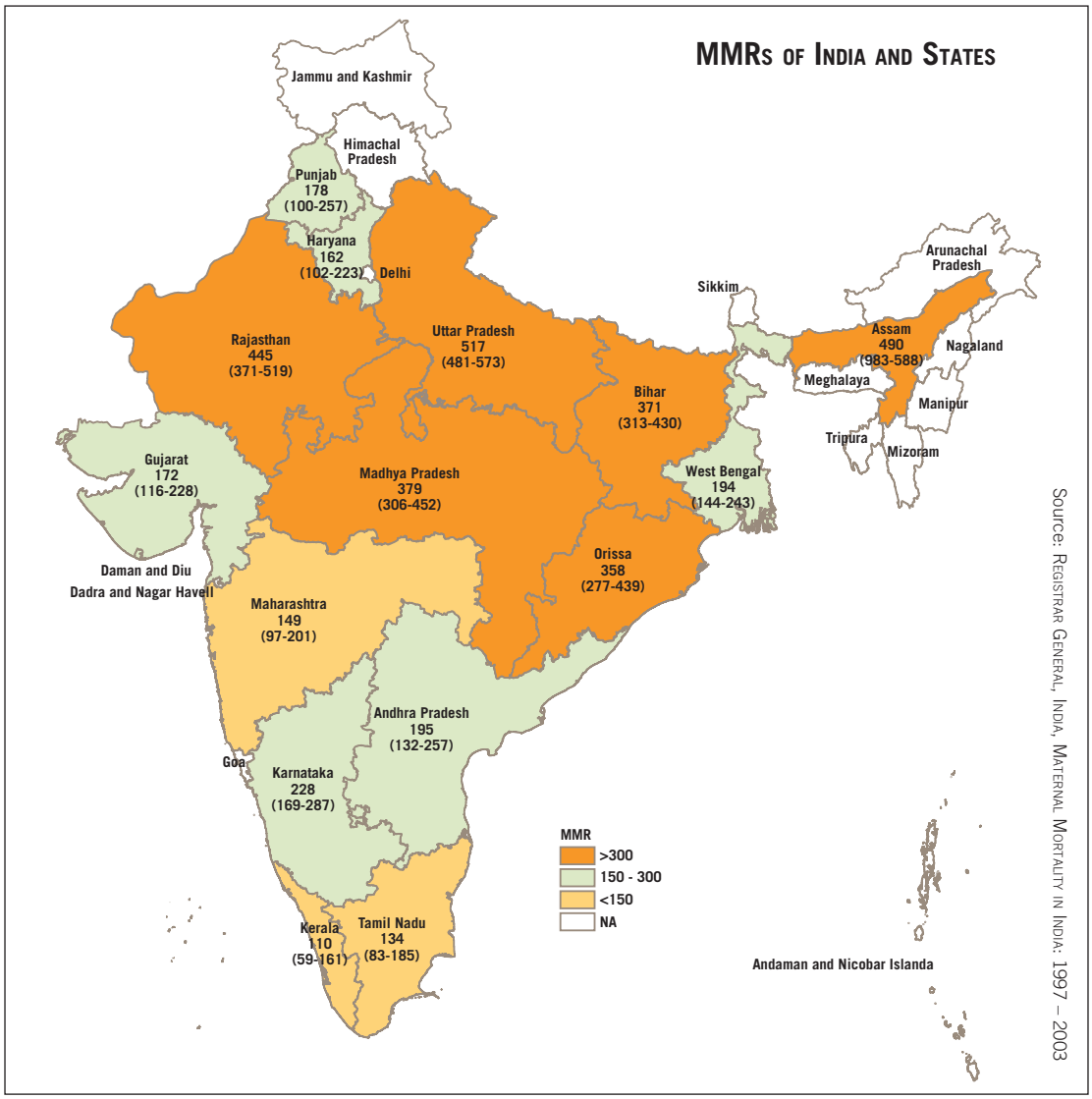
The report is divided into four interrelated chapters. Chapter One contains an overview of the situation of maternal health in India and discusses some of the common causes of maternal mortality and morbidity. Chapter Two presents the international human rights standards that support a woman's legal right to survive pregnancy and key observations made by treaty monitoring bodies and independent experts. Chapter Three discusses constitutional principles and leading examples of Indian Supreme Court jurisprudence that may be used by lawyers, judges and activists in conjunction with international human rights principles to claim constitutional protections for pregnant women through PIL and human rights advocacy. Chapter Four contains recommendations for lawyers, judges, legal academics and maternal health activists for working in collaboration to promote a human rights approach to maternal health.

Maternal death is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."[9]

CHAPTER I. THE SITUATION IN INDIA

Maternal mortality: An ongoing crisis

In India, roughly one maternal death occurs every five minutes.[10] According to the government, these deaths account for 15% of all deaths of women of reproductive age.[11] Data from the most recent National Family Health Survey (NFHS-3) suggest that the maternal mortality ratio has fallen from approximately 400 deaths per 100,000 live births in 1997 to 301 deaths per 100,000 live births in 2006,[12] but UN agencies put the true number much higher, estimating 450 deaths per 100,000 live births.[13] The quantitative decline presented in the NFHS-3 is somewhat misleading because it does not reflect disparities in maternal mortality ratios (MMR, measured in maternal deaths per 100,000 live births) among states and by income. MMR levels exceed the national ratio in certain geographic areas and are of greatest concern in the northern, central and eastern states. (See map below.)



The National Ministry of Health reports an MMR of 517 in Uttar Pradesh and 445 in Rajasthan,[14] while unofficial estimates of the disparities are higher still, suggesting that the MMR may be up to 700 in parts of Uttar Pradesh and Madhya Pradesh,[15] and 898 in some parts of Jharkhand.[16] Overall, maternal mortality is much more prevalent in rural India, where the UN estimates the MMR to be 619.[17]

Documentation: The data gap

Gaps in estimates of the number of deaths and the dearth of qualitative data may be attributed to the absence of an official registration and auditing system for maternal deaths.[18] Such deaths are not routinely reported or recorded by health authorities, making it difficult to determine the real number of deaths at any given time or examine the underlying causes.[19] Some providers are reluctant to officially record a maternal death for fear of being blamed for the death.[20] In response to the lack of accurate and complete national government data on maternal mortality, several forms of maternal death auditing have been developed as accountability measures in India, including the United Nations Children's Fund's (UNICEF) Maternal and Perinatal Death Inquiries and Response (MAPEDIR) "verbal autopsy" method and the Academy of Nursing Studies' (ANS) maternal death social audit. State governments are particularly well placed to undertake such studies; one example of a state addressing the national government's failure to document maternal deaths is Tamil Nadu's Maternal Death Audit reporting system. (See box below.)

AUDITING METHODOLOGIES: LINKING QUALITATIVE DATA WITH LEGAL STRATEGIES

Localized studies implemented through various methodologies offer invaluable perspectives on the incidence and nature of maternal deaths. As the examples below show, such audits have been undertaken in different parts of India by public health organizations, social scientists, community members and state governments.

MAPEDIR: To combat underreporting of deaths and the obscurity of underlying causes of maternal mortality, UNICEF introduced the Maternal and Perinatal Death Inquiries and Response (MAPEDIR) "verbal autopsy" method in 2006.[21] Volunteers gather information on the personal, familial, social and community factors that contributed to maternal deaths through confidential one-on-one interviews with members of communities with family members and health care workers in high-risk districts.[22] The data gathered is aggregated, periodically analyzed and then reported back to the district health workers.[23] MAPEDIR is aimed at increasing community participation and awareness of maternal mortality.[24]

ANS's Social Audit: The Academy of Nursing Studies (ANS) sought to document the comprehensive causes of maternal death through social audits of every single maternal death reported in Andhra Pradesh in 2006. Preliminary interviews were conducted with family members and health workers for each deceased woman, identifying the woman's medical and socioeconomic history. From those, 30 cases representing a confluence of socioeconomic factors and health system failures were identified, and follow up interviews were done two years after the death of the woman to see the impact of the death on the family. For more information on the ANS social audit, refer to box, p. 25.

Tamil Nadu's Maternal Death Audit: To gather information on the causes of maternal mortality and morbidity, in 2000 Tamil Nadu implemented a system where all maternal deaths are reported within 24 hours directly to the Commissioner of Maternal and Child Health and Family Welfare by the field

health officers, Anganwadi workers, and PHC medical officers.[25] Following the report, the district level investigation team in that district ensures that a detailed medical report is submitted by an obstetrician within 15 days, interviews the deceased's relatives and interviews staff and reviews records at the health facility or facilities where the woman received care.[26] The findings are reported to the health staff in that facility, and reviewed at the district level monthly and annually. The state secondarily reviews cases selected at random monthly.[27]

International bodies have noted the value of studies that reveal high maternal mortality rates by observing that they provide "an important indication for States parties of possible breaches of their duties to ensure women's access to health care."[28] Such data can also be a strong basis for initiating public interest litigation and developing human rights advocacy strategies to ensure state accountability for maternal deaths.

Leading causes of death and morbidity

Data generated by audits and other studies reveal the leading causes of maternal mortality and morbidity as composed of medical, socioeconomic and health system-related factors. The fact that most deaths occur among low-income women with little or no formal education, women belonging to scheduled castes and tribes, and adolescent girls locked in child marriage reveal that multiple forms of discrimination underlie these deaths. As shown by the case studies presented in this chapter, maternal deaths rarely occur due to one isolated cause; multiple foreseeable and preventable factors often converge to cause a maternal death.

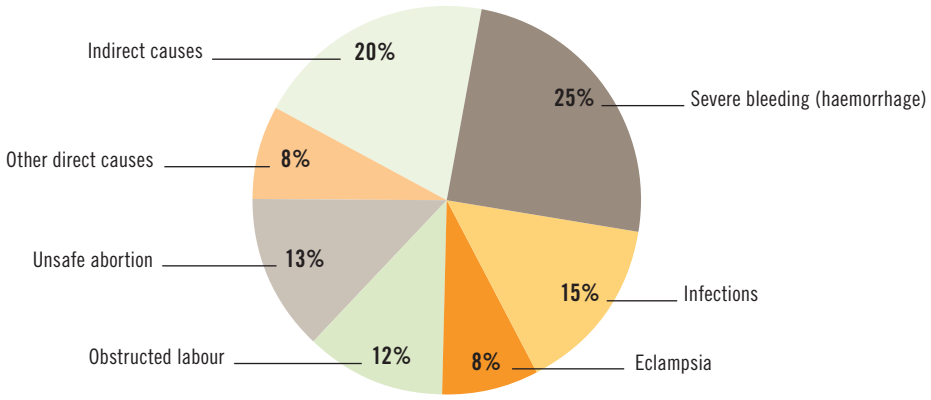
Medical Causes

The most common direct medical causes of maternal death around the world are hemorrhage, obstructed labor, infection (sepsis) and hypertensive disorders related to pregnancy, such as eclampsia.[29] These conditions are largely preventable and once detected, they are treatable. Complications from unsafe abortion are another common and preventable direct cause of maternal death.[30] The NFHS-3 and other studies confirm the widespread prevalence of these causes of maternal mortality in India.[31]

In India as well as globally, a significant portion of maternal deaths are ascribed to "indirect causes." (See chart, p. 14.) "Indirect causes" are those conditions or diseases that can lead to complications in pregnancy or which are aggravated by pregnancy.[32] In India, common "indirect causes" of maternal death are anemia, malaria and HIV/AIDS. However, many "direct" causes of death – such as hemorrhage – are themselves symptoms of an underlying "indirect" cause such as anemia, as will be described below.

Anemia and unsafe abortion are deserving of special note, as these two causes of maternal death are more common in India than they are in much of the world. As such, a closer look at those two phenomena can reveal certain root causes of maternal mortality that are especially prevalent in India.[33]

CAUSES OF MATERNAL DEATH – WORLDWIDE



Source: *The World Health Report 2005. Make every mother and child count.* Geneva, World Health Organization, 2005.

Anemia and malnutrition

Anemia, a condition associated with poor nutrition, leads to a "several-fold increase in the risk of a mother dying in childbirth."[34] The NFHS-3 and other studies indicate the notable prevalence of anemia as a cause of maternal mortality in India,[35] a factor not as common in other countries.[36] Anemia is a contributory factor in maternal deaths caused by hemorrhage, septicemia and eclampsia, and when severe can even cause cardiac arrest.[37] The percentage of maternal deaths caused by hemorrhage is greater in India than in the rest of the world and has been attributed to higher rates of anemia in Indian women.[38] Pregnant women who are anemic face multiple health risks in addition to the risk of maternal death. Anemic women are increasingly susceptible to communicable diseases such as tuberculosis (TB) and malaria,[39] which are associated with adverse outcomes during and after pregnancy.[40] Anemic women face the further risk of falling into a cycle of multiple pregnancies in their efforts to have children that survive, since nutritional deficiencies during pregnancy notably reduce the chances of infant survival.[41] In India, anemia is far more prevalent in women than in men, with the NFHS-3 reporting that 55% of women have anemia, as compared to only 24% of men.[42] Other studies place the prevalence of anemia in pregnant women in India as high as 85%.[43] In 2004, at least 22,000 maternal deaths were directly attributable to anemia.[44] Most troubling is the fact that the NFHS-3 reveals that the incidence of anemia among women in India has worsened over the past ten years.[45]

The prevalence of anemia in females in India has been noted by UNICEF to be a symptom of gender-based discrimination in access to food, nutrition and health care throughout the life cycle.[46] Childhood malnutrition predisposes girls to anemia,[47] but it can also stunt growth, which can then put girls at further risk of maternal mortality – as a result of obstructed labor – later in life.[48] World Bank experts have concluded that rates of child malnutrition in India are nearly twice as high as in sub-Saharan Africa[49] – the poorest part of the world – and UNICEF has attributed this fact to South Asia's deeply entrenched gender inequalities, which are a direct cause of poor maternal health.[50]

Complications from unsafe abortion

Complications from unsafe abortion account for a significant proportion of maternal deaths in India. According to the government, around 9% of total maternal deaths are caused by unsafe abortion,[51] but medical experts put the figure at almost 18%;[52] higher than the global average of 13%.[53] Although abortion is legally permitted on several grounds, each year approximately 6.7 million

abortions occur outside of government-recognized health centers, often in unhygienic conditions or by untrained abortion providers.[54] This problem disproportionately affects adolescents, as unsafe abortions account for *half* of all maternal deaths of women aged 15-19.[55] Most women in India are not able to obtain legal abortions for multiple reasons, including a dearth of information about safe abortion services;[56] inconsistent and prohibitive costs;[57] a shortage of trained providers and adequate equipment;[58] lack of confidentiality and informal demands for spousal consent;[59] poor access to facilities; [60] and lack of knowledge about the legal status of abortion – one study showed that only 9% of Indian women knew that abortion was legal.[61]

Socioeconomic factors

A higher incidence of mortality and morbidity is found to occur among woman and girls who are poor[62] or low-income, less educated and belong to socially disadvantaged castes and tribes. Child marriage puts young girls and adolescents at significant risk of pregnancy-related complications and mortality. Pregnant women living with HIV/AIDS experience an increased risk of pregnancy-related fatalities due to outright discrimination.

Poverty

Poor women are more susceptible to maternal death and morbidity than those economically well off. Of the 595 million of the world's poor that live in South Asia,[63] 455 million are in India.[64] India's population is over one billion, and while official government statistics show that 27.5% of the population lives below the poverty line,[65] this statistic belies the fact that almost half of the populace lives on less than $1.25 per day and 75% of India's population lives on less than two dollars per day.[66] An estimated 70% of the country's poor are women.[67]

The affordability of reproductive health services for women is a major concern. The burden of high out-of-pocket expenses for reproductive health care has been identified as a leading cause of poor reproductive health outcomes among low-income women in South Asian countries, including India.[68] This trend may be attributed to the fact that the government spends less than 1% of its Gross Domestic Product (GDP) on health which in turn has led to insufficient access to health care services and poor quality of care.[69] Consequently, hospitalization is frequently a cause of debt among the poor, which in turn leads to increased poverty.[70] In terms of barriers faced specifically by poor women to maternal health care, studies point to their increased likelihood of receiving a lower quality of care than rich women, which serves as a deterrent against seeking institutional health care, leading to higher risk of pregnancy-related complications and mortality.[71] Consequently, in India, the poorest women have significantly less access to antenatal health care than rich women.[72]

A regional study by the World Bank confirms that many of the conditions contributing to maternal death and morbidity are experienced more acutely by poor girls and women. For instance, in India, almost twice as many of the poorest rural girls aged 15-19 years of age are married compared with the richest;[73] and anemia is 25% higher among the poorest rural adolescent girls than among the more affluent.[74]

Illiteracy

Education level has been noted by experts as one of the most important indicators of women's status related to maternal mortality, in light of its affects on fertility rates and access to employment

and health care.[75] Female education and female literacy rates are strongly correlated to high rates of maternal mortality around the world.[76] Some national-level comparisons show that literacy is a stronger predictor of maternal health than economic wealth.[77] Lack of education adversely affects women's health by limiting their knowledge about nutrition, birth spacing and contraception.[78] This is particularly evident in India, where a woman's level of education strongly correlates to many indices of maternal health, including fertility rate, utilization of prenatal care, met need for contraception and higher age at first birth.[79] Furthermore, studies in India show that education level is a key determinant of the quality of care received by women in health care settings, and that illiterate women tend to experience significantly lower interpersonal quality of care in health facilities.[80]

Child Marriage

Child marriage is linked, both directly and indirectly, to maternal death and morbidity worldwide.[81] That is an especially relevant problem in India, where according to the NFHS-3 almost 50% of girls are given away in marriage before age 18.[82] An estimated 50% of maternal deaths in India occur before age 25,[83] and states with high rates of child marriage also have high rates of maternal mortality.[84] For instance, Uttar Pradesh, Madhya Pradesh and Rajasthan all have higher rates of child marriage than the national average, as well as higher-than-average rates of maternal mortality: 707, 498 and 670, respectively.[85]

THE DEATH OF SYEDA RIZWANABI: EARLY MARRIAGE AND CHILDBEARING

July 20, 2006, Andhra Pradesh: Syeda Rizwanabi was given away in marriage at 15 years of age, and she conceived three months later. Syeda registered her pregnancy during its third month and underwent three checkups with the Auxiliary Nurse Midwife (ANM), who informed her that she had high blood pressure, anemia, and edema. Anemic and weak, Syeda was advised to have a diet low in salt and low in meat. Syeda was also told that due to these conditions her delivery was likely to be complicated. Syeda was very young and not able to fully comprehend the seriousness of her situation. She continued to eat meats and high-sodium pickles, which were among her favorite foods. In the final month of her pregnancy, Syeda went for a routine checkup with her mother-in-law, as her husband was out of town. The doctor advised Syeda's mother-in-law to admit her to a hospital, but she ignored this advice and took her home. That night, Syeda started to suffer severe pains. She was later admitted to a hospital, but by then it was too late. Syeda began to have convulsions and suffered cardiorespiratory failure during labor and died.

Source: Academy for Nursing Studies, *Case Study: Syeda Rizwanabi* (2006) (on file with CRR)

Examples of human rights violated

Right to life: Syeda died when she was 15 due to foreseeable causes associated with early childbearing. The right to life obligates states to take steps to protect women against the unnecessary loss of life due to complications from pregnancy and childbirth.

Right to health: Syeda's health was compromised by an early pregnancy and delayed medical care at the time of delivery. The right to health is violated when adolescents lack the information and means available to protect their health.

Right to equality and nondiscrimination: Syeda's early marriage resulted in early pregnancy and her youth impeded her ability to comprehend her situation and take precautions. The Committee on the Elimination of Discrimination Against Women (CEDAW Committee) has identified 18 as the appropriate age for marriage due to the health risks associated with early marriage and childbearing.

COMPLICATIONS FROM PREGNANCY AND CHILDBIRTH *are the leading cause of death for young women and girls between the ages of 15 to 19 in developing countries.*[86]

The high incidence of maternal mortality among adolescents in India exposes more broadly the fact that adolescents lack access to reproductive health services and information, especially relating to fertility control, as well as a cultural dynamic that disregards the risks of unplanned pregnancy and childbearing for adolescents. Even if an adolescent girl bears a child at a young age and survives, her lifetime risk of maternal death is increased, as girls given away as child brides often find themselves trapped in poverty with no access to education, and both factors significantly increase the risk of maternal mortality later in life.[87] Young girls belonging to the officially designated scheduled castes and scheduled tribes have the lowest mean age at marriage among all social groups in India[88] and are therefore more vulnerable to pregnancy-related complications and death.

Caste and tribe

Traditionally disadvantaged groups are formally recognized by the government as "Scheduled Caste" (SC, also known as *Dalit*), "Scheduled Tribe" (ST) and "Other Backwards Classes" (OBC). Together, the SC/ST comprise about 24% of the Indian population.[89] However, studies show that while the SC make up only 16% of India's population,[90] it is estimated that they represent at least 25% of all maternal deaths.[91]

Caste and tribe are not simply levels of stratification, but are major social determinants of access to education[92] and other resources. This has been referred to as the "class-caste nexus"[93] and is characterized by the accumulation of power by a few groups and the political marginalization and cultural subordination of other groups.[94] Under this system, traditionally disadvantaged groups, especially women, have less access to resources and education, and as a result have very little upward mobility within the class structure.[95] The inability to access resources and health care facilities is further exacerbated by high rates of malnourishment, hunger,[96] poverty, unhygienic living conditions (such as homes lacking toilets or access to clean water) and systematic deprivation of health care, such as lack of childhood vaccinations.[97] Consequently, the majority of maternal deaths in India occur among women belonging to these social groups.[98] Although SC, ST and OBC Indians are entitled to special protection under the constitution,[99] official policies meant to prevent and ameliorate systemic discrimination against those groups have not resulted in better maternal health indicators.

Pregnant women living with HIV/AIDS

There is notable anecdotal evidence to suggest that pregnant women living with HIV/AIDS in India are at enormous risk of being provided with substandard maternal health care,[100] or even to be denied care entirely (see box - *The Death of Gita Bai*, p. 18). Although the actual scope of this problem is yet to be determined, compelling cases have surfaced revealing the vilification, discrimination and outright abuse that pregnant women are forced to endure when they attempt to seek reproductive health care, even at such a critical time as childbirth. It is estimated that between 2 and 3.6 million people in India are living with HIV or AIDS,[101] with women making up a significant—and increasing—portion of this total.[102] Denial of institutional health care can be especially devastating for pregnant women with HIV/AIDS since they are predisposed to a higher risk of complications[103] and other infectious diseases, such as tuberculosis[104] and malaria.[105] They are also susceptible to a higher risk of complications from the infections that can occur when forced to deliver in unhygienic conditions.[106] These women face an increased risk of pregnancy-related discrimination and, as a result, mortality, on account of the stigma associated with HIV/AIDS and ill-equipped health systems that inhibit providers in public health facilities from treating patients living with HIV/AIDS.[107]

THE DEATH OF GITA BAI: DISCRIMINATION AGAINST WOMEN LIVING WITH HIV/AIDS

April 3, 2007, Madhya Pradesh: Gita Bai was a member of the Banjara community (OBC) and a mother of two children aged five and three. She arrived at MY Hospital, Indore, with her husband and other family members, to deliver a baby from her third pregnancy on March 31. She was referred to MY Hospital by the doctor in her village. Upon arrival, she was examined and referred to the labor department by the chief medical officer. She was told to leave the hospital after the doctors reviewed her medical history and found out that she was HIV positive. The HIV had been diagnosed during her third pregnancy. Gita Bai's family begged the doctors not to send Gita Bai away; she was already in pain and on the verge of delivering her baby, but the doctors ignored their pleas. They even failed to provide Gita with nevirapine to avoid the risk of transmission of the virus to her newborn. Gita delivered a baby girl outside the hospital, without any medical assistance. After delivery, Gita tried to re-enter the hospital, but was prevented from doing so by the hospital staff, who used physical force to keep her out. When Gita Bai returned two days later for the treatment of complications, she was admitted to the hospital, but continued to be neglected by the doctors on duty. Gita eventually died on April 3, due to sepsis and excessive bleeding, two of the most common causes of maternal death.

Source: Human Rights Law Network, *Gita Bai* (2007) (on file with CRR)

Examples of human rights violated

Right to life: Gita was outrightly denied medical assistance at the time of delivery, which eventually led to her death from foreseeable and preventable causes. The right to life obligates states to take steps to protect women against the unnecessary loss of life due to pregnancy and childbirth.

Right to freedom from cruel, inhuman and degrading treatment: Gita Bai was denied essential obstetric care at the time of delivery. The right to life and human dignity requires state actors to refrain from causing physical and mental trauma to individuals by denying them essential medical care, as that may be considered cruel, inhuman and degrading treatment.

Right to health: Gita Bai was denied health care required to ensure a safe delivery and to prevent the transmission of HIV/AIDS to her newborn. Governments are obligated to ensure that women have access to a full range of high-quality reproductive health care and must remove barriers that prevent access.

Right to equality and non-discrimination: Gita Bai suffered blatant discrimination on account of her HIV/AIDS status. Governments are obligated to ensure that the right to health is guaranteed without discrimination of any kind.

Health-System-Related Factors

Essential reproductive health services are not available to the majority of women in India. The National Human Rights Commission (NHRC) reports that a mere 30% of the population receives services through the public health system.[108] The unavailability of basic reproductive health services including contraceptives, pre- and postnatal care and emergency obstetric care, as well as delays in seeking institutional care and the poor quality of care provided in government hospitals, have contributed dramatically to maternal deaths.

Inadequate access to methods of family planning and information

High maternal mortality rates correlate strongly with inadequate access to family planning information and services.[109] Unwanted pregnancies expose women to significant risks to their maternal health, including complications from unsafe abortions[110] (see "Complications from unsafe abortion," p. 14) and high-risk pregnancies. Studies show that women facing unwanted pregnancies are far more likely to seek induced abortions, including illegal abortions, and are much less likely to receive adequate prenatal care.[111]

The UNFPA estimates that one in three deaths related to pregnancy and childbirth could be avoided if all women had access to contraceptive services—meaning some 175,000 maternal deaths, and even more cases of maternal morbidity, could be prevented annually worldwide.[112] Women with the least access to contraceptive services, including young and poor women, have particularly high rates of maternal mortality.[113]

A regional study by the WHO confirms that women in India do not have access to a wide choice of contraceptives, particularly modern, nonpermanent contraceptives, leading to unwanted pregnancies that are poorly managed or often to unsafe abortions.[114] The inadequacy of contraceptive use is revealed by the NFHS-3 which shows that in India almost a quarter (21%) of all pregnancies that resulted in live births were unplanned and unwanted when the woman became pregnant.[115] Only 56% of Indian women use any method of contraception, and even less (49%) use modern forms of contraception.[116] More importantly, the use of modern contraceptives varies widely across states, and is as low as approximately 29% in Uttar Pradesh and Bihar,[117] 27% in Assam[118] and even lower at 18.5% in Meghalaya[119]—all "high focus states" under the National Rural Health Mission (NRHM).[120]

Unavailability of care

Even the most basic maternal health services lie beyond the reach of the majority of women in India.[121] Less than 50% of women give birth with the assistance of a skilled attendant and only 40% of deliveries occur in an institutional setting.[122] Although the WHO recommends that women receive four antenatal checkups during pregnancy[123] and the Indian government has promised to ensure that women are provided four checkups through the NRHM,[124] less than three-quarters of women in India receive any antenatal examination at all.[125]

Access to maternal health care varies greatly by state. In West Bengal over 90% of women receive at least one prenatal examination, while in Bihar that number is only 34%.[126] Low-income and rural women fare worst in both access to and quality of care.[127] A poor woman in India is much less likely than her affluent counterpart to have a skilled birth attendant assist her delivery.[128]

Likewise, there is a disturbing gap in the number of women who receive postnatal care. The NFHS-3 reveals that less than only 36.4% of women across the country receive postnatal care within two days of delivery.[129] One expert study contends that "half the [maternal] deaths could have been avoided if the health system had been alert and accessible."[130] While many factors affect the availability of care, studies show that in Indian primary health centers, absenteeism and poor quality of care are the norm.[131] For example, in one part of Rajasthan, community health centers are closed during 56% of regular opening hours.[132]

THE DEATH OF SUMITRA DEVI: POOR QUALITY OF CARE

December 15, 2007, Uttar Pradesh: Sumitra Devi was a 28-year-old poor, illiterate, *Dalit* woman, and a mother of three children. She was in the final term of her pregnancy and in overall good health when she experienced the onset of labor pains. She proceeded to the nearest Primary Health Center (PHC) by foot and rickshaw. Once admitted, she was given three injections by the ANM, which injections her family had to purchase from a pharmacy and bring to the hospital. Sumitra inquired about the purpose of the injections and was told that they would help her deliver quickly. Sumitra was at the PHC for four hours with no doctor present. Sumitra's family made several requests to the ANM for a doctor to be called, but they were told that none were available. Sumitra was given a total of 14 injections during this four-hour period by the ANM, a few of which were inserted with a bottle of glucose, without an explanation as to why so many injections were necessary. Sumitra felt very uncomfortable and she started to scream. The ANM swore at her and slapped her, accusing her of shouting without any reason. Shortly thereafter, Sumitra's entire body went cold. The ANM told the family to remove Sumitra from the bed and lay her on the floor. She told them to pay the medical fees and take Sumitra elsewhere, but she was already dead. Sumitra's family took the dead body home.

Source: SAHAYOG, *Case Study: Sumitra Devi* (2007) (on file with CRR)

Examples of human rights violated

Right to life: Sumitra died due to the poor quality of care and inappropriate handling of her case. The right to life obligates states to take steps to protect women against the unnecessary loss of life due to causes relating to pregnancy and childbirth.

Right to freedom from cruel, inhuman and degrading treatment: Sumitra was physically and mentally traumatized by the ANM's mishandling of the case and the physical and verbal abuse. The right to life and human dignity requires states to ensure that individuals are protected from cruel, inhuman and degrading treatment caused by acts leading to physical pain and mental anguish.

Right to health: Sumitra was not examined by a doctor, despite several requests by her family. The inappropriate care she received from the ANM, which included 14 injections in four hours, directly threatened her health and most likely led to her sudden death. Governments are obligated to ensure that health facilities, goods and services are scientifically and medically appropriate and of good quality, which includes ensuring the availability of skilled providers.

The three delays

Most maternal deaths are attributable to the 'three delays': the delay in deciding to seek care, the delay in reaching the appropriate health facility, and the delay in receiving quality care once inside an institution. The first delay, the delay in deciding to seek care, can occur due to inadequate resources, poor access to high-quality health care and lack of awareness at the household level of the importance of maternal health care.[133] Studies in areas of West Bengal and Orissa show that in 20-50% of maternal death cases, the women never sought formal health care at all, mostly because of the misperception that the woman was not sick enough or that symptoms such as blood loss are normal.[134] The first delay can also be caused by a woman's lack of decision-making power within her household. In those cases, when a woman has decided to seek care, she can suffer life-threatening delay if she requires the permission of her husband, mother or mother-in-law in order to receive care.[135] The second delay refers to lack of access to obstetric care. Lack of access can mean that appropriate facilities do not exist or are not physically accessible; or it can mean that financial, sociocultural or infrastructural barriers – such as impassable roads or lack of transportation options[136] – prohibit women from promptly gaining access to an existing facility.[137] The third delay typically results

from untimely diagnosis and treatment, poor skills and training of care providers, prolonged waiting time at the facility, shortage of equipment and blood, multiple referrals to different health facilities,[138] and shortages in electricity or water supply.[139] Other systemic factors implicated in the third delay include "the dismissive attitude of some providers [and] an…economic system that puts essential drugs and lifesaving equipment beyond the financial means of most hospitals."[140] Basic omissions in hospitals can lead to the third delay: one recent study found that despite the fact that eclampsia is the second most common cause of maternal death, health facilities in parts of the country do not stock the standard treatment for eclampsia, magnesium sulfate.[141]

Poor quality of care

Poor quality of care is a major concern not only because it is a major cause of maternal death and complications, but because it can lead to the underutilization of maternal health services among pregnant women, especially antenatal care.[142] Studies show that pregnant women may be deterred from utilizing health services due to poor clinical quality of care or interpersonal quality of care. Clinical quality of care is measured by factors such as the availability of appropriate physical examinations and tests and information about the dangers signs of pregnancy and delivery.[143] Interpersonal quality of care relates to a health service provider's behavior towards a client such as the amount of time spent with the client, demeanor and respect for privacy.[144] Public health facilities and providers have been shown to offer measurably worse services than private practitioners.[145] The situation in public clinics has been described by experts as "disastrous," insofar as doctors do not spend adequate time with their patients and, in some public clinics, barely ask their patients any questions, and if they do at all, it is done in a rude manner.[146] (See box – *The Death of Sumitra Devi,* p. 20.) Geographic location is a key determinant of quality of care as indicated by studies that reveal major differentials in the quality of maternal health care offered in Northern and Southern India.[147] (See box below.)

DISPARITIES IN QUALITY OF MATERNAL HEALTH CARE IN THE NORTH AND THE SOUTH

The disparities in maternal health care between North and South India are striking. These are not just disparities of access to health care, but of quality. According to an analysis of government data, while 93% of women in Southern India receive at least some form of antenatal care, only 43% of women in North India do. Further, even when Northern women do receive antenatal care, the quality of care is measurably worse than in Southern states. Among women who did receive antenatal care, the following disparities were reported:

- Only 40% of pregnant women in the North had their blood pressure measured, as compared with 87% in the South.
- Less than one third of women in the North had their weight measured in at least one of their antenatal visits, compared with 80% of women in the South.
- Only 40% of women in the North had their blood examined, compared with 79% in the South.
- Only 38% of women in the North had their urine examined, compared with 77% in the South.
- Only 23% of women in the North received information on danger signs during pregnancy and delivery care, compared with 44% in the South.
- Only 60% of women in the North were given iron and folic acid supplements, compared with 91% in the South.

Source: Manju Rani et al., *Differentials in the quality of antenatal care in India,* Int'l Journal for Quality in Health Care 3, tbl.1 (2007). This study used data from the NFHS in 1998-99, and studied four South Indian states (Andhra Pradesh, Karnataka, Kerala and Tamil Nadu) and four North Indian states (Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh).

National Targets and Initiatives

While it has been argued in the past that maternal mortality had taken a backseat in India to population control policies and child mortality reduction programs,[148] more recently the issue has received "meaningful national political attention."[149] In 2005, Prime Minister Manmohan Singh highlighted maternal mortality while calling for a commitment to holistic public health: "While we all are truly proud of our accomplishments in medical science and technology…[our] health indicators… do not do us proud…. Our maternal mortality rates…are unfortunately among the worst in the world."[150] That coincides with increased global attention to maternal mortality as demonstrated through the adoption of the Millennium Development Goals (MDGs) by world leaders in 2000, which include a global promise to reduce maternal mortality by three quarters by the year 2015.[151] This promise reinforces maternal mortality reduction goals agreed upon by the international community at the International Conference on Population and Development in 1994, and in subsequent international conferences. (See box – *Key Benchmarks,* p. 31.)

Under the MDGs, the Indian government made a commitment to bring the MMR down to 200 by 2007, a goal that it was unable to reach, and to 109 by 2015.[152] India's National Population Policy (NPP) 2000 has set the country an even more ambitious target of reducing the maternal mortality ratio to less than 100 deaths per 100,000 live births by 2010.[153] That goal was reiterated in the National Health Policy adopted in 2002.[154]

National Rural Health Mission and Janani Suraksha Yojana

In 2005, as part of its efforts to reduce maternal mortality, the Central Government initiated phase two of the Reproductive and Child Health Program (RCH-II) 2005-2010. The RCH-II has been encompassed within a larger initiative, the National Rural Health Mission (NRHM),[155] for a seven-year term from 2005-2012, which pledges to intensify strategies to reduce maternal mortality, especially in the 18 states that have the worst maternal health indicators.[156]

The NRHM is an ambitious strategy introduced by the government of India to provide health care to rural populations, with a focus on disadvantaged groups such as women and children, by strengthening the public health system, improving service delivery, increasing access to services, ensuring equity, promoting local ownership and advancing accountability. One important goal of the NRHM is to reduce the maternal mortality rate to 100 per 100,000 live births by 2012.[157] A core strategy of the NRHM is the appointment of an "Accredited Social Health Activist" (ASHA) in each village for promoting the use of health services by pregnant women belonging to households certified as being "below the poverty line"(BPL). The ASHAs serve as the main proponents of the Janani Suraksha Yojana (JSY), a financial assistance scheme that offers a cash payment of 700 rupees (approximately $20) to pregnant women who obtain antenatal[158] care during pregnancy, undergo institutional delivery and seek post-partum care. Under the JSY, ASHAs are meant to identify BPL women, register their pregnancies and help them receive services under ANMs, another cadre of workers under the NRHM.[159] The NRHM is charged with providing at least two ANMs to each village.[160] ANMs are trained midwives, while ASHAs are community members who are trained in basic safe pregnancy protocols. The NRHM's maternal mortality reduction strategy is premised upon successful collaboration between ASHAs, ANMs and other community health workers.[161]

All women belonging to BPL households are eligible for JSY benefits if above 19 years of age and for a maximum of two "live births." An exception is made for pregnant women residing in low-performing states who may receive cash incentives for a third "live birth" if "the mother of her own accord chooses to undergo sterilization in the health facility where she delivered, immediately after the delivery."[162] The JSY is funded entirely by the Central Government.

EXAMPLES OF SERVICE GUARANTEES FOR ANTENATAL CARE UNDER NRHM

- Registration of all pregnancies, ideally before the 12th week of pregnancy
- A minimum of four prenatal checkups for each pregnant woman, and a provision of comprehensive services. Checkups will be conducted regularly, starting from when the pregnancy is first suspected, then between the fourth and sixth months, at eight months, and then at nine months.
- During checkups, women will be provided with iron and folic acid tablets and tetanus toxoid (TT) injections, receive nutrition and health counseling, and be provided with other services as needed.
- Women will be tested at a minimum for hemoglobin levels, urine albumin, sugar and syphilis.
- High-risk pregnancies will be identified and managed appropriately, including referrals beyond the PHC if necessary.

Source: Centre for Health and Social Justice, Reviewing Two Years of NRHM, October 2007: Citizens Report

Implementation challenges

Field-based studies undertaken by prominent NGOs located in communities where the NRHM is being implemented reveal significant challenges to the implementation of this program. According to a recent study entitled *Reviewing Two Years of NRHM, October 2007, Citizens Report* (*Citizens Report*), corruption within the health system, the lack of institutional preparedness to provide quality care at the time of delivery, and the inadequate training of health workers were identified as major problems.

Corruption: The inability of pregnant woman to pay the informal demands for money in exchange for services has been identified as a leading cause of maternal mortality in Uttar Pradesh, one of the 18 NRHM focus states. An NGO based in Uttar Pradesh, SAHAYOG, reports that in one sample, out of 68 women who were eligible for payments under the JSY, only seven received any money; in some instances, providers illegally demanded over half of what the women received.[163] The *Citizens Report* reveals that other states, such as Bihar and Chhattisgarh, have had similar issues with corruption and failure to pay women.[164] It appears that JSY is wrongly being seen as a scheme to cover out-of-pocket costs for institutional delivery, which is supposed to be free, rather than as a cash assistance program for nutritional and other support.[165] There also have been reports of ANMs selling state-provided medicines illegally and pocketing the earnings.[166]

Lack of institutional preparedness: Many institutions are increasing promotion of institutional delivery without first addressing or improving the quality of care, which has led to poor services and medical care.[167] Often institutions are not fully staffed or do not offer services for evening births, leading to

women being turned away or being sent to private hospitals where they may incur huge medical costs (exceeding Rs. 20,000).[168] Health centers also have a lack of workable toilets and basic sanitation facilities.[169] Further, referral systems are weak or nonexistent, leading women to be shuttled back and forth between providers with no continuity of care.[170]

Inadequate training of health workers: Health workers are not adequately trained, which leads to mismanagement of delivery cases, such as the widespread, unsupervised use of oxytocin injections before delivery.[171] Another concern, as noted by the Joint Secretary of the Ministry of Health and Family Welfare, is the release of women as soon as six to eight hours after delivery, rather than the prescribed 48 hours.[172] An Uttar Pradesh study found that when women saw an ANM for prenatal care, their checkups only included iron folate tablets and tetanus injections, with no further examination or testing.[173] Most of the women in this study did not receive any advice from ASHAs or ANMs, and none of the women polled received a postpartum visit from an ANM within two days of birth.[174]

Problematic aspects of the policy

Certain provisions of the NRHM are problematic insofar as they fail to take into account circumstances that deny women the ability to control when, under what circumstances and how often they become pregnant. For instance, the cap on JSY eligibility at two pregnancies ignores the widespread occurrence of unplanned pregnancy among women, which may be attributed in large part to the government's failure to ensure universal access to family planning services and information. The exclusion of adolescents under age 19 as beneficiaries of cash payments under the JSY ignores the high incidence of child marriage in India and the higher risk of complications associated with early childbearing and pregnancy, a situation in which denial of monetary incentives could deter them from seeking health care and increasingly put their lives in jeopardy. Furthermore, making cash incentives conditional on consent for sterilization is a form of coerced sterilization, as women who belong to BPL households are not likely to have the financial ability to reject the cash payment, even if they prefer a nonpermanent method of birth control. The implications of these provisions for women's well-being and basic human rights have been overlooked by policymakers and need to be addressed.

INVESTIGATING MATERNAL DEATHS: ACADEMY OF NURSING STUDIES AUDIT OF MATERNAL DEATH IN ANDHRA PRADESH

Maternal death audits are important because they can be used to determine the factors leading to maternal deaths, and establish policy priorities for change.[175] Audits are not meant to assign blame for past maternal deaths, but rather to facilitate prevention of future deaths.[176]

In 2006, the Academy for Nursing Studies (ANS) initiated an ambitious project to identify every single maternal death that occurred in the state of Andhra Pradesh.[177] What was found to be most striking was the "clustering"[178] of maternal deaths around socio-economic characteristics: income level, social class, age, and education status. In 2007 with the assistance of the Center for Reproductive Rights, ANS undertook a detailed review of 30 cases selected from their state-wide survey to identify key barriers to the availability, accessibility, acceptability and quality of maternal health care in the state.[179]

Of the 30 women studied, almost all were daily wage laborers who were members of the scheduled caste, scheduled tribes, or "other backwards classes."[180] Many women were illiterate or had dropped out of school.[181] Almost half of the women were married at 18 years or younger, and none were older than 25 when they married.[182]

The study revealed that maternal mortality occurred more often in the postpartum rather than prenatal period.[183] Most women had a record of previously successful births; where the pregnant women died, delay or mismanagement seemed to be the main cause of death.[184]

The study found that pregnant women and their families were generally not aware of the health needs and risks during pregnancy and childbirth.[185] But even when pregnant women do seek medical care, they are often not provided with timely care – a delay that can lead to maternal death, and can be caused by negligence, lack of doctors, or strikes.[186] The study further reported that pregnant women and their families are treated with disrespect by providers at various levels and are even verbally abused.[187]

The study found that delays in seeking and providing care occur frequently. Once women arrive in formal institutions, the quality of care is very poor and basic protocols are not followed. However, the pregnant women seeking care and their family members are often too intimidated to question the advice offered by health professionals or their credentials.[188] Within the health care system, multiple referrals are quite common, adding to delays in treatment of complications and in the failure to take responsibility for providing care.[189] Indigent women with complications are referred to secondary or tertiary hospitals without any arrangement for medical fees to be paid or reimbursed by the government, resulting in delays in seeking treatment.[190] Similarly, family members are forced to bear the costs of basic medicines, which can quickly get extremely expensive when complications arise.[191] In addition, family members are often not told of a need for a blood transfusion until it is immediately necessary and are then left without assistance in locating blood, which results in further delay in care.[192]

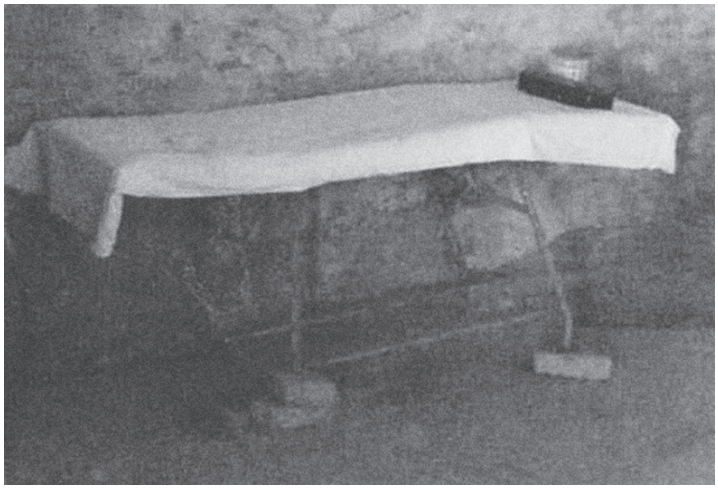
The study showed existing maternal health interventions to be ineffectual.[193] For instance, while ANMs may register pregnancies under the NRHM, this registry does not necessarily lead to improved prenatal care. Similarly, many women were not able to obtain the nutritional support offered under existing government schemes such as the Integrated Child Development Services (ICDS) program.[194]

Overall, the study confirms that maternal deaths are largely preventable mortalities which are caused by failures in the health system and are tied to social discrimination. None of the families had taken any legal action at the time of the survey.

Glimpses of maternal health care realities in India

Primary health care facility, Uttar Pradesh

Toilet in primary health center, Uttar Pradesh



Examination table in primary health sub-center, Uttar Pradesh

Non-functioning hand pump at health center, Uttar Pradesh

Source: Centre for Health and Social Justice, Reviewing Two years of NRHM: Citizens Report (2007)

CHAPTER II. THE HUMAN RIGHTS FRAMEWORK: INTERNATIONAL GUARANTEES, OBLIGATIONS AND MECHANISMS

"The scale of maternal mortality is an affront to humanity…The time has come to treat this issue as a human rights violation, no less than torture, disappearances, arbitrary detention, and prisoners of conscience." ***– Mary Robinson, former UN High Commissioner for Human Rights***[195]

The right to survive pregnancy and childbirth is a basic human right. Support for this right can be found in international legal guarantees of the rights to life, health, reproductive autonomy and equality and nondiscrimination. It is further supported by the right to a legal remedy that is essential for promoting state accountability for preventable maternal deaths. This chapter presents key provisions of international law, as embodied in formal treaties and international policy documents and interpreted by UN treaty monitoring bodies (TMBs) and other independent experts, which establish the scope and content of the right to survive pregnancy and a state's corresponding obligations to protect this right. Global policy statements adopted at the International Conference on Population and Development (ICPD), 1994; the Fourth World Conference on Women, 1995; and the Millennium Development Goals adopted in 2000 have helped establish key benchmarks for measuring state progress on maternal mortality reduction. More recently, the efforts of the former Special Rapporteur on the Right to the Highest Attainable Standard of Health have helped increase pressure on states with high maternal mortality rates to urgently address the issue.

Right to Life

Maternal mortality involves grave violations of the right to life. The right to life is "the most obvious right that could be applied to protect women at risk of dying in childbirth, due to lack of essential or emergency obstetric care."[196] Other related rights that are implicated in maternal deaths are the right to liberty and security and the right to freedom from cruel, inhuman and degrading treatment.

"EVERY HUMAN BEING HAS THE INHERENT RIGHT TO LIFE. *This right shall be protected by law. No one shall be arbitrarily deprived of his life."*
– International Covenant on Civil and Political Rights, art. 6(1)

The right to life obligates states to take measures to safeguard individuals from arbitrary and preventable losses of life.[197] This includes steps to protect women against the unnecessary loss of life related to pregnancy and childbirth[198] by ensuring that health services are accessible.[199] It also requires taking steps to ensure that women are not "forced to undergo clandestine abortions, which endanger their lives"[200] on account of the unavailability of safe abortion services. The Human Rights Committee (HRC) and the CEDAW Committee have repeatedly expressed concern over high rates of maternal mortality,[201] and have explicitly recognized preventable maternal mortality as a clear violation of women's right to life.[202]

Right to Liberty and Security

"EVERYONE HAS THE RIGHT TO LIBERTY *and security of the person…. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law." – International Covenant on Civil and Political Rights, art. 9(1)*

The protection of human liberty and security is essential for ensuring the right to life and a safe and dignified existence. Human rights bodies have recognized this right as providing the basis for a legal duty to provide health services when the lack of services jeopardizes the personal health and security of a person.[203] Deliberating on the right to personal security, the Inter-American Commission of Human Rights has recognized that: "The essence of the legal obligation incurred by any government... is to strive to attain the economic and social aspirations of its people by following an order that assigns priority to the basic needs of health, nutrition and education. The priority of the 'right to survival' and 'basic needs' is a natural consequence of the right to personal security."[204]

Prominent legal and medical experts have noted the development of the right to liberty and security of the person to be "one of the strongest defenses of individual integrity in the reproductive and sexual health care context."[205] Women's liberty and security interests entail formal measures to prevent them from resorting to risky health procedures such as laws governing the standard of medical treatment in clinics and hospitals.[206]

Right to Freedom from Cruel, Inhuman and Degrading Treatment

"NO ONE SHALL BE SUBJECTED TO TORTURE *or to cruel, inhuman or degrading treatment or punishment." – International Covenant on Civil and Political Rights, art. 7*

The protection of human life and dignity calls for respect for the right to freedom from cruel, inhuman and degrading treatment. International human rights bodies and courts have applied this right to require states to provide essential health services to individuals in situations where the refusal to do so may constitute inhuman and degrading treatment.[207] The HRC has explained that the purpose of this provision is to "protect both the dignity and the physical and mental integrity of the individual,"[208] and that it "relates not only to acts that cause physical pain but also to acts that cause mental suffering to the victim."[209] This right was applied by the HRC in the sexual and reproductive health context when it held the government of Peru responsible for causing cruel inhuman and degrading treatment to a pregnant 17-year-old by failing to ensure access to a legal abortion despite a diagnosis of a fatal fetal anomaly.[210]

Based on this view of the HRC, it is plausible to argue that a state should be held liable for violating its duty to protect the life and dignity of pregnant women when it fails to ensure access to essential obstetric care, as the physical and mental anguish resulting from the denial of such care could similarly constitute inhuman treatment.[211]

Right to Health

The right to health is "a fundamental human right indispensable for the exercise of other human rights."[212] It encompasses the freedom to control one's own sexual and reproductive health and an entitlement to a system of health care that enables individuals to "enjoy the highest attainable level of health."[213] This entitlement is recognized as a crucial component of a life with dignity.[214] International law requires states to protect women's health by providing access to "a full range of high quality and affordable health care, including sexual and reproductive services."[215] States are specifically obligated to remove barriers that deny women access to sexual and reproductive health services, information and education.[216]

Standards for the Provision of Health Care

The right to health is comprised of four "interrelated and essential elements"[217] that are often used as standards to assess the provision of health services: (1) availability, (2) accessibility, (3) acceptability and (4) quality.[218]

Availability: For health services to be available, states parties must provide, in sufficient quantity, functional public health facilities, goods and services, as well as programs.[219] Availability includes adequate provision of essential drugs, as defined by the WHO Program on Essential Drugs, necessary to save women's lives during pregnancy. It further includes adequate provision of "underlying determinants of health care"[220] that, as noted by experts, have "a direct influence on access to the health services that are essential for preventing maternal mortality."[221] These determinants include clean water and sanitation, information on sexual and reproductive health, literacy, nutrition and participation in health-related decision-making processes.[222]

Accessibility: This element includes four dimensions: (1) nondiscrimination in services particularly to the most marginalized sections of the population, (2) physical accessibility of health services and the underlying determinants of health such as potable water and adequate sanitation facilities, (3) economic accessibility (affordability) of health facilities, goods and services, including underlying determinants of health for all and (4) information accessibility which includes the right to receive information relating to health.[223] Additionally, accessibility entails that health facilities, goods and services must be provided in a timely manner.[224]

"[E]VERY HUMAN BEING IS ENTITLED *to the enjoyment of the highest attainable standard of health conducive to living a life in dignity." – Committee on Economic, Social, and Cultural Rights, General Comment 14*

Reducing maternal mortality depends on making health services more accessible, including through the expansion of relevant services especially in underserved areas.[225] The Committee on Economic, Social and Cultural Rights (CESCR) has expressed concern about the particularly high rates of maternal mortality among rural women[226] and those who are poor, lack a formal education and belong to indigenous communities;[227] the CESCR has asked states parties to ensure that those populations have access to health care.[228] Ensuring accessibility further requires that states take measures to address discriminatory laws, policies, practices and gender inequalities that prevent women and adolescents from seeking good quality services.[229] The CEDAW Committee has noted that a high maternal mortality rate is indicative of a state's failure to ensure access to health care for women.[230] (See "The Three Delays," p. 20, and "Implementation Challenges," p. 23.)

Acceptability: Under the right to health, states parties are obligated to ensure that "[a]ll health facilities, goods and services must be respectful of medical ethics and be culturally appropriate," as well as being designed to respect confidentiality and be sensitive to gender requirements.[231] This includes ensuring the availability of female providers and doctors where their absence may deter women from seeking health care.

The CEDAW Committee has explained the concept of acceptable services as follows: "Acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives."[232] The obligation to prevent coercion in the sexual and reproductive health context derives in part from this standard. As such, coercive practices including non-consensual sterilization have been deemed by the Committee as a violation of women's rights to informed consent and dignity.[233]

Quality: This essential component of health services requires states to ensure that "[h]ealth facilities, goods and services must be scientifically and medically appropriate and of good quality." Quality includes guarantees to "skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation."[234] (For information on the impact of quality of care on maternal mortality in India, see "Poor Quality of Care," p. 21.)

UN agencies have noted that "[o]ne of the critical pathways of reducing maternal mortality is improving the accessibility, utilization and quality of services for the treatment of complications during pregnancy and childbirth."[235] Stemming from the recognition of this relationship, international agencies have developed a series of indicators that assess different aspects of the provision and use of emergency obstetric care as an approach to monitoring states' progress in reducing maternal mortality.[236] These indicators – which measure geographic distribution of facilities, met need for emergency obstetric care and the proportion of maternal deaths amongst women admitted to facilities with emergency obstetric care services[237] – provide guidance for UN treaty bodies, courts and other bodies charged with evaluating or adjudicating whether states are respecting, protecting and fulfilling their right to health duties.[238] Furthermore, experts have identified concrete steps that can be taken to effectively reduce maternal mortality in significant numbers. (See box below.)

BASIC SOLUTIONS FOR PREVENTING MATERNAL DEATHS AND MORBIDITY

Basic solutions for preventing maternal deaths and morbidity that health systems should provide and which could help prevent almost 75% of all maternal deaths include the following:

- Oxytocin and misprostol for preventing deaths due to hemorrhage, which account for 25% of maternal deaths;
- Caesarean section for preventing deaths due to obstructed labor, which accounts for 12% of maternal deaths;
- Family planning and safe abortion services, including medical abortion and manual vacuum aspiration, for preventing deaths due to unsafe abortion, which accounts for 13% of maternal deaths;
- Antibiotics for preventing deaths due to sepsis/infection, which account for 15% of maternal deaths; and,
- Magnesium sulfate for preventing eclampsia, which accounts for 8% of maternal deaths.

Source for interventions: Family Care International, Focus on 5: Women's Health and the MDGs (Briefing Cards) (unpublished, preview copy, on file at CRR).

Source for percentages of maternal death causes: World Health Organization, The World Health Report 2005, Make every mother and child count (2005).

The duty to ensure maternal health is a core obligation

The urgent need for governments to prevent maternal death and ensure pregnancy survival is underscored by the fact that the CESCR has described the provision of maternal health services as comparable to a "core obligation" under the International Covenant on Economic, Social and Cultural Rights (ICESCR).[239] Governments have an immediate duty to ensure that the right to health is fully realized and enjoyed without discrimination of any kind.[240] That entails taking steps that are "deliberate, concrete and targeted as clearly as possible towards meeting the obligations

recognized in the Covenant."[241] It also includes the duty to introduce policies that are effective, establish key benchmarks and indicators that will allow progress to be measured and to maintain data disaggregated by sex, age and socioeconomic status to ensure that the needs of vulnerable populations are being met.[242] The nature of obligations established by UN treaty monitoring bodies with respect to maternal health indicates that the duty to prevent maternal deaths and ensure pregnancy survival must be a leading priority for governments worldwide.

Maternal mortality reduction has been a priority for the international community for decades.[243] Key benchmarks were adopted at the International Conference on Population and Development, in 1994, which have since been reaffirmed in subsequent international meetings. (See box below.) In 2000, governments adopted the Millennium Development Goals which set a clear target, based on previous commitments, for reducing maternal mortality, by three quarters, by 2015.[244] Unfortunately, as noted by the UN Secretary General Ban Ki–moon, this is the goal toward which the least progress has been made by governments and it is therefore unlikely to be met by 2015.[245] Describing maternal mortality as "unacceptable,"[246] he has called upon governments to do more to "put a stop to these senseless deaths."[247]

KEY BENCHMARKS

By 2015, countries with the highest levels of maternal mortality should aim to achieve a maternal mortality rate of below 75 per 100,000 live births.[248]

By 2015, all primary health care and family planning facilities should aim to provide, directly or through referral, essential obstetric care.[249]

By 2010, in countries where the maternal mortality rate is very high, 50% of all births should be assisted by skilled attendants and, by 2015, that figure should be at least 60%.[250]

Between 1990 and 2015, governments should reduce the maternal mortality ratio by three quarters.[251]

AN ESTIMATED 74% OF MATERNAL DEATHS COULD BE AVERTED *if all women had access to the interventions for preventing or treating pregnancy and childbirth complications, in particular emergency obstetric care.* [252]

Right to Equality and Nondiscrimination

There is no single cause of death and disability for men aged 15 - 44 that is close to the magnitude of maternal death and disability.[253]

Maternal mortality reflects a grave problem of systemic inequality and discrimination suffered by women on account of their reproductive capacity. International treaty law obligates governments to ensure basic human rights without discrimination of any kind.[254] The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) explicitly prohibits discrimination against women in all fields including health care.[255] CEDAW creates a positive obligation on states to introduce special measures of protection for women during pregnancy and explicitly notes that "measures aimed at protecting maternity shall not be considered discriminatory.[256] Deliberating on women and the right to health, the CESCR has highlighted the need for comprehensive strategies for addressing

"[A]LL HUMAN BEINGS ARE BORN FREE *and equal in dignity and rights".*
– Universal Declaration of Human Rights, art. 1.

women's health concerns throughout their life-cycle as a means to eliminate discrimination and stated that a major goal of such strategies should be maternal mortality reduction.[257]

Gender differences are an important determinant of health.[258] The right to nondiscrimination requires governments to recognize and respect the biological differences between men and women, the most distinct examples of which are pregnancy and childbirth.[259] As observed by legal experts, states have a duty to "reasonably accommodate"[260] these differences. In practice that duty may be interpreted as requiring states to ensure the formulation of women-centered health policies and the creation of a health system that includes services that respond specifically to women's health needs. The CEDAW Committee has applied this principle to call for the recognition and fulfillment of women's specific health interests by noting as follows:

> *"Measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect, and treat illnesses specific to women. It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women."*[261]

"DISCRIMINATION AGAINST WOMEN" *is defined as: "any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field." – CEDAW, art.1*

CEDAW requires states to provide appropriate health services to women during pregnancy and after childbirth which should include "free services where necessary and adequate nutrition during pregnancy and lactation."[262] In light of the potential risks posed by pregnancy to women's health and survival, the CEDAW Committee has noted quite clearly the positive obligation of states to "ensure women's right to safe motherhood and emergency obstetric services"[263] and instructed them to "allocate to these services the maximum extent of available resources."[264]

Discriminatory practices and stereotypes

Childbearing imposes "inequitable burdens"[265] on women in relation to access to education, employment and other activities, thereby perpetuating women's inequality in society. This inequality is reinforced by discriminatory social practices such as child marriage and stereotypes about women's role as procreators. CEDAW clearly states that "the role of women in procreation should not be a basis for discrimination"[266] and guarantees women's right to control their fertility by requiring states to ensure women have "the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights."[267] In order to fully address the harmful impact of discrimination on women's health, governments must address the social and cultural causes of maternal mortality by taking steps to "modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women."[268]

Inequality in marriage and family relations

Equality within marriage is a basic human right[269] and essential for ensuring that women and young married girls are able to make important decisions about marriage and pregnancy free from violence and coercion and protect themselves against major health risks. CEDAW instructs states to "eliminate discrimination against women in all matters relating to marriage and family relations."[270] The International Covenant on Civil and Political Rights (ICCPR) obligates states to take affirmative measures to ensure equality in marital relationships.[271] Matrimonial relationships based on

patriarchal norms inherently disadvantage women and make them vulnerable to a host of problems, including early pregnancy and sexual violence. The UN Rapporteur on Violence Against Women has highlighted child marriage as form of violence against women, due to, among other factors, the fact that girls' health and lives are jeopardized by early pregnancy and childbirth.[272]

A woman's age at the time of marriage is a crucial determinant of equality in marriage and pregnancy survival. The CEDAW Committee has identified 18 as the appropriate legal age of marriage for both men and women.[273] Arguments in support of an earlier age of marriage for girls have been rejected by the CEDAW Committee primarily because of the associated health risks.[274] The Committee on the Rights of the Child (CRC) has condemned early marriage as a harmful traditional practice[275] and noted with concern the connection between child and forced marriage and high maternal and infant mortality rates.[276] Respect for the "best interests of the child" standard recognized in the Convention on the Rights of the Child (Children's Rights Convention) requires governments to take stringent action against child marriages and to prevent early childbearing among young girls. (For information on the impact of child marriage on maternal health in India, see "Child Marriage," p. 16.)

Vulnerable subgroups of women

Low-income and rural women, adolescents, women belonging to socially disadvantaged groups and those living with HIV/AIDS are recognized in international law as vulnerable groups who may experience additional barriers and obstacles to health-care services on account of their socio-economic or health status.[277] The CEDAW Committee has noted that societal factors can lead to different outcomes in health status among women and has called for special attention to be given by states to the needs of those who are vulnerable such as young girls[278] and rural women.[279] Governments must ensure that health care services reach those in greatest need by guaranteeing the "equitable distribution of all health facilities, goods and services."[280] CESCR has emphasized the obligation of states to protect the needs of vulnerable populations "even in times of severe resource constraints"[281] through relatively inexpensive programs that target their needs.[282] CESCR has cautioned states that "inappropriate health resource allocation can lead to discrimination."[283]

ADOLESCENTS ARE AT GREATER RISK *of serious pregnancy-related complications such as obstructed labor, which can lead to injury and death for both the pregnant woman and newborn.*[284]

Governments bear a special responsibility to ensure that adolescent girls are able to access health services, in light of the additional barriers and discrimination they may face in accessing health services and related information due to their age. The Children's Rights Convention specifically recognizes the rights of children to the enjoyment of the highest attainable standard of health[285] and obligates governments to ensure adolescents' access to comprehensive reproductive health services.[286] (For information on the maternal health situation of vulnerable subgroups of women, see "Poverty," "Illiteracy," "Caste and Tribe," and "Pregnant Women Living with HIV/AIDS," pp. 15 - 18.)

Right to Reproductive Self-Determination

Women's right to reproductive self-determination finds legal support in international guarantees of the right to determine the number and spacing of children[287] and the right to privacy.[288] This right is based on recognition of the implications of childbearing and rearing on women's physical and mental health[289] and their ability to exercise other basic human rights crucial for their personal development, such as their rights to access education and employment opportunities.[290]

The CEDAW Committee requires governments to ensure that women have the right to control their fertility and to obtain family planning information, counseling and services without discrimination.[291] Protection of women's right to self-determination in the context of pregnancy requires states to take a holistic approach toward women's health and ensure access to a full range of family planning methods and services; access to safe abortion services; the availability of non-biased, medically accurate information about sexual and reproductive health; and safeguards against violations of confidentiality, privacy and quality of care.

Reproductive self-determination further implies the right to be free from all forms of violence, discrimination and coercion that affect a woman's reproductive or sexual life,[292] such as nonconsensual sex and coercive sterilization. The fulfillment of these obligations is essential for protecting women's autonomy, bodily integrity and dignity, which are key attributes of the right to reproductive self-determination. This includes measures to protect women and girls against discriminatory practices such as early marriage. (For information on the impact of lack of reproductive self-determination on maternal mortality among Indian women, see "Complications from Unsafe Abortion," p. 14, and "Inadequate Access to Methods of Family Planning and Information," p. 19.)

Legal remedy

States are obligated under international law to provide legal remedies for violations of human rights. The failure of a state to establish accountability mechanisms and procedures for seeking legal remedies for preventable maternal deaths violates the obligation to guarantee legal remedies for violations of human rights.

The CEDAW Committee has explicitly noted the obligation of states to "respect, protect and fulfill women's right to health care,"[293] which includes the responsibility to "put in place a system that ensures effective judicial action."[294] Noncompliance with this provision is considered to "constitute a violation of article 12" of the Convention.[295] The CESCR has likewise recognized the rights of individuals to legal remedies for violations of the right to health and "adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition."[296] Similarly, the HRC has emphasized the obligation to ensure "accessible and effective remedies"[297] for human rights violations and to take into account "the special vulnerability of certain categories of person."[298] Importantly, it has also noted that "a failure by a State Party to investigate allegations of violations could in and of itself give rise to a separate breach of the Covenant"[299] and that "cessation of an ongoing violation is an essential element of the right to an effective remedy."[300]

Specific obligations of the government of India

UN TMBs have specifically highlighted India's failure to uphold its obligations under international law to protect women's reproductive health and rights. They have consistently expressed concern about the high number of maternal deaths in India as a consequence of the lack of access to appropriate maternal health care services and the poor quality of care that undermines the safety of institutional deliveries. The former Special Rapporteur on the Right to Health has also expressed deep concern about the high incidence of maternal mortality in India.[301]

TMB concerns and recommendations

International treaties have established a formal process for TMBs to measure state compliance with treaty provisions. This is a collaborative process involving government representatives, civil society and treaty experts. India has reported to several TMBs in recent years, including CESCR, the CEDAW Committee, the Committee on the Elimination of All Forms of Racial Discrimination (CERD), CRC and the HRC. Together, those bodies monitor implementation of the entire gamut of civil, political, social and cultural rights, some with a focus on gender, race and age. All of those bodies have issued instructive comments to the government of India concerning maternal mortality and its leading causes that may be incorporated into legal strategies to promote accountability for the denial of health care and discriminatory practices that contribute to maternal mortality.

CESCR

In 2008, the CESCR expressed concern about the high incidence of maternal mortality in India, attributing it mainly to the absence of sex education[302] and the lack of progress in eliminating child marriage.[303] The Committee has urged the government to "expand availability and accessibility of reproductive and sexual health information and services for everyone, and ensure that the educational programmes, including within the school curriculum, as well as services on sexual and reproductive health, are widely available."[304] The Committee has also emphasized the need for stronger measures to eliminate child marriage.[305]

CEDAW

In 2007, the CEDAW Committee expressed deep concern about the high incidence of maternal mortality in India, especially in rural areas, which it noted as being "among the highest in the world."[306] The Committee specifically noted with concern the high prevalence of "malnutrition; anaemia; unsafe abortions; HIV infections" and the "inadequacy of services relating to obstetrics and family planning." [307] The Committee further noted the absence of the reliable health data on women's health status, especially "pregnancy and non-pregnancy-related morbidity and mortality."[308] Based on those concerns, the Committee has urged the government to prioritize maternal mortality reduction by taking action on several fronts, such as establishing mechanisms to monitor access to health care services; creating access to obstetric care services and safe abortion services; and ensuring access to contraceptives.[309]

CERD

In 2007, the CERD specifically noted with concern the relatively high proportion of maternal deaths among women belonging to disadvantaged castes and tribes.[310] The Committee has attributed this to the overall poor state of health care in tribal areas, where services are either absent or of a lower quality than in non-tribal areas.[311] CERD has called upon the government to address that inequality by ensuring equal access to reproductive health services for women belonging to scheduled castes and tribes and increasing the number of doctors and functional health facilities in tribal areas.[312] The Committee has asked the government to formally recognize members of tribal groups as entitled to special protection under international law.[313]

CRC

In 2004, the CRC similarly expressed concern about the "very high percentage of early and forced marriages of girls"[314] which the Committee noted "can have a negative impact on their health, education and social development…."[315] The Committee recommended that the government take the following actions: implement legislation prohibiting child marriage; strengthen programs to prevent early marriage; and strengthen reproductive health education and counseling for adolescents and ensure that these services are accessible.[316]

HRC

In 1997, the HRC expressed grave concern about the government of India's failure to give effect to legislation prohibiting child marriage and emphasized the need for action to "change the attitudes which allow such practices…."[317] In their recommendations, the Committee urged the government to introduce stronger measures to protect women from "all discriminatory practices, including violence."[318]

"FOR A MIDDLE-INCOME COUNTRY *of its stature, the rate of maternal deaths in India is shocking."*
– Paul Hunt, Former UN Special Rapporteur on the Right to Health[319]

Observations of the former Special Rapporteur on the Right to Health

In December 2007, the Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Health undertook an official visit to India to study the government's approach to maternal mortality and make constructive recommendations for action based on international human rights standards. Based on site visits, discussions with NGO representatives and meetings with government officials, some of the problems with the health system highlighted by the Rapporteur in his preliminary report include the following: financial bottlenecks including the underutilization of health budgets; wide variations in the quality of health care; unavailability of emergency obstetric care; emphasis on institutional delivery without sufficient attention to the range and quality of services offered in institutions; the absence of a civil registration system for maternal deaths; and inadequate regulation of public and private health services. The Rapporteur was particularly concerned by the disadvantages faced by rural women in access to health care.

The Special Rapporteur on the Right to Health's final report on India will be published in 2009. His recommendations should be incorporated into legal accountability and advocacy strategies to ensure the implementation of binding legal obligations under international law.

INTERNATIONAL TREATIES RATIFIED BY THE GOVERNMENT OF INDIA

- International Covenant on Civil and Political Rights *(April 10, 1979)*
- International Covenant on Economic, Social and Cultural Rights *(April 10, 1979)*
- Convention on the Elimination of All Forms of Discrimination against Women *(July 9, 1993)*
- International Convention on the Elimination of All Forms of Racial Discrimination *(December 3, 1968)*
- Convention on the Rights of the Child *(December 11, 1992)*
- Convention on the Rights of Persons with Disabilities *(October 1, 2007)*

Source: India: Ratification History, at http://www.bayefsky.com/pdf/india_t1_ratifications.pdf

REGIONAL BODIES IN ASIA

Regional human rights and political bodies in Asia are yet to take cognizance of the maternal mortality crisis in the region; however, it may be useful to consider the strategic value of engaging these bodies in a constructive dialogue on the issue in order to promote the visibility of maternal mortality as a regional human rights concern and to generate political will to take concerted action on the issue. While these bodies have less binding authority and proven merit than the international UN mechanisms described above, activists should consider engaging these mechanisms to complement strategies at the national and international levels.

Asian Human Rights Commission

The Asian Human Rights Commission (AHRC) is a nonprofit human rights organization that currently monitors human rights violations in the region. Founded in 1986, the AHRC has documented and protested violations relating to a range of human rights issues, such as forced disappearances, torture, censorship and racial discrimination. So far, it has not taken positions on widespread violations of reproductive rights in the region. However, importantly, it has facilitated the development of an Asian Human Rights Charter which recognizes women's reproductive rights in the following terms: "Women should be given the full right to control their sexual and reproductive health, free from discrimination or coercion, and be given access to information about sexual and reproductive health care and safe reproductive technology."[320] This provision of the charter offers a principled basis for recognizing pregnancy survival as a regional human rights priority.

South Asian Association for Regional Cooperation

Women's rights concerns feature prominently on the agenda of the South Asian Association for Regional Cooperation (SAARC). These concerns include topics such as citizenship, political representation, trafficking and sexual exploitation, gender and HIV/AIDS, female education and literacy, legal rights and economic empowerment and the impact of globalization on women. South Asia accounts for the second highest incidence of maternal deaths in the world.[321] As noted by one development expert, "High mortality and morbidity rates battle to rob children and women of their full potential – every day…."[322] SAARC's mandate provides a strong basis for arguing for greater political will to address what may be considered a regional human rights crisis. SAARC could serve as a useful forum for strengthening technical cooperation and promoting peer accountability in addressing maternal mortality in India and elsewhere in the region.

CHAPTER III. INDIAN CONSTITUTIONAL NORMS, JURISPRUDENCE AND PUBLIC INTEREST LITIGATION

"The Court welcomes wisdom from any source – it could be a convention, a foreign precedent, even a foreign statute. If the wisdom behind it makes sense, we will say let us adopt this here because the Parliament is slow to react to situations, and situations do not brook delay when it is a question of life and death." – ***Former Supreme Court Justice B. N. Srikrishna***[323]

Maternal deaths involve violations of human rights recognized as fundamental rights in the Constitution of India. Most notably, they implicate the rights to life, health and gender equality that have been interpreted broadly by the Supreme Court through landmark decisions issued in public interest cases. This chapter highlights key provisions of the Indian Constitution and select Indian Supreme Court decisions that may be used as a basis for claiming constitutional protection for the right to survive pregnancy and childbirth through PIL. This chapter further highlights new litigation initiatives being undertaken by activists in India.

Norms and jurisprudence

Life and Health: Article 21

"NO PERSON SHALL BE DEPRIVED *of life or personal liberty except according to the procedure established by law." – Constitution of India, art. 21*

Article 21 of the Constitution of India confers on every person the fundamental right to life and personal liberty.[324] The Supreme Court of India has described the constitutional guarantee of the right to life as "sacred and cherished."[325] Importantly, the Court has expanded the notion of life to include human dignity by observing that article 21 is not confined to a guarantee against the taking away of life and that it encompasses the right to live with human dignity.[326]

In addition to fundamental rights, the Constitution contains a set of Directive Principles of State Policy ("directive principles") that outline important priorities and areas of action for the government. Directive principles differ from fundamental rights in so far as they are not legally enforceable.[327] However, they are deemed by the Constitution as being "fundamental in the governance of the country"[328] and it is obligatory for the government to use these principles while formulating laws and policies.[329] The importance of directive principles has been elevated by the Supreme Court, which has recognized them as having the same status as fundamental rights.[330] The government's obligation to ensure the right to health is supported by a directive principle of state policy contained in article 47 of the Constitution, which describes the enhancement of public health as among the "primary duties" of the state.[331] The directive principles outline other important measures that support the right to health, such as the provision of maternity relief to pregnant women[332] and improvement of the nutritional status of the population.[333]

A series of groundbreaking judicial decisions have contributed significantly to the development of the right to health as a fundamental right under article 21: *Parmanand Katara v. Union of India*, *Paschim*

Banga Khet Mazdoor Samity v. State of West Bengal, *Chameli Singh v. State of Uttar Pradesh*, and *Consumer Education and Research Center v. Union of India*, which are described in brief below:

Parmanand Katara v. Union of India, *1989: Right to emergency medical care*

This case arose from the death of a road accident victim who succumbed to injuries as a result of delayed medical treatment.[334] The petitioner's claim that "every injured citizen brought for treatment should instantaneously be given medical aid to preserve life" was upheld by the Court, which recognized an individual's right to medical treatment.[335] Following a thorough examination of prevailing standards of medical ethics, the Court expressed the view that, "[P]reservation of human life is of paramount importance." Emphasizing the importance of this constitutional obligation, the Court extended this decision to both public and private doctors by noting that, "Every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life."[336]

Paschim Banga Khet Mazdoor Samity v. State of West Bengal, *1996: Constitutional obligation to preserve human life*

This case was brought by an association of workers after a member of the association who suffered life-threatening injuries to his head was severely traumatized as a result of being denied emergency medical treatment at several public hospitals before being admitted to a private health facility where he incurred heavy medical expenses. The question before the Court was whether the "nonavailability of facilities for the treatment of serious injuries" resulted in denial of the right to life under article 21. The Supreme Court held: "Failure on the part of a Government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21."[337] The Court further stated that the government cannot ignore its constitutional obligations on the pretext of "financial constraints"[338] and emphasized that this principle applies "with equal, if not greater, force in the matter of discharge of constitutional obligation of the State to provide medical aid to preserve human life."[339]

Chameli Singh v. State of Uttar Pradesh, *1995: Medical care as an aspect of life*

This case was brought by individuals who owned land that the government sought to acquire to establish housing for disadvantaged communities. The constitutional guarantee under article 21 of the right to life was interpreted to encompass the right to shelter and give rise to a state obligation to provide housing rights as a matter of individual dignity and equality.[340] Explaining the scope of article 21, the Supreme Court noted: "Right to live guaranteed in any civilized society implies the right to food, water, decent environment, education, medical care and shelter. These are basic human rights known to any civilized society."[341] The Court made explicit reference to the Universal Declaration of Human Rights and international policies on housing rights for the poor.[342] Emphasizing the interdependence rights, the Court noted: "All civil, political, social and cultural rights enshrined in the Universal Declaration of Human Rights and Convention[s] or under the Constitution of India cannot be exercised without these basic human rights."[343]

Consumer Education and Research Center v. Union of India, *1995: Health as a fundamental right*

This case was filed by a nonprofit organization out of concern for the health impact of occupational diseases arising from exposure to asbestos in mines and other various industries. At the time about

11,000 individuals were employed in such industries and were at risk.[344] The Supreme Court held that "the right to health and medical care is a fundamental right under Article 21…"[345] The Court referred extensively to international standards and safety rules issued by the International Labor Organization which were declared binding on all industries.[346] The Court's interpretation of article 21 was further informed by its view that "social justice," under the Indian Constitution, constitutes a "dynamic device to mitigate the sufferings of the poor, weak…deprived sections of society and to elevate them to the level of equality to live a life with dignity of person."[347] The central and state governments were instructed to review existing standards of permissible limits of exposure to asbestos and ensure compliance with international standards.[348]

These landmark cases illustrate how the right to health has evolved as a constitutional entitlement in India. Importantly, they reveal the Court's view of the relationship between health care, survival and human dignity. They also reveal the positive influence of international norms in the development of national standards and procedures relating to the right to health. These cases provide an important backdrop for a more recent landmark case in which the Court recognized the relationship between maternal health and food security.

People's Union for Civil Liberties v. Union of India, *(ongoing): Right to food and implementation of the National Maternity Benefits Scheme*

This public interest case was brought by the People's Union for Civil Liberties, a prominent NGO. In this case, petitioners sought recognition of the right to food as a fundamental right and, among other things, challenged the discontinuation of benefits under the National Maternity Benefits Scheme (NMBS, a financial assistance program for pregnant women) after the introduction of the JSY.[349] After considering statistical reports from states which revealed the weak implementation of the JSY and consulting with a commissioner appointed by the Court to investigate the government's performance under the JSY, the Supreme Court ordered the government to continue benefits under the NMBS, in the form of cash incentives, 8 to 12 weeks prior to delivery, to all pregnant women living below the poverty line,[350] regardless of the number of children and age.[351] The Court further instructed the government to effectively advertise the scheme[352] and cautioned it against spending the funds allocated for the NMBS on other activities.[353]

Equality and Nondiscrimination

Articles 14 and 15 of the Indian Constitution contain formal guarantees of the rights to equality and nondiscrimination. The Supreme Court has described gender equality as one of the "most precious Fundamental Rights guaranteed by the Constitution of India."[354] Article 15 explicitly prohibits discrimination on the basis of caste and sex.[355] Articles 14 and 15 when read together establish the equal right of men and women, and individuals of different socioeconomic groups and classes, to the same standards of health care without distinction.

*"**THE STATE SHALL NOT DENY** to any person equality before the law or the equal protection of the laws within the territory of India." – Constitution of India, art. 14*

Women and children are recognized by the Constitution as being particularly vulnerable to discrimination. Article 15(3) of the Constitution authorizes the government to make "special provisions" for their protection.[356] This provision is an important legal basis for addressing inequities in health care experienced by women and girls as a result of their sex, age, and inferior socioeconomic status.

"THE STATE SHALL NOT DISCRIMINATE *against any citizen on grounds only of religion, race, caste, sex, place of birth or any of them." – Constitution of India, art. 15 (1)*

The government's obligations to address inequalities arising from caste/tribe affiliation, geographic location and age have been established in the Constitution. The obligation to protect marginalized groups has been established through article 46, which instructs the government to promote the specific interests of "weaker sections of the people,"[357] especially members of scheduled castes and scheduled tribes. This obligation extends to the promotion of their educational and economic interests and protection from "social injustice and all forms of exploitation."[358] A relevant provision for those residing in parts of the country where access to facilities is limited is article 38(2), which creates the obligation to minimize such inequalities.[359] The obligation to protect children has been discussed in article 39(f), which requires the government to provide them with "the opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity."[360]

Gender equality has been promoted by the Supreme Court through the detailed interpretation of fundamental rights. Noteworthy is the use of international law and global consensus documents in defining the scope of the state's obligations to uphold women's rights and to prevent gender-based discrimination. Two leading cases on gender equality that reveal the judiciary's concern for women's rights and reliance on international law are as follows:

Vishaka v. State of Rajasthan, ***1997: Gender discrimination must be addressed by the state***

This public interest case arose out of the personal trauma of a social worker who was sexually harassed and subsequently gang-raped in retaliation to her advocacy to end child marriage. In this case, the Court recognized that sexual harassment violates fundamental guarantees of the rights to life and equality.[361] The Supreme Court acknowledged the absence of gender equality legislation and legal protections against sexual harassment.[362] The Court, relying on CEDAW and the CEDAW Committee's General Recommendation 19, laid down guidelines and norms to address sexual harassment in the workplace until legislation was enacted.[363] Citing the Beijing Platform for Action, the Court reiterated the government's obligation to defend women's human rights and institutionalize policies aimed at promoting gender equality.[364] The Court issued detailed guidelines based on international law for addressing sexual harassment in the workplace and outlined the obligations of employers to take measures to prevent and address violations.[365] Justifying the use of international law in its decision, the Court noted: "It is now an accepted rule of judicial construction that regard must be had to international conventions and norms for construing domestic law when there is no inconsistency between them and there is a void in the domestic law."[366] Drawing on comparative case law, the Court also took the view that the government's ratification of an international treaty creates a "legitimate expectation" that its provisions will be observed.[367]

Apparel Export Promotion Council v. Chopra, ***1999: Life and gender equality are precious rights***

This case involved an allegation of sexual harassment.[368] Echoing the Court's stance in *Vishaka*, the Court observed that sexual harassment violates the constitutional guarantees of the rights to life and gender equality that it went on to describe as "the two most precious fundamental rights guaranteed by the Constitution of India."[369] Commenting on the scope of gender equality as a constitutional right, the Court noted: "The contents of the fundamental rights guaranteed in our Constitution are of sufficient amplitude to encompass all facets of gender equality"[370] and, more importantly, emphasized that "courts are under a constitutional obligation to protect and preserve those fundamental rights."[371] Citing CEDAW, the Beijing Platform for Action and the ICESCR, the Court proclaimed that "the message of international instruments…which direct all state parties to take appropriate measures to prevent

discrimination in all forms against women besides taking steps to protect the honor and dignity of women is loud and clear."[372]

These landmark decisions reveal the Supreme Court's commitment to ensuring fundamental rights, especially the rights to life, health and gender equality. The Court's willingness to embrace new rights in order to promote social justice is striking and its use of international law in the interpretation and expansion of fundamental rights is exemplary. These trends underpin the Indian Supreme Court's dynamism that has helped it earn the reputation of a leader among judiciaries in the development of socio-economic rights.

Reproductive Self-Determination

The right of women to control the number, timing and spacing of their children has not been recognized in Indian constitutional law or jurisprudence. The grave implications of women's lack of control over their fertility – unplanned pregnancy, unsafe abortion and maternal mortality as result of frequent and closely spaced pregnancies – have not yet been directly addressed by the Supreme Court. The cases discussed in the preceding sections suggest that the Court may consider the harms resulting from women's inability to control their own fertility as violations of the rights to life, health and gender equality as recognized in the Constitution and under international law. However, it is possible that the Court may fail to take cognizance of the abysmal state of women's reproductive health in the country and the government's obligations under international law to protect women's health unless presented with compelling data and convincing legal arguments.

Furthermore, a concerning political reality looms in India that often favors limiting population growth over human rights. The role of the Court in ensuring the protection of the rights of individual citizens from attacks by government forces that are pursuing a population control agenda is of critical importance for women and their families, especially because of the direct implications for women's reproductive rights. In one recent case, *Javed v. State of Haryana, 2003,*[373] the Court upheld a state law that disqualifies men and women with more than two children from running for local public office.[374] The petitioners argued that this law violated the National Population Policy, which affirms voluntary choice and a target-free approach to family planning.[375] Rejecting that claim, the Court praised the law as being "salutary and in public interest,"[376] the public-interest goal being population control. More importantly, although the petitioners argued correctly that Indian women often lack reproductive decision-making power,[377] the Supreme Court rejected the claim, positing: "We do not think that with the awareness which is arising in Indian women folk, they are so helpless as to be compelled to bear a third child even though they do not wish to do so."[378]

***"THE PRINCIPLE OF INFORMED FREE CHOICE** is essential to the long-term success of family-planning programmes. Any form of coercion has no part to play." – ICPD Program of Action, para. 7.12*

The Supreme Court's decision is deeply troubling from the perspective of human rights. It displays the Court's disregard for the bleak reality confronting women in India, the majority of whom do not have access to family planning information and services. Furthermore, in this case, the Court clearly ignored the government's treaty obligations to protect human rights, which include the right to reproductive self-determination. It also disregarded global consensus documents such as the ICPD Program of Action[379] that condemn all forms of coercion for controlling population growth,[380] a view that has been incorporated into the NPP.[381] Coercive population measures have been opposed by the NHRC.[382] The Court's decision sadly disregards the NPP's recognition that sustainable development is not merely contingent on stabilizing population growth, but also depends on measures such as increasing the accessibility of reproductive health care and empowering women.[383]

STATE OF *HARYANA v. SMT. SANTRA*: A POSITIVE OUTCOME BUT FLAWED RATIONALE

This case involved a civil claim for compensation brought by a woman, Santra, who had an unplanned pregnancy as a result of a failed sterilization procedure.[384] Santra already had seven children prior to being sterilized and had chosen to undergo the procedure as she did not desire to have any more.[385]

The Supreme Court recognized Santra as a victim of medical negligence.[386] The doctor who performed the procedure had operated on Santra's right, but not left, fallopian tube.[387] The Court held the State of Haryana responsible for the unplanned birth, which, in the Court's view, created an "additional economic burden."[388] The Court ordered the state government to provide compensation to Santra to cover the expenses of the child born from this pregnancy until the age of puberty.[389]

While this judgment correctly recognizes the responsibility of medical professionals and the state for the appropriate care and treatment of patients, the reasoning underlying the Court's decision reveals a strong population-control approach.[390] It is not premised on recognition of the right of women to control their own fertility. The rationale underlying the decision in this case was expressed by the Court in the following terms:

"India is the second most populous country in the world…it is necessary that the growth of the population is arrested. It is with this end in view that family planning programme has been launched by the Government which has not only endeavoured to bring about an awakening about the utility of family planning among the masses but has also attempted to motivate people to take recourse to family planning through any of the known devices or sterilization operation."[391]

This decision reveals the Court's lack of understanding of its obligation to uphold women's reproductive rights under international human rights law. It highlights the need for advocates to sensitize the judiciary about women's reproductive rights.

Legal remedies

The government of India bears a constitutional obligation to ensure legal remedies for violations of fundamental rights. Article 39A requires the government to promote equal access to justice and free legal aid as a means to ensure that "opportunities for justice are not denied to any citizen by reason of economic or other disabilities."[392]

Legal recourse for violations of fundamental rights may be obtained under article 32 of the Constitution, which guarantees the right of individuals to approach the Supreme Court for the enforcement of fundamental rights,[393] and article 226, which authorizes state high courts to entertain such claims.[394] The state's ability to provide legal remedies for violations of fundamental rights has been strengthened by the Supreme Court, which has actively promoted the use of PIL as a means to "promote and vindicate public interest which demands that violations of constitutional or legal rights of large numbers of people who are poor, ignorant or in a socially or economically disadvantaged position should not go unnoticed or unaddressed."[395] The willingness of the Court to offer creative remedies for violations of fundamental rights is revealed in its observation that the power to enforce fundamental rights is a "constitutional obligation…to forge new remedies and fashion new strategies designed to enforce fundamental rights."[396]

RECENT PUBLIC INTEREST LITIGATION INVOLVING REPRODUCTIVE RIGHTS

In recent years, two prominent Public interest litigations that relate to women's reproductive rights have been filed in the Supreme Court: *Forum for Fact Finding Documentation and Advocacy v. Union of India*, 2003, which sought to hold the government accountable for failing to eliminate the harmful practice of child-marriage; and *Ramakant Rai v. Union of India,* 2003, which challenged nonconsensual sterilization practices in several states.

Forum for Fact Finding Documentation and Advocacy (FFDA) v. Union of India (pending)

This PIL was based on compelling evidence from several states across India that showed the widespread practice of child marriage and its harmful impact on the reproductive and sexual health of young girls. The petition noted the occurrence of a range of early marriage practices in the country, including mass marriages in states such as Rajasthan and Madhya Pradesh[397] and forced marriages of young girls who had become pregnant in Kerala.[398] The petition sought to draw the Court's attention to what was described as "the social injustice of child marriages, which are being forced upon children aged as young as 4 years old,"[399] and further highlighted the health impact of early marriage by noting that "12-year-old girls are giving birth, which is causing high mortality rates for both infants and mothers."[400]

The petitioners claimed that the government had failed to enforce the Child Marriage Restraint Act of 1929[401] and violated article 39 of the Constitution,[402] which directs the state to protect children against exploitation and to provide them with "opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity."[403] International conventions including the Children's Rights Convention and CEDAW were used as a basis for claiming violations of international human rights.[404]

During this legal proceeding, the Supreme Court was informed about new legislation that had been proposed in Parliament to address the issue of child marriage: the Prevention of Child Marriage Bill, 2004. Taking this into account, the Supreme Court refrained from issuing a final order in the case and instead issued an interim order in which it expressed the "hope"[405] that state officials would attempt to "prevent child marriages as far as possible and preferably in cases where mass marriages take place."[406]

Based on evidence submitted by NGOs of the continuing occurrence of child marriage in at least three states (Andhra Pradesh, Madhya Pradesh and Chattisgarh), the Court has asked the governments of those states to submit affidavits accounting for the alleged practices.[407] Furthermore, the Court has requested the NHRC and the respective state human rights commissions to investigate the allegations made by NGOs.[408]

Ramakant Rai v. Union of India (2007)

This case arose from concerns about the deplorable manner in which sterilization procedures were conducted on women and young girls in health facilities in Uttar Pradesh, Bihar and Maharashtra.[409] Data from surveys and other research showed that women were being sterilized in extremely unhygienic conditions and often without their full and free consent.[410] The evidence produced by petitioners showed that women were treated negligently by health care providers and even physically abused when they complained of pain.[411] Most women were not provided postoperative care, which often led to infection.[412] The petition also included evidence of individual cases involving the forced sterilization of a 15-year-old girl,[413] the failed sterilization of a woman who subsequently became pregnant again[414] and the death of a woman following a sterilization procedure.[415] The petition alleged violations of the National Sterilization Guidelines and the fundamental rights to life, health and nondiscrimination guaranteed in the Constitution.[416] International instruments including CEDAW and the ICPD Programme of Action were used to claim violations of human rights.[417]

In response to the PIL, the Court issued an interim order asking the states named in the petition as respondents to submit reports describing measures undertaken to regulate sterilization procedures.[418] Recognizing the lack of uniformity in how the national guidelines were followed, the Court instructed all states to address the concerns raised in the petition by taking several important steps, such as creating an approved panel of doctors to carry out sterilization procedures in accordance with criteria to be provided by the central government, developing a checklist of patient data for every doctor to complete before performing a procedure, circulating uniform patient consent forms, setting up quality assurance committees, investigating every breach of the procedures established under the National Sterilization Guidelines, maintaining overall statistics about sterilization procedures and resulting deaths, and creating an insurance policy.[419] The Court instructed the central government to take certain steps such as to create uniform standards for compensation and to introduce an insurance scheme.[420]

As instructed by the Court, the central government has introduced a national Family Planning Insurance Scheme that outlines provisions for monetary compensation to women and their families in cases of complications, pregnancy or death following a sterilization procedure in government or accredited private health facilities.[421] While implementation of the Court's orders has been a challenge and abuses reportedly still continue in parts of the country,[422] this PIL has been hailed by at least one leading health activist as "an important step towards curtailing unsafe and coercive sterilization practices."[423]

Public Interest Litigation

Most of the cases discussed in the previous section, which have contributed significantly to the development of the right to health and gender equality, were filed as public interest cases. Legal advocates should give increased attention to PIL as a possible accountability strategy for promoting state action to reduce maternal mortality for the following reasons:

"IT IS THE DUTY OF OTHER AWARE CITIZENS *of this country, the social activists, to see that the promise of constitutional rights is not merely a mirage, that it is a reality." – Justice J. S. Verma, Former Chief Justice of India*[426]

First, PIL was introduced by justices of the Supreme Court to "promote and vindicate" the fundamental rights of vulnerable and disadvantaged members of society.[424] The majority of women who succumb to pregnancy-related deaths are poor and socially disadvantaged. They are representative of the constituency for whom PIL was introduced as an accountability strategy by the justices of the Supreme Court.

Second, PIL has in the past presented the Supreme Court of India with important opportunities to develop fundamental rights and recognize basic entitlements otherwise not explicitly guaranteed in the Constitution, such as health care, emergency medical treatment, food, clean water, and sanitation.[425] Considering the enormous scale of maternal deaths in India and the implications for basic fundamental rights, advocates should consider using PIL to test the willingness of courts to provide constitutional protections for pregnant women and to prompt more meaningful enforcement and oversight of existing maternal health policies.

Third, a distinguishing feature of PIL, which lends this strategy well to the issue of maternal mortality, is that the victims need not come forward themselves in defense of their rights and may be represented by "any member of the public."[427] The absence of a narrow standing requirement for PIL gives lawyers and activists an opportunity to play a leading role in drawing the court's attention to maternal deaths arising from failed policies. As shown by the cases discussed in the previous section, concerned public citizens and NGOs have often been at the center of public interest lawsuits filed in court. Similarly the Supreme Court or a high court may take cognizance of a situation involving violations of fundamental rights and proceed *suo moto* to address the issue.[428]

Fourth, PIL can create unique opportunities for collaboration among individuals with a range of expertise and insights regarding the issue. While a PIL must be navigated through the legal system by lawyers, the overall strategy must be informed and supported by key actors and experts who have the data and information to show where and how the government has failed in its duty to ensure pregnancy survival. The input and cooperation of key actors and experts working on the frontlines of the issue is critical in all three stages of a PIL – case development, during the legal proceedings and in the implementation of court orders. If planned well, a PIL can be an inclusive and powerful strategy for change.

Finally, as governments across the world recognize the right to survive pregnancy as a human right, it is important for local actors to adopt legal strategies that can give this right the force of law and transform it into reality in the domestic arena. PIL can allow activists to transform the right to survive pregnancy from rhetoric into reality in India by combining key principles of domestic and international law into a legal strategy to generate binding court orders and jurisprudence that guide state action, and even prompt state action if the government is not doing enough.

SEEKING CONSTITUTIONAL RECOGNITION OF THE RIGHT TO SURVIVE PREGNANCY AND CHILDBIRTH: POTENTIAL LEGAL CLAIMS

Maternal deaths implicate a wide range of fundamental rights recognized in the Indian Constitution and directive principles which have been accorded the status of fundamental rights by the Supreme Court. Such deaths also have implications for important constitutional values such as respect for dignity and the preservation of human life. Convincing arguments in support of a constitutional right to survive pregnancy can be made based on key provisions of the Indian Constitution, Indian Supreme Court jurisprudence and international law. Some of these arguments may be developed on the basis of the following claims:

- High-quality pre-and postnatal care and timely emergency obstetric care are critical for ensuring women's dignity and survival during pregnancy and childbirth. The government's failure to ensure access to high-quality pre- and postnatal care and emergency obstetric care violates article 21, which has been interpreted to include the right to emergency medical care, and article 47, which directs the government to prioritize the improvement of public health.
- Maternal health services are required only by women. The government's failure to remove barriers to access to maternal health services violates their right to nondiscrimination and special protection under articles 14 and 15 and denies them their fundamental rights to life and health under article 21.
- The government's failure to protect young girls and adolescents from maternal deaths associated with early childbearing and marriage violates their fundamental rights to life, health, nondiscrimination and special protection under articles 21, 14 and 15 and the state's obligation to protect children's health and dignity under article 39(f).
- The government's failure to reduce the disproportionately high incidence of maternal mortality among women belonging to Scheduled Castes and Tribes violates their rights to life, health, nondiscrimination and special protection under articles 21, 14 and 15 and the obligation to protect them from social injustice as expressed in article 46.
- The government's failure to address disparities in access to maternal health care which have resulted in significant state-wide variations in the maternal mortality ratio violates the

government's obligation to reduce inequalities in status and access to services and facilities based on geographic location under article 38(2).

- The government's failure to improve the nutritional status of pregnant women and reduce the widespread incidence of anemia, an important factor in maternal deaths, violates the obligation to address nutritional deficiencies in the population established in article 47.
- The government's failure to create accessible and effective legal mechanisms and procedures that would create opportunities for seeking legal recourse and other types of remedies for violations arising from maternal deaths in individual cases and for promoting formal accountability within the health system violates the government's obligation to ensure that citizens are not denied opportunities for seeking justice as expressed in article 39A.
- The government's failure to reduce maternal mortality and ensure women's right to survive pregnancy puts the government of India in violation of its treaty obligations under ICCPR, ICESCR, CEDAW, the Children's Rights Convention, and the International Convention on the Elimination of All Forms of Racial Discrimination, and demonstrates disregard for international policies and benchmarks relating to maternal mortality implicating article 51(c) of the constitution, which obligates the government to respect international law and treaty obligations.
- The government's failure to reduce maternal mortality and to ensure the accessibility, availability, acceptability and high quality of maternal health services during pregnancy and after childbirth violates women's reproductive rights guaranteed under international law. This failure directly implicates their rights to life; personal security; freedom from cruel, inhuman and degrading treatment; health; equality and non-discrimination; and reproductive self-determination. Many aspects of these rights, and the obligation to enforce international law, have already been recognized in the Supreme Court's jurisprudence and should be applied to recognize women's rights to survive pregnancy and childbirth.
- To be in compliance with international treaty obligations and ensure the practical fulfillment of women's reproductive rights, the government must implement recommendations made by at least five major treaty monitoring bodies that have urged the Indian government to take effective measures to reduce maternal mortality by, among other things, ensuring access to reproductive health services, eliminating child marriage and addressing inequities in access to health care faced by disadvantaged social groups.

Challenges

No doubt, undertaking PIL involves several challenges. The lengthy duration of PIL proceedings, the time and effort required to build consensus among participating groups, the shortage of public interest litigators and the difficulty in enforcing court orders are some common practical impediments.[429] With respect to reproductive rights litigation, insufficient awareness of reproductive rights among judges constitutes an additional barrier.[430] It is imperative for advocates to develop convincing legal arguments that combine interpretations of constitutional guarantees of fundamental rights with claims of binding legal obligations under international law to obtain constitutional protections for pregnant women. (See box - *Seeking Constitutional Recognition of the Right to Survive Pregnancy and Childbirth: Potential Legal Claims*, above.) Judges need to be convinced that pregnancy survival is not simply a health issue, but involves fundamental questions of constitutional and international law. Advocates must develop creative legal arguments and use PIL strategically to demonstrate that pregnancy survival is both a matter of social justice and personal security for women that courts can no longer ignore.

Groundbreaking legal initiatives relating to maternal health

Despite the many practical challenges to promoting the protection of rights in the maternal health context through litigation in courts, more recently, there has been an encouraging trend in the collaborative use of PIL for accountability with state level high courts being used as the primary venue.

Maternal mortality: *Sandesh Bansal v. Union of India and Others*

This public interest case was filed in July 2008 by Sandesh Bansal, the coordinator of Jan Adhikar Manch, a network of local health organizations based in the state of Madhya Pradesh. The state of Madhya Pradesh has the third-highest maternal mortality ratio in the country, with 498 deaths for every 100,000 live births.[431]

This petition exposes the government's failure to implement official policies on maternal health as a result of which women in the state are not receiving adequate antenatal and postnatal care.[432] It uses data from the NFHS to show that less that half of all pregnant women in the state of Madhya Pradesh receive antenatal care and 20% do not receive any care at all.[433] This gap has contributed to the large number of high-risk pregnancies that go undetected in the state, leading to a high incidence of maternal deaths and morbidity.[434] It draws attention to the poor conditions of primary health centers in the state, which often lack clean water, electricity and basic sanitation.[435] It includes detailed accounts of women who have died in the process of what the petition describes as "struggling to give life to a new infant."[436] It further points to the failure of the Rogi Kalyan Samiti, an oversight body created under the NRHM, to execute its role of ensuring that government funds are spent appropriately on services most needed by women, such as emergency transportation,[437] and highlights concern about the use of financial resources, largely acquired through user fees, to substitute for government spending on hospital facilities – with no real improvement at all.[438]

The petition requests the court to order the state government to establish health facilities where needed and ensure that they are fully functional by taking measures such as appointing staff, ensuring the availability of proper equipment and lifesaving drugs, providing emergency transportation, assuring the quality of services, and monitoring the provision of services.[439] It seeks a guarantee that no pregnant woman shall be denied services and those who cannot pay for the services shall be provided emergency care without preconditions and for free.[440] It also calls for the creation of a surveillance mechanism to identify and review maternal deaths.[441]

As the case is being considered by the state high court, the petitioners have submitted an application seeking interim orders directing the government to urgently address the situation in Bhind District of Madhya Pradesh by issuing a license to the district hospital for a blood bank, ensuring the provision of electricity and potable water, and providing other goods and services as required under the Indian Public Health Standards.[442] The high court is currently awaiting the state's response, and is scheduled to consider the application for interim direction in January 2009.

Maternal morbidity: *Snehalata Singh v. The State of Uttar Pradesh and Others*

Snehalata "Salenta" Singh gave birth to her first five children at home without complications. When, in February 2007, she went to a PHC to deliver her sixth child, she suffered a debilitating injury – vaginal fistula, a hole between the wall of her vagina and urinary tract. Salenta had been left unattended while in labor for an entire night before she delivered the next morning.[443] In addition

to not being provided proper medical attention by the doctors at the PHC, the ANM refused to discharge Salenta until her husband paid her an informal fee, a fee that he could not afford pay and had to borrow from someone else.[444] Although the main symptom of fistula — urine leakage — became immediately apparent, it took three months and visits to five different hospitals for Salenta to get diagnosed, and another six months for her to get the surgery she needed to end her suffering and once again lead a normal life.[445] Her surgery was delayed on at least four different occasions, twice due to her inability to pay upfront for the procedure and twice because of the absence of a vacant bed.[446]

Salenta Singh and Healthwatch Forum, an advocacy network for women's health and rights that helped her finally get surgery, have filed a public interest lawsuit against the state of Uttar Pradesh with the intention of highlighting the implications of poor maternal health care for women's rights.[447] Salenta's case is emblematic of the devastating consequences of the poor quality of care provided to low-income women who opt for institutional delivery, which in this case resulted in fistula – a debilitating and stigmatizing pregnancy-related injury.[448] It exposes the corruption among health workers that has led to women and their families being exploited for money by the very providers from whom they seek care.

The petition requests compensation for Salenta's medical expenses and the trauma caused by the negligence of health care providers.[449] It also requests a court order requiring the state of Uttar Pradesh to provide free medical care for all pregnant women[450] and strict implementation of the National Rural Health Service Guarantees.[451] It further requests an order mandating the creation system for auditing maternal deaths in the state.[452]

MATERNAL MORBIDITY: FISTULA A NEGLECTED CONCERN

Many of the factors responsible for maternal mortality are also leading causes of maternal morbidity. Of the 300 million women worldwide estimated to be living with a pregnancy-related disability, it is believed that at least 2 million suffer from obstetric fistula, a serious but preventable condition.[453] Obstetric fistula – a hole in the vagina or rectum typically caused by obstructed labor without timely medical intervention such as a Caesarean section[454] – is one of the most serious injuries caused by childbearing.[455] The condition causes the continual leakage of urine, feces or both,[456] and can lead to infertility or infection.[457] Although surgical treatment is successful in 80-90% of cases,[458] many women live in areas where health care facilities do not exist, are unaware of the treatment or do not have the ability to afford or access such services.[459] Women with fistula are often abandoned by their families and are unable to find work, leading to social isolation and increased poverty.[460] Adolescent girls are especially at risk of obstetric fistula,[461] further evincing the risks inherent in early pregnancy and childbearing.

The United Nations Population Fund has stated that "[t]he persistence of fistula is a signal that health systems are failing to meet the needs of women."[462] Fistula has been virtually eliminated in the developed world since the late 19th century;[463] however, in the developing world "[o]bstetric fistula still exists because health care systems fail to provide accessible, quality maternal health care, including family planning, skilled birth attendance, basic and emergency obstetric care, and affordable treatment of fistula."[464] Interventions to prevent maternal mortality are essential means to prevent and treat fistula and other causes of maternal morbidity.[465] The World Health Organization reports that "most fistula occur among women living in poverty in traditional cultures, where a woman's status and self-esteem may depend almost entirely on her marriage and ability to bear children."[466]

In India, Community Health Centers have been mandated by the National Rural Health Mission to diagnose and treat cases of fistula,[467] but there is strong evidence to suggest that these services are not being provided to women. (See case summary of Salenta Singh, above.)

Suo moto *action by the High Court of Uttar Pradesh*

Instances of pregnant women being forced to give birth on the streets after being denied health care have become disturbingly common in Uttar Pradesh, which has one of the highest maternal mortality ratios in the country. A recent case is that of Sarvesh Kumari, who went to a community health center to deliver her baby and, despite being in critical condition, was told to leave the health center and to go to another hospital for delivery — as a result of which she delivered on the street.[468] A staff nurse was suspended in connection with this case.[469] When the impugned nurse filed a petition in the state high court challenging her suspension, she inadvertently exposed the sad state of affairs in the health system to the court, which immediately condemned the mistreatment of Sarvesh Kumari as a "highly inhuman act on the part of officials and staff posted at the Community Health Center."[470] The Court has ordered the Government of Uttar Pradesh to issue appropriate circulars and orders to check the recurrence of such incidents, which the court described as a "shame for entire humanity."[471] The court has further directed the government of Uttar Pradesh to take disciplinary action against doctors and staff who failed to assist Sarvesh Kumari during delivery and ordered that she be provided compensation.[472]

This is an exemplary move by the High Court of Uttar Pradesh and should be used by activists to prompt similar actions by high courts in other states. Furthermore, it is important for activists to advocate strongly for the implementation of these orders to prevent similar cases from occurring again within the state.

National Human Rights Institutions

National human rights institutions can serve as useful venues for promoting accountability for maternal deaths. Human rights institutions may be approached to conduct investigations, provide support for PILs and for broader human rights advocacy that can help address systemic barriers in the health system, and in local communities, that contribute to maternal deaths.

National Human Rights Commission

The NHRC has the legal authority to investigate human rights violations,[473] make recommendations for the effective implementation of international treaties[474] and support the work of NGOs working to promote human rights.[475] It is required by statute to "spread human rights literacy among various sections of society and promote awareness of the safeguards available for the protection of these rights."[476]

In a critical analysis of the health care system published in 2006, the NHRC notes with concern the failure of government policies to protect women's health. Noting that women have far less access to health care than men,[477] the NRHC describes the higher incidence of mortality among women as a "reflection of unequal gender relations inequalities in resource distribution, lack of access and availability of drugs and health services."[478] The study recommends various strategies for improving health care in India that include submitting petitions and memoranda to the NHRC to draw their attention to key issues.[479]

National Commission for Women

The National Commission for Women (NCW) can investigate violations of women's rights,[480] initiate

studies about discriminatory practices[481] and fund PIL.[482] It may also act *suo moto* to address the government's failure to implement laws and policies intended for women and make necessary recommendations.[483]

National human rights bodies are viewed as important human rights monitoring institutions by international legal bodies. Commenting on the role of national human rights commissions in protecting women's human rights, the CEDAW Committee recently noted that the work of national human rights institutions must be "based on the principle of formal and substantive equality between women and men and nondiscrimination."[484] The Committee asserted that women should "have easy access to all services for the protection of their rights provided by national human rights institution."[485]

The state-level counterparts of these national institutions can serve as important venues for seeking accountability for violations of health rights since the responsibility for protecting and promoting public health falls primarily on state governments.[486] Human rights advocacy with state human rights institutions can usefully complement PIL in state high courts.

THE CONSUMER PROTECTION ACT: AN ADDITIONAL BASIS FOR ACCOUNTABILITY

The Consumer Protection Act 1986 (CPA) is another potentially effective basis for legal recourse in maternal death and morbidity cases. Under the CPA, courts have the authority to handle claims of medical negligence and to award compensation to aggrieved individuals and families. In *Indian Medical Association v. V.P. Shanta*,[487] the Supreme Court established the legal right of patients to sue their doctor under the Consumer Protection Act. The Court's decision in this case aimed to create accountability within the medical profession by bringing services rendered by medical professionals within the ambit of a "service" as defined in the CPA.

The course of action available to victims of negligence under the CPA has been developed through several cases, which have established that even though services rendered by medical practitioners are of a personal nature they cannot be treated as "contracts of personal service," an excluded category under the CPA.[488] Their services shall be considered as "contracts for personal service," (emphasis ours) on the basis of which they may be sued in consumer protection courts.[489] Patients who sustain injuries in the course of treatment can sue doctors for acts of negligence and seek compensation.[490] The duty of care required from a doctor is an ordinary level of skill and not the highest degree of skill.[491] It is sufficient for a doctor to show that he acted in accordance with generally accepted norms of medical practice.[492]

The CPA does not apply if the service is rendered free of charge, or if the patients have paid only a nominal registration fee.[493] However, if patients' charges are waived because of their incapacity to pay, they are considered to be consumers and can sue under the CPA.[494]

CHAPTER IV. RECOMMENDATIONS

LAWYERS

Initiate litigation to seek accountability for human rights violations arising from maternal mortality:

- Collaborate with activists and public health experts to develop PIL claiming the right to survive pregnancy and childbirth as a constitutionally protected right.
- File public interest petitions seeking court orders for:
    - Immediate implementation of service guarantees for pregnant women under the NRHM;
    - Elimination of provisions that make maternal health care conditional on consent for sterilization and deny benefits to certain categories of women;
    - Clarification of the purpose of monetary incentives for pregnant women;
    - Punishment of those who make informal demands for money from pregnant women.
- File public interest petitions seeking the court to direct the legislative bodies to introduce comprehensive maternal health legislation based on human rights standards. Legislation should include official guarantees of maternal health services including:
    - Emergency obstetric care;
    - Enforceable standards for ensuring quality of care (clinical and interpersonal);
    - Guarantees of patient's rights to privacy, confidentiality and informed decision-making;
    - Guarantees of access to a wide range of contraceptive methods and related information and counseling;
    - Non-biased and medically accurate information about a complete range of sexual and reproductive health services;
    - Guarantees of free services for those who cannot afford to pay

  Legislation should also establish formal legal mechanisms for filing complaints against discrimination, mistreatment or negligence with tangible remedies.
- Develop multi-pronged legal accountability strategies for addressing issues relating to maternal mortality, such as lack of access to contraceptives, unsafe abortion and child marriage. Such steps could include accountability for poor implementation of the Medical Termination of Pregnancy Act and the Child Marriage Restraint Act.
- Directly incorporate provisions of international human rights law and comparative jurisprudence into legal accountability strategies.
- Engage the NCW, the NHRC, and their respective state counterparts in monitoring and accountability strategies.
- Engage with international human rights bodies by submitting shadow reports periodically highlighting the Indian government's successes and failures in complying with its treaty

obligations and advocate for the implementation of concluding comments and observations formally issued by those bodies.

JUDGES

- Utilize international law and comparative legal sources to develop jurisprudence on reproductive rights issues.
- Broadly interpret fundamental rights and apply directive principles to recognize the fundamental right to survive pregnancy and childbirth.
- Utilize opportunities created by PIL to appoint formal committees and independent experts to investigate violations and develop appropriate remedies.
- Take steps to increase public awareness about court orders and groundbreaking decisions to ensure effective implementation and to promote greater faith in judicial action.
- Take *suo moto* action to address health system failures that lead to maternal deaths.
- Give legal effect to recommendations made by UN TMBs and independent experts through judicial orders and decisions.

LEGAL ACADEMICS

- Introduce reproductive rights as part of the standard legal curriculum to promote greater awareness of reproductive rights violations and foster the development of legal solutions to address those violations by the next generation of lawyers.
- Undertake studies and publish legal analyses that can be used to frame reproductive health issues as legal issues of concern.
- Develop clinical programs through which law students can contribute to the development of PIL to address maternal mortality and related concerns in the community.

MATERNAL HEALTH ACTIVISTS

- Collaborate with lawyers to develop PIL petitions addressing violations of reproductive rights.
- Conduct public audits and field studies that can provide a basis for PIL and human rights advocacy. Use the findings from maternal death investigations to establish the occurrence of violations and to develop remedies.
- Monitor and evaluate the implementation of judicial orders and decisions at the grassroots level.
- Submit reports to the NHRC and the NCW and prompt them to take action.
- Organize events in collaboration with other key stakeholders to promote awareness of maternal mortality as a human rights issue and to develop effective accountability and advocacy strategies.

- Provide information to UN TMBs regarding the status of women's reproductive health during the periodic reporting process. Incorporate concluding comments and observations issued by those bodies into local advocacy strategies to promote compliance with international law. Use the forthcoming report by Paul Hunt, former Special Rapporteur on the Right to Health, to promote accountability for maternal deaths.
- Approach the AHRC to condemn the failure of the Indian government to prevent maternal mortality as a human rights concern, a failure that undermines Asian human rights principles and values.
- Mobilize SAARC members to adopt a political declaration that recognizes maternal mortality as a regional human rights issue and call for a regional dialogue on cooperation and monitoring to prevent maternal deaths.
- Urge the Indian Government to ratify the optional protocols to international conventions such as the CEDAW, the ICCPR, and the ICESCR, so advocates can pursue human rights claims at the international level after having exhausted all domestic remedies.

Endnotes

[1] Rebecca Cook and Bernard Dickens, Advancing Safe Motherhood through Human Rights 6 (World Health Organization 2001), *available at* http://www.who.int/reproductivehealth/publications/RHR_01_5_advancing_safe_motherhood/advancing_safe_motherhood_through_human_rights.pdf

[2] World Health Organization (WHO), Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and The World Bank 1 (2005), *available at* http://www.who.int/reproductive-health/publications/maternal_mortality_2005/mme_2005.pdf [hereinafter WHO, Maternal Mortality in 2005].

[3] The world total of maternal deaths was 529,000 in 2006. In Africa, the total was 251,000. In Asia the total was 253,000. Maternal deaths in Africa and Asia combined total 504,000, or 95.2% of the world total. WHO, Department of Reproductive Health and Research (RHR), *Monitoring and Evaluation*, (July 31, 2006), *at* http://www.who.int/reproductive_indicators/alldata.asp.

[4] *See* Joint Press Release, United Nations Population Fund (UNFPA), *Maternal Mortality Declining in Middle-income Countries; Women Still Die in Pregnancy and Childbirth in Low-income Countries* (Oct. 12, 2007), *available at* http://www.unfpa.org/news/news.cfm?ID=1042 [hereinafter UNFPA, *Maternal Mortality Declining in Middle-income Countries*]. *See also* Mission of Paul Hunt, The UN Special Rapporteur on the Right to the Highest Attainable Standard of Health, Oral Remarks to the Press in Delhi, India (Dec. 3, 2007), *available at* http://www2.essex.ac.uk/human_rights_centre/rth/docs/Mission%20Press%20remarks,%20Delhi%2003%20December.doc [hereinafter Paul Hunt, Oral Remarks to the Press].

[5] *See* UNFPA, *Maternal Mortality Declining in Middle-income Countries*, *supra* note 4. *See also* Paul Hunt, Oral Remarks to the Press, *supra* note 4.

[6] *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, para. 7.3, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *ICPD Programme of Action*], *available at* http://www.unfpa.org/icpd/icpd-programme.cfm.

[7] UNFPA, Maternal Mortality Update 2002: A Focus on Emergency Obstetric Care 6 (2003), *available at* http://www.unfpa.org/upload/lib_pub_file/201_filename_mmupdate-2002.pdf [hereinafter UNFPA, Maternal Mortality Update 2002]. *See also* UNFPA, State of the World's Population 2004, *Maternal Health: Maternal Morbidity*, at http://www.unfpa.org/swp/2004/english/ch7/page3.htm (last visited Dec. 17, 2008).

[8] UNFPA, Maternal Mortality Update 2002, *supra* note 7.

[9] WHO, Maternal Mortality in 2005, *supra* note 2.

[10] Roopa Bakshi, *UNICEF unveils new tool to combat maternal mortality in India*, UNICEF, Apr. 6, 2006, *at* http://www.unicef.org/infobycountry/india_33208.html.

[11] U.N. Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW Committee), *Consideration of Reports Submitted by States Parties Under Article 18 of the Convention on the Elimination of All Forms of Discrimination Against Women, Initial Report of States Parties: India*, para. 221, UN Doc. CEDAW/C/IND/1 (1999).

[12] The NFHS-3 indicates that the MMR has dropped from approximately 400 per 100,000 live births in 1997-8 to 300 per 100,000 live births in 2001-03. International Institute for Population Sciences (IIPS) and Macro International, National Family Health Survey (NFHS-3) 2005-06: India 4 (vol. 1, 2007), *available at* http://www.measuredhs.com/pubs/pdf/FRIND3/01Chapter01.pdf [hereinafter NFHS-3].

[13] WHO, Maternal Mortality in 2005, *supra* note 2, at 32.

[14] Ministry of Health and Family Welfare, *Rajasthan: Health Indicators of Rajasthan*, at http://mohfw.nic.in/NRHM/State%20Files/raj.htm (last visited Dec. 17, 2008).

[15] Deeti Ray, *Maternal Mortality: Women at Risk,* Society for the Study of Peace and Conflict (2006).

[16] Civil Society Meeting with Paul Hunt, Special Rapporteur on the Right to Health, in Delhi, India, (Dec. 1, 2007), *available at* http://www.chsj.org/pages/events/civil-society-meeting-with-un-special-rapporteur-on-the-right-to-health.php.

[17] Roopa Bakshi, *Maternal Mortality – a woman dies every 5 minutes in childbirth in India,* UNICEF, Mar. 2, 2006, *at* http://www.unicef.org/india/health_1341.htm.

[18] United Nations General Assembly, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Preliminary note on the mission to India*, para. 15, U.N. Doc. A/HRC/7/11/Add.4 (2008) [hereinafter *Report of the Special Rapporteur on the right to health: Mission to India*].

[19] *Id*. paras. 15-17.

[20] Academy for Nursing Studies, consultation and presentation: "Overview of Maternal Mortality in Andhra Pradesh," Hyderabad, India, August 21, 2008 (summary on file with CRR).

[21] Bakshi, *UNICEF unveils new tool*, *supra* note 10.

[22] *Id*.

[23] UNICEF, *India: Maternal and perinatal death inquiries*, *at* http://www.unicef.org/india/health_1342.htm (last visited October 3, 2008).

[24] *Id*.

[25] Government of India, Central Bureau of Health Intelligence, *Auditing Maternal Deaths, Tamil Nadu*, *at* http://cbhi-hsprod.nic.in/listdetails.asp?roid=22 (last visited October 3, 2008).

[26] *Id*.

[27] *Id*.

[28] CEDAW Committee, *General Recommendation 24, Women and Health (art. 12),* para. 17, UN Doc. A/54/38 (Part I) (1999), *available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CEDAW+General+recom.+24.En?OpenDocument [hereinafter CEDAW Committee, *Gen. Rec. 24*]

[29] UNFPA, Emergency Obstetric Care: Checklist for Planners 1 (2002), *available at* http://www.unfpa.org/upload/lib_pub_file/150_filename_checklist_MMU.pdf.

[30] *See id. See also* WHO, *Maternal Mortality: Making Pregnancy Safer* (2008), *at* http://www.who.int/making_pregnancy_safer/topics/maternal_mortality/en/index.html.

[31] Dileep Mavalankar, *State of Maternal Health in India*, Azad India Foundation, http://azadindia.org/social-issues/maternal-health-in-india.html (last visited Dec. 17, 2008) (citing statistics from the Registrar General of India which show that 19% of maternal deaths in 1998 were caused by anemia. According to the government, the direct causes of maternal death in India are hemorrhage (38%), sepsis (11%), hypertensive disorders (5%), obstructed labor (5%), abortion (8%) and "other conditions" (34%), a category that can include indirect causes such as anemia). Hemorrhage can also be related to anemia. Registrar General, India, Maternal Mortality in India: 1997 – 2003, 23 and 29, *available at* http://www.health.mp.gov.in/Maternal_Mortality_in_India_1997-2003.pdf [hereinafter Registrar General, Maternal Mortality in India].

[32] WHO, *Maternal Mortality: Making Pregnancy Safer, supra* note 30.

[33] Anemia and unsafe abortion are noteworthy causes of maternal mortality in India. Both are preventable, and both are more prevalent in India than in much of the world. According to the WHO, unsafe abortion "causes approximately 13% of all maternal deaths" worldwide. WHO, Unsafe Abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2003 iv (5th. ed. 2007), *available at* http://who.int/reproductive-health/publications/unsafeabortion_2003/ua_estimates03.pdf [hereinafter WHO, Unsafe Abortion 2003]. In India, however, the number of maternal deaths caused by unsafe abortion is estimated to be 15%. Anemia is also more prevalent among pregnant women in India than in much of the world. *See* Mavalankar, *supra* note 31.

[34] Meera Chatterjee, et al., *Better Reproductive Health for Poor Women in South Asia,* World Bank Working Paper No. 42027, 16 (2007), *available at* http://www-wds.worldbank.org/servlet/main?menuPK=64187510&pagePK=64193027&piPK=64187937&theSitePK=523679&entityID=000020953_20080108094613.

[35] The NFHS-3 confirms the link between malnutrition, anemia and maternal mortality and morbidity: "A woman with poor nutritional status…anaemia, or other micronutrient deficiencies, has a greater risk of obstructed labour…adverse pregnancy outcomes… death due to postpartum haemorrhage, and illness for herself and her baby." NFHS-3, *supra* note 12, at 267. 58.7% of pregnant woman aged 15-49 were found to be anemic in the NFHS-3. *See id.* at 310. *See also* Mavalankar, *supra* note 31. The Registrar General of India reports that "the higher haemorrhage percentage is also consistent with the high background rates of anaemia reported among Indian women." Registrar General, Maternal Mortality in India, *supra* note 31, at 17. *See also* UNICEF, *MAPEDIR Fact Sheet*, *available at* http://www.unicef.org/media/files/India_Mapedir_fact_sheet.doc ("Anemia, a common nutritional disorder in Indian women, also can increase maternal mortality. (9% in Purulia, West Bengal, 10% in Guna/Shivpuri, Madhya Pradesh, and 14% in Dholpur, Rajasthan). These deaths are preventable by improving girls' and women's nutrition, accessing antenatal care and providing blood when needed.").

[36] Mavalankar, *supra* note 31.

[37] UNICEF, Progress for Children: A Report Card on Maternal Mortality 6 (2008), *available at* http://www.unicef.org/childsurvival/files/Progress_for_Children-No._7_Lo-Res_082008.pdf.

[38] According to the government, the direct causes of maternal death in India are hemorrhage (38%), sepsis (11%), hypertensive disorders (5%), obstructed labor (5%), abortion (8%) and "other conditions" (34%), a category that can include indirect causes such as anemia. Hemorrhage can also be related to anemia. The Registrar General of India reports that "the higher haemorrhage percentage is also consistent with the high background rates of anaemia reported among Indian women." Registrar General, Maternal Mortality in India, *supra* note 31, at 17, 23.

[39] N. B. Sarojini, et al., Women's Right to Health 35 (National Human Rights Commission 2006), *available at* http://nhrc.nic.in/Publications/Womens.pdf.

[40] Malaria during pregnancy can have dire consequences for both women and newborns. According to Roll Back Malaria, a partnership initiated by WHO, UNDP, UNICEF and the World Bank in 1998, "[p]regnant women resident in areas of low to unstable malaria transmission are at a two- or threefold higher risk of developing severe disease as a result of malaria infection than are non-pregnant adults living in the same area." Additionally, "[i]n areas of high and moderate (stable) malaria transmission…the principal impact of malaria infection is associated with malaria-related anaemia in the mother and with the presence of parasites in the placenta. The resultant impairment of foetal nutrition…is a leading cause of poor infant survival and development." Roll Back Malaria (RBM), *Malaria in pregnancy, available at* http://www.rbm.who.int/cmc_upload/0/000/015/369/RBMInfosheet_4.htm. "Pregnant mothers with MDR-TB (multi-drug-resistant tuberculosis) have increased risk of neonatal complications and the mother herself has more advanced disease…" G.C. Khilnani, *Tuberculosis and Pregnancy*, 46 Indian J. of Chest Diseases & Allied Sciences, 105, 106 (2004), *available at* http://medind.nic.in/iae/t04/i2/iaet04i2p105.pdf.

[41] Chatterjee, *supra* note 34, at 11.

[42] NFHS-3, *supra* note 12, at 310 ("Fifty-five percent of women and 24 percent of men…were found to be anaemic.").

[43] Sarojini, *supra* note 39, at 35.

[44] Michele Gragnolati, et al., *India's Undernourished Children: A Call for Action*, HNDP Discussion Paper 5 (2005), *available at* http://siteresources.worldbank.org/SOUTHASIAEXT/Resources/223546-1147272668285/IndiaUndernourishedChildrenFinal.pdf.

[45] NFHS-3, *supra* note 12, at 310 ("The prevalence of anaemia for ever-married women has increased from 52 percent in NFHS-2 to 56 percent in NFHS-3. Therefore, the anaemia situation has worsened over time for both women and young children.").

[46] Refugee Women's Resource Project, *Refugee Women and Domestic Violence: Country Studies*, 15 - 16 (2003), *available at* http://www.unhcr.org/refworld/pdfid/478e3c6e0.pdf; Vulimiri Ramalingaswami, et al., *Commentary: The Asian Enigma,* UNICEF, http://www.unicef.org/pon96/nuenigma.htm (last visited Dec. 17, 2008).

[47] Marimuthu Sivakumar, *Gender Discrimination and Women's Development in India*, MPRA Paper No. 10901 (2008), *available at* http://mpra.ub.uni-muenchen.de/10901/1/MPRA_paper_10901.pdf.

[48] Azad India Foundation, *Gender Inequality in India,* http://www.azadindia.org/social-issues/GenderInequality.html (last visited Dec. 17, 2008).

[49] Gragnolati, *supra* note 44, at iii.

[50] Ramalingaswami, *supra* note 46.

[51] Committee on Economic, Social and Cultural Rights (CESCR), *Combined second, third, fourth and fifth periodic report submitted by states parties under articles 16 and 17 of the Covenant, India*, para. 567, U.N. Doc. E/C.12/IND/5 (Mar. 1, 2007).

[52] Suneeta Mittal, Chief Co-coordinator, Consortium on National Consensus for Medical Abortion, Introduction of Emergency Contraception in India, Address Before the Consortium for Emergency Contraception in India, All India Institute of Medical Sciences (AIIMS), *available at* http://aiims.edu/aiims/events/Gynaewebsite/ma_finalsite/drmittal.html.

[53] According to the WHO, unsafe abortion "causes approximately 13% of all maternal deaths and approximately 20% of the overall burden of maternal death and long-term sexual and reproductive ill health." WHO, Unsafe Abortion 2003, *supra* note 33, at iv.

[54] Ravi Duggal and Vimala Ramachandran, *The Abortion Assessment Project-India: A Brief Profile* 1 (2004) *available at* http://www.cehat.org/aap1/obj.pdf [hereinafter *The Abortion Assessment Project—India*].

[55] Centre for Development and Population Activities (CEPDA), Adolescent Girls in India Choose a Better Future: An Impact Assessment 7 (2001) *available at* http://www.cedpa.org/files/634_file_blp_report.pdf.

[56] Centre for Health and Social Justice, Reviewing Two years of NRHM, October 2007: Citizens Report 111 (2007), *available at* http://www.chsj.org/media/download_gallery/CITIZENREPORT-FIN.pdf [hereinafter Centre for Health and Social Justice, Reviewing Two years of NRHM: Citizens Report].

[57] *The Abortion Assessment Project—India*, *supra* note 54, paras. 5 - 8.

[58] M.E. Khan et al., *Availability and Access to Abortion Services in India: Myth and Realities* 8-10 (2001) *available at* http://www.iussp.org/Brazil2001/s20/S21_P10_Barge.pdf.

[59] "[S]ocial access remains restricted since providers, especially in formal and certified facilities, do not provide services to women if they come alone and/or if the spouse or some close relative does not give consent." *The Abortion Assessment Project—India*, *supra* note 54, para. 5.

[60] *The Abortion Assessment Project—India*, *supra* note 54, para. 7.

[61] WHO, Unsafe Abortion 2003, *supra* note 33, at 4.

[62] *Note on terminology:* The terms "poor" and "low-income" will be used variously in this report. "Poor" is used generally to describe those who have a low income and very little or no income at all.

[63] Chatterjee, *supra* note 34, at 2.

[64] World Bank, *Long-term prospects and poverty forecast* (Dec. 9, 2008), *at* http://web.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTDECPROSPECTS/EXTGBLPROSPECTS/0,,contentMDK:21540882~menuPK:4357639~pagePK:2904583~piPK:2904598~theSitePK:612501,00.html (According to the table, in India in 2005, 455,800,000 million people were living on less than $1.25 per day. The world total was 1,373,500,000. The number of people living on less than $2 per day was 2,561,500,000 world-wide, with 827,700,000 in India.)

[65] Press Information Bureau, Government of India, *Poverty Estimates for 2004-05*, *available at* http://planningcommission.nic.in/news/prmar07.pdf.

[66] *See* World Bank, *Long-term prospects and poverty forecast*, *supra* note 64.

[67] Sarojini, *supra* note 39, at 36.

[68] Chatterjee, *supra* note 34, at xii, para. 14.

[69] Sarojini, *supra* note 39, at 15.

[70] Chatterjee, *supra* note 34, at 10.

[71] Manju Rani, et al., *Differentials in the quality of antenatal care in India*, International Journal for Quality in Health Care 8 (2007).

[72] Chatterjee, *supra* note 34, at 10.

[73] *Id.*

[74] *Id.*

[75] *See* ActionAid, Hit or Miss? Women's Rights and the Millennium Development Goals 13-14, (2008), *available at* http://www.actionaid.org.uk/doc_lib/aamdg.pdf (discussing education as an enabling right that unlocks progress on other MDGs). *See also* WHO, Health Benefits of Family Planning 12 (1994), *available at* http://www.who.int/reproductive-health/publications/health_benefits_family_planning/health_benefits_fp.pdf; UNFPA, State of the World Population 2007: Unleashing the potential of urban growth 18 (2007), *available at* http://www.unfpa.org/swp/2007/presskit/pdf/sowp2007_eng.pdf ("Educated women tend to marry later and have fewer and healthier children. In adulthood, they have greater employment potential, income-earning capacity and decision-making authority within the household. Other benefits include knowledge and capacities to maintain and protect their health, including preventing unwanted pregnancies and sexually transmitted infections (STIs), including HIV/AIDS.") [hereinafter UNFPA, State of the World Population 2007].

[76] Chryssa McAlister and Thomas Baskett, *Female Education and Maternal Mortality: A Worldwide Survey,* 28 J. Obstetrics & Gynecology Canada 983, 988-989 (2006), *available at* http://www.sogc.org/jogc/abstracts/full/200611_WomensHealth_3.pdf ("the female literacy rate [as a percentage of the male literacy rate]…is a moderately powerful predictor of maternal mortality with a negative correlation….This relationship also holds true for the combined education enrolment ratio variable that looks at the percentage of females enrolled in primary, secondary, and tertiary levels of education. It is not surprising that maternal mortality is correlated with a discrepancy in education levels between males and females. Education gives women the knowledge to demand and seek proper health care.").

[77] In a comparison of 84 countries, the negative correlation between MMR and literacy was -0.79%; the negative correlation between MMR and GDP was only -0.46%. Nancy Sloan et al., *An Ecologic Analysis of Maternal Mortality Ratios,* 32 Studies in Family Planning 353 (2001), *available at* http://www.popcouncil.org/pdfs/councilarticles/sfp/SFP324Sloan.pdf.

[78] *See* UNFPA, State of the World Population 2007, *supra* note 75, at 18, 70.

[79] Chandrakant Lahariya and Jyoti Khandekar, *How the findings of national family health survey-3 can act as a trigger for improving the status of anemic mothers and undernourished children in India: A review*, 61 Indian J. of Med.Sciences 535 (2007). "The NFHS-3 findings show an inverse relationship between fertility and the educational status of the mother. When making a comparison between the fertility of women with no education and those with 10 or more years of education, a difference of two children is noticeable in majority of the states. Decreasing fertility may be attributable to increased CPR, increased age at marriage and increased age at the first child birth, as reported in NFHS-3." International Institute for Population Sciences, National Family Health Survey (NFHS-3): National Fact Sheet--India, *available at* http://www.nfhsindia.org/pdf/IN.pdf [hereinafter NFHS-3 Fact Sheet: India].

[80] Rani, *supra* note 71, at 4.

[81] USAID, *Maternal and Child Health: Technical Areas, Adolescent Maternal Health*, *at* http://www.usaid.gov/our_work/global_health/mch/mh/techareas/adolescent.html (last visited Dec. 17, 2008).

[82] According to the NFHS-3, in India in 2005-06, almost half (46%) of women age 18-29 years got married before the legal minimum age of 18. NFHS-3 Fact Sheet: India, *supra* note 79, at 4.

[83] Institute for Research in Medical Statistics, *Estimates of Maternal Mortality Ratios in India and its States: A Pilot Study*, 25 (2003), *available at* http://icmr.nic.in/final/Final%20Pilot%20Report.pdf [hereinafter *Estimates of Maternal Mortality Ratios in India*].

[84] For instance, the states of Uttar Pradesh, Madhya Pradesh and Rajasthan all have higher rates of child marriage than the national average, as well as higher-than-average rates of maternal mortality: 707, 498, and 670, respectively. In 2005-06, 53% of women in Madhya Pradesh had married prior to age 18. International Institute for Population Sciences, National Family Health Survey (NFHS-3): National Fact Sheet—Madhya Pradesh, *available at* http://nfhsindia.org/pdf/MP.pdf. According to NFHS-3, in India in 2005-06, 44.5% of women aged 20-24 had married before age 18, and 16% of women age 15-19 were pregnant or had already given birth by the time of the survey. NFHS-3 Fact Sheet: India, *supra* note 79. In Bihar, 60.3% of women had married by age 18; and 25% of women aged 15-19 were pregnant or had already had children by the time of the survey. International Institute for Population Sciences, National Family Health Survey (NFHS-3): National Fact Sheet—Bihar, *available at* http://nfhsindia.org/pdf/BH.pdf. In Rajasthan, 57.1% of women marry before age 18 and 16% of women age 15-19 were pregnant or had already given birth. International Institute for Population Sciences, National Family Health Survey (NFHS-3): National Fact Sheet—Rajasthan, *available at* http://nfhsindia.org/pdf/RJ.pdf.

[85] Ministry of Health and Family Welfare, *Rajasthan: Health Indicators of Rajasthan*, *supra* note 14.

[86] UNFPA, State of the World Population: The Cairo Consensus at Ten: Population, Reproductive Health and the Global Effort to End Poverty 76 (2004) *available at* http://www.unfpa.org/swp/2004/pdf/en_swp04.pdf.

[87] USAID, *Maternal and Child Health: Technical Areas, Adolescent Maternal Health, supra* note 81.

[88] Chatterjee, *supra* note 34, at 9.

[89] NFHS-3, *supra* note 12, at 3 ("16 percent of India's population belonged to scheduled castes and 8 percent belonged to scheduled tribes").

[90] NFHS-3, *supra* note 12, at 3.

[91] *Estimates of Maternal Mortality Ratios in India*, *supra* note 83, at 28.

[92] G. Nancharaiah, *Dalit Education and Economic Inequality, in* Education and the Disprivileged – Nineteenth and Twentieth Century India 163 (Sabyasachi Bhattacharya ed. 1999).

[93] For a more detailed discussion on the class-caste nexus in Indian society *see* K.L. Sharma, *The Class-Caste Nexus*, *in* The Legacy of G.S. Ghurye – A Centennial Festschrift 130 (A.R. Momin ed. 1996).

[94] Chinna Rao Yagati, *Education and Identity Formation Among Dalits in Colonial Andhra, in* Education and the Disprivileged – Nineteenth and Twentieth Century India 88 (Sabyasachi Bhattacharya ed. 1999).

[95] Samita Sen, *A Father's Duty – State, Patriarchy and Women's Education, in* Education and the Disprivileged – Nineteenth and Twentieth Century India 228 (Sabyasachi Bhattacharya ed. 1999).

[96] NFHS-3, *supra* note 12, at 15.

[97] *Id.* at 9 (children not in SC/ST/OBC are more likely to be vaccinated).

[98] *Estimates of Maternal Mortality Ratios in India*, *supra* note 83, at 28.

[99] Fali S.Nariman, *An Overview of the Provisions of the Constitution,* 1 J. OF THE NHRC 18, 23 (2002), *available at* http://nhrc.nic.in/Publications/NHRCJournal2002.pdf.

[100] Vaishali S. Mahendra et al., *Reducing AIDS-related stigma and discrimination in Indian Hospitals*, HORIZONS 34 (2006), *available at* http://www.popcouncil.org/pdfs/horizons/inplhafriendly.pdf.

[101] Avert, *Overview of HIV/AIDS in India*, http://www.avert.org/aidsindia.htm (last visited July 12, 2008) (citing UNAIDS 2006 number).

[102] Avert, *Who is affected by HIV and AIDS in India?*, http://www.avert.org/hiv-india.htm (last visited Oct. 6, 2008). *See also* NATIONAL AIDS CONTROL ORGANIZATION (NACO) (INDIA), NOTE ON HIV SENTINEL SURVEILLANCE AND HIV ESTIMATION 10 (2008) (showing an overall decline in people living with HIV-AIDS (PLHA) from 2002 to 2006, but increase in percentage of females as fraction of whole: 2002 total PLHA = 2.73 million; 2006 total PLHA = 2.47 million. 2002 total females LHA = 1.07m; 2006 total females LHA = .97m.)

[103] WHO AND UNFPA, SEXUAL AND REPRODUCTIVE HEALTH OF WOMEN LIVING WITH HIV/AIDS: GUIDELINES ON CARE, TREATMENT AND SUPPORT FOR WOMEN LIVING WITH HIV/AIDS AND THEIR CHILDREN IN RESOURCE-CONSTRAINED SETTINGS 3 (2006), *available at* http://www.who.int/reproductive-health/docs/srhwomen_hivaids/text.pdf ("Women living with HIV/AIDS have a greater risk of certain adverse pregnancy outcomes, such as intrauterine growth restriction and preterm delivery. Pregnant women living with HIV/AIDS have an increased risk of developing malaria and its consequences and therefore require additional precautions."). Complications such as sepsis, anemia and postpartum hemorrhage are all impacted by HIV. *See* James McIntyre, *Mothers infected with HIV: Reducing maternal death and disability during pregnancy*, 67 BRITISH MED. BULL. 127, 131 (2003), *available at* http://bmb.oxfordjournals.org/cgi/content/full/67/1/127.

[104] McIntyre, *supra* note 103, at 131.

[105] WHO AND UNFPA SEXUAL AND REPRODUCTIVE HEALTH OF WOMEN LIVING WITH HIV/AIDS, *supra* note 103, at 3.

[106] McIntyre, *supra* note 103, at 131.

[107] Interview with Dr. Umesh Chawla, India HIV/AIDS Alliance (New Delhi, India, August 19, 2008) (discussing the challenges providers face in treating patients with HIV).

[108] Sarojini, *supra* note 39, at 11.

[109] *See, e.g.,* CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Benin*, para. 42, U.N. Doc. E/C.12/1/Add.78 (2002); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Bolivia*, para. 23, U.N. Doc. E/C.12/1/Add.60 (2001); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Cameroon*, para. 25, U.N. Doc. E/C.12/1/Add.40 (1999); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Gambia*, para. 16, U.N. Doc. E/C.12/1994/9 (1994); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: India*, para. 33, U.N. Doc. E/C.12/IND/CO/5 (2008); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Mali*, para. 13, U.N. Doc. E/C.12/1994/17 (1994); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Nepal*, para. 25, E/C.12/NPL/CO/2 (2008); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Peru*, para. 16, U.N. Doc. E/C.12/Add.1/14 (1997).

[110] UNFPA, *Reducing Risks by Offering Contraceptive Services, at* http://www.unfpa.org/mothers/contraceptive.htm (last visited Dec. 9, 2008); World Bank, *Public Health at a Glance: Maternal Mortality* (2006), *at* http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTPHAAG/0,,contentMDK:20944136~menuPK:2656916~pagePK:64229817~piPK:64229743~theSitePK:672263,00.html.

[111] Family Health International, *The Importance of Family Planning in Reducing Maternal Mortality*, *at* http://www.fhi.org/en/RH/Pubs/Briefs/MCH/factsheet11.htm (last visited Dec. 9, 2008). *See also, e.g.,* CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Benin*, para. 42, U.N. Doc. E/C.12/1/Add.78 (2002); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Bolivia*, para. 23, U.N. Doc. E/C.12/1/Add.60 (2001); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Cameroon*, para. 25, U.N. Doc. E/C.12/1/Add.40 (1999); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Chile*, para. 26, U.N. Doc. E/C.12/1/Add.105 (2004); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: China*, para. 36, U.N. Doc. E/C.12/1/Add.107 (2005); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Mauritius*, para. 15, U.N. Doc. E/C.12/1994/8 (1994); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Mexico*, para. 29, U.N. Doc. E/C.12/1/Add.41 (1999); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Nepal*, para. 32, U.N. Doc. E/C.12/1/Add.66 (2001); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Paraguay*, para. 32, E/C.12/PRY/CO/3 (2008); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Poland*, para. 29, U.N. Doc. E/C.12/1/Add.82 (2002); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Russia*, para. 35, U.N. Doc. E/C.12/1/Add.94 (2003); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Trinidad and Tobago*, para. 23, U.N. Doc. E/C.12/1/Add.80 (2002).

[112] UNFPA, *Reducing Risks by Offering Contraceptive Services, supra* note 110; World Bank, *Public Health at a Glance: Maternal Mortality* (2006), *supra* note 110.

[113] UNFPA, *Reducing Risks by Offering Contraceptive Services, supra* note 110.

[114] *See* WHO, Regional Office for Southeast Asia, India and Family Planning: An Overview, *available at* http://www.searo.who.int/linkfiles/family_planning_fact_sheets_india.pdf (last visited December 9, 2008).

[115] NFHS-3, *supra* note 12, at 108.

[116] UNFPA, State of the World 2008: Reaching Common Ground 87 (2008), *available at* http://www.unfpa.org/swp/2008/en/.

[117] NFHS-3, *supra* note 12, at 127.

[118] *Id.*

[119] *Id.*

[120] The 18 "high focus states" under the NRHM are Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Orissa, Uttaranchal, Jharkhand, Chhattisgarh, Assam, Sikkim, Arunachal Pradesh, Manipur, Meghalaya, Tripura, Nagaland, Mizoram Himachal Pradesh and Jammu and Kashmir. National Rural Health Mission (2005 – 2012), Mission Document 12, *available at* http://mohfw.nic.in/NRHM%20Mission%20Document.pdf.

[121] *See* Centre for Health and Social Justice, Reviewing Two years of NRHM: Citizens Report, *supra* note 56; Lahariya and Khandekar, *supra* note 79, at 535.

[122] NFHS-3 Fact Sheet: India, *supra* note 79, at 3.

[123] WHO, Recommended Interventions for Improving Maternal and Newborn Health 2 (2007), *available at* http://whqlibdoc.who.int/hq/2007/WHO_MPS_07.05_eng.pdf.

[124] Centre for Health and Social Justice, Reviewing Two years of NRHM: Citizens Report, *supra* note 56, at 41.

[125] NFHS-3, *supra* note 12, at 4.

[126] *Id.*, at 186.

[127] Nirmala Murthy and Alka Barua, *Non-medical Determinants of Maternal Death in India*, 6 J. Health Mgmt 47 – 61 at Abstract (2004), *available at* http://jhm.sagepub.com/cgi/content/abstract/6/1/47 ("Most 'death cases' belonged to high-risk age groups, had high parity (3+), were socially disadvantaged, had not received prenatal care and advice to go to hospital…Delay in care was also because of lack of transport facilities, inappropriate referrals or poor emergency preparedness of referral facilities. Data suggested that about half the deaths could have been avoided if the health system had been alert and accessible.").

[128] UNFPA, *Maternal Mortality in 2005 Fact Sheet* (2005), "Skilled attendance for safer delivery," *available at* http://www.unfpa.org/swp/2005/presskit/factsheets/facts_rh.htm#ftn10 (citing the UN Millennium Project, Task Force on Child and Maternal Mortality).

[129] NFHS-3 Fact Sheet: India, *supra* note 79, p. 3.

[130] Murthy and Barua, *supra* note 127, at Abstract.

[131] Nazmul Chaudry et al, *Missing in Action: Teacher and Health Worker Absence in Developing Countries*, 20 J. Econ. Persp., 91-116 (2006).

[132] Abhijit Banerjee, Angus Deaton and Esther Duflo, *Wealth, health, and health services in rural Rajasthan*, 94 Amer. Econ. Rev., 326-330, *available at* http://ipa.phpwebhosting.com/images_ipa/WealthHealthRajasthan.BanerjeeEtAl_1.pdf

[133] Bakshi, *Maternal Mortality, supra* note 17; *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report on maternal mortality and access to medicines*, para. 21, U.N. Doc. A/61/338 (2006) [hereinafter *Report of the Special Rapporteur on the Right to Health: maternal mortality and access to medicines*].

[134] UNICEF, *MAPEDIR Fact Sheet*, *supra* note 35.

[135] *Id.*

[136] Bakshi, *Maternal Mortality, supra* note 17; *Report of the Special Rapporteur on the right to health: maternal mortality and access to medicines, supra* note 133, para. 21.

[137] The 'three delays' model was first developed in S. Thaddeus and D. Maine, *Too far to walk: maternal mortality in context,* 38 Social Science & Medicine 1091–1110 (1994). For further description of 'lack of access' in the 'three delays' model, *see* Family Health International, *Averting Maternal Death and Disability (AMDD),* http://www.fhi.org/en/RH/Programs/AMDD_rp.htm (last visited Dec. 17, 2008); Abul Barkat et al., *Modelling the First Two Delays of the "Three-Delays Model" for Emergency Obstetric Care in Bangladesh: A Choice Model Approach* 1 J. Health & Population in Developing Countries 57-67.

[138] UNICEF, *MAPEDIR Fact Sheet*, *supra* note 35.

[139] *Report of the Special Rapporteur on the Right to Health, maternal mortality and access to medicines*, *supra* note 133, para. 21.

[140] L.P. Freedman, *Using human rights in maternal mortality programs: from analysis to strategy*, 75 Int. J. Gyn. Obstet. 51, 54 (2001).

[141] UNICEF, *MAPEDIR Fact Sheet*, *supra* note 35.

[142] Rani, *supra* note 71, at 8.

[143] *Id.*

[144] *Id.* at 2.

[145] Jishnu Das, Jeffrey S. Hammer & Kenneth L. Leonard, *The Quality of Medical Advice in Low-Income Countries* (Jan. 1 2008) World Bank Policy Research Working Paper No. 4501, at 16, *available at* http://ssrn.com/abstract=1089272 ("The relationship between poverty in the area that the doctor practices in and his or her competence stands out. In India, Indonesia, and Tanzania, doctors in poorer areas are less competent than those in richer areas.")

[146] *Id.* ("…in the public clinics, the situation is disastrous. In these clinics, the average number of questions asked was one (and that one often asked rudely).")

[147] Rani, *supra* note 71, at 2 – 3.

[148] Jeremy Shiffman, *Generating Political Priority for Maternal Mortality: Reduction in 5 Developing Countries*, 97 Am. J. Public Health 801 (2007) [hereinafter *Generation Political Priority for Maternal Mortality: Reduction in 5 Developing Countries*].

[149] *Id.* at 798.

[150] Speech by Prime Minister Singh at the Golden Jubilee of the AIIMS, Sept. 25, 2005, New Delhi, India, *available at* http://pmindia.nic.in/speech/content.asp?id=200

[151] UN Millenium Development Goals, Goal 5, *available at* http://www.millenniumcampaign.org/site/pp.asp?c=grKVL2NLE&b=186385 (Goal 5: Reduce the maternal mortality ratio by three quarters between 1990 and 2015).

[152] Registrar General, Maternal Mortality in India, *supra* note 31, at vii.

[153] National Commission on Population, Government of India, National Population Policy 2000, *available at* http://populationcommission.nic.in/npp.htm [hereinafter National Population Policy]. The NPP further includes the goals of "promoting delayed marriage for girls, achieving 80 percent institutional deliveries and 100 percent deliveries by skilled birth attendants, and addressing the unmet need for basic reproductive and child health services," all within the next four years. The John D. and Catherine T. MacArthur Foundation, *India,* 1, Oct. 2006, *available at* http://www.macfound.org/atf/cf/%7BB0386CE3-8B29-4162-8098-E466FB856794%7D/GSS%20-%20INDIA.PDF.

[154] Department of Health, Ministry of Health and Family Welfare, Government of India, National Health Policy 2002, box IV (2002).

[155] National Rural Health Mission, Frequently Asked Questions, *available at* http://pib.nic.in/archieve/flagship/faq_nrhm.pdf.

[156] *See* National Rural Health Mission (2005 – 2012), Mission Document, *supra* note 120, at 3.

[157] Ministry of Health and Family Welfare, National Rural Health Mission: Framework for Implementation 2005-2012, at 10, *available at* http://health.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf (last visited September 26, 2008).

[158] *Note on terminology:* "Antenatal" and "prenatal" care are equivalent terms. Throughout this report, both terms will be used interchangeably; however "antenatal" is the preferred term in India so it will appear more frequently.

[159] Janani Suraksha Yojana, *Frequently Asked Questions, available at www.nihfw.org/ndc-nihfw/UploadedDocs/JSY.doc.*

[160] National Rural Health Mission: Framework for Implementation, *supra* note 157, at 28.

[161] *Id.* at 27-28.

[162] Ministry of Health and Family Welfare, Janani Suraksha Yojana: Guidelines for implementation 1 (Sept. 2006) *available at* http://mohfw.nic.in/layout_09-06.pdf.

[163] Sangeeta Mourya, SAHAYOG (Lucknow), Report re: Civil Society Meeting with Paul Hunt: Special Rapporteur on the Right to Health; Delhi, India, Dec. 1, 2007: "Out of 68 cases [in Uttar Pradesh], only 7 women received JSY money, and 3 or 4 of these women were asked to pay Rs 500 of their JSY money to the providers."

[164] Centre for Health and Social Justice, Reviewing Two years of NRHM: Citizens Report, *supra* note 56, at 45-6. (At 25: "[In Chhattisgarh]...out of twenty institutional child births, only 8 women…received the JSY entitlement. [In another block], the JSY money has not been paid for an entire year. In the Pratappur block, the Block Medical Officer does not give the [JSY] money at the facility. Instead, he goes to the beneficiaries' house and gives them the money, while keeping part of the amount for himself." In another block in Chhattisgarh, "there is an accumulation of more than 200 eligible BPL women who have given birth but still need to receive their JSY entitlement. The other issue which was vehemently brought up by the community is that of ANMs charging anything from Rs 200 to Rs 2000 for attending home births." At 45: "[In Bihar]…Family members of women who had been allured by the money incentive of JSY to go to a government health institution for childbirth complained that the nurse/*dai* who delivered the baby asked for '*neg'* (gift). This could be Rs 100-500 or even a sari. If they were unable to give anything, the nurses threatened that they would not hand over the baby," at 46: "Even after receiving [JSY] funds, they had to give some amount of money as bribe either to the PHC staff or the service providers who helped them. According to them, this process ended up costing as much money as they received."

[165] Centre for Health and Social Justice, Reviewing Two years of NRHM: Citizens Report, *supra* note 56, at 6, 45.

[166] *Id.* at 42.

[167] *Id.* at 49, 91.

[168] *Id.* at 25.

[169] *Id.* at 64.

[170] *Id.* at 3.

[171] *Id.* at 3, 11.

[172] *Id.* at 6. (Reporting the testimony of Amarjeet Sinha, Joint Secretary of the Ministry of Health and Family Welfare, Government of India, as calling for individuals to put pressure on institutions by demanding that women be made to stay in the hospital 48 hours after delivery and not be released within 6-8 hours).

[173] *Id.* at 96.

[174] *Id.* at 96.

[175] World Health Organization, Beyond the Numbers: Reviewing maternal deaths and complications to make pregnancy safer 45-46 (2004), *available at* http://www.who.int/reproductive-health/publications/btn/text.pdf (last visited December 4, 2008).

[176] *Id.* at 7-8.

[177] Dr.M. Prakasamma, Academy for Nursing Studies, "Overview of Maternal Mortality in Andhra Pradesh," Presentation given in Hyderabad, Andhra Pradesh, India, August 21, 2008.

[178] *Id.*

[179] *See* Academy for Nursing Studies, 30 Selected Case Studies (2008) (unpublished) (on file with Center for Reproductive Rights).

[180] Academy for Nursing Studies, Report on the Maternal Deaths in Andhra Pradesh 4 (unpublished) (on file with Center for Reproductive Rights).

[181] Academy for Nursing Studies, 30 Selected Case Studies, *supra* note 179.

[182] Ms. Mandakini, Academy for Nursing Studies, "Overview of Maternal Mortality in Andhra Pradesh," Presentation given in Hyderabad, Andhra Pradesh, India, August, 21, 2008.

[183] Academy for Nursing Studies, "Overview of Maternal Mortality in Andhra Pradesh," Presentation given in Hyderabad, Andhra Pradesh, India, August, 21, 2008.

[184] Academy for Nursing Studies, 30 Selected Case Studies, *supra* note 179.

[185] Dr.Balamba, Academy for Nursing Studies, "Overview of Maternal Mortality in Andhra Pradesh," Presentation given in Hyderabad, Andhra Pradesh, India, August 21, 2008. Dr. Balamba discussed prevalent food-related myths: that eating eggs during pregnancy will cause the baby to be born without hair; that greens will cause the child to be born dark; that rich/nutritious foods will cause the child to be big and necessitate a Caesarian section. Venkat Ramnayya remarked that some women do not receive care because their families are not aware that pregnancy can be harmful.

[186] Dr. Balamba, Academy for Nursing Studies, "Overview of Maternal Mortality in Andhra Pradesh," Presentation given in Hyderabad, Andhra Pradesh, India, August 21, 2008.

[187] *See* The Death of Sumitra Devi, (*Box,* p. 20) Academy for Nursing Studies, India.

[188] Academy for Nursing Studies, Report on the Maternal Deaths in Andhra Pradesh, *supra* note 180, at 18; *see also* Academy for Nursing Studies, 30 Selected Case Studies, *supra* note 179.

[189] Academy for Nursing Studies, Report on the Maternal Deaths in Andhra Pradesh, *supra* note 180, at 18; *see also* Academy for Nursing Studies, 30 Selected Case Studies, *supra* note 179.

[190] Academy for Nursing Studies, Report on the Maternal Deaths in Andhra Pradesh, *supra* note 180, at 18; *see also* Academy for Nursing Studies, 30 Selected Case Studies, *supra* note 179.

[191] *See* Academy for Nursing Studies, 30 Selected Case Studies, *supra* note 179.

[192] Academy for Nursing Studies, Report on the Maternal Deaths in Andhra Pradesh, *supra* note 180, at 18; *see also* Academy for Nursing Studies, 30 Selected Case Studies, *supra* note 179.

[193] *See* Academy for Nursing Studies, 30 Selected Case Studies, *supra* note 179.

[194] The ICDS is not part of the NRHM, but is a freestanding program existing since 1975 aimed at providing supplementary nutrition to young children, pregnant women, and women of reproductive age. *See* http://www.ncbi.nlm.nih.gov/pubmed/12173700

[195] International Initiative on Maternal Mortality and Human Rights, Informational Brochure (2007), *available at* http://www.righttomaternalhealth.org/iimmhr_brochure_v2.pdf

[196] Rebecca J. Cook et al., Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law 161 (2003) [hereinafter Cook, reproductive Health and Human Rights].

[197] Human Rights Committee, *General Comment 6: The Right to Life (Art. 6)* (16th Sess., 1982).

[198] Human Rights Committee, *General Comment 28: Equality of right between men and women (article 3)*, para. 10, U.N. Doc. CCPR/C21/Rev.1/Add.10 (Mar. 29. 2000) [hereinafter HRC, *Gen. Comment 28*].

[199] Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003).

[200] *Id.*

[201] HRC, *Gen. Comment 28*, *supra* note 198, para. 10. *See also* CEDAW Committee, *Concluding Observations of CEDAW*, *e.g., Antigua and Barbuda*, part II, para. 260, U.N. Doc. A/52/38/Rev.1 (1997); *Argentina*, part II, para. 304, U.N. Doc. A/52/38 Rev.1 (1997); *Argentina*, para. 360, U.N. Doc. A/57/38 (2002); *Argentina*, para. 380, U.N. Doc. A/59/38 (2004); *Armenia*, para. 52, U.N. Doc. A/57/38 (2002); *Australia*, part II, para. 397, U.N. Doc. A/52/38/Rev.1 (1997); *Azerbaijan*, para. 63, U.N. Doc. A/53/38 (1998); *Bangladesh*, part II, para. 438, U.N. Doc. A/52/38/Rev.1 (1997); *Bosnia and Herzegovina,* para. 35, U.N. Doc. CEDAW/C/BIH/CO/3 (2006); *Brazil,* para. 126, U.N. Doc. A/58/38 (2003); *Burkina Faso,* para. 274, U.N. Doc. A/55/38 (2000); *Burkina Faso,* para. 349, U.N. Doc. A/60/38 (2005); *Burundi,* para. 61, U.N. Doc. A/56/38 (2001); *Cambodia,* para. 29, U.N. Doc. CEDAW/C/KHM/CO/3 (2006); *Cameroon,* para. 59, U.N. Doc. A/55/38 (2000); *Colombia,* para. 612, U.N. Doc. A/50/38 (1995); *Democratic Republic of the Congo,* para. 227, U.N. Doc. A/55/38 (2000); *Dominican Republic,* para. 337, U.N. Doc. A/53/38 (1998); *Eritrea,* para. 22, U.N. Doc. CEDAW/C/ERI/CO/3 (2006); *Ethiopia,* para. 257, U.N. Doc. A/59/38 (2004); *Fiji,* part I, para. 62, U.N. Doc. A/57/38 (2002); *Gambia,* para. 203, U.N. Doc. A/60/38 (2005); *Georgia,* para. 111, U.N. Doc. A/54/38 (1999); *Ghana,* para. 31, U.N. Doc. CEDAW/C/GHA/CO/5 (2006); *Guatemala,* para. 192, U.N. Doc. A/57/38 (2002); *Guinea,* para. 128, U.N. Doc. A/56/38 (2001); *India,* para. 78, U.N. Doc. A/55/38 (2000); *India*, para. 40, U.N. Doc. CEDAW/C/IND/CO/3 (2007); *Iraq*, para. 203, U.N. Doc. A/55/38 (2000); *Israel*, part II, part 162, U.N. Doc. A/52/38 Rev.1 (1997); *Kyrgyzstan*, para. 136, U.N. Doc. A/54/38 (1999); *Kyrgyzstan*, para. 157, U.N. Doc. A/59/38 (2004); *Laos People's Democratic Republic*, para. 96, U.N. Doc. A/60/38 (2005); *Madagascar*, para. 244, U.N. Doc. A/49/38 (1994); *Malawi*, para. 31, U.N. Doc. CEDAW/C/MWI/CO (2006); *Maldives*, para. 142, U.N. Doc. A/56/38 (2001); *Mali*, para. 33, U.N. Doc. CEDAW/C/MLI/CO/5 (2006); *Mexico*, para. 32, U.N. Doc. CEDAW/C/MEX/CO/6 (2006); *Mongolia*, para. 273, U.N. Doc. A/56/38 (2001); *Morocco*, para. 68, U.N. Doc. A/52/38/Rev.1 (1997); *Myanmar*, para. 129, U.N. Doc. A/55/38 (2000); *Namibia*, part II, para. 111, U.N. Doc. A/52/38/Rev.1 (1997); *Nepal*, para. 212, U.N. Doc. A/59/38 (2004); *Nicaragua*, para. 300, U.N. Doc. A/56/38 (2000); *Nigeria*, para. 170, U.N. Doc. A/53/38/Rev.1 (1998); *Paraguay*, para. 32, U.N. Doc. CEDAW/C/PAR/CC/3-5 (2007); *Peru*, para. 337, U.N. Doc. A/53/38/Rev.1 (1998); *Peru*, para. 482, U.N. Doc. A/57/38 (2002); *Philippines*, para. 27, U.N. Doc. CEDAW/C/PHI/CO/6 (2006); *Republic of Moldova*, para. 30, U.N. Doc. CEDAW/C/MDA/CO/3 (2006); *Russian Federation*, para. 545, U.N. Doc. A/50/38 (1995); *Samoa*, para. 56, U.N. Doc. A/60/38 (2005); *Slovenia*, para. 214, U.N. Doc. A/58/38 (2003); *Tajikistan*,

para. 31, U.N. Doc. CEDAW/C/TJK/CO/3 (2007); *Togo*, para. 28, U.N. Doc. CEDAW/C/TGO/CO/5 (2006); *Turkey*, para. 375, U.N. Doc. A/60/38 (2005); *Ukraine*, para. 289, U.N. Doc. A/57/38 (2002); *United Republic of Tanzania*, para. 237, U.N. Doc. A/53/38/Rev.1 (1998); *Venezuela*, para. 236, U.N. Doc. A/52/38/Rev.1 (1997); *Yemen*, para. 397, U.N. Doc. A/57/38 (2002).

[202] *See e.g.,* CEDAW *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38 (1999); *Colombia*, para. 393, U.N. Doc. A/54/38 (1999); *Dominican Republic*, para. 337, U.N. Doc. A/53/38 (1998); *Madagascar*, para. 244, U.N. Doc. A/49/38 (1994); Human Rights Committee *Concluding Observations: Bolivia*, para. 22, U.N. Doc. CCPR/C/79/Add.74 (1997); *Guatemala*, para. 19, U.N. Doc. CCPR/CO/72/GTM (2001); *Hungary*, para. 11, U.N. Doc. CCPR/CO/74/HUN (2002); *Libyan Arab Jamahiriya*, para. 9, U.N. Doc. CCPR/C/79/Add.101 (1998); *Mongolia*, para. 8(b) U.N. Doc. CCPR/C/79/Add.120 (2000); *Paraguay*, para. 123, U.N. Doc. A/51/38 (1996); *Senegal*, para. 12, U.N. Doc. CCPR/C/79/Add 82 (1997); *Sudan*, para. 10, U.N. Doc. CRC/C/15/Add.10 (1993); *Zambia*, para. 9, U.N. Doc. CCPR/C/79/Add.62 (1996).

[203] Cook and Dickens, Advancing Safe Motherhood through Human Rights (WHO), *supra* note 1, at 29-31.

[204] Cook, Reproductive Health and Human Rights, *supra* note 196, at 164, *citing* Inter-American Commission of Human Rights, *Annual Report*, 1980-1981, 125. Cited in: *Annual Report*, 1989-1990, 187.

[205] Cook, Reproductive Health and Human Rights, *supra* note 196, at 164.

[206] Cook and Dickens, Advancing Safe Motherhood through Human Rights (WHO), *supra* note 1, at 30.

[207] Cook, Reproductive Health and Human Rights, *supra* note 196, at 173.

[208] Human Rights Committee, *General Comment 20*: *Replaces general comment 7 concerning prohibition of torture and cruel treatment or punishment*, para. 2, U.N. Doc. HRI/GEN/1/Rev.7 (1992).

[209] *Id.* para. 5.

[210] Human Rights Committee, Communication No. 1153/2003, *K.L. v. Peru,* U.N. Doc. CCPR/C/85/D/1153/2003 (2005).

[211] Cook, Reproductive Health and Human Rights, *supra* note 196, at 173.

[212] Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health*, para. 1, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR, *Gen. Comment 14*].

[213] *See id.* para. 8.

[214] *Id.* para. 1.

[215] *Id.* para. 21.

[216] *Report of the Special Rapporteur on the Right to Health: maternal mortality and access to medicines, supra* note 133, para. 14

[217] CESCR, *Gen. Comment 14*, *supra* note 212, para. 12.

[218] *Id.*

[219] *Id.* para.12(a).

[220] *Id.* para. 12(a).

[221] *Report of the Special Rapporteur on the Right to Health: maternal mortality and access to medicines, supra* note 133, para. 18.

[222] CESCR, *Gen. Comment 14*, *supra* note 212, paras. 3, 4.

[223] *Id.* para. 12(b).

[224] *Id.* para. 11.

[225] *Report of the Special Rapporteur on the Right to Health: maternal mortality and access to medicines, supra* note 133, para. 17(c).

[226] *See, e.g.,* Committee on Economic, Social and Cultural Rights, *Concluding Observations: Algeria*, para. 37, U.N. Doc. E/C.12/1/Add.71 (2001); *Benin*, para. 25, U.N. Doc. E/C.12/BEN/CO/2 (2008); *Columbia*, para. 24, U.N. Doc. E/C. 12/1/Add.74 (2001); *Japan*, para. 55, E/C.12/1/Add.67 (2001); *Mexico*, para. 44, U.N. Doc. E/C.12/MEX/CO/4 (2006); *Nepal*, para. 32, U.N. Doc. E/C.12/1/Add.66 (2001); *Paraguay***,** para. 16, U.N. Doc. E/C.12/1/Add.1 (1996).

[227] *See, e.g.,*Committee on Economic, Social and Cultural Rights, *Concluding Observations: Peru*, para. 16, U.N. Doc. E/C.12/Add.1/14 (1997).

[228] *See, e.g.,* Committee on Economic, Social and Cultural Rights, *Concluding Observation: Nepal,* para. 46, U.N. Doc. E/C.12/NPL/CO/2 (2008); *Paraguay***,** para. 28, U.N. Doc. E/C.12/1/Add.1 (1996); *Peru*, para. 36, U.N. Doc. E/C.12/Add.1/14 (1997).

[229] *Report of the Special Rapporteur on the Right to Health: maternal mortality and access to medicines, supra* note 133, para. 17(c).

[230] CEDAW Committee, *Gen. Rec. 24, supra* note 28, para. 17.

[231] CESCR, *Gen. Comment 14, supra* note 212, para. 12(c).

[232] CEDAW Committee, *Gen. Rec. 24*, *supra* note 28, para. 22.

[233] *Id.*

[234] CESCR, *Gen. Comment 14*, *supra* note 212, para. 12(d).

[235] UNICEF, World Health Organization, & the United Nations Population Fund (UNFPA), Guidelines for Monitoring the Availability and Use of Obstetric Services 1 (Oct. 1997) [hereinafter UNICEF, Guidelines for Monitoring].

[236] *See id.*

[237] UNICEF, Guidelines for Monitoring, *supra* note 235, paras. 5.2.2 - 6, at 77-80.

[238] Cook and Dickens, Advancing Safe Motherhood through Human Rights (WHO), *supra* note 1, at 62-63.

[239] CESCR, *Gen. Comment 14*, *supra* note 212, para. 44(a).

[240] *Id.* para. 30.

[241] CESCR, *General Comment 3*: *The Nature of States Parties Obligations (Art. 2, Para. 1 of the Covenant)*, para. 1, UN Doc. HRI/Gen/1/Rev.3 (1997).

[242] *Report of the Special Rapporteur on the right to health: Mission to India, supra* note 18, para. 48.

[243] Center for Reproductive Rights, Surviving Pregnancy and Childbirth: An International Human Right 11-12 (2005), *available at* http://www.reproductiverights.org/pdf/pub_bp_surviving_0105.pdf.

[244] UN Millenium Development Goals, Goal 5, *supra* note 151.

[245] *Ban Ki-moon gathers global health experts to improve care for world's poorest,* UN News Centre (May 9, 2008), *at* http://www.un.org/apps/news/story.asp?NewsID=26612&Cr=global&Cr1=health (last visited Dec. 22, 2008)

[246] *Id.*

[247] *Id.*

[248] *ICPD Programme of Action, supra* note 6, at Chap. VII, sec. C.

[249] *Key Actions for the Further Implementation of the Programme of Action of the ICPD – ICPD + 5*, para. 53 (1999), available at http://www.unfpa.org/icpd/icpd5-keyactions.cfm

[250] *Id.* para. 64 (1999).

[251] UN Millenium Development Goals, Goal 5, *supra* note 151.

[252] Adam Wagstaff & Mariam Claeson, *Millenium Development Goals: Rising to the Challenges*, World Bank, 47 (2004).

[253] Alicia Ely Yamin & Deborah P. Maine, *Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations*, Human Rights Quarterly 564 (1999).

[254] International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 52, art. 2, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered in to force* Mar. 23, 1976) [hereinafter ICCPR]; International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, art. 2(2), U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976), art. 12(1) [hereinafter ICESCR]; Convention on the Elimination of Discrimination Against Women, *adpoted* Dec. 18, 1979, G.A, Res. 34/180, UN GAOR 34th Sess., Supp. No. 46, art. 1, U.N. Doc. A/34/46. 1249 U.N.T.S. 13 (*entered into force* Sept. 3, 1981) (*ratified by India* July 9, 1993) [hereinafter CEDAW]; Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, UN GAOR, 44th Sess., Supp. No. 49, at 166, art. 2(1), U.N. Doc. A/44/49 (1989) *reprinted in* 28 I.L.M. 1448 (*entered into force* Sept. 2, 1990) [Children's Rights Convention]; African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, arts. 18(3), 28, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) [Banjul Charter]; Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003 [Protocol on the Rights of Women in Africa] at art. 2(1); American Convention on Human Rights, Nov. 22, 1969, art. 1(1), O.A.S.T.S. No. 36, O.A.S. Off. Rec. OEA/Ser.L/V/II.23, doc. 21, rev. 6 (*entered into force* July 18, 1978); Convention for the Protection of Human Rights and Fundamental Freedoms, Nov. 4, 1950, art. 2, Europ. T.S. No. 5, art. 14 [European Convention].

[255] CEDAW, *supra* note 254, art. 21(1).

[256] *Id.* at art. 4(2).

[257] CESCR, *Gen. Comment 14*, *supra* note 212, para. 21.

[258] *Id.* para. 10.

[259] Cook, Reproductive Health and Human Rights, *supra* note 196, at 197.

[260] *Id.*

[261] CEDAW Committee, *Gen. Rec. 24*, *supra* note 28, para. 11.

[262] CEDAW, *supra* note 254, arts. 4(2), 12; *see also Report of the Special Rapporteur on the Right to Health: maternal mortality and access to medicines, supra* note 133, para. 13.

[263] CEDAW Committee, *Gen. Rec. 24*, *supra* note 28, para. 27.

[264] CEDAW, *supra* note 254, art. 27; *see also* CEDAW Committee, *Gen. Rec. 24*, *supra* note 28, at para. 27 (stating that "the duty to fulfill rights places an obligation on States parties to take appropriate legislative, judicial, administrative and budgetary, economic measures to the maximum extent of their available resources to ensure that women realize their rights to health care. Studies such as those which emphasize the high maternal mortality and morbidity rates worldwide…provide an important indication for States parties of possible breaches of their duties to ensure women's access to health care.").

[265] Committee on the Elimination of Discrimination against Women, *General Recommendation 21: Equality in Marriage and Family Relations* (13th Sess., 1994), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, art. 16 (1) (e), para. 21, U.N. Doc. HRI/GEN/Rev.5 (2001) [hereinafter CEDAW Committee, *Gen. Rec. 21*].

[266] CEDAW, *supra* note 254, preamble.

[267] *Id.* at art. 16 (e).

[268] *Id.* at art. 5 (a).

[269] Universal Declaration of Human Rights, *adopted* Dec. 10, 1948, G.A. Res. 217A (III), art. 16(1), U.N. Doc. A/810 at 71 (1948).

[270] CEDAW, *supra* note 254, art. 16(1).

[271] ICCPR, *supra* note 254, art. 23(4).

[272] Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, *Cultural practices in the family that are violent towards women,* para. 56, U.N. Doc E/CN.4/2002/83 (2002). ("She will have to submit to sex with an older man and her immature body must endure the dangers of repeated pregnancies and childbirth.").

[273] CEDAW Committee, *Gen. Rec. 21, supra* note 265, paras. 9, 20.

[274] CEDAW Committee, *Gen. Rec. 21, supra* note 265, art. 16(2), para. 36.

[275] *See e.g.* Committee on the Rights of the Child, *Concluding Observations: Eritrea*, paras. 62-63, U.N. Doc. CRC/C/ERI/CO/3 (2008).

[276] Committee on the Rights of the Child, *General Comment 4,* para. 31, U.N. Doc CRC/GC/2003/4 (2003).

[277] *See* CESCR, *Gen. Comment 14*, *supra* note 212, para. 12 (b).
[278] CEDAW Committee, *Gen. Rec. 24*, *supra* note 28, para. 6.
[279] *Id.* para. 28.
[280] CESCR, *Gen. Comment 14*, *supra* note 212, para. 43 (e).
[281] CESCR, *Gen. Comment 14*, *supra* note 212, para. 18.
[282] CESCR, *Gen. Comment 14*, *supra* note 212, para. 18.
[283] CESCR, *Gen. Comment 14*, *supra* note 212, para. 19.
[284] In addition, "a pregnant adolescent below the age of 18 is 2-5 times more likely to die as a result of pregnancy than a pregnant woman between 18 and 25 years old… Infants of young mothers are more likely to be premature and have low birth weights." *See* Maternal Health: Implications for Children and Adolescents, (prepared by Ipas in consultation with ACPD, CEDPA, CFFC, CRLP, FCI, IPPF, IWHC, Latin American & Caribbean Youth Network for Sexual and Reproductive Rights, NAPY, and Youth Coalition for ICPD) , at 1 *available at* http://www.reproductiverights.org/pdf/pub_fac_adoles_maternalhealth.pdf; *see also* UNICEF, *Early Marriage: A childhood interrupted*, (Apr. 17, 2006), *at* http://www.unicef.org/india/child_protection_1536.htm.
[285] Children's Rights Convention, *supra* note 254, art. 24(1).
[286] Center for Reproductive Rights, Implementing Adolescent Reproductive Rights Through the Convention on the Rights of the Child (1999) *available at* http://www.reproductiverights.org/pdf/pub_bp_implementingadoles.pdf.
[287] CEDAW, *supra* note 254, art. 16.1.
[288] ICCPR, *supra* note 254, art. 17.1.
[289] CEDAW Committee, *Gen. Rec. 21, supra* note 265, para. 21.
[290] *Id.*
[291] CEDAW, *supra* note 254, arts. 10, 12 (1).
[292] *ICPD Programme of Action, supra* note 6, para. 7.2.
[293] CEDAW Committee, *Gen. Rec. 24*, *supra* note 28, art. 12(1), para. 13.
[294] *Id.*
[295] *Id.*
[296] CESCR, *Gen. Comment 14*, *supra* note 212, para. 59.
[297] Human Rights Committee, *Gen. Comment 31*, Nature of the General Legal Obligation on States Parties to the Covenant, para. 15, U.N. Doc. CCPR/C/21/Rev.1/Add.13 (2004).
[298] *Id.*
[299] *Id.*
[300] *Id.*
[301] Paul Hunt, Oral Remarks to the Press, *supra* note 4.
[302] Committee on Economic, Social, and Cultural Rights, *Concluding Observations: India,* para. 37, U.N. Doc. E/C.12/IND/CO/5 (2008).
[303] *Id.* para. 25.
[304] *Id.* para. 77.
[305] *Id.* para. 80.
[306] Committee on the Elimination of Discrimination against Women, *Concluding Observations: India*, para. 40, U.N. Doc. CEDAW/C/IND/CO/3 (2007).
[307] *Id.*
[308] *Id.*
[309] *Id.* para. 41.
[310] Committee on the Elimination of All Forms of Racial Discrimination, *Concluding Observations:India*, para. 24, U.N. Doc. CERD/C/IND/CO/19 (2007).
[311] *Id.*
[312] *Id.*
[313] *Id.* para. 10.
[314] Committee on the Rights of the Child, *Concluding Observations: India*, para. 90, U.N. Doc. CRC/C/15/Add.228 (2004).
[315] *Id.*
[316] *Id.*
[317] Human Rights Committee, *Concluding Observations: India,* para. 88, U.N. Doc CCPR/C/79/Add.81 (1997)
[318] *Id.* para. 16.
[319] Paul Hunt, Oral Remarks to the Press, *supra* note 4.
[320] Asian Human Rights Charter, art. 9.3.
[321] 232,000 maternal deaths occur each year in the Asia region, based on the number of maternal deaths in Southeast and South-Central Asia in 2000. WHO, Department of Reproductive Health and Research (RHR), *Monitoring and Evaluation, supra* note 3. *See also Maternal mortality in South Asia is second highest in the world, UNICEF says*, UN News Centre, July 27, 2005, *at* http://www.un.org/apps/news/story.asp?NewsID=15184&Cr=child&Cr1 (last visited December 22, 2008).
[322] *Maternal mortality in South Asia is second highest in the world, UNICEF says*, *supra* note 321
[323] Center for Reproductive Rights and Avani Mehta Sood, Using Public Interest Litigation and International Law to Promote Gender Justice in India 38 (2006) [citing interview with B. N. Srikrishna, former judge (Mar. 8, 2006)].
[324] India Const. art. 2.
[325] *Shakila Abdul Gafar Khan v. Vasant Raghunath Dhoble*, A.I.R. 2003 S.C. 4567, para. 4.
[326] *Francis Coralie Mullin v. The Administrator, Union Territory of Delhi*, A.I.R. 1981 S.C. 746 ("…the right to life includes the right to live with human dignity and all that goes along with it…").
[327] India Const. art. 37.
[328] India Const. art. 37.
[329] India Const. art. 37.
[330] According to the constititon, directive principles are not enforceable by any court. However, "in the case *Keshavananda Bharati vs. the State of Kerala*…the Court recognized that the directive principles should enjoy the same status as 'traditional' fundamental rights." Sarojini, *supra* note 39, at 87.
[331] India Const. art. 47 ("Duty of the State to raise the level of nutrition and the standard of living and to improve public health: The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption

except for medicinal purpose of intoxicating drinks and of drugs which are injurious to health.").

[332] India Const. Part IV, art. 42.

[333] India Const. Part IV, art. 47.

[334] *Parmanand Katara v. Union of India,* (1989) 3 S.C.R. 997.

[335] *See Parmanand Katara v. Union of India,* (1989) 3 S.C.R. 997. Other leading cases on the right to health include: *C.E.S.C. Ltd. Etc. v. Subhash Chandra Bose and Ors.*, A.I.R. 1992 S.C. 573, 585 (holding that the right to health is a fundamental right); *Consumer Education and Research Centre v. Union of India (1995) 3 S.C.C. 42 (holding that the health and health care of workers is an essential component of the right to life)*; *Kirloskar Brothers Ltd. vs. Employees' State Insurance Corporation*, (1996) 2 S.C.C. 682 *(holding that the health and health care of workers is an essential component of the right to life); State of Punjab and Others v. Mohinder Singh Chawla and Ors* 1996 (2) S.C.C. 83 *(holding that the health and health care of workers is an essential component of the right to life)*; *State of Punjab vs. Mohinder Singh Chawla* 1996 2 S.C.C. 83 (holding that the right to health care for government employees is integral to the right to life).

[336] *Parmanand Katara v. Union of India*, (1989) 3 S.C.R. 997.

[337] *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, A.I.R. 1996 S.C. 2426, para. 9 (The health system failures that contributed to the violations in this case included the absence of a single vacant bed, and the failure of hospital staff to make alternative arrangements in the face of an emergency, in five of the hospitals where treatment was sought; the staff at two of the hospitals claimed lack of appropriate facilities.).

[338] *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, A.I.R. 1996 S.C. 2426, para. 169 ("It is no doubt true that financial resources are needed for providing these facilities. But at the same time it cannot be ignored that it is the constitutional obligation of the State to provide adequate medical services to the people. Whatever is necessary for this purpose has to be done. In the context of the constitutional obligation to provide free legal aid to a poor accused this Court has held that the State cannot avoid its constitutional obligation in that regard on account of financial constraints.").

[339] *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, A.I.R. 1996 S.C. 2426, para. 16.

[340] *Chameli Singh v. State of Uttar Pradesh*, (1995) 6 S.C.R. 827, para. 8.

[341] *Id.*

[342] *Id.* paras. 8, 10.

[343] *Id.* para. 10. In reaching this conclusion, the Court cited India's obligations under the ICESCR. *Id.* para. 3 (citing Universal Declaration of Human Rights, art. 25(1); ICESCR, *supra* note 254, art. 11(1)). The Court further incorporated into its decision recommendations adopted by the UN General Assembly as guidelines for States to ensure housing rights at the national level. *Id.* para. 10.

[344] *Consumer Education and Research Center v. Union of India,* (1995) 1 S.C.R. 626, para. 2.

[345] *Id.* para. 26.

[346] *Id.* para. 32.

[347] *Id.* para. 20.

[348] *Id.* para. 33(4).

[349] *People's Union for Civil Liberties v. Union of India and Others,* W.P. Civ. 196 of 2001, Supreme Court, Order dated Nov. 20, 2007, paras. 1-2 (case ongoing).

[350] *Id.* para. 14(a).

[351] *Id.* para. 14(b).

[352] *Id.* para. 14(e).

[353] *Id.* para. 14(f).

[354] *Apparel Export Promotion Council v. Chopra* (1999) 1 SCR 117, para. 27.

[355] India Const. art. 15.

[356] India Const. art. 15. ("Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth. (1) The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex, place of birth or any of them. (2) No citizen shall, on grounds only of religion, race, caste, sex, place of birth or any of them, be subject to any disability, liability, restriction or condition with regard to — (a) access to shops, public restaurants, hotels and places of public entertainment; or (b) the use of wells, tanks, bathing ghats, roads and places of public resort maintained wholly or partly out of State funds or dedicated to the use of the general public. (3) Nothing in this Article shall prevent the State from making any special provision for women and children. (4) Nothing in this Article or in clause (2) of Article 29 shall prevent the State from making any special provision for the advancement of any socially and educationally backward classes of citizens or for the Scheduled Castes and the Scheduled Tribes.").

[357] India Const. Part IV, art. 46.

[358] India Const. Part IV, art. 46.

[359] India Const. Part IV, art. 38(2).

[360] India Const. Part IV, art. 39(f).

[361] *Vishaka v. State of Rajasthan,* (1997) 6 SCC 241

[362] *Id.* para. 16.

[363] *Id.* paras. 13, 16.

[364] *Id.* para. 13.

[365] *Id.* para. 17.

[366] *Id.* para. 14.

[367] *Id.* para. 15, referring to a case at the High Court of Australia, *Minister of State for Immigration and Ethnic Affairs v. Ah Hin Teoh* (1995) 183 CLR 273, 288.

[368] *Apparel Export Promotion Council v. Chopra* (1999) 1 SCR 117, para. 23.

[369] *Id.* para. 26.

[370] *Id.*

[371] *Id.*

[372] *Id.*

[373] *Javed v. State of Haryana*, A.I.R. 2003 S.C. 3057.

[374] *Id.* paras. 2, 4, 5, 66. The Haryana Provision's two-child norm went into effect one year after the commencement of the act, and applied only to candidates who had a

third child or more after that point—i.e., those who were reproductively active. *Javed,* paras. 2-3.

375 National Population Policy, *supra* note 153, para. 6. *See also* National Human Rights Commission National Human Rights Commission, Ministry of Health and Family Welfare and United Nations Population Fund, Declaration adopted at the National Colloquium on Population Policy, Development and Human Rights (2003), *available at* http://www.nhrc.nic.in/Publications/PopulationP.pdf (last visited Dec. 18, 2008) ("Note[s] with concern that population policies framed by some State Governments reflect in certain respects a coercive approach through use of incentives and disincentives which in some cases are violative of human rights. This is not consistent with the spirit of the National Population Policy.").

376 *Javed*, *supra* note 373, para. 65.

377 *Id*.

378 *Id*. para. 63.

379 *See generally ICPD Programme of Action, supra* note 6.

380 *Id*. para. 7.12.

381 National Population Policy, *supra* note 153.

382 National Human Rights Commission, Government of India, Declaration on Population Policy, Development and Human Rights 1-2 (2003).

383 National Population Policy, *supra* note 153, para. 5.

384 *State of Haryana v. Smt. Santra*, (2000) 5 S.C.C. 186, paras. 1, 44.

385 *Id*. para. 2.

386 *Id*. paras. 5, 6.

387 *Id*. para. 6.

388 *Id*. para. 44.

389 *Id*.

390 *Id*. para. 37.

391 *Id*. paras. 37, 42.

392 India Const. Part IV, art. 39(a).

393 India Const. arts. 32(1) and 32(2). In *Fertilizer Corp. Kamgar Union v. Union of India,* the Supreme Court stated: "The jurisdiction conferred on the Supreme Court by Article 32 is an important and integral part of the basic structure of the Constitution because it is meaningless to confer fundamental rights without providing an effective remedy for their enforcement, if and when they are violated." *Fertilizer Corp. Kamgar Union (Regd.) v. Union of India and Ors*, (1981) 2 S.C.R. 52, para. 11.

394 India Const. art. 226.

395 *People's Union for Democratic Rights (PUDR) v. Union of India*, (1983) 1 S.C.R. 456, para. 2.

396 *M.C. Mehta and Anr. v. Union of India and Ors.*, (1987) 1 S.C.R. 819, para. 3 ("[There is] a constitutional obligation on this Court to protect the fundamental rights of the people and for that purpose this Court has all the incidental and ancillary powers to forge new remedies and fashion new strategies designed to enforce fundamental rights.").

397 Petition at para. 10, Forum for Fact Finding Documentation and Advocacy (FFDA) v. Union of India, W.P. (Civ.) No. 212 of 2003 (Supreme Court of India, Apr. 25, 2003) [hereinafter *FFDA* Petition]. HRLN provided legal representation in this case. CRR provided international legal research assistance on certain aspects of the case.

398 *Id*. para. 13 (iv).

399 *Id*. para. 14.

400 *Id*. para. 14.

401 *Id*. para. 19.

402 *Id*. para. 18(ii).

403 India Const. art. 39.

404 *FFDA* Petition, at paras. 21(I), (V), *supra* note 397.

405 Interim Order, *Forum for Fact Finding Documentation and Advocacy v. Union of India*, W.P. (Civ.) No. 212 of 2003, Item No. 303 (Supreme Court of India, Feb. 28, 2005).

406 *Id*.

407 Center for Reproductive Rights and Avani Mehta Sood, *supra* note 323, at 75.

408 *See id.* at 75 (2006), *citing* Interim Order, *Forum for Fact Finding Documentation and Advocacy v. Union of India*, W.P. (Civ.) No. 212 of 2003 (Supreme Court of India, May 13, 2006); Human Rights Law Network Internal Report (undated, on file with Avani Mehta Sood).

409 *Ramakant Rai & Health Watch U.P. and Bihar v. Union of India*, W.P. (Civ.) No. 209 of 2003, at *Synopsis,* A (Supreme Court of India, 2003) [hereinafter *Ramakant Rai* Petition]. HRLN provided legal representation in this case. CRR drafted a legal memo containing international and comparative legal arguments in support of this case which was submitted to the Supreme Court by HRLN.

410 *Id*. para. 1.

411 *Id*. para. 9.

412 *Id*. para. 9.

413 *Id*. para. 10(i).

414 *Id*. para. 10 (iv).

415 *Id*. para. 10 (v).

416 *Id*. para. 14, *Grounds* (D)-(E).

417 *Id. Grounds* (F).

418 Center for Reproductive Rights and Avani Mehta Sood, *supra* note 323, at 77.

419 In October 2005, the Court partly modified its order to double the compensation amount in states where insurance schemes were not viable due to the low rate of sterilization deaths. Telephone Interview with Abhijit Das, Director, SAHAYOG and Director, Centre for Health and Social Justice, New Delhi, India (Aug. 11, 2006) [hereinafter Interview with A. Das, Aug. 11, 2006] cited in Center for Reproductive Rights and Avani Mehta Sood, *supra* note 323, at 77.

420 Center for Reproductive Rights and Avani Mehta Sood, *supra* note 323, at 77.

421 Secretary for Health and Family Welfare, Manual for Family Planning Insurance Scheme 3-5 (2008), *available at* http://mohfw.nic.in/dofw%20website/FP_Manual_2008-Final.pdf.

422 Email to Reprohealth-India Listserv from Shakuntala Joshi, Health Watch Forum, Uttar Pradesh, describing

the situation in Beheri, Uttar Pradesh, Nov 10, 2008 (on file with CRR).

[423] Interview with A. Das, Aug. 11, 2006, cited in Center for Reproductive Rights and Avani Mehta Sood, *supra* note 323, at 77. For more information about this case, see Center for Reproductive Rights and Avani Mehta Sood, *supra* note 323, at 75 – 78.

[424] *People's Union for Democratic Rights (PUDR) v. Union of India*, (1982) 3 S.C.C. 235, para. 1.

[425] *See Subhash Kumar v. State of Bihar*, A.I.R. 1991 S.C. 420 (upholding the right to pollution free water and air); *Virender Gaur v. State of Haryana*, (1995) 2 S.C.C. 577 (upholding rights against environmental, ecological, air and water pollution; *Attakoya Thangal v. Union of India,* (1990) 1 K.L.T. 580 (upholding the right to clean water); *Chameli Singh v. State of U.P.,* (1996) 2 S.C.C. 549 (upholding the right to housing); *Ahmedabad Municipal Corporation v. Nawab Khan Gulab Khan and Ors.*, (1997) 11 S.C.C. 121 (upholding the right to housing); *Bandhua Mukti Morcha v. Union of India,* (1984) 3 S.C.C. 161 (upholding the right to education); *Mohini Jain v. State of Karnataka*, (1992) 3 S.C.C. 666 (upholding the right to education); *Unni Krishnan J.P. and Ors. v. State of Andhra Pradesh and Ors. Union of India*, (1993) 1 S.C.C. 645 (upholding the right to education).

[426] Center for Reproductive Rights and Avani Mehta Sood, *supra* note 323 at 81 (citing Interview with Justice J. S. Verma (Mar. 29, 2006)).

[427] *S.P. Gupta and Ors. v. President of India and Ors.* 1981 Supp. SCC 87, para. 17.

[428] *Suo moto,* meaning 'on its own motion,' means that the court need "not insist on a regular writ petition to be filed…" *S.P. Gupta and Ors. v. President of India and Ors.* 1981 Supp. SCC 87, para. 17.

[429] *See* Center for Reproductive Rights and Avani Mehta Sood, *supra* note 323, at 80 – 85 (in-depth discussion on challenges of PIL based on in-person interviews).

[430] *See* Center for Reproductive Rights and Avani Mehta Sood, *supra* note 323, at 24 - 29.

[431] International Institute for Population Sciences, National Family Health Survey (NFHS-3): National Fact Sheet—Madhya Pradesh, *available at* http://nfhsindia.org/pdf/MP.pdf.

[432] *Sandesh Bansal v. Union of India and Others* , W.P. (Civ.) No. 9061 of 2008, (M.P. High Court), at para. 5.13. HRLN is providing legal representation in this case. CRR drafted a legal memo containing international arguments in support of this case which was submitted to the State High Court of Madhya Pradesh by HRLN.

[433] *Id.* para. 5.8.

[434] *Id.* paras. 5.8 – 5.11

[435] *Id.* paras. 34.6 – 5.34.9.

[436] *Id.* para. 5.21.

[437] *Id.* para. 5.15.

[438] *Id.* paras. 5.16.1 – 5.16.3

[439] *Id.* para. 7.

[440] *Id.* paras. 7(d) and (e).

[441] *Id.* para. 7(g).

[442] *Id.* Application for Seeking Interim Direction, Prayer paras. 1-4.

[443] Petition, *Snehalata Singh v. The State of Uttar Pradesh and Others*, 2008, (U.P. High Court). HRLN is providing legal representation in this case. CRR will submit a legal memo to the High Court of Uttar Pradesh with international arguments in support of the case.

[444] *Id.* para. 5.

[445] *Id. supra* note, paras. 5 – 19

[446] *Id.* paras. 12, 16 (regarding inability to pay); *Id.* paras. 17, 19 (regarding absence of bed).

[447] *Id.* para. 2.

[448] See *Id.* Facts, paras. 5, 6, 7.

[449] *Id.* paras. 1 – 3.

[450] *Id.* para. 4.

[451] *Id.* para. 5.

[452] *Id.* para. 8.

[453] WHO, Obstetric Fistula: Guiding principles for clinical management and programme development 3-4 (2006), *available at* http://whqlibdoc.who.int/publications/2006/9241593679_eng.pdf.

[454] Fistula occurs when there is prolonged pressure on the soft tissue between the descending fetus' head and the mother's pelvic bone, resulting in a lack of blood flow that causes the tissue to die. When the tissue dies, a hole is created between the mother's vagina and bladder (called vesicovaginal fistula), between the vagina and rectum (called rectovaginal fistula) or both. UNFPA Campaign to End Fistula, *Frequently Asked Questions*, *available at* http://www.endfistula.org/q_a.htm (last visited September 30, 2008).

[455] UNFPA, *Obstetric Fistula: A Tragic Failure to Deliver Maternal Care*, *available at* http://www.unfpa.org/mothers/fistula.htm (last visited September 30, 2008).

[456] UNFPA Campaign to End Fistula, *supra* note 454.

[457] UNFPA, Report on the 2nd Asia and Pacific Regional Workshop Strengthening Fistula Elimination in the Context of Maternal Health 1 (2006), *available at* http://www.fistulanetwork.org/FistulaNetwork/user/admin/asia_and_pacific_regional_workshop_april06.pdf.

[458] UNFPA, Report on the 2nd Asia and Pacific Regional Workshop, *supra* note 457, at 1.

[459] WHO, Obstetric Fistula: Guiding principles for clinical management and programme development, *supra* note 453, at 6.

[460] *Id.* at 3.

[461] *Id.* at 3.

[462] UNFPA, *Obstetric Fistula: A Tragic Failure to Deliver Maternal Care, supra* note 455.

[463] UNFPA, Report on the 2nd Asia and Pacific Regional Workshop, *supra* note 457, at 1.

[464] WHO, Obstetric Fistula: Guiding principles for clinical management and programme development, *supra* note 453, at Preface.

[465] *Report of the Special Rapporteur on the Right to Health: maternal mortality and access to medicines, supra* note 133, para. 30.

[466] WHO, Obstetric Fistula: Guiding principles for clinical management and programme development, *supra* note 453, at 6.
[467] National Rural Health Mission: Framework for Implementation, *supra* note 157, at 121.
[468] Petition, *Smt. Shakuntala Devi v. State of U.P. and Others*, W.P. (Civ.) No. 4999 of 2008, (U.P. High Court, Lucknow Bench) at para. 2.
[469] *Id.* para. 3.
[470] *Id.* para. 7.
[471] *Id.* para. 11.
[472] *Id.* para. 12.
[473] Protection of Human Rights Act 1993, No. 10, Acts of Parliament, 1994, sec. 12(a), *available at* http://nhrc.nic.in/Publications/HRActEng.pdf.
[474] *Id.* sec. 12(f).
[475] *Id.* sec. 12(j).
[476] *Id.* sec. 12(h).
[477] Sarojini, *supra* note 39, at 33.
[478] *Id.*
[479] *Id.* at 105.
[480] National Commission for Women Act, No. 20, Acts of Parliament, 1990, sec. 10(f), *available at* http://ncw.nic.in/page21.htm.
[481] *Id.* sec. 10(g).
[482] *Id.* sec. 10(l).
[483] *Id.* sec. 10(f)(ii).
[484] CEDAW Committee, *Statement by the Committee on the Elimination of Discrimination against Women on its relationship with national human rights institutions, Annex II*, para. 4, UN Doc. E/CN.6/2008/CRP.1 (2008), *available at* http://www.un.org/womenwatch/daw/csw/csw52/crps/crp1_e.pdf.
[485] *Id.*
[486] India Const., Directive Principles of State Policy, art. 47, (constitutional provision identifying public health as a state subject), *available at* http://lawmin.nic.in/coi/coiason29july08.pdf
[487] *Indian Medical Association v. V.P. Shanta,* AIR 1996 SC 550.
[488] *State of Orissa v. Divisional Manager, LIC and Another*, (1996) 8 SCC 655, para. 6.
[489] *Indian Medical Association v. V.P. Shantha, supra* note 487, para. 56(3).
[490] *Id.* para. 52.
[491] *Dr. Ravinder Gupta and Others v. Ganga Devi and Others*, 1993 (1) CTJ 1004, para. 18.
[492] *Pearey Lal Varma v. Dr. A.K. Gupta and Others*, 1993 (1) CTJ 827, para. 6.
[493] *Indian Medical Association v. V.P. Shantha, supra* note 487, paras. 55(5), (6), (9).
[494] *Id.* paras. 45, 56(8).

The right to survive pregnancy and childbirth is a basic human right.

The Government of India has a legal obligation to ensure that women do not die or suffer complications as a result of preventable pregnancy-related causes. The staggering scale and continuing occurrence of maternal deaths and morbidity in India reveals the Government's failure to protect women's rights and comply with international law.

As the nation leading the world with respect to the number of maternal deaths, the Indian government has an immediate obligation to take meaningful steps to dramatically reduce maternal mortality by fully implementing national policies on maternal health and holding those responsible for the failure of its policies accountable.

This report is intended to serve as a resource for those interested in using international and constitutional legal norms and mechanisms to establish government accountability for maternal deaths and pregnancy-related morbidity through public interest litigation and human rights advocacy.

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The Center's Mission

The Center for Reproductive Rights uses the law to advance reproductive freedom as a fundamental right that all governments are legally obligated to protect, respect and fulfill.