2011 UPDATE

MATERNAL MORTALITY IN INDIA

Using International and Constitutional Law to Promote Accountability and Change

CENTER FOR REPRODUCTIVE RIGHTS

HRLN
Human Rights Law Network

The Center for Reproductive Rights

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.

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.

Human Rights Law Network

Mission

The Human Rights Law Network is a collective of lawyers and social activists dedicated to the use of the legal system to advance human rights in India and the sub-continent. HRLN collaborates with human rights groups, and grass-roots development and social movements to enforce the rights of poor marginalised people and to challenge oppression, exploitation and discrimination against any group or individual on the grounds of caste, gender, disability, age, religion, language, ethnic group, sexual orientation, and health, economic or social status. HRLN provides pro bono legal services, conducts public interest litigation, engages in advocacy, conducts legal awareness programmes, investigates violations, publishes 'know your rights' materials, and participates in campaigns.

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"[N]o woman, more so a pregnant woman, should be denied facility or treatment at any stage irrespective of her social and economic background.... This is where the inalienable right to health which is so inherent in the right to life gets enforced."

– Hon'ble Justice S. Muralidhar

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Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
United States
Tel +1 917 637 3600
Fax +1 917 637 3666
publications@reprorights.org
www.reproductiverights.org

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Table of Abbreviations and Glossary

ABBREVIATION OR TERM	COMPLETE TERM OR DEFINITION
AAY	Antyodaya Anna Yojana; a scheme to provide food to the poorest people
AIDS	Acquired immune deficiency syndrome. The stage at which an individual's immune system is weakened by HIV to the point where he or she may develop any number of diseases or cancers, or where a laboratory test shows his or her immune system to be severely damaged
Amicus curiae	Latin for "friend of the court," an organization or group of individuals permitted by a court to participate in a case although they are not one of the litigants; the typical role of an amicus is to file a brief that adds a perspective not otherwise before the Court. *Amici* is plural of *amicus*
Anemia (Anaemia)	Condition characterized by an insufficient supply of red blood cells or hemoglobin, often caused by iron or folic acid deficiency
Anganwadi centers	Community centers where Anganwadi workers provide child- and maternal-health and education services
Anganwadi workers	Workers trained by the government to deliver basic child- and maternal-health and education services
ANM	Auxiliary Nurse Midwives
Antenatal care	Health care given to women during pregnancy, also referred to as prenatal care
ASHA	Accredited Social Health Activist
BPL	Below the poverty line
CAG	Comptroller and Auditor General
Central government/Union government	The governing authority of the federal Union of India, which includes all states and union territories in the country
CHARM	Centre for Health and Resource Management
Constitution	The Constitution of India
Fistula (obstetric)	Serious medical condition brought on by inadequate care during childbirth, in which a hole develops between the rectum and vagina or bladder and vagina
FPS	Fair Price Shops
FSB	Food Security Bill
General Comment	Comprehensive interpretation of a particular article of a treaty issued by the respective UN treaty monitoring body
HIV	Human immunodeficiency virus; a retrovirus that infects cells of the immune system, destroying or impairing their function. As the infection progresses, the immune system becomes weaker, and the person becomes more susceptible to infections

HRLN	Human Rights Law Network
ICDS	Integrated Child Development Scheme
IPHS	Indian Public Health Standards
JSY	Janani Suraksha Yojana; component of the NRHM entailing cash payments to BPL women who obtain certain maternal health services
Malaria	A life-threatening but preventable and treatable disease caused by parasites that are transmitted to people through the bites of infected mosquitoes
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
NAC	National Advisory Council
NFBS	National Family Benefit Scheme
NMBS	National Maternity Benefit Scheme
NRHM	National Rural Health Mission
OHCHR	Office of the High Commissioner for Human Rights
PIL	Public interest litigation
PUCL	*PUCL v. Union of India*
Ration card	Document issued by state governments in India for the purchase of essential commodities at a subsidized rate from fair price shops; distinctive ration cards are issued to Above Poverty Line, BPL, and AAY families, and these documents are often used by government for identification purposes, including in voting
Special Rapporteur	An individual appointed by the UN Human Rights Council to investigate, monitor, and recommend solutions to human rights problems
UN	United Nations
UNFPA	United Nations Population Fund
UNHRC	United Nations Human Rights Council

Introduction

In 2004, the Center for Reproductive Rights (the Center) launched a global litigation campaign to promote accountability under national and international law for violations of women's reproductive rights. In India, the Center in collaboration with the Human Rights Law Network (HRLN) has carried forward this strategy through a series of workshops and consultations designed to build legal capacity and aimed at promoting compliance with international and Indian constitutional law to legally ensure a woman's right to survive pregnancy and childbirth. The Center's report *Maternal Mortality in India: Using International and Constitutional Law to Promote Accountability and Change* (the original report), published in 2008, was designed as a legal resource for Indian advocates seeking to use public interest litigation (PIL) and human rights advocacy to establish government accountability for maternal deaths and pregnancy-related morbidity. The report articulated the international and constitutional legal framework supporting the right to survive pregnancy and childbirth as a fundamental right, and recommended strategies for promoting legal accountability for preventable maternal deaths and morbidities.

Since its release, the original report has been distributed extensively in India and utilized in the development of several groundbreaking maternal health cases filed by HRLN. The Center and HRLN are pleased to present this update to the original report, with the goal of ensuring that the report remains a useful tool for advocates for maternal health within India as well as globally. The update demonstrates the meaningful impact public interest litigation is having on efforts to address maternal mortality in India, especially in terms of establishing that the right to survive pregnancy and childbirth is legally protected, and this right encompasses maternal health benefits guaranteed through state policies and schemes. The cases HRLN has spearheaded since 2008 have awakened a justice system that had previously been a passive spectator to the suffering and fatalities endured by women during pregnancy and childbirth. The litigation led by HRLN in collaboration with its clients, who include aggrieved individuals, surviving family members, and nongovernmental organizations working to reduce maternal mortality across states in India, establish the important role that the legal community—lawyers and judges—can play in addressing a major national health crisis.

This update is divided into four sections. Chapter I contains a brief description of the present state of maternal health in India with a focus on current maternal mortality statistics and recently reported issues and trends. Chapter II discusses recent developments at the international level, where international and regional human rights bodies have affirmed that governments have a legal obligation to reduce maternal mortality and morbidity and emphasized that a human rights approach is essential to preventing these deaths and injuries. Chapter III provides an account of PIL strategies currently being undertaken in different states across the country and highlights key outcomes. Chapter IV presents key observations and recommendations for further action.

Chapter I. The Current State of Maternal Health in India

According to the United Nations Interagency Maternal Mortality Estimates for 1990–2008, released in September 2010, the absolute number of maternal deaths in India has fallen from 117,000 to 63,000.[1] This data is supported by a study published in *The Lancet* in April 2010, which shows that India's maternal mortality ratio (MMR) declined from 677 maternal deaths for every 100,000 live births in 1980 to 254 in 2008.[2] There has been some controversy as to the accuracy of the MMR claims, with experts from the Indian Institute of Population Sciences carrying out simultaneous assessments and arriving at estimates for MMR in the range of 325 to 350.[3] Despite this apparent progress, however, India is not on track to meet either its national or international targets.[4]

Moreover, while noteworthy, the decline in India's MMR is small in relation to the scope of the problem and does not reflect the deep disparities and inequities that remain within India. Estimates of progress cannot mask the fact that poor and marginalized women are suffering maternal mortality at rates far higher than the national average.[5] The debate around estimates should not distract the government from the urgent need to focus on equitable access to quality maternal health services and the proper implementation of government maternal health schemes. In 2010, India's Union Health and Family Welfare Minister Ghulam Nabi Azad, who is responsible for health policy, including government programs relating to family planning, issued a directive for an audit of maternal deaths to be conducted across the country.[6] This is a positive step; however, reports from the ground suggest that these audits are not being conducted systematically by concerned government authorities even though funds have been allocated for this purpose.[7]

Many obstacles continue to stand in the way of continued progress toward the government's goals for maternal mortality reduction: poor health infrastructure, especially emergency obstetric services;[8] scarcity of specialists;[9] low government budgetary allocations for health;[10] discrimination against women, particularly poor women and those belonging to scheduled castes and tribes;[11] and cultural attitudes that do not consider professional prenatal and delivery care necessary.[12] The poor state of the health infrastructure and workforce is a serious concern as it is generally estimated that approximately 15% of women in any population will experience complications related to pregnancy.[13] In addition, unmet need for contraception[14] results in a substantial number of unplanned pregnancies, and access to safe abortion services remains inadequate.[15] These are some of the most critical underlying causes of preventable maternal mortality and morbidity.

National Rural Health Mission Evaluations

Introduced in 2005, the National Rural Health Mission (NRHM) is the Government of India's flagship program, designed to deliver healthcare to vulnerable populations in 18 states with a strong focus on women living below the poverty line (BPL). It establishes a key target of reducing maternal mortality to fewer than 100 per 100,000 live births by 2012. (See p. 22 of the original report for more information on the NRHM.) Evaluations undertaken by civil society organizations, government agencies, and the United Nations Population Fund (UNFPA) indicate that despite the launch of the NRHM and the implementation of the Janani Suraksha Yojana (JSY), women throughout the country, particularly marginalized women, still lack equitable, affordable, and quality maternal healthcare. (See p. 22 of the original report for more information on the JSY.) A periodic audit conducted by the Comptroller and Auditor General (CAG) reported that high-focus states, where diseases are endemic and health

SCANDALS ACROSS INDIA

According to reports, a survey in the Barwani district hospital located in Madhya Pradesh revealed at least 25 maternal deaths between April and November 2010, even though the hospital has been designated a comprehensive emergency obstetric care unit, equipped to deal with childbirth complications day and night.[1] Activists from local nongovernmental organization Jagrit Adivasi Dalit Sangathan recorded a number of cases in the Barwani district in which poor pregnant women were turned away from the community health centers of their villages and were beaten and abused by nurses and health staff of the district hospital.[2] In an unprecedented move, district officials in Madhya Pradesh went so far as to issue criminal proceedings against peaceful protesters seeking answers about the causes of the maternal deaths.[3] As reported by Human Rights Watch, the state government of Madhya Pradesh failed to examine the causes of these deaths, despite a central government mandate that requires states to investigate maternal deaths and take appropriate remedial action.[4]

Similarly, during February and March 2011, at least 28 pregnant women died in two government hospitals in Jodhpur, Rajasthan, supposedly after being administered contaminated intravenous fluids. In connection with the maternal deaths, the state government has thus far suspended three doctors,[5] a drug inspector, and a storekeeper at one of the hospitals where the deaths happened.[6] HRLN, on behalf of itself, local women's equality coalition Mahila Atyachar Virodhi Manch, and national grassroots health rights movement Jan Swastha Abhiyan, filed a PIL petition in the Rajasthan High Court (Jodhpur bench) alleging violations of the right to survive pregnancy and childbirth as articulated in Indian and international law.[7] The petition seeks individual compensation for the families of the pregnant women who died; payment of benefits that the women and, in cases of maternal death, their families are entitled to under the government's maternal health schemes; and the implementation of the NRHM as well as systemic reform, such as adequate referral systems, maternal death audits, and monitoring of health facilities in Jodhpur.[8]

indicators poor, were in fact receiving "relatively lesser central grants."[16] Under NRHM, states were to be allocated grants according to the norms developed on the basis of a composite index incorporating factors such as population, disease burden, health indicators, and the state of the public health infrastructure.[17] However, no such composite index was developed.[18] As a result, grants were allocated among various states mainly on the basis of population, to the detriment of states such as Bihar and Assam, which received the least although their health infrastructures are believed to be in a shambles.[19] In addition, the CAG report noted that the release of funds to the states, and consequently to district and block levels, required "further streamlining to ensure prompt and effective utilisation of funds."[20] Notably, the report found that various existing programs, such as the National Maternity Benefit Scheme (NMBS), had been closed down with the initiation of the NRHM, and the unutilized balances under these programs remained unspent in 31 states (all states/Union Territories other than Sikkim, Dadra and Nagra Haveli, Chandigarh, and Puducherry).[21] The central government has demanded that the funds be returned.[22] The discontinuation of the NMBS by states and the demand for the return of funds directly contradicts an order issued by the Supreme Court in 2007 in *PUCL v. Union of India (PUCL)* that clarified that nutrition benefits guaranteed under the NMBS and the cash incentives provided under the JSY are independent of each other; pregnant women are entitled to both regardless of their age and the number of children they have;[23] and funds allocated for NMBS must not be used for other activities.[24]

DOCUMENTED ISSUES WITH NRHM AND JSY

- The Ministry of Health and Family Welfare and the Centre for Health and Social Justice report in separate studies that a shortage of specialists, doctors, nurses, and paramedics is one of the biggest impediments to streamlining the NRHM.[1] Similarly, a UNFPA study found that the health system will need more capacity in terms of workforce, supplies, and quality of care to meet the JSY-induced demand for institutional deliveries.[2]
- UNFPA reported that despite the substantial increase in the proportion of institutional deliveries, the short duration of stay by mothers at the institution after delivery remains a cause for concern, particularly because it results in minimal or no postpartum care, and half of maternal deaths take place postpartum.[3]
- The Center on Globalization and Sustainable Development report also notes that infrastructure building needs to keep up with the demand to deliver quality care.[4] The report points out that the simple availability of a building designated as a public health facility does not guarantee that it is functional, and even if it is functional, it may not be accessible to groups of people who may be restricted in their use of public healthcare services because of their caste, religion, or gender.[5] In addition, the delivery of quality healthcare services is not guaranteed, particularly in rural areas where the infrastructure is substandard and there is a severe lack of even basic drugs and equipment.[6]
- The Ministry of Health and Family Welfare has raised concerns about inadequate provision of crucial services such as antenatal care,[7] emergency contraceptives,[8] and safe abortions[9] under the plans. The Centre for Health and Social Justice noted the lack of widespread information dissemination on safe abortion, and found that in some cases healthcare workers were not providing accurate information on safe abortion.[10]
- Both the Ministry of Health and Family Welfare and the Centre for Health and Social Justice called for a review of training and functioning of Accredited Social Health Activists (ASHA), particularly because there is an increase in demand; however, the quality of care varies.[11]
- In a report tabled in parliament in March 2011, India's Public Accounts Committee called for a complete reappraisal and redesign of the NRHM, citing multiple findings of untrained personnel, substandard conditions, misuse of government property, and ineffective or nonexistent monitoring and review mechanisms.[12] Similarly, the Ministry of Health and Family Welfare and the Centre for Health and Social Justice have also reported that corruption at all levels is a major problem and noted that "departmental monitoring, oversight and accountability mechanisms still need to be developed further and strengthened for meticulous implementation."[13]

The distribution of financial incentives under the JSY has been recognized by several sources as being fraught with problems. The Ministry of Health and Family Welfare undertook a review of the NRHM and found that often JSY payments were not made in time due to lack of funds at the facility level, and in some districts immediate payments to JSY beneficiaries could not be made even after two months because of lack of funds.[25] The review called for improved documentation at the facility level to support JSY payments.[26] Similarly, separate studies undertaken by UNFPA at the request of the Government of India in five high-focus states and by the Centre for Health and Social Justice have reported on the lack of payment and delayed payment of JSY entitlements as well as the trouble the beneficiaries had to go through to receive payment.[27] (For more information, see box above—Documented Issues with the NRHM and JSY.)

Maternal mortality has various economic dimensions and consequences that require serious consideration. Corruption within the healthcare system has prevented benefits promised under various schemes from reaching the majority of BPL women who are simply not in a position to demand them, and there is no legal accountability for these corrupt practices. At the same time, significant amounts of money allocated for schemes and maternal death audits remain underutilized, indicating a troubling lack of management capacity.[28] The cost burden on women and families of accessing healthcare services to address potentially life-threatening medical complications, including those experienced by women during pregnancy, can be crushing and can throw families into a cycle of indebtedness and extreme poverty.[29] Further, studies show that maternal deaths undermine a nation's economic development with the "lost productivity of women alone estimated to reach nearly $8 billion annually."[30] These trends show that it is in the interest of communities and the nation as a whole to ensure that pregnant women are able to go through pregnancy safely and do not suffer injuries or fatalities. It is paradoxical that India is one of the fastest-growing economies in the world, yet the cost of maternal mortality to the nation's economic development has not been recognized or tackled.

Chapter II. International Legal Developments

Over the past few years, human rights bodies at the international and regional levels have begun to recognize that preventable maternal mortality and morbidity is a human rights violation and that states should be held accountable for the failure to prevent these deaths and disabilities.

United Nations Human Rights Council Resolutions

In June 2009, the United Nations Human Rights Council (UNHRC) adopted a landmark resolution, Preventable Maternal Mortality and Morbidity and Human Rights (Resolution 11/8), marking the first time that this U.N. body has officially recognized maternal mortality as a human rights concern.[31]

Through the UNHRC resolution, governments express grave concern for the unacceptably high rates of maternal mortality and morbidity, acknowledge that this is a human rights issue, and commit to enhancing their efforts at the national and international levels to protect the lives of women and girls worldwide.[32] They officially recognize that the elimination of maternal mortality and morbidity requires the effective promotion and protection of women's and girls' human rights, including their rights to life; to be equal in dignity; to education; to be free to seek, receive, and impart information; to enjoy the benefits of scientific progress; to freedom from discrimination; and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health.[33]

Specifically, the resolution calls on states to renew their commitment to their international human rights obligations to ensure safe pregnancy and childbirth, and to "redouble" existing efforts to fulfill these obligations, which includes allocating more resources to public health systems so that they will be better equipped to handle the causes of preventable maternal illness and death.[34] The resolution calls upon states to incorporate a human rights-centered approach to the programs and policies to eliminate preventable maternal mortality and morbidity, and stresses that a human rights-based approach makes efforts against maternal mortality and morbidity more effective and sustainable.[35] The resolution also commissioned a study by the Office of the High Commissioner for Human Rights (OHCHR) that examines the international

human rights framework and standards on maternal mortality and morbidity and how the UNHRC can add value to existing initiatives through a human rights analysis.[36] (See box—2010 OHCHR Study on Preventable Maternal Mortality and Morbidity and Human Rights, p. 16.)

In October 2010, the UNHRC adopted a follow-up resolution calling on states to renew their political commitment to eliminate preventable maternal mortality and morbidity at the local, national, regional, and international levels.[37] Notably, the follow-up resolution welcomed the OHCHR study on preventable maternal mortality and morbidity and human rights, and called on key stakeholders to implement the findings and recommendations of the study.[38] Specifically, the resolution calls on governments to collect disaggregated data and to adopt national-level targets and indicators reflecting the main underlying causes of maternal mortality and morbidity, such as poverty, malnutrition, harmful practices, lack of accessible and appropriate healthcare services, and lack of information and education on gender inequality, as well as to pay particular attention to eliminating all forms of violence against women and girls, as part of their efforts to ensure "effective monitoring of policies and programmes."[39] The follow-up resolution also recognizes that women's full enjoyment of all human rights is an important means for achieving all of the U.N. Millennium Development Goals,[40] which is particularly crucial for India, as it is not on track to achieve its MDG target of reducing maternal mortality to 109 per 100,000 live births by 2015.[41] The resolution also requests that the OHCHR prepare a study, to be presented at the UNHRC's eighteenth session in September 2011, that will examine initiatives undertaken by states and other relevant stakeholders that exemplify good or effective practices in adopting a human rights-based approach to eliminating preventable maternal mortality and morbidity.[42]

Although India, unlike its neighbors Sri Lanka and Nepal, was not a state sponsor of the Resolution 11/8, the government is still internationally obligated to take concrete measures to comply with this resolution as well as the 2010 follow-up resolution.[43] The UNHRC resolutions provide advocates with powerful tools for demanding government accountability for failure to protect and promote every woman's basic human right to safe and healthy pregnancy and childbirth, particularly in relation to developing and implementing maternal mortality action plans that adopt a human rights-centered approach.

Special Rapporteur on the Right to Health: Mission to India

In April 2010, the Special Rapporteur on the Right to Health released a report on maternal mortality in India, based on an official visit conducted in 2007, which analyzes the government's approach to addressing maternal mortality and recommends action based on human rights standards.[44] (See p. 36 of the original report for more information on the 2007 visit.) The Special Rapporteur's report focuses on two main themes—the health workforce and accountability—and documents several barriers to maternal healthcare in India, including a lack of data on the causes of maternal deaths, a failure to invest adequate public funds into maternal health programs and to utilize such funds efficiently, and a lack of "urgent, focused, sustained, systematic, and effective implementation, reinforced by robust independent monitoring, accountability, and redress."[45] The report states that regarding India's obligations under right to health, "[p]ublic spending on health that continues to bracket India with 'the lowest in the world' is in breach of this international legal obligation."[46] It further recommends that India establish an independent body to collect and analyze data on maternal deaths and on emergency obstetric care indicators.[47] The report highlights the Center's original report, the 2008 publication *Maternal Mortality in India*, in its discussion of the need to improve "monitoring, accountability and redress in relation to maternal mortality."[48]

REGIONAL HUMAN RIGHTS MECHANISMS EXPRESS CONCERN ABOUT MATERNAL MORTALITY

In June 2010, the Inter-American Commission on Human Rights published *Access to Maternal Health Services from a Human Rights Perspective*, a report analyzing the connection between states' human right obligations and maternal health.[1] The report describes states' obligation to guarantee that women, especially those who have historically been marginalized, have equal access to health services related to pregnancy and childbirth as well as other reproductive health services.[2]

The European Parliament passed a similar resolution in 2008 recognizing preventable maternal deaths as a violation of women's rights to life, to the highest attainable standard of physical and mental health, and to nondiscrimination in access to basic healthcare.[3] The resolution called upon the European Union to intensify efforts to eliminate preventable maternal mortality and morbidity through development, implementation, and regular evaluation of road maps and action plans for the reduction of the global burden of maternal mortality and morbidity.[4]

That same year, the African Commission on Human and Peoples' Rights adopted a resolution recognizing that maternal mortality is a human rights issue and calling upon states to integrate a human rights-based approach when formulating country programs and strategies to reduce maternal mortality in Africa.[5] The resolution called for the participation of women and civil society in the formulation, implementation, monitoring, and evaluation of policies and frameworks aimed at addressing maternal mortality.[6]

Although Asia-Pacific's first regional human rights body, the Association of Southeast Asian Nations (ASEAN) Intergovernmental Commission on Human Rights, does not yet have a comparable resolution, it has prioritized maternal health as an issue for action and is exploring future strategies to promote and protect maternal health in ASEAN member states.[7]

Maternal health advocates in India have been working to disseminate the Special Rapporteur's report widely and engage concerned stakeholders in discussing its findings and recommendations. One such event in New Delhi, organized by the National Alliance for Maternal Health and Human Rights in August 2010,[49] created public dialogue about the report among members of the National Human Rights Commission, the National Women's Commission, the Planning Commission, members of parliament from the Parliamentary Standing Committee, officials from the Ministry of Health and Family Welfare, NRHM advisory groups, technical agencies and donors, health providers' associations, the media, and civil society organizations.[50]

In August 2010, as part of a broader advocacy strategy to build political support in favor of implementation and reform of maternal health policies and programs, the Center in collaboration with the Indian Association of Parliamentarians on Population and Development organized a special briefing for parliamentarians.[51] In line with the findings of the Special Rapporteur's report, this event emphasized the importance of accountability for maternal deaths. It also featured the strong orders issued by the judiciary in a groundbreaking Delhi High Court decision on maternal health to illustrate measures the government is mandated to implement to address maternal mortality. (For more information on the Delhi High Court case and other judicial developments, see Chapter III, p. 17.)

2010 OHCHR STUDY ON PREVENTABLE MATERNAL MORTALITY AND MORBIDITY AND HUMAN RIGHTS

The study by OHCHR states unequivocally that maternal mortality and morbidity are matters of human rights and that a human rights-based approach is essential to addressing these serious global problems.[1] The study notes that preventable maternal mortality and morbidity reflect stark inequalities and multiple forms of discrimination and violence faced by women and girls throughout their lifetimes.[2] It emphasizes that sustainable progress can only be made by guaranteeing the full range of women's human rights, including sexual and reproductive rights.

The report explicitly states that international human rights obligations require states to "take legislative, administrative, and judicial action, including through the commitment of maximum available resources to prevent maternal mortality and morbidity."[3] Such actions include implementing effective programming, strategies, and policies that integrate these seven key human rights principles: accountability, participation, transparency, empowerment, sustainability, nondiscrimination, and international assistance and cooperation.[4] The report notes that regular monitoring of the health system and of the underlying physical and socioeconomic determinants that affect women's health and ability to exercise their rights is essential to correct systemic failures in reducing maternal mortality and morbidity and ensure that vulnerable communities are benefiting from healthcare schemes.[5] In addition, the report emphasizes that "effective access to remedies and reparation contributes to a constructive accountability framework by focusing on system failures and encouraging repair" to prevent and redress maternal deaths and disabilities.[6]

Commission on Information and Accountability for Women's and Children's Health

In December 2010, the U.N. established the Commission on Information and Accountability for Women's and Children's Health, which was charged with developing a framework for global reporting, oversight, and accountability regarding women's and children's health. The Commission is composed of high-level commissioners from government, civil society, academia, and multilateral agencies and includes Union Minister of Health and Family Welfare Azad. The Commission held its first meeting in January 2011, and just released its final report in May 2011.

The Commission's report *Keeping Promises, Measuring Results*, sets out ten recommendations for practical actions towards greater accountability.[52] The recommendations proposed by the Commission focus on the establishment of a robust health information system to track birth and death registration; use of indicators to monitor reproductive and maternal health which taken into account measures of gender equity; and putting in place an effective national accountability mechanism to review data and track progress. Having concluded its work, the Commission will establish an Expert Review Group to report regularly to the U.N. Secretary General on implementation of its recommendations.

Chapter III. Legal Accountability for Violations of the Right to Maternal Health in India

The Government of India has introduced several maternal health schemes, but the continued lack of implementation of these policies and schemes combined with corruption within the health system and public distribution systems have prevented women from receiving these crucial benefits and services and contributed to the high incidence of preventable maternal deaths. Following a training and strategy-building consultation conducted by the Center in collaboration with HRLN in 2006 on the use of strategic litigation to address women's reproductive health concerns, including maternal mortality, in 2008 HRLN initiated a wave of cases in several Indian state high courts seeking accountability for preventable maternal health violations suffered by Indian women, ranging from fistula to outright denial of care.

This PIL initiative has resulted in the restoration of benefits to women who have been unjustly deprived of their entitlements; compensation being paid where women were denied maternal healthcare; the establishment of a water supply in a primary health center that previously had none; a blood bank in a district hospital that previously had no blood supply; the construction of shelters to provide maternal health services for destitute urban women; and the convening of government camps that allowed hundreds of people living below the poverty line, including many pregnant women, access to food rations. This chapter will discuss these pathbreaking decisions and interim orders, and provide updates on cases throughout India where litigators and maternal health advocates are currently working to ensure similar accountability and reform.

Groundbreaking Delhi High Court Orders and Judgments

Laxmi Mandal v. Deen Dayal Harinagar Hospital and Others **(Delhi High Court, 2008) and** ***Jaitun v. Maternal Home, MCD, Jangpura and Others*** **(Delhi High Court, 2009)**

In 2008 and 2009, HRLN filed two cases in the Delhi High Court concerning the right to maternal health for urban poor women, focusing specifically on the government's failure to ensure that pregnant women are able to access essential services and entitlements guaranteed under government benefit schemes, including the NMBS, the JSY, the National Family Benefit Scheme (NFBS), the Integrated Child Development Scheme (ICDS), and the Antyodaya Anna Yojana (AAY).[53] These cases sought accountability for the maternal death of Shanti Devi, a migrant woman belonging to a scheduled caste, and for health complications and denials of services experienced by Fatema, a severely anemic and epileptic urban poor woman who was forced to deliver under a tree due to denial of maternal health services.[54] (See box—Facts and Orders in the Consolidated *Laxmi Mandal/Jaitun* Case, p. 18.)

The Delhi High Court consolidated these cases in January 2010, and on June 4, 2010, Justice S. Muralidhar issued a landmark ruling in both cases holding that the denial of maternal healthcare is a violation of fundamental constitutional and human rights.[55] Justice Muralidhar emphasized that the Indian Government is obligated to ensure maternal health services under the judicially-recognized constitutional rights to health and reproductive rights[56] as well as under its international legal commitments, citing the Universal Declaration of Human Rights[57] and the Convention on the Elimination of All Forms of Discrimination Against Women,[58] as well as the International Covenant

FACTS AND ORDERS IN THE CONSOLIDATED *LAXMI MANDAL/JAITUN* CASE

Shanti Devi's and Fatema's tragic experiences with pregnancy are the core of the Delhi High Court's groundbreaking decision in 2010. Despite qualifying for benefits under various government schemes formulated to promote maternal health and survival, Shanti Devi and Fatema were repeatedly denied the medical care, rations, and financial support they were entitled to, resulting in humiliation, suffering, and, for Shanti Devi, death.

Shanti Devi's legal case began in 2008, when HRLN filed a lawsuit on her behalf seeking compensation for payment demanded for emergency medical care that should have been free under the NRHM and the JSY.[1] Shanti Devi, a poor woman from Bihar, became pregnant for the fifth time in 2008 while she and her husband were living in Faridabad, Haryana.[2] During her seventh month, she fell down the stairs of her home, after which her health began to deteriorate rapidly and she could no longer feel the fetus moving.[3] Shanti Devi was repeatedly denied care at several hospitals on several grounds, including a refusal by one hospital to accept proof of her BPL status and inability to pay the hospital's demanded fee of INR 250,000–300,000 (USD 5,300-6,360).[4] She eventually was referred to Deen Dayal Hospital in Delhi, where she finally was able to have the fetus removed five days after its death[5] but was charged INR 1,000 (USD 21.20),[6] paid by her brother, Laxmi Mandal, and her husband, and was not provided complete follow-up care.[7] HRLN filed this case in December 2008,[8] and in January 2009, the Court issued an order that Shanti Devi be readmitted to Deen Dayal Hospital and treated free of cost.[9] Shanti Devi finally received the necessary medical care, but was advised that any future pregnancies would be dangerous.[10] However, within several months, Shanti Devi became pregnant again.[11] Shanti Devi's sixth pregnancy was never registered nor was she provided services as guaranteed under the NRHM and the JSY. Due to her traumatic experience with the public health system during her fifth pregnancy, Shanti Devi was deterred from even trying to seek antenatal care.[12] On January 28, 2010, Shanti Devi gave birth prematurely at home without a skilled birth attendant and died.[13] A maternal death audit conducted after the case found that Shanti Devi had tuberculosis, was severely anemic, and died of postpartum hemorrhage.[14]

Fatema, a homeless BPL woman living in Jangpura, Delhi, was similarly neglected by those responsible for providing services under the JSY and the NRHM.[15] Fatema suffered from anemia and epilepsy, and during her pregnancy experienced severe epileptic fits.[16] Concerned for her daughter's health, her 75-year-old mother, Jaitun, repeatedly visited the maternity home in Jangpura—sometimes up to three times in one week—in an attempt to secure medical care. She was met with ridicule and harassment and was accused of only coming to the hospital to beg.[17] With nowhere to turn for delivery, Fatema was ultimately forced to give birth in full public view under a tree.[18] Her birth was entirely unattended, and Fatema never received outreach services from government health workers as guaranteed under India's healthcare schemes.[19] Fatema suffered serious health complications as a result of anemia, but also never received her food rations under the ICDS and the AAY and was never visited by an Anganwadi worker, a government trained worker trained to deliver basic child- and maternal-health and education services, or a ANM.[20]

Both of these women experienced outright denials of medical care and nutritional support guaranteed by the state, discrimination on the basis of socioeconomic status, and poor quality of care. In analyzing the facts, the Delhi High Court first set out the various benefits that should have been provided to Fatema and Shanti Devi, and then identified where the women had been wrongly denied benefits and services. The Court issued a series of groundbreaking orders to address the individual suffering experienced by Fatema, Shanti Devi, and their families as well as the systemic breakdowns and gaps in the government's policies and programs concerning maternal health.

The Court stated the following:

> *These two petitions highlight the deficiencies in the implementation of a cluster of schemes funded by the Government of India, which are meant to reduce infant and maternal mortality. The issues common to both petitions concern the systemic failure resulting in denial of benefits to two mothers below the poverty line (BPL) during their pregnancy and immediately thereafter under the Janani Suraksha Yojana ('JSY'), the Integrated Child Development Scheme ('ICDS'), the National Maternity Benefit Scheme ('NMBS'), the Antyodaya Anna Yojana ('AAY') and the National Family Benefit Scheme ('NFBS').*[21]

Importantly, the Court noted that although the "interrelatedness of these schemes"[22] was recognized by the Supreme Court in the 2001 *PUCL* case concerning the right to food, much still needs to be done to ensure that pregnant women are able to benefit from these schemes.[23]

In Shanti Devi's case, the Court found that her death was "clearly avoidable"[24] and ordered the following compensation for Shanti Devi's death:[25]

- INR 240,000 (USD 5,088) from the State of Haryana to her family for "the avoidable death of Shanti Devi."[26]
- Consideration of Shanti Devi's death as the death of a primary breadwinner under the NFBS, entitling Shanti Devi's family to INR 10,000 (USD 212) for her death.[27]
- Payment to Shanti Devi's husband the benefits she should have received, including INR 500 as required under the NMBS and INR 500 as required under the Balika Samridhi Yojana as a post-birth grant to mothers of female babies.[28]
- INR 1,000 (USD 21.20) to Shanti Devi's husband to compensate for the costs improperly charged by the Deen Dayal Hospital during her fifth pregnancy as treatment should be free for anyone with BPL status.[29]

For Fatema, the Court held that her fundamental rights had been violated when she was forced to give birth under a tree,[30] and ordered the following:[31]

- Payment of INR 50,000 (USD 1,060) into a trust for "the denial of basic medical services under various schemes."[32]
- Immediate examination of the complaint that she, up to the date of the Court order, had not received her rations under the AAY and assurances that she will receive the quote she is entitled to therein.[33]
- Treatment and care for her epilepsy, including medicine every 15 days, medical checkups every two months, and, if necessary, arrangement of ambulance services to the hospital.[34]

In addition to the individual remedies, the Court issued a series of orders aimed at strengthening maternal healthcare provisions generally, including improving implementation of various government schemes and policies as follows:

- **Portability of benefits.** Instruction that the onus is on the government to ensure that individuals who are declared BPL in one state are able to avail themselves of free public health services even in another part of the country.[35] Likewise, all levels of government must address portability of AAY benefits as well.[36]
- **Benefits regardless of number of children or age.** Clarification must be issued immediately by the central government to all state governments to prevent denials of cash assistance to women with more than two children or who are under age 19.[37]
- **The NMBS and the JSY as independent schemes**. Clarification must be issued immediately by the central government to explain that NMBS and JSY benefits are mutually exclusive, and that the JSY does not replace the NMBS.[38]
- **Under the NFBS, families experiencing maternal death are entitled to INR 10,000**. The central government must issue instructions clarifying that maternal deaths should be considered the death of the primary breadwinner and entitle legal heirs to INR 10,000 (USD 212) under the NFBS.
- **Implementation of *PUCL* orders regarding ANMs and ASHAs.** The Supreme Court's interim orders in the *PUCL* case must be implemented, including periodic reviews of ANM and ASHA performance as well as the development of registers by the Delhi and Haryana governments to be maintained by medical officers supervising ASHAs and ANMs.[40] ASHAs must maintain a log of visits and have a checklist of NRHM service guarantees; this log must be countersigned by the ANM and checked periodically by the ANM.[41] Denials of care by women themselves should be reported to the medical officer by the ASHA and followed up by visits from the officer.[42]
- **Implementation of *PUCL* orders regarding schemes.** Special cells ideally must be set up within the central and state governments for monitoring the implementation of schemes on a regular basis.[43] It must be ensured that cash assistance under various benefits, including the JSY and the NMBS, is promptly provided to each beneficiary;[44] there must be a review of the Supreme Court's order directing issuance of AAY cards to eligible beneficiaries; [45] and Anganwadi centers, from where Anganwadi workers can provide services, must be set up by the Delhi and Haryana governments and monitored under the ICDS.[46]

on Economic, Social, and Cultural Rights[59] and General Comment 14 issued by the Committee on Economic, Social and Cultural Rights.[60]

> *"These petitions are essentially about the protection and enforcement of the basic, fundamental and human right to life under Article 21 of the Constitution. These petitions focus on two inalienable survival rights that form part of the right to life: the right to health (which would include the right to access and receive a minimum standard of treatment and care in public health facilities) and in particular the reproductive rights of the mother."*[61] – Hon'ble Justice S. Muralidhar

The Court ordered the Government of India to take specific steps to ensure accessibility of maternal health services and benefits to pregnant women living below the poverty line,[62] including by clarifying that participation in one benefit scheme does not exclude eligibility for other schemes.[63] The decision clearly establishes that the benefits guaranteed under maternal health schemes such as the JSY and the NMBS are legal entitlements protected by the Indian Constitution and human rights law, and that denial of these benefits constitutes a justiciable violation of legal rights. Further, citing a past Supreme Court order in *PUCL*, the Delhi High Court emphasized that the nutritional benefit under the NMBS and the childbirth cash incentive under the JSY are independent, and women are entitled to both benefits simultaneously without discrimination based on their age or number of children.

The decision clearly articulates the right to maternal health as an unequivocal, legally enforceable right, and establishes that where women are deprived of this right, compensation must be provided. The decision held that, "no woman, more so a pregnant woman, should be denied facility or treatment at any stage irrespective of her social and economic background…. This is where the inalienable right to health which is so inherent in the right to life gets enforced."[64] As a result of Shanti Devi's avoidable death and the humiliation experienced by Fatema, the Court has ordered the State Government of Haryana and the Government of the National Capital Territory of Delhi (the Delhi Government) to provide compensation for the pain and suffering experienced by the women and their families and to make retroactive payments of the benefits that were denied.[65] The Court also emphasized that under the NFBS, the death of a family's breadwinner entitles the family to INR 10,000 (USD 212) in compensation, and it established that pregnant women who are homemakers should be recognized as breadwinners of their household, meaning that in maternal death cases the families should be provided reparation under the NFBS.[66] Finally, the Court stated that a woman who qualifies for healthcare benefits must be able to avail herself of care even when crossing state lines, and that the onus is on the government to ensure that the benefits promised by the state reach women.[67]

> *"This is the first decision that we know of in the world to hold maternal mortality as a human rights violation, and order compensation and other reliefs against the government for such violations."* – Colin Gonsalves, Founder Director, HRLN

The governments of Haryana and Delhi initially delayed providing compensation to the petitioners, but after a contempt proceeding initiated by HRLN, the governments transferred the awarded compensation to Shanti Devi's husband,[68] and Fatema as ordered.[69] HRLN is continuing to monitor implementation of the case. Additionally, in March 2011, HRLN filed a review application requesting that the Court ensure compliance with its orders to the Government of India, specifying, among other requirements, that clarification be issued to all state governments regarding the implementation of the NMBS benefits;

issuance of a directive that a person declared BPL in any state of the country be assured continued access to public healthcare services where such person moves; implementation of monitoring and oversight mechanisms for the work of ASHAs and ANMs; and compensation for maternal deaths under the NFBS as decided in the case.[70]

***Court of Its Own Motion v. Union of India* (Delhi High Court, 2010)**

Just months after its historic ruling in the *Laxmi Mandal* and *Jaitun* consolidated case, the Delhi High Court initiated a *suo moto* legal proceeding affirming the government's obligation to protect the fundamental right to life of pregnant women.[71] On August 29, 2010, the *Hindustan Times* published a news report concerning a destitute woman, Laxmi, who died in the middle of a bustling market in Delhi four days after giving birth.[72] On September 1, 2010, at the written request of Justice Muralidhar, Chief Justice B.C. Patel of the Delhi High Court initiated a petition addressing the issues of discrimination and denial faced by homeless women, particularly pregnant and lactating women, and further appointed legal experts, including Senior Advocate Colin Gonsalves, Founder Director, HRLN, and Senior Advocate Jayant Bhushan as *amici curiae*.[73]

Following a submission by the *amici*, the chief justice issued an interim order in October 2010 to the Delhi Government to establish five shelters exclusively for destitute pregnant and lactating women.[74] The government was ordered to provide adequate medical assistance, food, and professionally trained personnel in these shelters.[75] The Court further ordered the creation of outreach mechanisms, including mobile medical units, hotlines, and awareness camps and campaigns.[76] The government filed counter affidavits alleging that the existing women's shelters run by the government were sufficient to meet the Court's order and that no further steps were necessary. In January 2011, the Court found that most of the shelters cited by the government were not publicly funded nor did they have the capacity to serve pregnant or lactating women. The Court ordered the government to immediately establish at least two shelter centers meant for destitute pregnant and lactating women and to file a proper and comprehensive affidavit describing the details of available shelters within a period of four weeks. At the time of printing, the Delhi Government had constructed the two shelter homes it had been instructed to create immediately, and both are functional.[77]

> *"We just cannot become the silent spectators waiting for the Government to move like a tortoise and allow the destitute pregnant women and lactating women to die on the streets of Delhi.… Such a situation cannot be countenanced … in the backdrop of Article 21 of the Constitution."*[78]
>
> – Hon'ble Chief Justice B.C. Patel and Hon'ble Justice Sanjeev Khanna

***Premlata w/o Ram Sagar and Others v. Govt. of National Capital Territory of Delhi* (Delhi High Court, 2010)**

In November 2010, HRLN filed a petition in the Delhi High Court on behalf of five pregnant and lactating women living below the poverty line in the Nangloi slums in Delhi. They had been denied their constitutional rights to food since August 2009 and their reproductive and child health benefits during and/or after their pregnancies,[79] and they are currently suffering from malnutrition and anemia.[80] HRLN's petition highlights the critical links among food security, nutrition, and reproductive health, particularly maternal health, and seeks accountability for the mismanagement of Fair Price Shops (FPS) in Delhi.[81] The FPS are essential elements of the government's public distribution system for procuring and distributing food and other essential commodities to its citizens.[82] The FPS unjustly denied all five

women in the case the basic food and household items to which they were entitled under the AAY and the ICDS and which they and their families needed to survive, including during their pregnancies and while lactating.[83] The petitioners were also denied their maternal health benefits under the NMBS, the JSY, and the Balika Samridhi Yojana, despite the intervention of community health workers on their behalf.[84] The Delhi Government claimed that these denials were justified because access to these benefits is limited by the JSY's restrictive provisions, including the two birth limitation[85] and an age bar that prevents girls under 19 from accessing JSY benefits.[86] (See p. 23 of the original report for more discussion of these limitations.) Petitioners filed a response citing the *Laxmi Mandal/Jaitun* decision that stated that these restrictions are invalid, and sought a court order clarifying that the Court has previously "invalidat[ed] the two live births and the age limitation under [the] JSY scheme … [and therefore] such limitation cannot be justified on any rational basis as it runs counter to [the] health and welfare of the citizens."[87]

After the initial hearing in October 2010, Justice Muralidhar, also the judge in the *Laxmi Mandal/ Jaitun* case, ordered the state government to organize a camp in which people who had been denied benefits could have the cards necessary to procure rations reauthorized quickly.[88] He also ordered the government to undertake an intensive survey of the FPS in the region.[89]

Due to the government's failure to properly implement the Court's orders, including by attempting to eschew the order to organize a camp by holding a poorly advertised, two-hour camp with limited staff in December 2010, in early 2011 the Delhi High Court ordered the state government to organize a three-day camp during which hundreds of families submitted their grievances to government officials.[90] Since the camp was held, food grains have been distributed on a consistent basis and the government has begun addressing some of the grievances set forth in the petition.[91] Once again echoing the Supreme Court's order in the *PUCL* case, the Court's order also stresses that the government's maternal health benefits, including the JSY and the NMBS, are separate and distinct, meaning that women are entitled to benefits under each simultaneously; the Court ordered the government to properly implement these schemes.[92] These interim orders establish that pregnant and lactating women, among others, have a right to food and, as with the decision in the *Laxmi Mandal/Jaitun* case, emphasize that the onus is on the government to ensure that women can access the necessary ration cards and food supplies.[93]

In April 2011, following delays by the Union of India in submitting a response to the Court's inquiries concerning the failure to fund and implement the NMBS, Justice Muralidhar imposed a fine on the government of INR 5,000 (USD 106) per petitioner to penalize it for its delay tactics, which the government has since paid.[94] In May 2011, in response to the Delhi Government's subsequent argument that it could not provide ration cards due to having exceeded the "cap" set by the central government on the number of BPL persons it was allowed to recognize and provide with ration cards, Justice Muralidhar issued another interim order establishing that state governments in India have the authority to exceed caps as needed because, "[d]enial of a ration card to a BPL person is virtually a denial of his or her right to food and thereby the right to life under Article 21 of the Constitution."[95] Significantly, although the case was filed only on behalf of five women, Justice Muralidhar called on the government to account for violations more broadly, stating that, "[t]his Court is concerned that apart from the Petitioners who have approached this Court there could be many others similarly placed in need of redress….This Court will be informed by the FSD [Food and Supply Department of the Delhi government] on the next date whether the grievances of such persons have been addressed."[96]

(For more information on government efforts to increase nutritional benefits, see box below — Recommendations of the Prime Minister's National Advisory Council to Include Nutritional Benefits in the Food Security Bill.)

RECOMMENDATIONS OF THE PRIME MINISTER'S NATIONAL ADVISORY COUNCIL TO INCLUDE NUTRITIONAL BENEFITS IN THE FOOD SECURITY BILL

Following the series of orders issued in the landmark *PUCL v. Union of India* case, a decade-long litigation establishing the right to food in India, the government began drafting the Food Security Bill (FSB), which it envisions "as a path-breaking legislation, aimed at protecting all children, women and men in India from hunger and food deprivation."[1] The prime minister's National Advisory Council (NAC) put forward a proposed draft FSB in 2010 that recognized the legal entitlement to maternal nutrition,[2] but fell short of meeting advocates' demands that the FSB provide universal entitlements under the NMBS and the ICDS as ordered by the Court in *PUCL*.[3] (For information on the *PUCL* orders, see p. 41 of the original report.)

> *"[A] large majority of Indian women across all ages suffer from undernutrition and are especially vulnerable during pregnancy and while nursing their infants. Maternity benefits are therefore essential in order to compensate for income loss in pregnancy and maternity, provide financial support for adequate nutrition during this period, ensure women get adequate rest, and enhance their food intake.[4]"* – National Advisory Council

In February 2011, the NAC issued an explanatory statement clarifying what benefits would be legally available to pregnant women under the maternity benefits schemes in place as well as the ICDS if the FSB were enacted.[5] Citing the Court's order in *PUCL*, the NAC explanatory statement established universalization of the ICDS to all pregnant and lactating women, and emphasized the quality of service provision under the scheme.[6] While the explanatory statement did not name the NMBS specifically nor clarify that the ICDS and the NMBS are mutually exclusive, the NAC explanatory statement does state that maternity benefits should be provided unconditionally due to the barriers to access for poor women, and recommends that the benefit be extended to pregnant girls under 19 and to women who have more than two children.[7]

Status of PILs in Select NRHM States

In addition to the cases in Delhi, lawyers from HRLN have filed petitions in several other Indian states seeking legal accountability and implementation of the JSY, the NMBS, and other maternal health schemes. This section provides updates on two such cases that were discussed in the original report (see p. 49), as well as one case that was just filed this year and two that are currently being developed. Together, these cases address the lack of adequate referral systems; lack of quality care and adequate infrastructure in government health facilities; the need for maternal death audits; and discrimination against certain groups of women based on health status. In each of these cases, the Center either has provided or will be providing supplementary briefs discussing the government's legal obligations under its human rights commitments to ensure the right to maternal health.

***Sandesh Bansal v. Union of India and Others* (Madhya Pradesh High Court, 2008)**

As discussed in the original report, HRLN filed its first PIL petition on maternal mortality in 2008 in the case of *Sandesh Bansal v. Union of India and Others* and requested a series of interim orders based on a detailed fact-finding mission directing the government to urgently address the violations it documented in the Bhind district of Madhya Pradesh (see p. 49 of the original report) by issuing a blood bank license to a district hospital, ensuring the provision of electricity and potable water, and providing other goods and services as required under the Indian Public Health Standards (IPHS).[97] The Center submitted a memorandum citing international legal standards in support of the litigation.[98] Since the publication of the report, the Madhya Pradesh High Court has reviewed HRLN's report of violations documented during its fact-finding mission and directed the Court Registrar to conduct an enquiry into the implementation of the NRHM's Concrete Service Guarantees and the IPHS in the Bhind district's primary health centers including those in Bijora, Supurna, and Kishupura.[99] (See p. 23 of the original report for information on the NRHM service guarantees.) The Court Registrar's Enquiry report, submitted in January 2009, confirmed the concerns raised in the PIL regarding gaps in the implementation of the NRHM and the IPHS in the Bhind district.[100] The PIL specifically called for legal remedies to be granted following the lengthy delays and the government's illegal demands for money from the Bhind district hospital related to the acquisition of its license to set up a blood bank and conduct blood transfusions, despite having met all the requirements; a license was granted after the PIL was filed.[101] Similarly, the Supurna Primary Health Center in Bhind district, which previously had no connection to a water supply in contravention of the IPHS, was ordered to construct and has since built a water tank at the health center.[102]

In addition to the *Bansal* PIL, HRLN also is pursuing accountability for maternal mortality in Madhya Pradesh through three individual cases that have been joined by the judiciary into one matter.[103] In May 2010, three cases were filed in the Madhya Pradesh High Court against the Sultania District Hospital, a government facility.[104] The cases involved maternal deaths and stillbirths, and alleged medical negligence as well as violations of Articles 14, 15, and 21 of the Constitution of India.[105] (See p. 39 of the original report for further discussion of the constitutional arguments.) Through these cases, HRLN is highlighting the need for better registration of births and deaths and for adequate blood storage facilities, as well as the problem of pervasive physician absenteeism in government facilities.[106] Notices were issued by the court in this case in August 2010 to concerned officials serving in the government of Madhya Pradesh;[107] however, due to a shortage of judges in Madhya Pradesh, there have been significant delays in getting the matter listed for hearing.[108]

***Snehalata "Salenta" Singh and Others v. State of Uttar Pradesh and Others* (Uttar Pradesh High Court, 2009)**

The Salenta case, first described in the original report, is an individual case brought in April 2009 by Snehalata "Salenta" Singh, a woman from Uttar Pradesh who developed fistula in part due to medical neglect during delivery in a primary health center, where she was encouraged by an accredited health worker to seek care under the JSY program that offers a financial incentive of INR 1,400 (USD 29.68) for undergoing an institutional delivery.[109] (See p. 49 of the original report.) The Center supported the petition by submitting both a supplementary brief arguing for government accountability under international human rights law and a brief articulating the government's violations of Indian constitutional law. Through 2009, the Writ Petition was listed on thirty different occasions on the Allahabad Bench of the Uttar Pradesh High Court's docket for hearings, yet the case has not been heard.[110]

In August 2010, petitioners through HRLN submitted an affidavit providing the Court with additional facts, including an update on Salenta's condition and circumstances, and expanding the legal claims under Article 21 (right to life incorporating right to health and dignity), Article 14 (right to equality), Article 15 (right to nondiscrimination), and Article 15(3) ("special provisions" for the protection of women) of the Indian Constitution.[111] (See pp. 39–43 of the original report for more information on these provisions.) Despite this submission, at the time of printing the case had still not been heard by the Court. This is believed to be due in part to the judicial system in Uttar Pradesh, which requires that judges' dockets be rotated periodically.[112]

Centre for Health and Resource Management v. State of Bihar and Others **(Bihar High Court, 2011)**

In March 2011, HRLN filed a PIL on behalf of the Centre for Health and Resource Management (CHARM) addressing maternal mortality in Bihar, which is one of the high-focus states under the NRHM due to its poor indicators for health generally as well as for maternal health.[113] In support of this petition, the Center submitted a supplementary brief discussing the international human rights guarantees.

Building on the experience in the *Bansal* case, where fact-findings in specific districts were done to provide the Madhya Pradesh High Court with concrete evidence of violations and to seek interim orders to bring about immediate change, a fact-finding team from HRLN traveled to Bihar to assess implementation of maternal health schemes and services in health facilities in the Munger District.[114] HRLN filed a PIL on the basis of the violations documented, including improper routine collection of fees for referral and registration of pregnancy, even though such services should be free for pregnant women; a lack of electricity, toilets, water, blood supply, adequate staff, maternal death audits, and maintenance of hygienic conditions; and unavailability of safe abortion services.[115] HRLN also alleged violations based on its interviews with women in Bihar, who complained about these barriers and further noted that they are unable to access JSY payments for months after delivery and are referred from one health facility to another with little or no follow up regarding whether they received care.[116]

In addition to citing the Delhi High Court's recognition of reproductive rights as inalienable survival rights in the *Laxmi Mandal/Jaitun* decision and claiming violations of the fundamental rights to health and nondiscrimination as stated in previous petitions, HRLN's petition in the *CHARM* case alleges that the violations experienced by women in Munger District constitute cruel, inhuman, and degrading treatment under international law.[117] The PIL argues that the right to be free from cruel, inhuman, and degrading treatment, which has been recognized judicially by Indian courts to be an integral element of the Article 21 right to life, is violated where governments willfully deny women reproductive health services and cause foreseeable pain, suffering, and death.[118] The petition asks the Court to order the government to upgrade existing health facilities in accordance with NRHM standards and the IPHS or construct new ones; to ensure provision of all reproductive health services guaranteed under the NRHM, including maternal health services and safe abortion services; to introduce a maternal death audit system; and to develop and implement a grievance redressal mechanism for complaints about mistreatment in health facilities.[119]

Building a Nuanced Recognition of the Right to Maternal Health: New Cases

New cases being filed in India highlight the need for a more nuanced understanding of the right to maternal health. These cases aim to ensure that maternal health services reach women who are at particularly high risk for pregnancy-related complications, including HIV-positive women and women

living in areas with a high prevalence of malaria. They also expose the systematic discrimination experienced by certain groups of pregnant women on the basis of their health status.

***Mr. X v. Union of India and Others* (Calcutta High Court, 2010)**

U.N. agencies have reported that in countries where there is a high incidence of HIV/AIDS, it has become "a leading cause of death during pregnancy and the post-partum period."[120] India has one of the highest numbers of pregnant women living with HIV/AIDS.[121]

Newspapers around the country have consistently published many accounts of the difficulties women living with HIV/AIDS face in accessing maternal healthcare, and these cases persist without any recognition of rights violated or accountability.[122] In 2010, HRLN filed a PIL in the Calcutta High Court seeking to order government authorities to prevent discrimination against pregnant women who are HIV-positive.[123]

The case involves a woman who sought maternal healthcare services at a private nursing home[124] while she was in labor and was forced along with her husband to submit to a mandatory HIV test before being admitted.[125] When their tests turned out to be positive, she was told to leave on the pretext that the delivery could not be performed at the facility.[126] As described by the petitioner, nursing home staff pulled his wife off the hospital bed and dragged her through the corridors toward the exit.[127] While she was being dragged out, a doctor and a nurse saw that she was on the verge of actually delivering the baby and led her to a room where she delivered.[128] However, following delivery, she was denied appropriate assistance, including stitches, and was commanded to leave the hospital immediately.[129] She and her husband were able to negotiate an overnight stay in the hospital after much pleading, but no care was provided to her or to her baby, although the health staff stated that they had ascertained that her newborn was in fact HIV-positive.[130]

After they left the nursing home, their family members arrived. The woman's HIV status as well as her child's were disclosed, and her family was advised to stay away from her or risk being infected.[131] When her husband later went to clear their bills at the health facility, he was further humiliated and verbally abused by the staff.[132] The treatment in the health facility and the ostracization of the couple by their family has resulted in stigma, humiliation, and mental trauma that have become unbearable for the couple, and both now wish to end their lives.[133]

The husband and wife's experience is representative of the abuse and denials of care suffered by countless HIV-positive women in India. Although the petitioner's wife in this case was fortunate enough to survive childbirth, she continues to suffer the physical, mental, and social consequences of being unfairly discriminated against and denied appropriate medical care, and of having her right to confidentiality violated by those responsible for her care and treatment.[134] Claiming multiple violations of constitutionally protected and internationally recognized rights, including the rights to dignity, freedom from inhuman treatment, access to quality medical treatment, privacy, and nondiscrimination, the petition seeks compensation for the trauma suffered by the petitioner and his family and requests that the Court order the local authorities to ensure the availability of proper treatment without discrimination

for all HIV-positive patients in all public and private facilities through appropriate guidelines, campaigns, and workshops.[135] The case has yet to be heard by the Calcutta High Court.[136]

***Petitioners v. States of Orissa and Others* (Orissa High Court, 2011)**

Fact-finding visits conducted by HRLN in 2010 and 2011 have revealed that due to failure to properly implement the NRHM as well as gaps within the policy itself, women in Orissa are denied the services necessary to ensure adequate protection of their health during pregnancy. The World Health Organization has stated that malaria is the foremost health problem in Orissa, contributing to 50% of the nation's malaria death cases.[137] Malaria accounts for a staggering 23% of maternal deaths in affected parts of Orissa.[138] Malaria, like all major causes of maternal death, is preventable and treatable,[139] and the government's failure to adequately address these deaths represents of a host of rights violations.

Based on its fact-finding, HRLN will file a petition in the High Court in Orissa in June 2011 seeking accountability and reform, and the Center will submit a supplementary brief drawing from international treaties and guidelines.[140] The petition argues that the state under the auspices of its constitutional and human rights obligations must provide specific prevention and treatment services to ensure safe motherhood, including taking steps to bring the existing NRHM policy as well as India's malaria policy, the National Vector Borne Disease Control Programme, into alignment with international standards for prevention and treatment of malaria among pregnant women.[141] The petition will request that the High Court issue an order directing the government to adopt internationally recommended guidelines to prevent and treat malaria in pregnant women, including early registration of pregnancy, routine testing for malaria during examination and pregnancy testing, issuance of bed nets, presumptive dosage in high-rate areas, and monitoring of high-risk pregnancies.[142]

Chapter IV. Key Observations and Recommendations for Action

While human rights bodies and governments around the world have finally recognized maternal mortality as a human rights concern, the Indian Government has continued to neglect the specific health needs and human rights of pregnant women by failing to implement and monitor maternal health policies and programs with attempted impunity, leading the country to persist in accounting for the highest number of maternal deaths worldwide for decades. In 2010, the Indian Government expressed its disregard for women's health and human rights when it opted not to cosponsor the UNHRC's groundbreaking Resolution 11/8. However, as the accountability interventions highlighted in this report show, the government's refusal to publicly acknowledge India's maternal health crisis does not absolve it of its legal obligations as a signatory to major international treaties and under its own constitution to effectively reduce maternal mortality and provide reparations for violations of human rights; this is why the role of the courts in handling this crisis has become crucial.

As governments worldwide acknowledged in Resolution 11/8, maternal mortality is not solely a result of a lack of equitable access to quality maternal healthcare, but a consequence of gender discrimination that must be addressed. In India, this would mean, for example, that while discriminatory nutritional practices against girl children by family members predispose them to anemia and ultimately to high-risk pregnancies, just bringing a pregnant woman into the health system will not prevent her death unless the law fully addresses discrimination by health workers on the grounds of socioeconomic and health status, which in turn leads to the kinds of delays and denials of healthcare experienced by Shanti Devi, Fatema, Mrs. X, and Salenta. As such, the Government of India must make a robust effort to simultaneously address discrimination against women and girls in communities and in the health system as it strives to improve access to quality maternal healthcare to meet its maternal mortality reduction targets.

The growing body of interim orders and national jurisprudence coming out of courts in India that recognize that maternal healthcare is a constitutionally protected right is an important development, and one that has strengthened the legal basis for seeking accountability for maternal deaths through the use of international and constitutional law. In India, a decision issued by a high court in one state is legally binding on that particular state and is of persuasive value for high courts in other states. Since the barriers and systemic causes of maternal mortality and morbidity being addressed through the cases filed by HRLN are common to most states, the decisions and interim orders issued by state high courts can be utilized by advocates across the country to push for much needed legal, policy, and health system reform and the proper implementation of existing schemes. Many of the interim orders address specific failures in the implementation of government maternal health schemes, expose where the health system and public distribution systems are broken, and point to government neglect of underlying determinants of healthcare such as water and electricity. Similarly situated women across the country who are denied key benefits and entitlements due to these same gaps and failures can advocate locally for reform and appropriate remedies by using as a guide these formal interpretations of the law and the state's legal duties vis-à-vis pregnant women.

The decision issued by the Delhi High Court in the *Laxmi Mandal* and *Jaitun* consolidated case is squarely grounded in Indian Supreme Court precedent and international law and therefore binding on all state high courts and government authorities involved in the management and administration of maternal healthcare services. The Delhi High Court decision is critical in that it challenges the

notion that maternal death is a natural outcome of pregnancy by recognizing that such deaths are avoidable and that when they do occur due to the government's failure to ensure the availability of maternal healthcare services and entitlements as promised through various policies and schemes, the government can be held responsible because maternal healthcare is an inalienable survival right. This decision provides a firm legal basis for women and maternal health advocates to legally claim that the fundamental right to maternal health services needed to ensure safe pregnancy and childbirth is constitutionally protected and to seek reparations when this right is violated. This legal guarantee must now be applied in practice and expanded in meaning through activism that demands high-quality maternal health services and constructive engagement with key government actors to ensure the implementation of government policies and schemes at all levels of governance—village, state, and central. It must be used to demand maternal health services; accountability for human rights violations associated with the denial of entitlements and benefits; an end to discrimination in healthcare facilities against women seeking pregnancy-related care; and improved quality of health services.

Recommendations for action:

Promptly implement the Delhi High Court decisions. Legal interventions by lawyers and public pressure by maternal health advocacy groups are needed to ensure that the concerned authorities in the Government of India promptly issue the following clarifications and/or take the following steps ordered by the Court:

- Clarification by the central government to all the state governments that the nutrition benefit promised under the NMBS is independent of the cash incentive offered to women under the JSY so that pregnant women across the country are not denied cash assistance for nutrition during pregnancy.
- Clarification by the central government to all the state governments that the nutrition benefit under the NMBS and the cash incentive guaranteed under the JSY should not be denied to women who have had more than two live births and to women who are under 19 years of age, and that these funds should be dispensed promptly.
- Clarification by the central government to the state governments that in the event of a maternal death, the surviving family members (legal heirs) are entitled to the cash benefit of INR 10,000 (USD 212) as guaranteed in cases involving the demise of a primary breadwinner under the NFBS.
- Instructions to ensure that if a person is declared BPL in any state of the country and is availing himself or herself of public health services in any part of the country, such person should be assured of continued availability of access to public healthcare services wherever such person moves as a means to ensure the portability of benefits. Steps must be taken to ensure that women who migrate from one state to another do not lose their AAY benefits.
- The central government must ask state governments to furnish information about the percentage of the total number of deliveries that are institutional to ensure meaningful assessment of the effectiveness of schemes.
- Monthly camps should be held in rural areas where the Anganwadi Centers are not functional so that pregnant women and children can undergo health checkups.
- To ensure that the benefits promised by the government reach pregnant women, the health departments of the Delhi Government and the State of Haryana are required to devise formats of registers to be maintained by medical officers who are supervising the work of ANMs and ASHAs and periodically review their performance.

Promptly and fully implement interim orders. Public monitoring of the implementation of interim orders issued in the Delhi High Court *suo moto* case, the *Premlata* case, and the *Sandesh Bansal* case is needed to ensure that the reliefs granted by the Delhi and Madhya Pradesh high courts are made available to women and their communities. Maternal health advocates must support the successful implementation of these orders by ensuring that the shelters ordered by the Court for destitute pregnant women are functional; that FPS are not denying pregnant women their entitlements; that ration cards are granted immediately to BPL women and their families; and that primary health centers are fully functional and equipped with clean water, electricity, and blood transfusion facilities. Taking a cue from the orders issued in these cases, maternal health advocates can investigate similar breakdowns in health systems and public distribution systems in other districts and states, and demand similar remedies.

Immediately consider the *Salenta* case. The Uttar Pradesh High Court should immediately consider the case of Salenta Singh, who suffered fistula in the course of an institutional delivery and subsequently suffered physical and mental trauma as a result of being denied timely corrective surgery. The case has been languishing in court for three years and has not been heard despite being listed more than thirty times. Salenta and her family are still suffering the economic consequences of her ordeal and should be provided a fair hearing and reparations immediately.

Elected leaders must take public action to address maternal mortality as a national crisis. Members of parliament and of the state legislatures must use their political influence to seek accountability for the implementation of maternal health schemes at the national and state levels. They should call for the maternal death audits authorized by the Union Minister of Health to be implemented by states and for the data regarding the incidence of maternal deaths and the poor state of implementation of maternal health policies, schemes, and strategies to be reported back to parliament and the state legislatures. They should call for official inquiries into the cessation of NMBS schemes where the JSY is being implemented and make sure that the funds allocated for the NMBS are utilized for this purpose in accordance with the Supreme Court's orders in the *PUCL* case.

Strengthen the health system and check impunity. In light of estimates that on average almost one-fifth of the population of pregnant women will experience complications, it is absolutely imperative for the central and state governments to take immediate steps to fully equip and update the health system and the health workforce with the skills and tools needed to identify and monitor high-risk pregnancies and to promptly respond to complications when they arise through emergency obstetric care and timely referrals. An increased focus on postpartum care is also necessary to minimize the risk of maternal death. Complications and maternal morbidities such as fistula often result from negligence during childbirth combined with the discriminatory attitudes of health workers. In light of the unequal power dynamic that exists between health workers and pregnant women seeking healthcare in public hospitals, health workers must be trained and sensitized to refrain from engaging in such discriminatory behavior, and disciplinary action must be taken whenever such incidents occur. Appropriate mechanisms must be established to check abuse and corruption in the healthcare system and to end impunity.

Ensure the implementation of additional precautionary and preventive measures for vulnerable groups. Specific precautionary and preventive measures are needed to ensure pregnancy survival and minimize the risk of complications among vulnerable groups of women such as those suffering from anemia, those living in high-risk areas for malaria, and pregnant women diagnosed with HIV/AIDS. Young girls

are particularly vulnerable to the risks of early pregnancy and related complications due to early marriage and lack of access to reproductive health services and information. These gaps must be addressed by ramping up the health system to identify and deal with the specific needs of these groups and through the prevention of early marriage. At a minimum, NMBS benefits should be provided to all women; the National Vector Borne Disease Control Program must develop a specific focus on pregnant women that must be integrated into the NRHM; and discrimination against pregnant women living with HIV/AIDS must be prohibited and their right to confidentiality protected.

Ensure universal access to safe and affordable contraceptives and abortion services. A large number of maternal deaths could be prevented by averting the occurrence of unplanned and closely spaced pregnancies. The government must make it an immediate priority to ensure that women and adolescent girls have access to a full range of high-quality contraceptives and comprehensive counseling on their appropriate use. Likewise, unsafe abortion is a leading cause of maternal mortality and morbidity in India. A successful maternal mortality reduction strategy will require direct investment in safe abortion services and the creation of universal access.

Implement the framework enunciated in the UNHRC's Resolution 11/8. The Government of India must refine and improve its approach to maternal mortality through formal legal recognition of the human rights of pregnant women and corresponding state obligations to ensure these rights through official statements and directives that clarify these rights and obligations and establish legal consequences for noncompliance. The central and state governments must intensify existing efforts significantly to reduce maternal mortality by equipping the nation's health workforce to handle the common causes of preventable maternal illness and death and incorporating a human rights-centered approach to the programs and policies to eliminate preventable maternal mortality. These efforts should include mechanisms to monitor implementation, check corruption, promote accountability, and provide reparations.

Implement recommendations of the Special Rapporteur on the Right to Health. The Government of India must take immediate steps to implement key recommendations issued by the Special Rapporteur on the Right to Health. The following goals call for immediate prioritization: an increase public spending on health to more than 3% of gross domestic product; the removal of bottlenecks in the health system that have led to the underutilization of budgets for maternal health programs; and measures to effectively address the policy implementation gap. The central and state governments must stop passing the buck and take responsibility for ensuring the right to health and reducing maternal mortality.

Conclusion

Lawyers in India have broken new ground with regard to securing legal accountability for maternal deaths. Given the scope of the problem, there is much that still needs to be done to expose and remedy the multiple failings of the health system and governing bodies in protecting women's health and human rights in the context of pregnancy; however, a new trend has been set into motion, and it is imperative for maternal health advocates to join forces with the legal community and build on its momentum. It is clear that the nation's courts have a crucial role to play in ensuring that the rights of pregnant women are upheld and their lives preserved. In tandem with other strategies, PIL offers a promising new way to address the causes of maternal mortality and morbidity through legal accountability that can be replicated in other countries and regions struggling to combat high rates of pregnancy-related deaths and complications that undermine women's health and violate their human rights.

Endnotes

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24 *Id.* para. 53.
25 The Court issued several orders for Shanti's daughter as well which are not discussed here due to the focus on maternity-related benefits and compensation for maternal deaths specifically. *See id.* paras. 55(c)-(e).
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27 *Id.*
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31 The Court issued several orders for Fatema's daughter as well which are not discussed here due to the focus on maternity-related benefits and compensation for maternal deaths specifically. *See id.* paras. 58-60.
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Recommendations of the Prime Minister's National Advisory Council to Include Nutritional Benefits in the Food Security Bill

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

This report is an update to *Maternal Mortality in India: Using International and Constitutional Law to Promote Accountability and Change*, published by the **Center for Reproductive Rights (the Center)** in 2008. Since its release, *Maternal Mortality in India* has been distributed extensively, and has been utilized in the development of several groundbreaking maternal health cases filed by the **Human Rights Law Network (HRLN)** in India.

This update serves two purposes. First, it highlights some of the most important international legal developments that have taken place toward the formal recognition of maternal mortality as a human rights issue since the launch of the original report. It also demonstrates the meaningful impact of public interest litigation on efforts to address maternal mortality in India. The Center and HRLN are pleased to present this report to illuminate the recent progress made in establishing maternal mortality as a human rights issue and to expose some of the challenges encountered. We hope that our experience will inspire the use of legal accountability strategies to address this ongoing crisis in other countries and regions throughout the world.

CENTER FOR REPRODUCTIVE RIGHTS

120 Wall Street
New York, New York 10005 USA
Tel 917 637 3600 Fax 917 637 3666
www.reproductiverights.org

HRLN
Human Rights Law Network

576 Masjid Road, Jungpura
New Delhi 110014 India
Tel +91 11 24374501
www.hrln.org