Every Woman's Right to Continuum of Quality and Respectful Maternal Care in India

joint stakeholders' report s
united nations
universal periodic review III

Submitted by SuMa-Rajasthan White Ribbon Alliance for Safe Motherhood
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Introduction and Background

SuMa-Rajasthan Alliance for Safe Motherhood is being anchored by CHETNA, Ahmedabad since 2002 and has more than 70 listed members. SuMa advocates for reduction of maternal and neonatal mortality in the state and at the national level. This is the first time the alliance has engaged with the Universal Periodic Review.

A consultation was organised by CHETNA in partnership with 14 national and state alliances working on Health and Nutrition Rights in December 2015 with support from the Working Group on Human Rights, to orient them about the UPR process. A national round table was organised on 15th September 2016 to prepare for joint submission. Members also contributed in the regional and national consultation organised by WGHR and the Regional Consultation by National Human Rights Commission, India and contributed in the National CSO report on Right to Health.

The alliance would like to report the following progress on Maternal Health.

- The UPR-II Recommendations 150-153 to India focus on reducing high level of Maternal Mortality and better and equal access to maternal health services.[1]
- The Sustainable Development Goal 3 target is to reduce, between 2016 and 2030, the global maternal mortality ratio to less than 70 per 100 000 births, with no country having a maternal mortality rate of more than twice the global average.
- The Right to health has been firmly established in the ICESCR atr.12 and other international human rights treaties and have recognized and referred to the right to health or its elements "Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health"[2]

1 *UPR-II (150): Take further practical Steps to reduce the high level of maternal and child mortality, interalia through better access to maternal health services.(Austria)*

UPR-II (151): Further efforts towards addressing the challenge of maternal and child mortality. (Egypt)

UPR-II (152): Strengthen its efforts to improve maternal health and act to effectively balance the skewed sex-ratio among children, including by combating female foeticide. (Norway)

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

[2] *International Covenant on Economic, Social and Cultural Rights, art. 12 The 1965 International Convention on the Elimination of All Forms of Racial Discrimination: art. 5 (e) (iv);The 1966 International Covenant on Economic, Social and Cultural Rights: art. 12;The 1979 Convention on the Elimination of All Forms of Discrimination against Women: arts. 11 (1) (f), 12 and 14 (2) (b) The 1989 Convention on the Rights of the Child: art. 24 The 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families: arts. 28, 43 (e) and 45 (c)The 2006 Convention on the Rights of Persons with Disabilities: art. 25 key reports from the UN Office of the High Commissioner for Human Rights, the Human Rights Council and the UN Special Rapporteur on the Right to Health which have refined the definition of the right to the highest attainable standard of health as well as rights pertaining specifically to maternal mortality and morbidity. Ibid*.

- The Indian constitution articulates a duty of the state as follows: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties…" **Constitution of India (1950): Part IV, art. 47.**a
- In India, around 44,000 women dying from **preventable** causes related to pregnancy and childbirth [3] is a failure of India's obligation to respect, protect and fulfil women's Right to life, Survival and Health.
- Documentation by civil society organisations indicate that a majority of these deaths take place among **women from disadvantaged and vulnerable social sections** [4]. Thus violating their rights to be equal in dignity, to freedom from discrimination, to education, to be free to seek, receive and impart information, to enjoy the benefits of scientific progress, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health.
- Women die due to preventable causes at a very **young age**. 72% deaths are in the age group of 15-29 years of these 45% are in the age group of 15-24 years [5] This is a gross violation of young women's right to life and health.

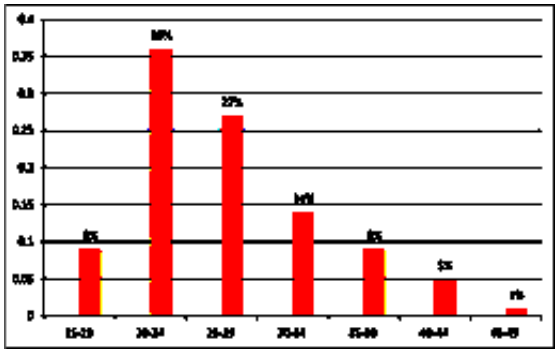

Figure 1 Age distribution of Maternal Deaths in India;SRS 2013

3MMR has reduced from 301 per 100,000 live births in 2001-03 to 167 in 2011-13, a reduction of more than 100 points in a decade but missing the MDG target of 109. ; Sample Registration System (SRS) Special Bulletin on Maternal Mortality 2010-2012; December 2013. The reduction in maternal mortality is uneven across states making women's lives more vulnerable according to the place she lives. The Empowered Action Group (EAG) states & Assam: 246 from 308 in 2007-09(16 %); the Southern States reaching the MDG at 93 from 127 in 2007-09(17 %) and other states: 115 from 149 (15 %) in 2007-09 http://www.censusindia.gov.in/vital_statistics/mmr_bulletin_2011-13.pdf

4 IyengarKirti, Gupta, Narendra (2001): People's Accounts of Maternal Deaths in Jodhpurhttp://www.hrln.org/hrln/images/stories/pdf/HRLN-Using-The-Law-For-Public-Health-dr%20Narendra%20Gupta.pdf ARTH and PRAYAS (2011): documented 12 deaths in Umaid Hospital Jodhpur, Rajasthan in 2011 ; Ekjut and Soumik Banerjee (2011-12): documented 23 deaths in Godda district Jharkhand; Jan Swasthya Sahyog documented 26 cases from their field area in Chhattisgarh; SEWA Rural (2007 onwards): documented 20 cases in the area of work in Bharuch district, Gujarat; Vd. Smita Bajpai; CHETNA (2012): documented eighteen cases from underserved areas of 14 districts in Gujarat,India; Gender and Health Equity project, IIM Bangalore (2005-11): documented 43 cases in Koppal district, Karnataka ; ANSWERS (2008): documented 108 cases from 22 districts, Andhra Pradesh;
http://mohfw.nic.in/WriteReadData/l892s/3503492088FW%20Statistics%202011%20Revised%2031%2010%2011.pdf;
http://www.icmr.nic.in/final/Final%20Pilot%20Report.pdf; http://www.ssjournals.com/index.php/ijbar/article/viewFile/467/465;
http://mospi.nic.in/mospi_new/upload/sel_socio_eco_stats_ind_2001_28oct11.pdfhttp://www.commonhealth.in/Dead%20Women%20Talking%20full%20report%20final.pdf;

5 http://www.censusindia.gov.in/vital_statistics/mmr_bulletin_2011-13.pdf

- Despite Maternal Death Reviews being institutionalised in India since 2010, only 24.44% of maternal deaths are reported.[6] The updated status of these committes, including action taken to address the violation and report on maternal deaths are not available in the public domain .

- Implementation of programmes and legislations to protect young girls from marriage and pregnancy at early age is poor. The mean age at effective marriage of women is 21.3 years and varies from 21 years in rural areas to 22.5 years in urban areas (SRS 2013). About 47 percent girls are married by the age of 18, the legal age of marriage for women in India. 16 percent girls become pregnant or give birth between the ages 15-19 years.

- Women do not have equal access to Maternal Health Services and the situation has not improved signficantly. According to the Health and Family Welfare's MIS System, between 2013-14 and 2014-15, the percentage of registered women receiving the mandated three antenatal checkups increased from 76.4 to 77.5%. Despite the push on institutional deliveries, the percentage of deliveries reported against estimated deliveries decreased from 36.6 to 35.5% and remained inadequate. Of these the percentage of Institutional deliveries increased from 87 to 88.3% and those in public facilities decreased from 74.6 to 73.6%. The number of women receiving post natal check-up within 48 hours of birth decreased from 69,45,874 to 69,12,280.

- The health service conditionality in provisioning often prevents the most poor and vulnerable women from accessing their maternity benefits. The HMIS report on percentage of women receiving maternity benefits from those who delivered in public institutions increased from 59.4 in 2014 to 62.4% in 2015. Around 38 percent women remain excluded from receiving their entitlement to maternity benefit .[7]

[6] http://nhsrcindia.org/index.php?option=com_content&view=article&id=184&Itemid=681

[7] *https://nrhm-mis.nic.in/SitePages/Home.aspx*

- Inequities in women's access to care across rural-Urban and socio economic categories. For example the percentage of women receiving full antenatal care is 17.3% for rural and 25.2 % for urban women; 23.2% for women from other category, 15% from Schedule tribes; 18% from Scheduled caste and 19.6% from Other Backward classes; 31.3percent from Highest Wealth Index and 9.5% from the lowest wealth index.[8]
- More than half (56.2 percent) of the women in the reproductive age group (15-49 years) are anaemic. Anaemia during pregnancy and postpartum is almost universal and inadequately addressed. Only 31.2 percent women received or purchased Iron Folic Acid Supplement during pregnancy. Of these, the percentage of women from urban areas and Highest Wealth Index was higher(RSOC,2015).
- Coverage of nutrition supplementation during pregnancy and postpartum is poor and grossly inadequate with 40.7percent women receiving supplementation during pregnancy and 42.4% women during lactation, excluding almost 60 percent women.(RSOC,2015)
- Maternal nutrition is key to survival of mothers and newborns. National data on weight gain during pregnancy is not available though it is a part of the Ante Natal care package and collected through the pregnancy card.
- Public provisioning of life saving services –emergency obstetric care -is inadequate. The Rural Health Statistics(2015) indicate that the national shortfall of specialists at Community Health Centres is 81 percent and that of Obstetricians and Gynaecologists is 76 percent. Women are compelled to seek life saving services from private sector incurring high out of pocket expenses and leading them to debt trap.
- Women are at risk of losing their lives in the absence of a policy for safe homebirths. The difficult geographic terrain often affects womens' access to health facilities in

[8] *http://wcd.nic.in/issnip/National_Fact%20sheet_RSOC%20_02-07-2015.pdf*

time. The number of reported home deliveries to total reported deliveries has reduced from 13% to 11.7%. (HMIS,2015). Traditionally, communities access the services of Traditional Birth Attendants (TBAs/*Dais*) who play a critical role in assisting women during childbirth at home. TBAs remain outside the public health system.

- There is a direct correlation between a woman's economic status and her access to quality maternal health services. For example, 59 percent of mothers in the lowest wealth quintile households received some ANC while those in the highest wealth quintile received 97 percent.[9].
- Child Mortality is declining in India but the decline is slow and uneven across the states[10]. The gap in under five mortality between girls and boys has increased from 13% in 2013 to 17% in 2014. (Male – 42, Female 49). State action is needed given the fact that India is one of the only two countries in the world to have this gender disadvantage for survival of girl child.[11]
- Participation of women and communities in health services is inadequate. Efforts made by CSOs have led to increased participation and improvement in services.[12] Despite structures created at the village and facility level there is lack of political will including investments in their strengthening.

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9 *National Family Health Survey (NFHS-3), India, 2005-06. Mumbai: International Institute for Population Sciences* http://www.rchiips.org/NFHS/nfhs3_national_report.shtml

10 *About a third of newborns in India are born with low birth weight (LBW). About 43 % of children under the age of five are underweight and 48% stunted and 74% of children are anemic .The recently released report from the Registrar General of India-SRS 2014 for every 1000 live children born, 26 die within the first month and 39 die within the first year of their lives. 45 per 1000 die before they reach five. Though the progress in reduction of under-five mortality rate is good for both boys and girls but is slower for girls there by increasing the gender gaps. . States have shown varying level of progress across different age groups in terms of reduction of deaths of children in their first month of life and within first five years indicating disparities in chances of survival of children.*
http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/SRS%20Bulletin%20-Sepetember%202014.pdf

11 *International Institute for Population Sciences (IIPS) (2010): District Level Household and Facility Survey (DLHS-3), 2007-08, India, Mumbai: IIPS,* http://www.rchiips.org/

12 http://chetnaindia.org/wp-content/uploads/sAMAJIK-JAVABDEHITA.pdf

Recommendations

1. The states' obligation to respect, protect and fulfill every woman's right to life and health, particularly with a focus on the young and socio-economically vulnerable sections needs to be recognized within the human rights framework.
2. The states' constitutional duty of raising of the level of nutrition and the standard of living of its people and the improvement of public health must be fulfilled, specially the rights of the young and the most vulnerable social sections- difficult and conflict areas, scheduled and nomadic tribes , scheduled caste, other backward class, disabled, migrants, poor etc.
3. Robust and accurate accountability framework needs to be in place with accurate, desegregated data according to location of vulnerable sections, young, migrants, wealth quintiles and caste at country and state level and ensure its availability in the public domain.
4. Strict enforcement of legislations to prevent early marriage and pregnancy and by programmes and adequate resources for social change.
5. Maternal Death Review process needs to be improved and reports must be made public through national and state annual reports, along with desegregated data and stating remedial action taken to prevent similar deaths.
6. Mechanisms for grievance redress must be available, accessible and accountable at all levels, particularly for the poor/less literate.
7. Universalisation of continuum of quality care and services- across time, place, the young and socio economically vulnerable groups needs to be ensured. Vulnerable populations such as tribal, poor, migrants, workers etc and geographies such as the deserts, hills, forests, mines, saltpans etc.
8. The Right to Food Act needs to guarantee food and nutrition security and implemented on a priority basis..
9. Universal women's access to nutritious food, particularly during, adolescence, pregnancy and post partum period must be ensured and monitor their weight gain.
10. A policy needs to be in place to ensure Home based care keeping the geographical reality in view. Local community based attendants including the trained traditional birth attendants must be recognized and included in the public health system to provide home deliveries and basic management of complications in remote, unreached areas.
11. Women's participation, particularly from socio economically vulnerable groups as right holders must be ensured in design, planning and monitoring of maternal health programmes. Their representation in the Local Self Government, Facility based committees and Village Health Sanitation and Nutrition Committees must be ensured, including adequate investments for their capacity enhancement and operationlising.

We Endorse-

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