

Maternal and Reproductive Health

Joint Stakeholder Report to UNHRC for India's UPR – III

*Submitted on Behalf of the Coalition of Organizations on Sexual and
Reproductive Rights, India (SRHRIndia)*



**National Alliance for
Maternal Health and
Human Rights
(NAMHHR)**



**Coalition for
Maternal-Neonatal Health
and Safe Abortion**



**Jan Swasthya Abhiyan
(People's Health Movement
– India)**

Contributors:

1. Jashodhara Dasgupta & Sandhya Y.K, SAHAYOG Lucknow,
2. Renu Khanna, SAHAJ and CommonHealth
3. Subha Sri B. CommonHealth
4. Sana Contractor Centre for Health and Social Justice, New Delhi
5. Sandhya Gautam, National Alliance for Maternal Health and Human Rights
6. Richa Chintan, Centre for Budgets and Governance Accountability (CBGA)
7. Amit Sengupta, National Coordinator JSA (People's Health Movement, India)
8. Vandana Prasad and others of the Working Group for Children under six of the JSA

Contents

About the Contributors.....	3
Methodology.....	7
Health systems in India.....	8
Resource allocations for health	9
Health workforce shortages	10
Rise of the private sector:.....	10
Maternal Health	11
State efforts to promote safe childbirth:.....	11
Institutional childbirth is not always safe childbirth:.....	12
Burden on the poor:.....	12
Safe Abortion Access:	17
Contraceptive services and reproductive rights:.....	19
Adolescents' Sexual and Reproductive Health	21
An emerging concern- Women and Social Protection - Maternity Entitlements	24
Recommendations:.....	25

About the Contributors

National Alliance for Maternal Health and Human Rights (NAMHHR)

National Alliance for Maternal Health and Human Rights (NAMHHR) is a network of activists and academics from across the country working together on maternal health and human rights issues. Since its inception in 2010, NAMHHR is dedicated to attaining the highest quality of maternal health for the marginalized in India. Several civil society organizations from seven states of India got together on 20th January 2010 and agreed on the need to strengthen maternal health as an issue of women's human rights, given the sheer scale of the problem at seventy to eighty thousand women dying each year in India of preventable causes related to maternity. The Alliance has members from different states of India, as well as expert advisors working with research, Right to Food, public health, right to medicines and budget accountability. The Common Minimum Principles of NAMHHR are that the group stands for gender equality, sexual and other diversity, social justice, transparency, accountability and do not accept – sexual harassment, any form of discrimination, or communal or any other form of violence

The alliance recognizes that there is an urgent need for women's organizations, health organizations and groups working on law and human rights, and mass-based organizations to come together on this issue. Strong rights-based strategies are needed to build greater accountability for these thousands of preventable deaths among women in India.

NAMHHR's Rights Based Strategies for Improving Maternal Health include Community Empowerment through organizing, monitoring and Jan Sunwais, legal strategies, media advocacy, Information dissemination: studies and evidence building, legislative advocacy, State PIP recommendations, capacity building and budget tracking.

For more details see: <http://namhhr.blogspot.in/>

Postal Address: C/O Center for Health and Social Justice, Basement of Young Women's Hostel, Avenue 21, G Block, Saket, New Delhi – 110017, Delhi, India.

Email: namhhr.india@gmail.com

CommonHealth, (Coalition for Maternal-Neonatal Health and Safe Abortion) is a national group of individuals and institutional members with the following vision and mission:

Vision: A society that ensures maternal–neonatal health and safe abortion for all, and especially those from the poor and marginalized communities, in India.

Mission: To raise visibility of the unacceptably high mortality, morbidity among mothers and newborns, and the lack of access to safe abortion services, especially among the disadvantaged. To mobilise advocates from different constituencies to:

- a. ensure effective implementation of relevant policies and programmes.
- b. contribute to the development of new policies and changing of existing ones when needed.
- c. build a rights based and gender sensitive perspective within communities, health care providers, researchers, administrators, elected representatives and the media, among others.

CommonHealth Thematic Areas

Maternal Health

- Make every instance of maternal morbidity and maternal death count.
- Advocate for safety, quality and respect for women's rights in delivery care.
- Promote health system strengthening and accountability through community mobilization.

Neonatal Health

- Generate and disseminate information on neonatal health. Encourage labour monitoring for improving perinatal and neonatal outcomes.
- Advocate for right to health for newborns, through a. Counting of stillbirths and newborn deaths. b. Attention to newborn outcomes by promoting safety and quality in delivery. c. Legal, policy and economic measures to support newborn care. d. Greater participation of men, families and the community in essential newborn care.

Safe Abortion

- Carry out sustained campaigns to promote access to safe and quality abortion services for all women irrespective of marital status, especially those from disadvantaged sections.
- Support the prevention of sex-determination through stringent implementation of the PC-PNDT Act and campaigns against gender discrimination, without compromising on women's access to safe abortion services

The Coalition currently has 27 institutional members and 181 individual members (as of August 2016) and its work is overseen by a nine-member Steering Committee¹ (SC) elected from within the membership.

For more details see: <http://www.commonhealth.in/>

¹ Currently the Steering Committee of the Coalition has nine members – Suchitra Dalvie, Subha Sri (Chairperson), Renu Khanna, Nilangi Sardeshpande (Financial Advisor), Alka Barua, Sangeeta Macwan, Anand Pawar, Sanjeeta Gawri, Bhuvanaeswari Sunil.

Postal Address: C/O Rural Women's Social Education Centre RUWSEC, 61 Karumarapakkam Village, Veerapuram Post, Thirukazhukundram (via), Kancheepuram District, Tamilnadu, India. PIN 603109.

Email: cmnhsa@gmail.com

Jan Swasthya Abhiyan (JSA)

Jan Swasthya Abhiyan (JSA) is a network of concerned civil society groups and individuals espousing the goal of Health and Health Care for all in India. It is the Indian circle of the People's Health Movement, a worldwide movement to establish health and equitable development as top priorities through comprehensive primary health care and action on the social determinants of health. The Jan Swasthya Abhiyan coalition consists of over 21 national networks and organisations as well as a large number of state level JSA platforms (which are present in almost all states in the country).

JSA was formed in 2001, with the coming together of 18 national networks that had organised activities across the country in 2000, in the lead up to the First Global Peoples Health Assembly, in Dhaka, in December 2000. It is a major national platform that co-ordinates activities and actions on health and health care across the country. Network partners of the JSA include a range of organisations, including NGOs working in the area of health, feminist organisations, people's science organisations, service delivery networks and trade unions.

JSA aims to draw public attention to the adverse impact of the policies of iniquitous globalization on the health of Indian people, especially on the health of the poor and locates the campaign to achieve 'Health For All' in the campaign to establish the Right to Health and Health Care as basic human rights. JSA expresses the need to confront commercialization of health care, while establishing minimum standards and rational treatment guidelines for health care and promote decentralization of health care and build up integrated, comprehensive and participatory approaches to health care that places "Peoples Health in Peoples Hands". It aims to promote a wide variety of people's initiatives that would help the poor and the marginalized to organize and access better health care, while contributing to building long-term and sustainable solutions to health problems.

The thematic areas of JSA's activities include strengthening the Public Sector; women's health rights and gender equity; access to medicines and rational use of medicines; privatization and public private partnerships; regulation of the health sector and social determinants of health.

For more details see :<http://phmindia.org/about-us/>

Postal Address: JSA National Secretariat, c/o Public Health Resource Network

G-46, First Floor, Green Park Main, New Delhi 110016, Ph. 011-40560911
Email:jsasect.delhi@gmail.com

Methodology

In January 2016, the National Human Rights Commission (NHRC) and JSA jointly conducted a Public Hearing on health rights violations in Maharashtra, Goa, Rajasthan and Gujarat, where detailed documentation of violations were presented. Many JSA members are also active in NAMHHR and CommonHealth who have been conducting maternal deaths reviews across the country; it was decided to focus on the accepted UPR 2 recommendationsⁱ related to maternal health within a larger health systems perspective. Additionally, NAMHHR has been involved in the UPR process since 2012-13 when the NHRC initiated an exercise to draft monitoring indicators for the Government of India on the accepted UPR 2 recommendations. Individuals from these three networks wrote up specific sections of this document based on their experience in the field. Feedback was obtained from others in the drafting group and colleagues active in related campaigns.

The document was circulated widely among the networks' membership for endorsements.

This report provides observations on the situation of maternal and reproductive health in India between 2012-2016, with a commentary on the overall health systems, health budgets as well as actual provision of maternal health services and social support.

Health systems in India

Relevant Accepted UPR 2 Recommendations to India

Number	Accepted Recommendation	Country
138.135	Allocate more resources in sectors that provide basic services such as health, education and employment opportunities	Malaysia
138.146	Continue efforts aimed at improving the level of public health in the country to attain better results in the area of health and access to health	Saudi Arabia
138.157	Continue to strengthen/develop programmes and initiatives geared towards guaranteeing the rights to health and education	Cuba
138.149	Meet the stated commitment from the Common Minimum Program of 2004 to dedicate 3 percent of India's GDP to health and 6 percent to Education	Slovenia
138.159	Increase the budget allocated to health from 1 percent of the GDP to 2 percent	Luxembourg

1. Since 2005 India has put in place several programmes to improve the health of its population and has certainly seen some achievements². Since the mid 2000s we have seen major initiatives related to healthcare delivery including the setting up of the National Rural Health Mission (NRHM) in 2005 whose goal was³, to strengthen and scale up public services was laudable, and has led to some improvements in public services. But these broad ambitions have rarely been met as the scheme has consistently been underfunded⁴. India's public spending⁵ on health sector overall is 1.3% of GDP; allocations for the Ministry of Health and Family Welfare have remained stagnant at 0.25 percent of GDP since 2012-13.

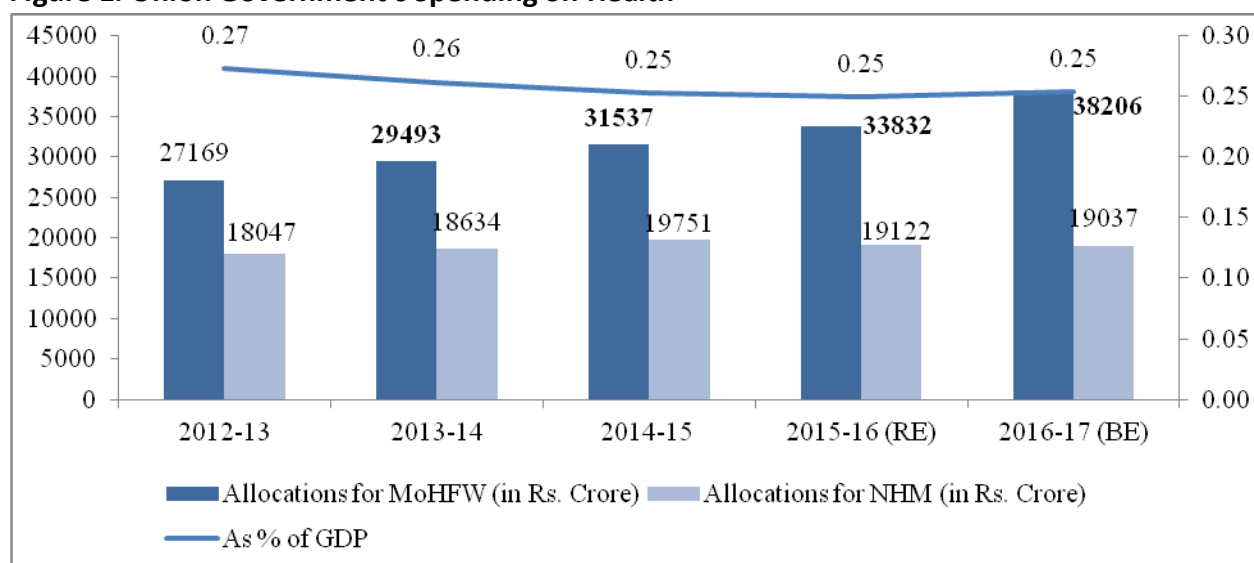
² In 2013, the infant mortality rate was 40 per 1000 live births—down by a third since 2003. Between 2001 and 2013, the maternal mortality ratio fell from 301 per 100 000 live births to 167 per 100 000 live births. The spread of HIV/AIDS has been contained, and, in March, 2014, WHO officially declared India polio free. In August, 2015, WHO declared India free of maternal and neonatal tetanus (Patel et al, 2015)

³ Now it combines Rural and Urban health and is called National Health Mission or NHM

⁴ The underfunding of the NHM should be read in the light of the draft National Health Policy's comment that "*The budget received (for the National Rural Health Mission) and the expenditure ... was only about 40 percent of what was envisaged for a full re-vitalization in the NRHM Framework*".

⁵ India stands 12th from the bottom in the company of Myanmar, Haiti, South Sudan, Timor-Leste and Pakistan

Figure 1: Union Government's Spending on Health⁶



2. Currently, India's health system is one of the most privatised in the world and public expenditure is one of the lowest, with only 32% the total expenditure on healthcare being public expenditure⁷.

Resource allocations for health

3. This very low level of public spending on health in India places a huge financial burden on households. The cost of health care has become a leading cause of poverty; every year around 55 million people are pushed to poverty due to expenses on healthcare⁸. There have also been more recent changes in the fiscal architecture for India in terms of allocations for states, which has impacted upon health service provisioning⁹. The data indicates that the overall allocations for Maternal and Child

⁶ This information has been compiled from Union Budget documents for the respective years.

⁷ India is the 16th lowest (among 190 countries in the World Bank Database) in the august company of countries such as Sierra Leone, Afghanistan, Haiti and Guinea

⁸ Consumer expenditure survey estimates by the National Sample Survey Organization (NSSO)

⁹ As recommended by the 14th Finance Commission, there has been an increase in the share of States in the divisible pool of central taxes from 32 percent to 42 percent every year since 2015-16. However, there have also been reductions in Union Government's financial assistance to States for their Plan spending. Thus, the 10 percentage point increase in the States' share in central taxes has come at the cost of the reductions in Union Government support for a number of schemes in the social sectors. While in States like Bihar and Uttar Pradesh there is a visible increase in allocations for the health sector in the 2016-17 budget, in States like West Bengal and Chhattisgarh there is a decline in 2016-17 (BE) as compared to 2015-16. Further, the NITI Aayog has replaced the Planning Commission and the five-year plans system is scheduled to undergo significant changes. As recommended by the Sub-group of Chief Ministers on Restructuring of the Centrally Sponsored Schemes (CSS) constituted by the NITI Aayog, National Health Mission (NHM) now has a changed Centre-State funding pattern in the ratio of 60:40 from the erstwhile 75:25. This changed funding pattern has transferred larger responsibilities of financing some of

Health (MCH) have been low across States getting translated into low per capita spending in most of the States including those with poor health indicators, pointing towards an urgent need to increase allocations for these interventions.

Health workforce shortages

4. The health system in rural areas is also severely under-staffed in terms of skilled personnel. The Parliamentary Standing Committee report on the Demand for Grants (April 2016) observes that ‘there is an increasing ‘shortfall of 81.2% specialists (including 83.4% surgeons, 76.3% Obstetricians and Gynecologists and 83% physicians) at the Community Health Centres as compared to the requirements (owing to which) people in rural areas have little access to quality medical services..’ⁱⁱ According to Hazarika (2013ⁱⁱⁱ), states such as Bihar, Uttar Pradesh, Jharkhand and Chhattisgarh have severe shortages of health workers¹⁰. The ratio of nurses to doctors is extremely low at 1.5 nurses: 1 doctor.¹¹

Rise of the private sector:

5. The low level of public spending on health sector has resulted in poor infrastructure, supplies and inadequate human resources in this crucial sector, which compels people, even the poor, to turn to the private sector for life-saving care, which has led to a burgeoning¹² private health sector draining the scarce finances of the poor and leading to indebtedness. The private sector also competes for skilled human resources for health. Further the introduction of public funded health insurance schemes since 2007 such as the RSBY¹³, allows beneficiaries to access in-patient care in accredited private facilities. The problem lies not only with inadequate coverage but also with the way the

the crucial social sector schemes like NHM to the States. Over the post 14th Finance Commission recommendations and NITI Aayog Report, the trends in allocations/expenditure for the health sector across different States have not been uniform. Although it is too early to comment on the trends in allocations for health sector across States, it appears that with the expenditure responsibilities in health being shifted over to States, some States may not be able to prioritise this crucial sector adequately in their budgets. This would have a direct bearing on the health outcomes in these States. The Departmentally Related Parliamentary Standing Committee on Health and Family Welfare (2016) notes that increasing public health expenditure to 2.5% of GDP will have to be Centre-led.

¹⁰ less than 1 per 1000 population as compared to WHO’s critical shortage ratio of 2.3

¹¹ instead of 4 nurses:1 doctor as recommended by WHO

¹² It is also largely unregulated- a heavily diluted Clinical Establishments Act, designed to regulate all health care facilities, was passed by Parliament, but even its limited provisions have not even been notified in most states.

¹³ RSBY is the *Rashtriya Swasthya Bima Yojana* (National Health Insurance Scheme) and now the *Rashtriya Swasthya Suraksha Yojana* (National Health Protection Scheme). Such schemes have been started both at state levels (eg, the first such scheme was in AP, called the Arogyasri scheme) and at the central level like RSBY

system is milked by unscrupulous private providers for financial gains. These schemes have been indicted in several states for defrauding the public exchequer of millions of Rupees by performing unnecessary surgeries upon vulnerable women¹⁴

Maternal Health¹⁵

Relevant Accepted UPR 2 Recommendations to India

138.150	Take further practical steps to reduce the high level of maternal and child mortality, inter alia, through better access to maternal health services	Austria
138.151	Further efforts towards addressing the challenge of maternal and child mortality	Egypt
138.154	Contribute to further reduction of maternal mortality through the establishment of an independent organ to accelerate programmes and project in this areas	Honduras

- Given this condition of the health system, it is hardly surprising that India has the second largest number of maternal deaths in the world and failed to achieve MGD 5¹⁶. Maternal deaths are highest in nine low performing states¹⁷. Maternal and child health care in these states is predominantly provided through the government health care system which is free of charge.

State efforts to promote safe childbirth:

- The Government of India in 2005 launched a nationwide *Janani Suraksha Yojana*¹⁸ (Eight years into implementation of the JSY, periodic sub national surveys ([RG & CC](#),

¹⁴ There are several examples of increasing misuse of hysterectomy as a routine treatment for gynecological ailments, particularly in young, premenopausal women (Desai et al 2016, HRLN 2013, OXFAM 2013^{14 14})

¹⁵ The government of India has in 2013 displayed intentions fulfil its obligation to ensuring the access of all women to reproductive health services through a policy called the RMNCH+A (***A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India*** 2013). If we examine the reality on the ground in the last four years, we find the government has not fulfilled its obligations to ensure women's right to health; in fact there have been a number of notable incidents of severe violations of women's rights to health in different parts of India.

¹⁶ reducing maternal mortality to 109 per 100000 live births by 2015

¹⁷ Rajasthan, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Orissa and Assam, which together account for about **12% of global maternal deaths** (half of India's population and 62% of India's total maternal deaths) ([RGI, 2011](#)¹⁷)

¹⁸ JSY, Mothers' Protection Scheme) ([MoHFW 2006](#)¹⁸) is a cash incentive program that intended to reduce inequality in access to institutional care (and by assumption to skilled birth attendance) for pregnant women during childbirth by reducing financial barriers for them.

2011^{iv}) have shown steep rises in institutional delivery proportions (41% in 2004 to 73% in 2012, RGI 2013).

Institutional childbirth is not always safe childbirth:

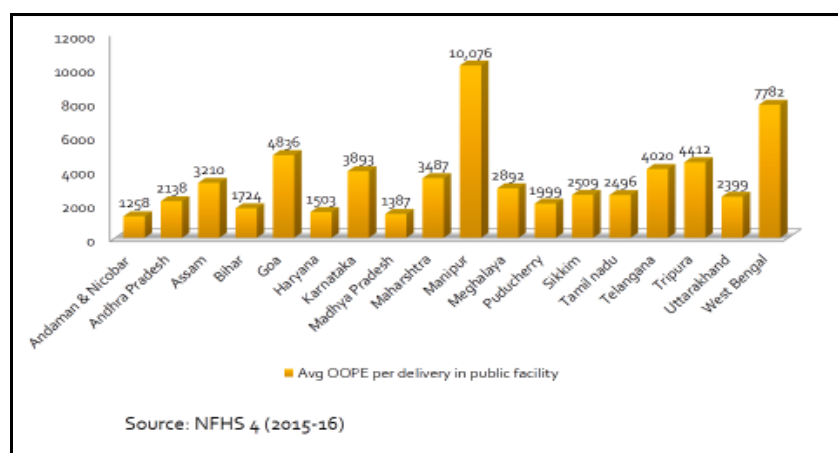
8. But given how dysfunctional the public health facilities are, and the lack of skilled care by competent personnel, institutional childbirth for poor women did not result in maternal survival. The women with highest incomes showed four times higher reduction in maternal deaths as compared to the poorest ones during 2007-2009 to 2010 ([Randive et al., 2013^v](#)). In fact recent expenditure data indicates that the trend in the number of beneficiaries under JSY shows a decline in a number of States. The NSS 71st Round (2014) estimates that about 20% of the childbirths in rural areas were at home or any other place other than the hospitals, whereas for urban areas this was 10.5%. A multi-state study of traditional home-based birthing practices (Jeeva study^{vi}) shows that traditional attendants are often preferred by women since they are easily accessible, especially in remote areas where public health facilities are either absent or nonfunctional. The costs and poor treatment at health facilities also prompts poorer women to opt for home births
9. The *Janani Shishu Suraksha Karyakram*¹⁹ launched in 2011 to provide free and cashless services to pregnant women, including normal deliveries and caesarean operations and care for the sick newborn (up to 30 days after birth), in government health institutions in both rural and urban areas, aimed at mitigating the burden of out of pocket expenses.

Burden on the poor:

10. Yet it appears that financial burden remains for women giving birth in hospitals. The National Family Health Survey 4 data – Figure 2 - shows that the average per capita expenditure for childbirth in public facilities ranged from Rs. 1,258 (in Andaman and Nicobar) to Rs. 10,076 in Manipur^{vii}. Further, recent trends in the allocations made for the JSSK, shows that there is a decline in States like Bihar, Chhattisgarh and Jharkhand. According to the 71st Round of the NSS^{viii} in rural areas, an average of Rs. 5544 was spent per childbirth (as inpatient) in rural area and Rs. 11685 in urban area. Other evidence from across India shows that JSSK has failed to live upto its promises^{ix}:

Figure 2 - Out of Pocket Expenditure for Childbirth in Public Facilities

¹⁹ Janani Shishu Suraksha Karyakram (Mother and Child Protection Programme)



Equity and exclusion in maternal health care:

11. CommonHealth (2014) observes that women with vulnerabilities get left out of services like antenatal and post-partum care. Dasgupta et al (2016) observe that since the health of women who belong to marginalized communities or live in under-served areas is already compromised owing to compounded vulnerabilities²⁰ any complication during pregnancy or childbirth can cause death unless there are skilled and effective health services that respond promptly. Many women who die have multiple vulnerabilities which coalesce to produce cumulative effects, and women face severe challenges in accessing health care (see case of Heena²¹).
- a. Certain sections of the society remain neglected and marginalised, and great disparities exist in access and utilisation of services, particularly among SC, ST and Muslim women as well as younger women and adolescent girls (see NFHS- 3^x). Studies show that Muslim and SC/ST women are less likely to receive good quality antenatal and postnatal care, and are less

²⁰ (poorly nourished, low weight or stunted height, early marriages and closely spaced repeated pregnancies with poor health status and anemia)

²¹ Heena was a 22 year old tribal woman in Kendujhar district of Odisha. Both she and her husband were illiterate, landless, extremely poor, and according to her husband, often did not have enough to eat. They lived in a remote hamlet (nearest motorable road is 10 kms away) the hamlet could not be reached in inclement weather. Heena's first child had died at 6 months due to an infected abscess. During her second pregnancy, Heena did not seek or receive any care. When Heena's labour pains started, her husband tried for 8 hours to arrange for transport to take her to a health facility (they did not have the number of the public transport facility), but they received no help from peripheral health workers. They set out to the nearest Community Health Centre that was 50 kms away, but Heena delivered on the way and died soon after, probably due to excessive bleeding.

Soni Baghel a tribal woman gave birth unattended on the labour table at the Jagdalpur Medical College hospital (Bastar, Chhattisgarh) and the newborn fell into the dustbin. Even though the Mitani (ASHA) Community Health Worker had tried to call the doctors and nurses, they did not come. Afterwards they made the mother and the Mitani clean the blood stains on the delivery table and the floor. The newborn died of infection after 11 days.

likely to deliver in institutions.^{xi} Differential utilisation of maternal health schemes may be due to lack of information and absence of documentation to establish eligibility.^{xii}

- b. Studies related to marginalised women's interactions with health workers indicate harmful discriminatory practices by providers such as reluctance to touch a lower caste woman, refusal to visit areas where Dalits reside^{xi} and abusive treatment of Muslim women owing to the stereotype of large families.^{xiii} Crucial data on differential access for disabled women, HIV+ women, migrant women and women in conflict areas is unavailable.
- c. Two recent studies^{xiv} conducted in the tribal villages of Jharkhand and Odisha states, indicate that exclusion and marginalization of tribal communities is not limited to geographical isolation but many other factors²². Studies^{xv} reveal although home births are common among tribal communities, they are overlooked by the health system without ensuring women's safety, and no attention to training local providers who may be accessible in these difficult areas. The studies by NAMHHR show that tribal communities experience social exclusion and alienation from the health system²³. The high prevalence of anaemia (nutritional as well as sickle cell anaemia), malaria (especially falciparum malaria) and malnutrition in tribal communities contributes to the risk of bleeding to death with an obstetric complication. With blood transfusion not easily available in rural areas this becomes a major cause of death.

Causes behind maternal deaths:

- 12. Civil society studies (SAHAYOG & NAMHHR 2016^{xvi} and CommonHealth 2014^{xvii}) of 139 and 124 maternal deaths respectively among marginalized populations in selected districts of several Indian states²⁴ indicate that the basic components of maternal care (ante-natal examinations, pre-natal counseling, routine care for normal childbirth and emergency obstetric care in hospitals) are not available for women who live in these

²² Their context is of economic marginalization combined with marginalization owing to political, social and economic factors that are contributing to tribal deprivation

²³ Although the government earlier had a budgetary provision to ring-fence a certain percentage (around 8%) for specific interventions in every line-department which was called the Tribal-Sub Plan approach to budgeting, but its potential has not been effectively utilized. Tribal blocks are severely under-served in terms of health infrastructure and workforce, since skilled health workers are often unwilling to move into tribal areas, and quality of services continues to be a concern. The ill-equipped public health system and weak referral linkage often compels poor families to seek care at the private sector which tends to be extremely exploitative (in terms of irrational procedures, coercion as well as high out of pocket expenses). Local tribal maternal health practices have neither been recognized, studied nor integrated into provider training and practice (U.N. declaration on the Rights of Indigenous Peoples –UNDRIP, 2007). Some tribal communities have a very sophisticated system of healing and traditional practices for maternal health, several of which are beneficial to women. These have not sufficiently been documented or acknowledged by the formal health system, nor included among the non-Allopathic health systems within the government's "AYUSH" categories.

²⁴ Odisha, West Bengal, Jharkhand and Uttar Pradesh

districts. These documentations show that several groups of marginalized women lack access to maternal health care, leading to disproportionately large numbers of maternal deaths in them.

- a. **Inadequate care during pregnancy-** Antenatal care in the community is largely unavailable and whatever women received is grossly inadequate – often restricted to receiving a dose of tetanus toxoid and a few iron tablets but missing essential components that can indicate the potential high-risk status of a pregnant woman. Anaemia, though an extremely serious problem²⁵, is left undetected and untreated; blood tests are often not done during antenatal care and even when done, no treatment or follow up is done (See case of Urmila²⁶).
- b. **Lack of skilled care during childbirth** - Although the government's policy is to promote hospital childbirth (in order to reduce maternal deaths), normal deliveries in hospital are also leading to heavy bleeding and infections that can kill women: in fact childbirths were actually attended by poorly trained nurses or auxiliary nurses and women sometimes never saw the doctor before they died.
- c. **Management of complications:** If there is a complication during the childbirth, most of the hospitals in these districts do not have the skilled providers, medicines or supplies that can save the women's lives. Women are bounced around from one hospital to another to avoid responsibility. Women in a critical condition have been referred out without transportation support, leaving the family to look for vehicles causing delay and high expenses. In fact women with perceived complications were hastily shunted out of hospitals; even when lower level facilities could have provided some initial first aid, this is not done.
- d. **Lack of emergency obstetric care at tertiary centres.** Even in tertiary hospitals, life saving emergency obstetric care is unavailable, delayed and inappropriate; health providers lack skills to identify complications, are over-pressured due to under-staffing, there is a lack of essential drugs, supplies and blood and there is failure to attend to a woman with an emergency immediately.

²⁵ According to a report released in 2015, more than half the women in India are anaemic while half the adolescent girls in India would be categorized on the basis of BMI as being 'thin'. Chronic nutrition deficiency manifests itself in that 6% of women are severely undernourished (body-mass index less than 16 kg/m²), which is among the highest in low-income and middle-income countries

²⁶ Urmila (name changed), an adivasi woman from Panchmahals in Gujarat, worked as a migrant labourer in cotton mills. This was her fourth pregnancy. She had delivered her first child at a construction site where she had been working and the next two at home. She had also had tuberculosis earlier and had completed treatment. She had only one antenatal care visit at a Primary Health Centre, but her haemoglobin was not checked and she was given only 10 iron folic acid tablets. She finally developed breathlessness and sought care at multiple places before being taken back home and dying, probably of anaemia and congestive heart failure.

- e. **Violations of the JSSK:** Among the maternal deaths documented, bewildered family members were asked to negotiate the complex procedures of the blood bank and families were made to pay large amounts for medicines, transportation and services in public hospitals despite the JSSK. Emergency transport is unavailable or delayed leading to delays in reaching health facilities. (Case of Garli²⁷). Post-partum care is unavailable, even though this is the most crucial period where mortality occurs. Lack of blood continues to be a critical gap despite plans to establish blood banks in every district and blood storage units in every First Referral Unit (Case of Salma²⁸).
- f. **Abortion and Miscarriages:** There is an absence of information and accessible services for abortion or post-abortion/miscarriage complications, compelling women to use unsafe methods with no supervision and inadequate knowledge of danger signs (Case of Sukanti²⁹).
- g. **Poor quality care at exorbitant costs in private sector:** Quality of care in the private sector is very poor, often very expensive with no accountability mechanisms in place (Case of Phool³⁰).

²⁷ When Garli (name changed), an adivasi woman in Rajasthan delivered her fifth baby in a Community Health Centre, the placenta was retained. The nurse gave some injections and waited for one hour before calling the doctor. The doctor waited another 1 ½ hours before referring her further. She was not provided a vehicle though she was bleeding, nor did any health care provider take responsibility to accompany her. By the time her husband arranged money and got a vehicle to transport her, another 1½ hours had elapsed. Garli died on the way to the higher centre.

²⁸ Salma was admitted in a civil hospital in Assam in the fifth month of her second pregnancy with bleeding – her family was told she needed a D&C and was asked to arrange blood – by the time they managed to do so, the doctor had left, so Salma could not receive the transfusion and she died soon after.

²⁹ Sukanti was an adivasi woman living in Jharkhand. When she got pregnant for the fifth time after four previous closely spaced pregnancies, she opted for an abortion. She obtained abortion inducing herbs and inserted them into her vagina. Soon after she began bleeding profusely, became breathless, started gasping and sweating. However before the family could get help she died within an hour of the onset of the complications.

³⁰ Phool a resident of Uttar Pradesh developed fever four days after her delivery. Her husband took her to a 'Bengali doctor' (quack) in the nearby bazaar. He gave her an injection and medicines which gave her temporary relief. However when the pain recurred in the middle of the night, they hired a vehicle, travelled for an hour and reached the Community Health Centre at 6 am. In the absence of a doctor they took her to a private clinic run by a government doctor. The doctor told them to get an ultrasound done in a private diagnostic closeby. After examining the report, the doctor did not initiate treatment; instead he told the family to take her elsewhere. The family had already spent four hours in this clinic. Phool was taken to another registered private family and reached within 20 minutes. The doctor there gave her an injection which costed Rs 1300. However soon after her condition began to worsen, the doctor then told the family to take Phool to the Mission Hospital. The family arranged for a private vehicle to take her there but Phool died on the way thrashing her limbs and in extreme pain. The family had spent a total of Rs. 7000 in their attempts to save Phool.

h. Accountability failures: The state demonstrates a lack of accountability to end preventable maternal deaths by making policies that actively exclude vulnerable women, by allowing providers in the public sector to refuse care, by allowing them to violate all ethical norms of care (Case of Kala³¹), and by allowing referral systems to toss women in critical condition from one facility to the next. The state has failed to adopt or implement the Technical Guidance^{xviii} of the Human Rights Council that indicates how the maternal health policies, budgets and programmes can respect, promote and fulfil women's human rights. Data fails to indicate the extent of discrimination against various categories of marginalized women in the process of seeking maternity care; there is no social profile of the maternal deaths being counted in the country by the Registrar General. The harassment and poor quality of care for women seeking maternal or reproductive health services have not been addressed through any grievance redress mechanism that can be used easily by poor and less-educated populations. Neither has the government been able to fully implement social accountability processes that were mandated within the NRHM across the country.

13. Underreporting of Maternal Deaths still continues³². Maternal Death Reviews are largely restricted to finding a medical cause for death rather than identifying gaps in the health system and instituting corrective action, and there is lack of the information from this process in the public domain. This precludes any engagement from other stakeholders like civil society, academics, professional associations in the process and signals a major lack of accountability.

Safe Abortion Access:

Relevant Accepted UPR 2 Recommendations to India

³¹ Kala reached a Community health centre in Uttar Pradesh at 11pm and the staff nurse agreed to admit her on the condition that the family arranged for candles, injections, medicines, blade, thread and soap. The delivery was conducted by candle light and Kala delivered a still born at 3 am. She was not given a bed and was made to lie in the veranda. She was bleeding profusely but despite Kala's husband going to call the doctors in their staff residence, none of them came. On being urged by Kala's husband to do something to stop the bleeding, the nurse told him off saying, "We are not your servants. You will have to wait for the doctor who will come in the morning and give treatment or refer your wife. I have done whatever I was supposed to do. If you decide to take her elsewhere, you will be responsible for the consequences." With no doctor or nurse to attend to her, Kala's condition steadily worsened and she died two and half hours after child birth.

³² By the government's own admission, as of March 2012, only 18% of all expected maternal deaths were being reported under the maternal death review (MDR) process, and of these, only two-thirds were being reviewed by the district level committee for MDR.

138.153	Take further measures to ensure that all women without any discrimination have access to adequate obstetric delivery service and sexual and reproductive health services, including safe abortion and gender sensitive comprehensive contraceptive services	Finland
---------	---	---------

14. Abortion has been legal in India since 1971 when the Medical Termination of Pregnancy Act (MTP Act) was passed by the Parliament.^{xix} More than 80 percent of women in the country still do not know that abortion is legal and available. ^{xx} Many medical students either do not know about the MTP Act ^{xxi} or do not have the right attitudes towards abortion services for women. The situation has been made more challenging in the last decade with the vigorous implementation of the PCPNDT Act^{xxii} whose posters and slogans have made it seem as though all abortions were illegal, rather than conveying that sex determination is illegal^{xxiii}. Second trimester abortions are more likely to be denied due to fear of sex determination and such women are forced to seek informal and unsafe abortion services^{xxiv}.

15. It is estimated that among the six million abortions that take place annually in the country only one million are legal.^{xxv} Abortion related morbidity and mortality is very high and unsafe abortions are believed to contribute to^{xxvi} 9%–13% of the maternal mortality in India and as much as 50% of the maternal mortality in some of the districts in India.^{xxvii}

16. The Indian Penal Code, still criminalizes abortion, specifying punishments for the provider as well as the woman³³. During the 66th General Assembly of the United Nations, (October 2011), the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, said “Criminal laws penalizing and restricting induced abortion provide examples of State interference with women’s right to health,” adding that such laws restricted women’s control over their bodies, undermined their dignity and infringed on their autonomy^{xxviii}.

³³ See section 312 of the Indian Penal Code: “312. Causing miscarriage.--Whoever voluntarily causes a woman with child to miscarry, shall if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine. Explanation. -A woman who causes herself to miscarry, is within the meaning of this section.” Available here: <http://indiacode.nic.in/>

Contraceptive services and reproductive rights:

Relevant Accepted UPR 2 Recommendations to India

138.153	Take further measures to ensure that all women without any discrimination have access to adequate obstetric delivery service and sexual and reproductive health services, including safe abortion and gender sensitive comprehensive contraceptive services	Finland
138.2	Intensify the efforts working towards the MDG5, including by withdrawing its reservation to Article 16 in Convention on the Elimination of All Forms of Discrimination against Women, and by ensuring access to information and counselling on SRHR as set out in its National Population Policy	Sweden

17. Access to voluntary contraceptive services and information is critical to upholding women's and girls' reproductive rights, as it provides women the right to decide whether to have children, and the number and spacing of children thereby preventing unwanted pregnancies, and minimizing their adverse impact on the women's health and well-being. However, it is essential to ensure that adoption of contraceptive methods is informed and voluntary, and that standards of care are upheld.

18. The government of India promises women informed choice in the matter of reproduction but plans and budgets actually promote female sterilization as the predominant method. The state emphasis on terminal contraceptive methods is unsuitable for a largely young population. The neglect of male responsibility for contraception exacerbates the continued violation of women's reproductive health and rights. There is an anxiety over burgeoning population; in reality, however, population growth in India has been slowing over the past two decades. Many states have reached a replacement fertility rate³⁴.

19. Although on paper, there are no Family Planning targets imposed upon health managers and providers, in reality the budget leads to setting ELAs (Expected Levels of Achievement) which translate on the ground as targets for female sterilization. Female sterilization is performed under extremely hazardous conditions in India leading to

³⁴ The growth in absolute numbers is owing to the phenomenon of "population momentum" meaning that the 'extra' population growth that we see is not due to women and couples having more babies, but more women and couples having babies, because our population comprises mostly of youth.

deaths, complications and illnesses as well as failure and unwanted pregnancy.³⁵ None of the Quality Assurance Mechanisms mandated by the orders of the Honorable Supreme Court are actually functioning on the ground.

20. According to the Guidelines on Female Sterilization issued by the Government of India (2005), a detailed plan for quality assurance has been laid out. Despite this order, violations of the standards of care continue to take place. The most prominent of such violations, was death of 13 women who had been operated in a routine sterilization camp in Chhattisgarh in November 2014³⁶. This incident is one in a long series of deaths, disability and contraceptive failure faced by women desperate to control their reproductive lives, and condoned by a government ready to put women's lives at stake in order to demonstrate 'strict population control' measures.
21. Violation of informed consent: India's National Population policy of 2000, in accordance with ICPD 1994, adopted a target-free approach to family planning in order to promote voluntary rather than target driven adoption of contraception. However, coercive measures such as the two-child norm (by which those with more than two children are excluded from elections, jobs and welfare benefits), continue to operate. Studies from the field show that women are unaware of any contraceptive method apart from

³⁵ Several other instances of violations of the quality guidelines have been reported in the news, from the states of Odisha (where a cycle pump was used as an insufflator Bicycle pump used in Odisha sterilization operations, Times News Network, 30th November 2014. <http://timesofindia.indiatimes.com/india/Bicycle-pump-used-in-Odisha-sterilization-operations/articleshow/45321725.cms>), Uttar Pradesh (where sterilization operations were conducted under torchlight In Azamgarh fifty women sterilized in torch, mobile light in four hours flat, TwoCircles.net, 14th March 2015. <http://twocircles.net/2015mar14/1426317952.html#.V9k1Pfl97IU>), Bihar and Jharkhand (where women were made to lie on the floor in the winter, after operations *Yahan Mareezon ko nahin milta hai bistar*, (Here patients do not get a bed) Dainik Bhaskar, 4th February 2015.) and Madhya Pradesh (where there have been multiple reports of complications and deaths following sterilization "Nasbandi operation mein laparvahi, shareer mein phaila infection, mahila ki ma ut" (Negligence during sterilization operation, spread of infection leads to woman's death), Dainik Bhaskar, Sagar District, 14th May 2016. <http://epaper.bhaskar.com/sagar/167/14052016/mpcg/1/>). Civil society networks such as the Madhya Pradesh Maternal Health Rights Campaign have reported from observations of 28 camps across 12 districts in the state of Madhya Pradesh, that in several of these camps, women were not explained the contents of the consent letter before signing it, were not told about the possible complications and were made to lie in the verandah after the procedure. In 9 camps, operations took place after the stipulated time of 5 pm, and two of the camps were not even conducted at a health facility, but in school and *dharamshala* (public inn).

³⁶ In November 2014, following a 'mass sterilization camp' performed under shockingly negligent conditions, 13 young women in Bilaspur, Chhattisgarh state, lost their lives due to a negligent national family planning programme funded by the Government of India. (*Jan Swasthya Abhiyan, NAMHHR and SAMA (2014) Camp of Wrongs: The Mourning afterwards- a fact-finding report on sterilisation deaths in Bilaspur, 16-18 November 2014*) Despite such an incident there was no acknowledgement of failure by the Central Government Ministry which funded these 'camps' and no announcement of a shift in the policy of targeting women. The state government instituted a one-member judicial enquiry commission that made no effort to reach the survivors' and bereaved families. After the Commission report was tabled, there was no further public announcement of culpability. Redress was limited to providing a one-off cash amount to the families.

female sterilization and are also unaware of side effects and possible complications of the surgical procedure and are therefore not in a position to make any informed choices^{xxix}. Recently the Government of India has been promoting the use of Post-partum IUCD³⁷. Even with this method, experience from the field shows that women are not counselled about PPIUCDs in the antenatal period and often the device is inserted without their knowledge, and they only discover it later when there is an infection³⁸. An example of one such case is given here³⁹

22. Disproportionate burden of contraception on women and no meaningful involvement of men: In India, female sterilization is the most prevalent method of modern contraception being used today; female sterilization accounts for 72% of modern contraceptive use in India⁴⁰. Service statistics show that female sterilizations as a proportion of total annual sterilization operations (male or female), have increased from 78.6% in the early 1980s to 98.1% in 2015. Similarly, there has been an inappropriate focus on female sterilizations in the budgets⁴¹.

Adolescents' Sexual and Reproductive Health

Relevant Accepted UPR 2 Recommendations to India

138.2	Intensify the efforts working towards the MDG5, including by withdrawing its reservation to Article 16 in Convention on the Elimination of All Forms of	Sweden
-------	---	--------

³⁷ A spacing method inserted immediately after delivery

³⁸ Even though there is no systematic study documenting this evidence, such stealth procedures have been reported by field practitioners from both Madhya Pradesh and Uttar Pradesh.

³⁹ Case of PPIUCD insertion without information or consent from Uttar Pradesh: B, resident of Badhya village, delivered in a CHC in Maharajganj district of Uttar Pradesh in January 2016, after which PPIUCD was inserted by someone from the hospital staff without her knowledge nor by the consent of anyone in her family. After returning home she used to regularly experience pain in her stomach. Her husband informed the ASHA of the pain and that is when the ASHA told him that the PPIUCD had been inserted which may be causing the pain. She advised him to wait for a few days for it to get better on its own. B wanted to get the PPIUCD removed but did not know how and from where. Her husband contacted the staff nurse at the CHC who advised him against getting it removed. However, B was in immense pain and they approached the CHC again. On her second visit she was told by the staff nurse that the PPIUCD had gotten removed on its own. But the pain did not go away and therefore B met the staff nurse again who asked B to get an ultrasound done from a private lab. The report revealed that the PPIUCD was still in the body and was 'stuck'. The PPIUCD was removed at the private facility. B incurred an expenditure of 6500 rupees in the whole process and she still feels physically weak

⁴⁰ As per data from 2008 (DLHS III), It is pertinent to note that there is no national survey data on contraception available after 2008. However even as per the NFHS 4 (2015) for which key figures from 10 states have been released, female sterilization remains the most commonly used modern method of contraception in all states with the exception of Tripura

⁴¹ For instance in the year 2011-12, 2% of the total planned family welfare expenditure was spent on sterilizations and 1.9% was spent on female sterilizations.

	Discrimination against Women, and by ensuring access to information and counselling on SRHR as set out in its National Population Policy	
138.82	Review the budgets and social laws taking into account gender issues	Morocco

Laws-

23. The Government of India has enacted many laws ranging from the Prohibition of Child Marriage Act, 2006 to the Protection of Children from Sexual Offences Act 2012 and the Criminal Law (Amendment Bill) 2013. Despite these laws vulnerabilities persist and evidence suggests that adolescents are not making healthy transition to adulthood. Adolescents (more girls but also boys) continue to face early marriage, early and unsafe initiation into sexual activities, early childbearing, limited knowledge about and access to contraception, unwanted pregnancies, lack of access to safe abortion services and exposure to sexually transmitted infections^{xxx}.
24. One issue with the different legislations – as well as policies and programmes – is that they define adolescents differently. According to the PCMA, the age of marriage is 18 for girls and 21 years for boys. In The Indian Majority Act, 1875, The Juvenile Justice (Care and Protection) Act, 2000, and the Protection of Children from Sexual Offences Act, 2012, children, both male and female, are defined as persons upto the age of 18 years^{xxxi}.
25. There are many contradictions between related laws. For example under the Protection of Children from Sexual Offences (POCSO) Act, 2012, sexual relations with a girl under 18 is considered rape. Boys under the age of 18 years, as well as older men, in consensual sexual relationships with girls aged below 18 can get booked for rape. If they were to elope, the boys and men would be charged with kidnapping. However, if the same acts occur under the shroud of marriage, they are considered legal.^{xxxii} Inconsistencies and contradictions that can jeopardise rights of adolescents – for example, mandatory reporting to law enforcement, under the POCSO goes against the right to privacy and confidentiality and access to safe abortion and other sexual and reproductive health services for adolescents^{xxxiii}.

26. ***Rashtriya Kishor Swasth Karyakram (RKSK National Adolescent Health Strategy)***^{xxxiv}The

Government of India announced the RKSK in January 2014⁴² The Strategy also envisaged a convergent model of service delivery with coordinated action of the health department with teachers of the Education Department, Anganwadi Workers and the Sabla programme of the Women and Child Department, and Nehru Yuvak Kendra Sangathan volunteers of the Youth Department. The Strategy reiterates that the States should operationalize and strengthen Adolescent Friendly Clinics called ARSH⁴³ at the Primary Health Centre, Community Health Centre as well as the District Hospital. **The ARSH Clinics never took off as planned, as a large national evaluation showed^{xxxv}. Neither has the RKSK taken off in many states such as Gujarat, Uttar Pradesh, Tamil Nadu and, Maharashtra.**

27. Existing adolescent health programmes largely focus on girls' nutrition and anaemia control which though much needed, take an instrumentalist view of girls as 'future mothers'. Body literacy and sexuality education is missing; emergency contraceptives are not available as a part of government supply in the ASHAs' (community level health worker in the government programme) kit^{xxxvi}. Menstrual hygiene seems to have come on the agenda of some state governments but mainly as a commodities and social marketing intervention, devoid of an understanding that girls also require information on menstruation and menstrual irregularities, as well as water supply and privacy of bathrooms and toilets^{xxxvii}. Adolescent health programmes thus remain fragmentary at present – access and availability of health services continues to be severely limited. The vision of the National Adolescent Health Strategy, with its critical components of addressing gender based violence and mental health needs, and the promised interdepartmental convergence, is hard to see on the ground in the intervening (almost) three years.

28. ***SABLA Programme***- The Rajiv Gandhi Scheme for Empowerment of Adolescent Girls- Sabla (henceforth referred to as Sabla) was launched in 2010 in 205 pilot districts, by the Government of India (GoI) as an effort to empower adolescent girls The scheme anchored by the ICDS programme, uses the anganwadi centres in the villages, to conduct a range of activities with out of school girls to empower them. An evaluation of the two years' of the pilot programme in 2013 showed that it was successful on several counts^{xxxviii}. The evaluation recommended the scaling up of the scheme across the

⁴² The RKSK has six thematic areas - Nutrition, Sexual and Reproductive Health, Injuries and Violence (including Gender-Based Violence), Non- Communicable Diseases, Substance Misuse and Mental Health.

⁴³ ARSH – or Adolescent Reproductive and Sexual Health - Clinics were to have started as a part of the Reproductive and Child Health II Programme. (RCH II) in 2005.

country even as it pointed out the gaps that needed to be addressed. In many states where Sabla was piloted, non government organisations undertook projects to support the anganwadi workers to implement the programme so that it could fulfil its potential. Evaluations and reviews of several of these collaborative Sabla implementation projects showed the tremendous value addition by the NGOs^{xxxix} xl. The anganwadi workers, overworked with other responsibilities, welcomed the support of the NGOs. The creative and participant centred training by the NGOs resulted in shifts in cultural norms in communities. As a result there was increase in mobility of girls, re-enrolment in schools, delaying (stopping) of early/forced marriages, increased discussion on reproductive and sexual health and in general, increased confidence amongst girls. Despite the positive evaluations, **Sabla has not been upscaled across the country. In fact, the budget of the Ministry of Women and Child Department and specifically the ICDS department was decreased in the Union Budget of 2015-16.**

An emerging concern- Women and Social Protection - Maternity Entitlements

29. In India, women workers are overwhelmingly in the informal sector (around 95%), which does not have the protection of labour laws and therefore do not get any paid leave during maternity, There is a lack of social support during pregnancy and after childbirth; at the time when food and nutrition demands are highest for the woman, the family income is often at lowest ebb for each episode of maternity calls for a substantial expenditure for poor families^{xli}.
30. The participation of women in the labour force and employment rates are decreasing⁴⁴, heavily impacted by economic, social and cultural issues and care work distributions in the home (Human Development Report-HDR, 2015). The lack of paid leave for maternity could even push women back into wage work before their bodies are fully recovered and deprive the child of exclusive breastfeeding for six months. This takes its toll on child nutrition which is reinforced through a vicious cycle of causes - **poor nutrition** of the woman during adolescence aggravated during and after pregnancy; **lack of social**

⁴⁴ According to the fourth Annual Employment-Unemployment Survey conducted by the Labour Bureau during the period January 2014 to July 2014, the Labour Force Participation Rate (LFPR) (usual principal status) for women is significantly lower than that for males in both rural and urban areas. The Worker Population Ratio (WPR) reflects a similar pattern, with women having lower participation rate in comparison to men in both rural and urban areas. As per Census 2011 also, the workforce participation rates for females trails behind that for males.

security for maternity compelling many women to return to wage work early, and **absence of crèche facilities** which means women have to leave children at home, therefore children are deprived of exclusive breastfeeding for the first six months.

31. The current Bill to modify the existing Maternity Benefits Act (1961) has been passed by the Upper House of Parliament but has completely excluded women who are in the informal sector. A promise was made in the National Food Security Act 2013, within which the Central Scheme for maternity benefits was meant to be made universal; but has not been implemented even now. In fact the only existing Central Scheme for maternity benefits is the '*Indira Gandhi Matritva Suraksha Yojana*' (IGMSY)⁴⁵ which excludes the most vulnerable women by disqualifying anyone with more than two children. This effectively de-bars the poorest, those from marginalized groups like Dalits and tribal women.⁴⁶

Recommendations:

1. Increase the budgetary allocation for health to at least 2.5 percent, as recommended in the draft National Health Policy (2015). Within this, ensure adequate budgetary allocation for adolescent health programmes, maternal health and abortion services, and put in place a mechanism for monitoring expenditure.

⁴⁵ Was started more than five years ago as a 'pilot' across 50-odd districts of the states and Union Territories. Till date it remains as a pilot in these few districts.

⁴⁶ The data indicates that in all, half the women will get potentially disqualified for the IGMSY; and among vulnerable groups like such as SC, ST and non-literate women, almost 60% will potentially get excluded, with two-thirds non-literate women unable to access the maternity benefit.

Table- Social Profile of Women Aged 15-49 who recently gave birth & Percentage of selected categories of women and under five child mortality

Category of Women	% of all Women Aged 15-49 who have given birth to children in the last year (NFHS 2005-06)	Among Women Age 15-49 Who Give Birth in a Year		Caste profile of Under-five child mortality
		% of Women Aged 15-49 Years having 2 or < 2 Births	% of Women Aged 15-49 years having More than 2 Births	
All women	100	52	48	
SC/ST/poor having no education*	66	41	59	
SC and ST	31	44	56	66.4 and 54.4
Poor Women	40	37	63	92.1
No education	46	34	66	

Source: Lingam and Yelamanchili 2011⁴⁶ and India Alliance for Child Rights (Computed from NFHS-3, 2005-06).

* Figures in categories overlap with more than one variable

2. Following changes in the federal fiscal architecture where there is greater budgetary devolution to the states, the Centre must ensure that health and other social sectors do not get neglected by States.
3. Shift the distorted focus of annual budgets away from sterilization of women and promote meaningful involvement of men in taking contraceptive responsibility and promotion of spacing methods.
4. Reconcile the inconsistencies in laws that affect reproductive and sexual rights of citizens, especially the contradictions between the Medical Termination of Pregnancy Act and Section 312 of the Indian Penal Code. Amend the Protection of Children from Sexual Offences Act 2012, to decriminalize sexual activity before the age of 18 years, and do away with mandatory reporting to law enforcement; this would improve access to SRHR services for adolescents.
5. Ensure concrete measures to increase health human resources according to standards, including counsellors who are critical to provision of sexual and reproductive health services (including emergency obstetric care, adolescent health, contraceptive and abortion services).
6. Training of human resources must include appropriate skills and competencies, as well as professional ethics and value clarification to reduce stigma (related to abortion, HIV, disability, caste/religion/tribal status).
7. Strengthening health facilities at all levels to ensure comprehensive provision of antenatal, delivery and post natal care, especially emergency preparedness including availability of free transport and streamlined referral systems. Ensure availability of life saving drugs and supplies especially blood at block levels and above.
8. Ensure that ethical and medical standards of care are strictly adhered to and Implement Quality Assurance mechanisms as laid down in policy, in the provision of maternal health, contraceptive, adolescent health and safe abortion services.
9. Ensure complete range of surgical and medical abortion services in first trimester at all rural health clinics up to 24/7 PHCs. Amend the MTP Act to include a clause of accountability for public sector facilities down to 24/7 PHCs. Include non MBBS medical

practitioners in a phased manner into the training programme. Ensure value clarification in all training to reduce abortion related stigma.

10. Establish a surveillance mechanism and maintain a National Registry of complications and deaths arising out of unsafe contraceptive and abortion services. Ensure regular audits and performance reviews of all centers providing abortion and contraceptive services, in public sector as well as private. Review maternal deaths including cases of unsafe abortion (deaths and morbidity) in order to prevent such cases.
11. Ensure complete reporting of MTPs provided from all public sector and private sector facilities since the data is critical to inform the budgetary allocations.
12. Camp-based sterilization operations and informal targets/ELAs must be stopped with immediate effect in accordance with the Supreme Court order of 14th September 2016 (Writ petition (Civil) No.95 of 2012).
13. Stop incentives and disincentives to motivators and service providers as this provides grounds for coercion. Remove all disincentives to persons with more than two children, in all policies and schemes of the state and central governments.
14. Shift the focus away from permanent methods like sterilization (which are inappropriate for younger ages of reproducing couples in India) towards promoting spacing methods.
15. Ensure that programmes providing age appropriate comprehensive sexuality education (with abuse prevention skills) are effectively implemented in a sensitive and nonthreatening manner.
16. Ensure that SRHR programs and policies are culturally appropriate and sensitive and integrate local maternal health practices in accordance with the U.N. declaration on the Rights of Indigenous Peoples (UNDRIP) 2007.
17. Immediate implementation of the Maternity Entitlements section of the National Food Security Act (2013) and revision of the Maternity Benefits Act (1961) to include women working in all sectors. Maternity entitlements must be universal and unconditional
18. Ensure participation of community-based organizations (CBOs) especially community women in need identification, problem prioritisation, planning and community-based monitoring of SRHR interventions.

19. Ensure that policies and programs address the engagement of young boys and men in order to develop equitable gender role attitudes, and take on greater responsibility in contraception, child bearing and caring.

Endnotes

- i Report of the Working group on the Universal Periodic Review India A/HRC/21/10 United Nations Human Rights Council 2012, paragraph 138, # 135, 146, 148, 150-153, 155-158
- ii Parliament of India Rajya Sabha Departmentally related Parliamentary Standing Committee on Health and Family Welfare, **93rd Report on Demand for Grants (2016-17) of the Department of Health and Family Welfare**, Rajya Sabha Secretariat April 2016
- iii Hazarika I, Health Workforce in India: assessment of availability, production and distribution WHO South East Asia Journal of Public Health 2013;2 pp 106-112
- iv Registrar General and Census Commissioner, 2011. Annual Health Survey 2010-11, Ministry of Home Affairs. Government of India, New Delhi. Available at http://www.censusindia.gov.in/vital_statistics/AHSBulletins/AHS_Factsheets_2012_13.html
- v Randive, B., Diwan, V., De Costa, A., 2013. India's conditional cash transfer programme (the JSY) to promote institutional birth: is there an association between institutional birth proportion and maternal mortality? PLoS One 8 (6), e67452. <http://dx.doi.org/10.1371/journal.pone.0067452>
- vi Qadeer I, Roy B and Gautam S Must history repeat itself? The role of Dais in maternity Care in backward districts of Himachal Pradesh **India Social Development Report 2014: Challenges of Public Health** Council for Social Development, Oxford University Press 2014
- vii CommonHealth. Cost of Childbirth in India: Field Experience. A presentation made by Priya John in HRLN Consultation, July 23, 2016, New Delhi
- viii Key Indicators of Social Consumption in India- Health January – June 2014, NSS 71st Round, Government of India, Ministry of Statistics and Programme Implementation (National Sample Survey Office), June 2015
- ix Several sources-
- Mohanty, Sanjay K. and Srivastav Akanksha. Out-of-pocket expenditure on institutional delivery in India. Health Policy Plan. (2013) 28(3):247-262.
 - Nandi Sulakshana, Sinha Dipa, Deepika Joshi, Rajesh Dubey, Vandana Prasad. Evaluation of the JANANI SHISHU SURAKSHA KARYAKRAM: Findings on Inequity in Access from Chhattisgarh, India. DOI:10.1136/bmjgh-2016-EPHPabstracts.4 Published 7 July 2016. (accessed from http://gh.bmj.com/content/1/Suppl_1/A4.1 on September 12, 2016)
 - Neetu Tripathi, Sushma Kumari Saini and Shankar Prinja. Impact of Janani Shishu Suraksha Karyakram on Out-of-pocket Expenditure among Urban Slum Dwellers in Northern India. Indian Paediatrics 2014;51: 475-477. (accessed on September 12, 2016. <http://www.indianpediatrics.net/june2014/june-475-477.htm>)

-
- Mondal Janmenjoy, Mukhopadhyay Dipta Kanti, Mukhopadhyay Sujishnu, Sinhababu Apurba. Does Janani Shishu Suraksha Karyakram ensure cost-free institutional delivery? A cross-sectional study in rural Bankura of West Bengal, India. Indian Journal of Public Health. Year : 2015 | Volume: 59 | Issue Number: 4 | Page: 279-285.
(<http://www.ijph.in/article.asp?issn=0019-557X;year=2015;volume=59;issue=4;spage=279;epage=285;aulast=Mondal>)
 - Suresh Sharma Manisha Bothra. Maternal and Child Healthcare: An Analysis of Out-of-pocket Expenditure under the Janani Shishu Suraksha Karyakaram. IEG Working Paper No. 366 2016. (http://www.iegindia.org/upload/profile_publication/doc-020816_112403WP%20366%20Sharma.pdf)
- x National Family Health Survey III, 2005-2006, Department of Health and Family Welfare, India.
- xi Social Exclusion and Inequalities in Maternal Health, Center for Health and Social Justice.
<http://www.chsj.org/uploads/1/0/2/1/10215849/mhsepaper-final.pdf>
- xii Balasubramaniam and Santhi (2011) How does NRHM help tribal women? A study of financial incentives for maternal health services in Heggadadevanakote taluk, Mysore district, Karnataka. Rapid Assessment Studies of Health Programmes Implementation in India.
- xiii Khanday, Zamrooda & Tanwar, Yavnika. (2013). Exploring Religion based Discrimination in Health Facilities in Mumbai. Mumbai: CEHAT.
<http://www.cehat.org/go/uploads/Library/R%2091%20Exploring%20religion%20based%20discrimination.pdf>
- xiv Maternal Health in Tribal Communities: a qualitative Enquiry into local practices and interactions with the health system in Rayagada, Odisha, SAHAYOG & NAMHHR (2015) & Maternal Health & Nutrition in Tribal Areas: report of the fact-finding mission to Godda, Jharkhand, NAMMHR and TORANG Trust (2014)
- xv Banerjee, S et. al (2013) 'Stairway to Death: Maternal Mortality Beyond Numbers' EPW August 3, 2013 vol XLVIII no. 31
- xvi Dasgupta, J, et al (2016) Chronicles of Deaths Foretold: A civil society analysis of maternal deaths In seven districts from the states of Odisha, West Bengal, Jharkhand and Uttar Pradesh, India SAHAYOG & NAMHHR <http://www.sahayogindia.org/wp-content/uploads/2012/06/Chronicles-of-Deaths-Foretold.pdf>
- xvii Sri BS, Khanna R. Dead Women Talking: A civil society report on maternal deaths in India. CommonHealth, Jan Swasthya Abhiyan; 2014.
- xviii United Nations (2012) Technical Guidance On The Application Of A Human Rights-Based Approach To The Implementation Of Policies And Programmes To Reduce Preventable Maternal Mortality And Morbidity Report of the Office of the United Nations High Commissioner for Human Rights United Nations July 2012 A/HRC/21/22

xix Medical Termination of Pregnancies Act, 1971, Available At: <http://tcw.nic.in/Acts/MTP-Act-1971.pdf>

xx Exploring the pathways of unsafe abortion in Madhya Pradesh, India

[Sushanta K. Banerjee, Ipas India http://dx.doi.org/10.1080/17441692.2012.702777](http://dx.doi.org/10.1080/17441692.2012.702777)

xxi International Journal of Research in Medical Sciences 2015; 3(10): **2729-2733** Awareness regarding abortions and medical termination of pregnancy act among medical students in Puducherry, India. Palo LB et al <http://www.scopemed.org/?ift=93&ft=93-1440435053>

xxii The Pre-Natal Diagnostic Techniques (Prohibition of Sex-Selection), Act, 1994 Act no. 57 of 1994. Available at: [http://www.rajswasthya.nic.in/PCPNDT%2005.12.08/PCPNDT%20Act%20\(2\).pdf](http://www.rajswasthya.nic.in/PCPNDT%2005.12.08/PCPNDT%20Act%20(2).pdf)

xxiii A walk down memory lane: An insider's reflections on the campaign against sex selective abortions. Manisha Gupte. http://geneticsandsociety.org/downloads/200308_gupte.pdf See also: Pratigya Campaign <http://www.pratigyacampaign.org/pratigya/calls-for-solidarity/>

xxiv Dalvie SS Second trimester abortions in India. Reproductive Health Matters. 2008 May;16 (31 Suppl):37-45. doi: 10.1016/S0968-8080(08)31384-6.

xxv Duggal R, Ramchandran V. The Abortion Assessment project India: Key findings and recommendations. CEHAT.

xxvi Dixit, Neha (2013): "Shamed and Scarred: Stories of 'Legal' Abortions in India," (<http://www.firstpost.com/living/shamed-and-scarred-stories-of-legal-abortions-in-india-1179659.html>).

xxvii Srivastava, P C, R K Rai, S Saxena, S K Roy Chaudhary and H K Singh (2013): "Unsafe Abortion: A Study in a Tertiary Care Hospital," Journal of Indian Academy of Forensic Medicine, July- September, Vol 35, No 3, pp 0971-73.

xxviii <http://www.ishr.ch/news/special-rapporteur-right-health-links-decriminalisation-abortion-right-health>

xxix Community based Monitoring on Family Planning and Quality of Care done by Uttar Pradesh Health Watch Forum and Bihar Health Watch Forum. The study was done in 10 districts of UP and Bihar in 2014.

http://www.chsj.org/uploads/1/0/2/1/10215849/state_level_consolidated_report_of_bihar.pdf

xxx "Adolescents in India: A desk review of existing evidence and behaviours, programmes and policies." 2013. New Delhi: Population Council & UNICEF.

xxxi HAQ. Report of the National Consultation, 'Come Together' August 2014

xxxii HAQ. Strengthening Existing Systems for Prevention of Child Marriage - Impact Report by Renu Khanna. May 2015

xxxiii Establishing a Comprehensive Health Sector Response to Sexual Assault. Mumbai: CEHAT, 77 p., 2012, Available at:
<http://www.cehat.org/go/uploads/Publications/R87%20Establishing%20a%20Comprehensive%20Health%20Sector%20Response%20to%20Sexual%20Assault.pdf>

xxxiv Government of India. Rashtriya Kishor Swasth Karyakram. Strategy Handbook. January 2014. New Delhi

xxxv Trios. Adolescent Reproductive and Sexual Health in India - Mapping and developing operational framework for enhanced access. Powerpoint presentation. 2nd Advisory Group meeting, 6th January 2012 . TRIOS Development Support (P) Ltd. New Delhi.

xxxvi SAHAJ. Report of Workshop with 8 NGOs in Gujarat on Maternal Health. Sept. 13-18, 2016. Vadodara.

xxxvii SAHAYOG. A qualitative study on the local belief and practices around menstruation in selected blocks of three districts in Uttar Pradesh and one district in Uttrakhand. Lucknow. 2016.

xxxviii ASCI. Evaluation of Sabla Scheme. A Report submitted to Government of India. September 2013. Administrative Staff College of India. Hyderabad.

xxxix SAHAYOG. TARANG – An Initiative to Support Sabla: An Evaluation Report by Renu Khanna. September 2013.

xl SAHAJ. Mid Term Review of Adolescents' Rights Programme. Nilangi Sardespande. July 2016.

xli The Crisis of Maternity- Healthcare and Maternity Benefits for Women wage workers in the Informal Sector in India, SAHAYOG and NAMHHR 2012, available at
<http://new.sahayogindia.org/wp-content/uploads/2012/05/the-crisis-of-maternity.pdf>