

April 17, 2008

To: The Committee on Economic, Social and Cultural Rights

Re: Supplementary Information on India
Scheduled for review by the Committee on Economic, Social and Cultural Rights
during its 40th Session

Dear Committee Members:

This letter is intended to supplement the periodic report submitted by India, scheduled to be reviewed by this Committee during its 40th session. The Center for Reproductive Rights, (the Center) an independent non-governmental organization, hopes to further the work of the Committee by providing independent information concerning the rights protected in the International Covenant on Economic, Social and Cultural Rights (ICESCR). In this letter, we will describe several areas of concern pertaining to women's reproductive health and rights in India, including a list of questions that we hope the Committee will raise with the official delegation from India.

Reproductive rights are fundamental to women's health and equality, and as such these rights receive broad protection under the International Covenant on Economic, Social and Cultural Rights. The Covenant protects reproductive rights by recognizing "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," [Article 12],¹ which is inseparable from the right to self-determination [Article 1] and the right to enjoy of the benefits of scientific progress [Article 15(b)]. The Covenant articulates that all people, regardless of sex, must be guaranteed all the rights set forth in ICESCR [Articles 2(2) and 3],² and specifically obligates governments to provide special protections for women before, during and after childbirth [Article 10]. Women's ability to receive appropriate reproductive health care can thus be seen as an indicator of a state's compliance with Articles 1, 2, 3, 10, 12, and 15(b) of the ICESCR.

In General Comment 14, this Committee has articulated that health care must be *available, accessible, and acceptable*, and has affirmed that the right to health "include[s] the right to control one's health and body, including **sexual and reproductive freedoms**."³ According to this Committee, preventing discrimination in access to those rights is a "core obligation" of the State.⁴ Article 3, on "the equal right of men and women to the enjoyment of all...rights set forth in the Covenant,"⁵ is further defined by General Comment 16⁶ to obligate states to take measures to ensure *de facto* and not just *de jure* equality for women.⁷ This imperative for states to work towards substantive equality for women is of special relevance to India, where policies often do not achieve their stated goals. Programs that purport to improve women's access to quality health care are often ineffective due to deficiencies in implementation, accountability⁸ and oversight; and marred by a broader failure to address underlying determinants of health such as gender discrimination and socio-economic disparities.

Although the last time India reported to this body was in 1990, recent Concluding Observations issued to India by other treaty-monitoring bodies have included specific recommendations to improve women's reproductive health. The CEDAW Committee in 2007 called upon India to "pay increased attention to female health... including in key areas of pregnancy and non-pregnancy-related morbidity and mortality...prioritize decreasing **maternal mortality** rates by establishing adequate obstetric delivery services and ensuring women access to health services, including **safe abortion** and gender-sensitive comprehensive

contraceptive services.⁹ The Committee noted that although the state has nominally created programs “to improve women’s access to health care and decrease maternal mortality,”¹⁰ the government of India has not described how it would monitor and implement these programs. This lack of data, according to CEDAW, will impede the state from being able to “establish benchmarks and monitor progress,”¹¹ a problem also identified by the UNFPA and the WHO as a major barrier to India’s compliance with the Millennium Development Goals.¹²

The CERD Committee in 2007 called on the state to specifically include reproductive health within state’s efforts to address overarching geographic and socioeconomic inequities, urging India to “ensure equal access to...adequate health care facilities [and] reproductive health services... and to increase the number of doctors and of functioning and properly equipped primary health centres...in tribal and rural areas.”¹³

India’s combined second through fifth periodic report to the Committee on Economic, Social and Cultural Rights describes efforts made to reduce maternal mortality and morbidity, including the ambitious goal of reducing its maternal mortality ratio (MMR) to 100 (maternal deaths out of 100,000 live births)¹⁴ by 2010.¹⁵ The report also describes efforts made to reduce illegal abortion and sex-selective abortion,¹⁶ and to expand access to family planning services.¹⁷

Nevertheless, in spite of these efforts, the majority of Indian women today do not have access to comprehensive reproductive health care, leaving them unable to enjoy the full complement of their economic, social, and cultural rights. The following are the areas of greatest concern regarding women’s health and rights in India: (1) Maternal Mortality; (2) Unsafe Abortion; (3) Access to Family Planning; (4) Sexuality Education; (5) Patriarchal Jurisprudence.

1. High Rates of Maternal Mortality

More maternal deaths occur in India than anywhere else in the world, with approximately 117,000 women dying from complications in pregnancy or childbirth per year.¹⁸ Paul Hunt, the UN Special Rapporteur on the Right to Health, has remarked that “for a middle-income country of its stature, the rate of maternal deaths in India is shocking.”¹⁹ In India, there is roughly one maternal death every five minutes, and these deaths account for 15% of all deaths of women of reproductive age.²⁰ India has claimed to this and other UN bodies that reduction of maternal mortality is a high priority,²¹ but there is no evidence that the incidence of maternal death is decreasing – data from the most recent National Family Health Survey (NFHS-3), in fact, suggests that rates of maternal mortality are stagnating.²²

Although the government does acknowledge that its rates of maternal mortality are “unacceptably high,”²³ it reports to this Committee that its maternal mortality ratio has decreased from 437 in 1993 to 407 in 1999.²⁴ However, the UNFPA and WHO’s 2006 estimate of maternal mortality in India is substantially higher than 407, reporting 540 maternal deaths per 100,000 live births.²⁵ The fifth Millennium Development Goal calls upon states to reduce maternal mortality to one-quarter of 1990 levels by 2015, but India is not on track to meet that goal.²⁶ In some Indian states official reported MMRs are higher than the national average, with the National Ministry of Health reporting 517 in Uttar Pradesh²⁷ and 445 in Rajasthan.²⁸ NGO estimates of the disparities are higher still, counting over 700 in Uttar Pradesh and Madhya Pradesh²⁹ and 898 in some areas of Jharkhand.³⁰ Although the most common direct causes of maternal death are hemorrhage, sepsis and anemia,³¹ the underlying causes of the epidemic are poor or inaccessible health care facilities; lack of access to family planning and safe abortion; and poor nutrition.³² Rural and low-income women fare worst in both access to and quality of care.³³ A low-income woman in India is seven times less likely than an affluent woman to have a skilled birth attendant assist her delivery,³⁴ and according to a study published by the World Bank, “the relationship between poverty in the area that the doctor practices in and his or her competence stands out. In India...[both public and private] doctors in poorer areas are less competent than those in richer areas.”³⁵

Although the WHO recommends that women receive four antenatal checkups during pregnancy,³⁶ less than three-quarters of women in India receive any antenatal examination at all.³⁷ Access to prenatal and maternal health care varies greatly from state to state – in West Bengal, over 90% of women receive at least one prenatal examination, while in Bihar, that number is only 34%.³⁸ Similarly, only 37% of mothers in India receive the post-natal care recommended by the WHO.³⁹

Acknowledging that maternal mortality has not decreased sufficiently, in its report to this Committee the government of India presents ambitious goals for confronting the problem, and includes reduction of MMR as a key objective of the National Rural Health Mission (NRHM) and the National Population Policy (NPP). The Reproductive and Child Health Program (RCHP) and the Janani Suraksha Yojana (JSY) National Maternity Benefit Scheme are key MMR-reduction programs under the Tenth Five-Year Plan and the NRHM. However, within its own report to this Committee, the state party contradicts itself about its own MMR reduction goals. In one reference to its maternal health component of the RCHP, the state describes the program as aiming to “reduc[e] maternal mortality to **less than 100 by 2010**”⁴⁰, but elsewhere in the report, the same program is “aim[ed] at reducing maternal mortality rate [sic] to **less than 180 by 2010**.”⁴¹ Not only are both of these stated goals unrealistic given the existing rate of change, the fact that the maternal health benchmark seems unclear to the state party itself reveals a careless inattention to maternal mortality on the part of the state. The emptiness of these goals and reckless disregard for implementation suggest that state policy-makers are either not in touch with or not sufficiently interested in the tragic realities of women’s health in India. A more serious approach to maternal mortality would involve setting more modest goals, and implementing a multi-pronged effort to achieve them.

The lack of a civil registry and cause-of-death attribution system makes accurate assessment of MMR almost impossible.⁴² Although one of the goals of the NPP, introduced in 2000, was to fully record births and deaths by 2010,⁴³ India still does not have a national, uniform system for counting and reporting maternal deaths.⁴⁴ In the state of Andhra Pradesh, for example, the government estimates about 5,000 maternal deaths each year, but only 1,000 of these are reported as such.⁴⁵ According to the WHO, “it is difficult to measure accurately the levels of maternal mortality...in settings where routine recording of deaths is not complete within civil registration systems...Even in developed countries where routine registration of deaths is in place, maternal deaths may be underreported, and identification of the true numbers of maternal deaths may require additional special investigations into the causes of deaths.”⁴⁶

The under-prioritization of maternal health in India is further evidenced by the fact that for a country with over one billion citizens, there are only three national-level technical officers for maternal health, and almost none at high levels within state governments.⁴⁷ There is also a wide discrepancy between India’s funding for public health and the global average. As of 2007, India spent about 0.9 % of its GDP on public health systems; amongst similar-income countries the average is 2.5% of GDP.⁴⁸ Although India pledged to increase health spending from 0.9% to 2 - 3% of GDP by 2010,⁴⁹ the government’s 2008-2009 budget⁵⁰ belies this laudable goal, as health sector spending still amounts to less than 1 % of India’s GDP.⁵¹

Private spending per capita on health care in India is far greater than in every other country in the region,⁵² a testament to both the shortage and inadequacy of public health services. While there are 1.4 million health care providers in India, only 10% of them are in the government services,⁵³ and in primary health centers, absenteeism and poor quality of care are the norm.⁵⁴ For example, in one part of Rajasthan, community health centers are closed during 56% of regular opening hours.⁵⁵ Not only are public health facilities and providers insufficient in number, they offer measurably worse service than private practitioners.⁵⁶ According to a study published by the World Bank, although private doctors do not spend enough time with their patients, “in the public clinics, the situation is disastrous. In these clinics, the average number of questions asked was one (and that one often asked rudely).”⁵⁷ Rural women lack competent primary care, appropriate referrals, and timely transport to emergency facilities. One study found that “**half the [maternal] deaths could have been avoided if the health system had been alert and accessible**. The critical determinants of avoidable

death were families' awareness about complications, emergency transport and preparedness of referral facilities."⁵⁸

While an increase in state health spending will be an important step toward improving public health, the rampant bottlenecks, lack of accountability, and corruption in the system lead to health monies going unspent at the local level, with one district reporting spending only 55% of its health budget.⁵⁹ Even when funding is allocated specifically for maternal mortality, the money does not always reach the intended recipients. NGOs report that state governments are not given any information about how to use the funding they receive from the National Rural Health Mission (NHRM).⁶⁰ One of the components of the RCHP, launched in 1997, was to improve access to emergency obstetric care (EmOC); however, due to insufficient management, the EmOC strategy was not implemented, and even today the government has no system to monitor how many fully functional EmOC facilities exist in the country.⁶¹ WHO experts have noted that, given India's strong economic growth, **"the key reasons [for MMR stagnation in India] are political, administrative, and managerial rather than a lack of technical knowledge."**⁶²

The "Janani Suraksha Yojana" (JSY) scheme exemplifies India's mishandled and misconceived approach toward maternal mortality reduction. The JSY aims to reduce MMR by paying 500 Rupees per pregnancy, for the first two pregnancies, to below-poverty-line (BPL) women over age 19 who opt for institutional delivery.⁶³ On its face, this policy discriminates against the majority of India's most vulnerable women, as 60% of women deliver in the home,⁶⁴ and, contrary to the state's report to this Committee that child marriage is only prevalent **"in some parts of the country,"**⁶⁵ almost 50% of Indian women are given away in marriage before age eighteen.⁶⁶ The policy penalizes and discriminates against low-income women giving birth for a third or subsequent time. Excluding these three indicators from JSY eligibility endangers the majority of India's most at-risk women.⁶⁷ The JSY is also in part inherently coercive, as women must consent to sterilization in order to receive funding for delivery care on a third birth.

In implementation, the JSY is also under-realized, as public health care providers often demand 'informal' payments in exchange for ostensibly free services,⁶⁸ and JSY entitlement money rarely reaches to the women to whom it is allocated.⁶⁹ In one sample from Uttar Pradesh, only 10% of eligible women received their JSY payment. Similarly, despite India's assurance that JSY is "a 100% centrally sponsored scheme,"⁷⁰ implementation differs vastly from state to state.⁷¹ In its report to this Committee, India does not address corruption within the JSY scheme, despite the fact that public providers' illegally demanding payment has been identified by Indian NGOs as the single greatest barrier preventing low-income women from accessing reproductive health services.⁷²

In addition to discriminating against adolescent women, those giving birth for a third or subsequent time, and those who deliver at home, the JSY is flawed conceptually in that it relies purely on institutional deliveries as the sole indicator of quality obstetric care. Increasing institutional deliveries has been the core element of the state's maternal mortality reduction agenda,⁷³ and deliveries taking place in official health centers have indeed increased. The state presents this statistic as proof that maternal health is improving,⁷⁴ but the Special Rapporteur on the Right to Health and Indian NGOs characterize this indicator as a "false proxy"⁷⁵ for quality obstetric care, as public facilities can be grossly inadequate, understaffed and underequipped.⁷⁶ Although India's report to this Committee acknowledges the disparity in quality of public health facilities,⁷⁷ it still conflates institutional deliveries with quality maternal health care, and describes efforts to improve institutional facilities by hiring more ANMs (auxiliary nurse midwives)⁷⁸ and providing more EmOC drug kits.⁷⁹ This overreliance on one objective ignores both the realities and strategic opportunities regarding maternal health and childbirth in India. The WHO has stressed that the most important factor for a safe delivery is the presence of a *skilled birth attendant*,⁸⁰ which does not entail that births must take place inside a hospital. According to the WHO, countries seeking to reduce MMR need not focus entirely on increasing institutional delivery but should instead enact a two-pronged approach wherein local, decentralized primary health centers are staffed by competent health workers with midwifery skills, and that these providers are able to utilize an effective and prompt referral system to get women to hospitals offering EmOC should they need

it. Strategic coordination of these two levels of care has led to significant MMR reduction in countries such as Botswana, China, Malaysia, Honduras, Sri Lanka, and Thailand,⁸¹ and could have the potential for success in India as well.

In addition to protecting the rights to life, health and medical technology, India is obligated under the Covenant to provide special protection for women before, during, and after childbirth.⁸² This Committee has repeatedly instructed states parties to take active measures to reduce rates of maternal mortality,⁸³ especially among rural, low-income, and uneducated women,⁸⁴ and has interpreted maternal death and morbidity as violations of the right to health. India's high rates of maternal mortality, compounded by the state's visible failure to reduce said rates by any significant amount over a period of fourteen years⁸⁵ (1992-2006) demonstrate India's obvious failure to protect maternal health as prescribed by ICESCR.

2. Prevalence of Unsafe Abortion

Unsafe abortion accounts for a significant proportion of maternal deaths in India. The state reports to this Committee that 9% of total maternal deaths are caused by unsafe abortion,⁸⁶ but medical experts put the figure at almost 18%;⁸⁷ higher than the global average of 13%.⁸⁸ Although abortion is permitted on several grounds under India's Medical Termination of Pregnancy Act of 1971 (MTP Act), each year approximately 6.7 million abortions occur outside of government-recognized health centers, often in unhygienic conditions or by untrained abortion providers.⁸⁹ This problem disproportionately affects adolescents, as unsafe abortions account for *half* of all maternal deaths of women aged 15 - 19.⁹⁰ The need for abortion stems primarily from a lack of access to family planning, as women who cannot obtain safe, effective, and affordable contraception – primarily low-income, adolescent, and/or rural women – are most likely to seek abortion, and then to have access only to clandestine and unsafe abortions.⁹¹ Notably, India is the **only country in world in which legalization of abortion has not reduced rates of unsafe abortion.**⁹² This troubling fact reveals that most women in India are not able to obtain legal abortions should they need one, for reasons including inconsistent and prohibitive costs;⁹³ lack of trained providers and adequate equipment;⁹⁴ lack of confidentiality; poor access to facilities;⁹⁵ and ignorance of the legal status of abortion – **in one sample, only 9% of Indian women knew that abortion was legal.**⁹⁶

In an attempt to address the prevalence of women turning to clandestine providers, the MTP Act was amended in 2002 to provide more specificity on places and persons authorized to perform abortions,⁹⁷ and to prescribe stricter punishments for unauthorized providers. However, studies show that many **authorized facilities are not functional**, and several have never performed abortions⁹⁸ due to a lack of trained providers and adequate equipment.⁹⁹ One study found that out of 1746 abortion providers in Rajasthan, 78% were unqualified according to the standards of the MTP Act.¹⁰⁰ In the rest of the country, facilities are few, with only four medically sound (although not necessarily certified) abortion facilities per 100,000 people in the country.¹⁰¹ Most qualified facilities are located in urban areas, and rural government health centers, which by default are authorized to perform abortions under the MTP Act, often do not provide abortions.¹⁰² Private services can cost up to eleven times as much as those in public facilities. This discrepancy leads to **higher rates of unsafe abortions in rural areas and among low-income women** who cannot afford private health care.¹⁰³ Private providers also avoid accountability by neglecting to report or document the medical details of the procedures they perform, leaving women with no recourse should complications or malpractice occur. This reliance on unauthorized providers in lieu of satisfactory public services also **disproportionately endangers adolescents**, as they often lack both the money and knowledge about where and how to seek safe abortion services.

Reliance on the under-regulated private provision of health care is a problem for many reasons; in 2007, the CEDAW Committee called on India to “balance the roles of public and private health providers in order to maximize resources and the reach of health services. It instructed the State party to **monitor the privatization of health care** and its impact on the health of poor women.”¹⁰⁴ This Committee has repeatedly criticized states for relying too heavily on private sources of health care, as this can unduly restrict citizens’

access to health care and thus to their enjoyment of their right to health.¹⁰⁵ However, in its report to this Committee, India does not mention the privatization of health care as a factor implicit in its high maternal mortality rates, nor does the state acknowledge the under-regulation of private providers as a cause of maternal death and unsafe abortion.

Not only are authorized facilities often inadequate in medical terms, women are often dissuaded from using them due to **lack of confidentiality, poor quality of care, high costs, non-legal consent requirements,** and the fact that when women seek abortion, they are often **pressured or coerced into undergoing sterilization.**¹⁰⁶ The MTP Act only requires parental consent for women under 18, however providers are known to deny abortion to women over 18 who attempt to obtain an abortion without the consent of a spouse or male relative.¹⁰⁷ As the CEDAW Committee has noted, confidentiality is an important component of women's right to health.¹⁰⁸ When women are not able to confidentially access reproductive health services, including abortion, their rights to autonomy and equality are also jeopardized.

While we share with the state party a concern about sex-selective abortion, as mentioned in its report to this Committee,¹⁰⁹ we fear that efforts to curtail the selective abortion of female fetuses may result in indiscriminate persecution of women seeking abortions for any reason, and infringe on these women's rights to confidentiality in access to health. While we applaud the state for identifying that the root cause of sex-selective abortion is "the attitude of society towards women and their poor socio-economic conditions as reflected in the practice of dowry [etc],"¹¹⁰ India's reported efforts to prevent sex-selective abortions do not reflect this holistic understanding of causality, and instead punish women and abortion providers. One effort to fight sex-selective abortion utilizes "former police chiefs...to form a Special Cell to fight female foeticide...The Cell will act as a watchdog...go on undercover operations [and] have prosecution powers too."¹¹¹ This framing of abortion as "foeticide" is problematic in that it vests the fetus with legal status, when under the MTP Act women's rights to abortion are protected in cases when the woman's life or health are at risk, or if the fetus is developmentally compromised. In abortion cases before international courts of law, fetal rights claims have been consistently rejected in favor of women's human rights.¹¹²

When women are intimidated from seeking abortions in legitimate facilities, they will turn to clandestine providers and rates of unsafe abortion will persist. Given its awareness of the root causes of sex-selective abortion, the state must reorient its response to the problem away from the punitive approach outlined in its report to this Committee and to CEDAW, and towards systematic responses to societal and traditional norms that de-value women, such as son preference, child marriage, and dowry.

In previous Concluding Observations, this Committee has repeatedly expressed deep concern over the link between prevalence of unsafe abortions and high rates of maternal morbidity and death.¹¹³ In its report to this Committee, India expresses the admirable intention to "increase access and decentralize early safe abortion service at a grass root [sic] level in the health care system," but the only new approach mentioned toward increasing access to "early safe abortion" is a pilot project, still under consideration, which would introduce manual vacuum aspiration—a less invasive abortion technique widely available in many other countries—in eight selected states.¹¹⁴ Unfortunately, an intervention of this scale is not an adequate response to a problem of this scope. Upgrading the technological capacity of abortion providers should be a top priority in India under ICESCR's articles 12 and 15(b), as most abortion providers still use the outdated and more invasive technique of dilation and curettage, even at early stages where electric and manual vacuum aspiration or medical abortion are indicated; similarly, pain-management techniques are not up to standards, with most providers using either general anesthesia or no anesthesia at all.¹¹⁵

Wide-scale introduction of medical (non-surgical) abortion would be especially valuable in the Indian context, as medical abortion requires less intensive training, skill, and infrastructure to administer¹¹⁶ than surgical abortion. However, there is no mention of this technique in the state's report. Although the MTP Act was updated in 2002 to specify with great stringency who may perform abortions and where, it does not contain any technical guidelines or protocols for *how* the procedure should be performed and does not prescribe

avenues for redress should providers fail to meet basic standards of care.¹¹⁷ This lack of a universal standard leads to the gross discrepancies we see in access to safe abortion even in government-certified locations. Similarly, in its efforts to reduce unsafe abortion the state must take into account the preferences and needs of women, by prioritizing the availability of contraceptives in all regions of the country. India's report to this Committee also mentions an initiative to train *dais* (traditional birth attendants) to perform abortions.¹¹⁸ This may be a more valuable type of intervention, but it is not described with any detail.

This Committee has repeatedly exhorted states to reduce rates of unsafe abortion.¹¹⁹ Women must be made aware of the legal status of abortion and the indications for MTP Act eligibility. Until safe, legal abortions are made affordable, accessible and free from coercion and intimidation, women will continue to endanger their lives by resorting to unsafe abortion or following through with unwanted or unsafe pregnancies. In addition to compromising their rights to health and to self-determination, the lack of access to safe abortion and medical abortion, and the lack of a standardized abortion protocol, constitute serious violations of the right to enjoy the full benefits of scientific progress as protected by Article 15(b).

3. Inadequate Access to Family Planning Services

Access to family planning is a crucial component of any strategy aiming to reduce maternal mortality and unsafe abortion, and encompassed in the right to health, according to this Committee¹²⁰ and other treaty monitoring bodies. According to the UNFPA, access to appropriate family planning can prevent up to 35 % of maternal deaths.¹²¹ India launched an official family planning program in 1952, yet access to contraception is still not universal.¹²² The WHO estimates that if all unwanted births in India were prevented, India's fertility rate would drop to replacement level.¹²³ The RCHP, which entered its second phase in 2003, seeks to create awareness about the right to health care, promote contraceptive use, and provide a full range of contraceptive methods, including condoms and sterilization. The RCHP also seeks to reduce the unequal burden on women regarding contraception, by enhancing "visibility for men."¹²⁴ In a similarly positive initiative, India's National Population Policy (NPP), adopted in 2000, sought to establish universal access to family planning information, counseling, and contraception, with the ultimate aim of stabilizing the population growth rate by 2045.¹²⁵ The NPP portends to prioritize women's health through family planning, and "affirms the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target-free approach in administering family planning services."¹²⁶ However, despite the commendable policy goals of the RCHP and the NPP, affordable modern contraceptives remain out of reach for the majority of Indian citizens, the burden of family planning continues to rest unequally upon women, and coercive and punitive approaches to population growth are still widespread.

Female sterilization is the most prevalent and most well-known method of contraception in India. Although less than half of all married women of child-bearing age use a modern method of contraception,¹²⁷ of those who do, female sterilization is approximately ten times more prevalent than condoms, IUDs, and birth control pills.¹²⁸ India's approach to family planning has been punitive, with states implementing laws and policies to punish couples for having more than two children by denying them public benefits and even participation in government.¹²⁹ The sanctioning of these state-level laws shows that the national government and the judiciary are allowing state governments to flout the National Population Policy, and in practice are disregarding the principles of a human-rights based approach to population growth acceded to at Cairo in the ICPD Programme of Action¹³⁰ and espoused in the NPP.

Although the NPP and RCHP claim to promote access to family planning technologies and information thereabout, after 50 years of family planning policy, no specific directives or statutes exist to ensure that local government units actually comply with the mandates of the NPP and the RCHP,¹³¹ and contraceptive prevalence is less than 50%.¹³² Knowledge about and access to non-permanent means of contraception, such as condoms and pills, varies drastically from state to state; according to the National Family Health Survey, less than half of women in Andhra Pradesh and Karnataka know about condoms.¹³³ Accordingly, in these

states (and Tamil Nadu), approximately 60% of married women have been sterilized, compared to the national rate of 37%.

The over-reliance on female sterilization provides more evidence that the full range of less permanent and invasive modern contraceptive technologies (such as the pill, the IUD, injectables, etc) is not available to most women in India, and that the family-planning burden unfairly affects women. Alarming, when women get sterilized in health centers, only three out of ten women are told about other methods of contraception.¹³⁴ Although India introduced the “No Scalpel Vasectomy Project” in 1998 to popularize male sterilization, it was only implemented in twenty states,¹³⁵ and female sterilizations continue to account for more than 95% of all sterilizations performed in India. Also troubling is the fact that the JSY payment program, which compensates below-poverty-line women 500 Rupees for their first two live births, will pay a woman (in the most depressed states) 500 Rupees for her third live birth if, post-delivery, she consents to undergo sterilization.¹³⁶ Paying women to undergo permanent sterilization is inherently coercive and violates women’s fundamental rights as protected by the Covenant.

A public interest case from Uttar Pradesh, brought to the Supreme Court of India in 2003, *Ramakant Rai v. Union of India*,¹³⁷ revealed female-sterilization procedures to be often unsafe and life-threatening, and that public health officials had coerced women to undergo sterilization procedures in sub-standard and unsafe facilities, several of which failed and/or resulted in death.¹³⁸ As a result of this case, the Supreme Court ordered state governments to immediately regulate providers of sterilization services, and to compensate women who suffer complications from botched or sub-standard procedures and the relatives of women who die from such operations. Unfortunately, these orders have not been fully implemented by the state governments, and violations continue.

Additionally, although the Department of Family Welfare announced in 2006 that it would introduce Emergency Contraceptive (EC) pills into its RH Program, access to emergency contraception is often not available to those living in rural areas, and its accessibility is limited due to its status as a scheduled substance, available only by prescription. EC is six times as widely used in Delhi than in rural areas, and studies suggest that were EC available over-the-counter or from paramedical professionals such as ANMs, women would be more willing and able to utilize it.¹³⁹ One study found that in 2003, **“awareness about emergency contraception among the general population and paramedical workers [was] practically nonexistent.** Precise knowledge about EC among doctors (both gynecologists and general practitioners) [was] also inadequate.”¹⁴⁰

The WHO has noted that in India there is a particularly low reliance on “male or couple-based methods”¹⁴¹ of contraception., and the CEDAW Committee has expressed concern that “family planning is only targeted at women,”¹⁴² and noted that “inadequate implementation of laws are serious impediments to the realization of women’s human rights in India.”¹⁴³ This Committee has repeatedly emphasized that access to family planning information and services are entailed in the right to health,¹⁴⁴ and that states must ensure *de facto* equality between men and women.¹⁴⁵

India’s failure to ensure that women and girls have access to the full complement of modern contraceptive technologies without discrimination, coercion, or risk constitutes a violation of their right to health and to the benefits of scientific progress, and the lack of effort on the part of the state to increase the involvement of men in undertaking family planning responsibilities perpetuates the undue burden on women, and contravenes India’s obligation under the Covenant **“not [to] maintain, but rather alleviate, the inherent disadvantage** that particular groups experience.”¹⁴⁶

4. Sexuality Education

Although the issue of adolescent and youth sexuality education was not addressed in India’s report to this Committee, sexuality education is an essential component of any comprehensive attempt to eradicate gender

injustice and improve public health. As the ICESCR protects the rights to health and education, this Committee requires governments to establish “education programs for behavior-related health concerns such as sexually transmitted diseases.”¹⁴⁷ In 2007, the Indian Central Government attempted to introduce comprehensive sex education in CBSE schools (those schools certified by the Central Board of Education), but a number of states refused to implement the curriculum. In response to this backlash, Parliament formed a committee to solicit ideas and input from the public on the subject of sex education in schools, but it is unclear if there has been any progress since.

As outlined above, adolescents are the population most at risk of unsafe abortion and maternal mortality. As such, it is crucial that unbiased and scientific information regarding safe sexual behavior be available to adolescents before the onset of puberty, as recommended by the WHO.¹⁴⁸ UNAIDS has also concluded that the most effective sex education models begin before the onset of sexual activity among youth.¹⁴⁹ Other UN treaty-monitoring bodies have highlighted India’s particular need for a comprehensive sex education program. The CRC recommended that India “strengthen sexual and reproductive health education, mental health and adolescent-sensitive counseling services and make them accessible to adolescents.”¹⁵⁰ CEDAW has repeatedly noted the importance of sexuality education in preventing the spread of HIV/AIDS,¹⁵¹ and sex education is also a crucial tool for preventing early onset of unsafe sexual activity, early unplanned pregnancies, and concomitant indices of unsafe abortion and maternal morbidity and death. The health of adolescents is also jeopardized by the prevalence of child marriage. While the state asserts that child marriage occurs only in “certain areas”¹⁵² of the country, in reality **almost half of women under age 29 were married before they reached legal majority.**¹⁵³ The phenomenon of child marriage, while needing to be addressed in its own right, could yield better maternal health outcomes if young women were exposed to more information about contraceptive use in school, as only 8 % of married adolescents in India use contraceptives.¹⁵⁴ Sixteen percent of all women age 15 – 19 have already begun childbearing, with great disparities between rural and urban communities. In Jharkhand, West Bengal, and Bihar, over 25% of women under age 19 have had children.¹⁵⁵

In addition to improving women’s reproductive health, age-appropriate and scientifically accurate sex education can also contribute to other important provisions of ICESCR by empowering young women to advocate for themselves in relationships,¹⁵⁶ teaching respect and gender equality to young men,¹⁵⁷ and helping to eradicate taboos and mythologies around sexuality and gender roles that, as the state itself has noted,¹⁵⁸ create a climate wherein discriminatory and dangerous practices such as dowry and child marriage further threaten women’s autonomy and health. Sex education can also help adolescents deal positively with the relationships and emotions that debut during adolescence, and can help young people develop crucial communication and negotiation skills that they can use to protect themselves from potential sexual violence, unwanted pregnancies, and STIs.¹⁵⁹

This Committee has repeatedly emphasized the link between sexuality education and the right to health.¹⁶⁰ In General Comment 14, the Committee interprets Article 12 to require “the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases”¹⁶¹ and has also discussed sexuality education as a means to combat high rates of maternal mortality, adolescent pregnancies, HIV/AIDS¹⁶², and illegal abortion.¹⁶³ We applaud India’s Parliament for taking a first step towards a national-level sex education standard. Providing the curricula are gender-sensitive and scientifically accurate, we strongly encourage this Committee to urge the state to move forward with this important initiative, and to provide more information on this topic in its next report to this Committee.

5. Recent Court Decisions Threaten Women’s Health and Rights

While national-level reproductive health policies, such as the National Population Policy, may suffer in implementation, they are at least grounded in international human rights norms.¹⁶⁴ In contrast, many recent decisions from the Supreme Court of India seem to disregard human rights standards altogether, to the severe detriment of India’s women and other vulnerable populations. In a few recent cases, the Supreme

Court of India has demonstrated a troubling lack of understanding and awareness of women's reproductive rights as established in international law. Court decisions arising from this conceptual gap have created precedents for behavior on the state and community level that further confounds India's ability to achieve its ambitious policy goals of eradicating gender injustice and improving indices of women's health.

Two examples of this disturbing judicial trend are the recent decisions in the cases of *Javed v. Haryana* and *Ghosh v. Ghosh*. In *Javed*, the Supreme Court in 2003 upheld a law disqualifying men and women with more than two children from running for public office.¹⁶⁵ The *Javed* plaintiffs challenged a coercive population control law in Haryana state (the Haryana Panchayati Raj Act of 1994), wherein persons with more than two living children are disqualified from holding certain offices in the *panchayats*.¹⁶⁶ They argued that this type of law violates the National Population Policy, which “affirms the commitment of government towards **voluntary and informed choice**...and continuation of the **target free** approach in administering family planning services.”¹⁶⁷ However, the Supreme Court upheld the law, praised it as being “salutary and in the public interest,”¹⁶⁸ and rejected petitioners' arguments that the law was discriminatory and coercive. The *Javed* Court also declared, erroneously, that the Haryana policy “is consistent with the national population policy.”¹⁶⁹ Although the petitioners in *Javed* argued correctly that Indian women often lack reproductive decision-making power¹⁷⁰, the Supreme Court rejected that argument, revealing its ignorance of the reality of gender dynamics and inequities in contemporary Indian society, positing: “we do not think that with the awareness which is arising in Indian women folk, they are so helpless as to be compelled to bear a third child even though they do not wish to do so.”¹⁷¹

Coercive and punitive laws such as the Haryana act not only violate the ethos of India's NPP but also violate the rights to equality, privacy, and autonomy as protected by the ICESCR. These types of policies disproportionately affect women, as they fail to take into account the “social context of early marriages, early pregnancies and son preferences...all the responsibility is placed only on individuals, particularly women, with serious consequences for them.”¹⁷² Policies such as the Haryana provision exacerbate social problems such as sex-selective abortions and the abandonment of female infants.¹⁷³ Other consequences of the Haryana policy and similar include rampant falsification of hospital and birth records; marital desertion; divorce; denial of paternity by male political candidates; and general disenfranchisement of the women who are already underrepresented in decision-making bodies—those from marginalized and poor communities.¹⁷⁴ Although the Court argued that the Haryana policy is in “the national interest”, any policy that violates the human rights of half of the population cannot be within the national interest.

Public health experts in India have criticized *Javed* not only for its paternalistic and discriminatory nature but for its upholding of a policy which is simply ineffective at curtailing population growth. According to the director of the Population Foundation of India (PFI), “even if population growth is a problem, the solution does not lie in rigid, restrictive policies...they have never worked in India or elsewhere in the world. There are other measures that can be taken, like better access to healthcare, equitable access to education, better employment opportunity...[these measures] will definitely lower the population.”¹⁷⁵ A former Supreme Court justice who supports population control said “measures which are punitive are not the answer...A great focus is required on methodology. The end is all right, but the means also matter.”¹⁷⁶

In 2007, another Supreme Court decision threatened women's reproductive rights. The decision in *Ghosh v. Ghosh* held that a wife's **failure to obtain spousal consent for an abortion, refusal to have sexual intercourse, and refusal to bear children** could all be considered forms of “mental cruelty” to a husband.¹⁷⁷ This mode of reasoning from India's highest court runs counter to Arts 2(2) and 3 of ICESCR due to its patriarchal nature and basis in gender stereotypes. The *Ghosh* Court ignores the disproportionate burden of childbearing on women, the inherent health risks associated with child-bearing, and the unequal power relations that can exist within marriage. The legal reasoning in the *Ghosh* decision rests entirely on stereotypes about women's roles and men's privilege, contrary to India's mandate under this Committee, which acknowledges that “women are often denied equal enjoyment of their human rights...by virtue of the lesser status ascribed to them by tradition and custom,”¹⁷⁸ and as such states must “**take steps aimed**

directly at the elimination of prejudices...and stereotyped roles for men and women.”¹⁷⁹ *Ghosh*, on the contrary represents a step backwards, towards more deeply entrenched and **legally sanctioned gender stereotypes** and inequities.

When women cannot obtain safe reproductive health services, including abortion, their rights to health and to the benefits of scientific progress are violated. Not only must reproductive health care be accessible and affordable, such services must be confidential, for if women are forced to disclose details of their personal and private decisions, their rights to autonomy and equality are compromised as well as their right to health. However, *Ghosh* potentially threatens women’s ability to **confidentially** access reproductive health services, including abortion, contrary to India’s claims to this Committee that recent policies aim to “encourage changes in personal laws such as those related to marriage, divorce...so **as to eliminate discrimination against women**.”¹⁸⁰ Troublingly, a Delhi district court in 2007 issued a decision in the divorce case of *Chand v. Devi*¹⁸¹ that not only aligned with *Ghosh*, but went a step further by seemingly accepting the claim that the woman should have obtained her husband **and in-laws’** consent to obtain an abortion. The *Chand* decision, therefore, suggests that India’s judiciary believes that a husband and his family should have equal or greater control over a woman’s decision to bear children than the woman herself. This view contradicts and undermines the principle of autonomy which is legally protected by international law.

General Comment 16, on the equal rights of men and women, states that “the implementation of article 3, in relation to article 12, requires at a minimum the removal of legal and other obstacles that prevent men and women from accessing and benefiting from health care on a basis of equality. This includes, inter alia...the removal of legal restrictions on reproductive health provisions...”¹⁸² CEDAW has emphasized that consent restrictions on abortion compromise women’s right to health.¹⁸³

In spite of state obligations under the ICESCR and CEDAW, *Javed*, *Ghosh*, and *Chand* point to the sanctioning of regressive, patriarchal norms by India’s judiciary. These patriarchal decisions contravene ICESCR’s protections of women’s rights to self-determination (Art. 1), women’s right to the highest attainable standard of health (Art. 12), women’s right to take advantage of scientific progress (Art. 15), and women’s abilities to fully enjoy all of the rights enumerated in ICESCR, as protected by Articles 2(2) and 3.

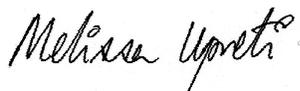
We request that the Committee consider addressing the following questions to the government of India:

1. How does the government propose to realize its ambitious goals of reduction in maternal mortality over the next two years? What procedures, mechanisms, and protocols will it implement to monitor, investigate and prevent maternal mortality throughout the entire country, especially in rural and underserved areas?
2. What steps is the government taking to protect women from death and morbidity due to unsafe abortion, and expand access to safe and affordable abortion? How will the government ensure that patients’ confidentiality and privacy are safeguarded so that women may exercise reproductive choices without fear of discrimination or stigma? What steps will the government take to enhance public awareness of abortion’s legality under MTP Act provisions?
3. Towards India’s stated goal of expanding access to safe and legal abortion, will the government consider implementing a standard protocol for abortion, including medical abortion, such as the protocol developed by the WHO¹⁸⁴?
4. How will the government reconcile its desire to combat sex-selective abortion with its mandate to ensure that women can receive legal abortions under the MTP Act in safety, confidentially and free from intimidation?
5. How does the government plan to fulfill its stated goal in the NPP of ensuring universal access to family planning services and information including age appropriate, non-biased sex education for adolescents? How does the government plan to enhance the roles and responsibilities of men in the area of family planning?

6. What steps will the government take to better regulate private health care providers, and to ensure that women's rights to health and confidentiality are protected and enforced when they seek private health care services?
7. More broadly, how will the government of India ensure that its public health policies such as the RHCP and the NPP translate into actual, practical change? What steps will they take to implement protocols, monitor results, and hold local and state governments accountable for implementation?
8. What steps will be taken to address, and prevent in the future, patriarchal and discriminatory court decisions such as *Ghosh* and *Javed* that threaten women's abilities to exercise reproductive autonomy, and set dangerous precedents for more patriarchal jurisprudence and legislation?

We respectfully urge the Committee on Economic, Social, and Cultural Rights to take this information into consideration as it reviews the Government of India's compliance with ICESCR, and use it as a basis for emphasizing the urgent need to prioritize the protection and fulfillment of women's reproductive rights as a matter fundamental to economic, cultural, and social justice. If you have any questions or would like further information, please do not hesitate to contact the undersigned.

Sincerely,



Melissa Upreti
Senior Manager and Legal Adviser for Asia
Center for Reproductive Rights

¹ International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 49, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976), art. 12(1) [hereinafter ICESCR].

² Article 2(2) guarantees all persons the rights set forth in the ICESCR without discrimination, specifically as to "sex, social origin or other status,"² and Article 3 further articulates that States parties to ICESCR must "undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the Covenant."

³ Committee on Economic, Social and Cultural Rights, General Comment 14, *The Right to the Highest Attainable Standard of Health*, para. 8, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR Gen. Comment 14].

⁴ *Id.*, para 14.

⁵ ICESCR, *supra* note 1, art. 3.

⁶ Committee on Economic, Social and Cultural Rights, Gen. Comment 16, *The Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights*, U.N. Doc. E/C.12/2005/4 (2005) [hereinafter CESCR Gen. Comment 16] [Full text of General Comment 16 *available at*

[http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/7c6dc1dee6268e32c125708f0050dbf6/\\$FILE/G0543539.pdf](http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/7c6dc1dee6268e32c125708f0050dbf6/$FILE/G0543539.pdf)]

⁷ *Id.*, para. 15.

⁸ *Concluding comments of the Committee on the Elimination of Discrimination against Women: India*, 32nd Sess. 761st to 762nd mtgs., para. 7, U.N. Doc. CEDAW/C/IND/CO/3 (2007) [hereinafter *Concluding Observations of CEDAW: India* (2007)].

⁹ *Id.*, para. 41.

¹⁰ *Id.*, para. 40.

¹¹ *Id.*

¹² WORLD HEALTH ORGANIZATION (WHO) ET AL., MATERNAL MORTALITY IN 2005: ESTIMATES DEVELOPED BY WHO, UNICEF, UNFPA at 8, 10 (2007) [hereinafter WHO, MATERNAL MORTALITY IN 2005].

¹³ *Concluding Observations of the Committee on the Elimination of Racial Discrimination: India*, 70th Sess, 1809th mtg., para. 24. U.N. Doc CERD/C/IND/CO/19 (2007).

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- ¹⁴ MMR = Maternal Mortality Ratio, given as a number of pregnancy and/or childbirth-related deaths for every 100,000 live births. (WHO, MATERNAL MORTALITY IN 2005, *supra* note 12)
- ¹⁵ *Combined second, third, fourth and fifth periodic report submitted by States parties under articles 16 and 17 of the Covenant, India*, Committee on Economic, Social and Cultural Rights, March 1, 2007, para. 250, U.N. Doc. E/C.12/IND/5 [hereinafter *India Report to CESCR* (2007)].
- ¹⁶ *Id.*, paras. 327-332.
- ¹⁷ *Id.*, paras. 513, 558.
- ¹⁸ WHO MATERNAL MORTALITY IN 2005, *supra* note 12 at 22; Mission of Paul Hunt, UN Special Rapporteur on the Right to the Highest Attainable Standard of Health, Oral Remarks to the Press, Monday Dec. 3, 2007, Delhi, India. [hereinafter Paul Hunt Remarks, Delhi, 2007]
- ¹⁹ Paul Hunt Remarks, Delhi, 2007, *supra* note 18.
- ²⁰ Consideration of Reports Submitted by States Parties under Article 18 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Initial report of states parties, India, CEDAW Committee, 22nd Sess., para. 221 UN Doc. CEDAW/C/IND/1 (1999). [hereinafter *India Report to CEDAW* (1999)]
- ²¹ *India Report to CESCR* (2007), *supra* note 15, paras. 235-257
- ²² INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES (IIPS) AND MACRO INTERNATIONAL, NATIONAL FAMILY HEALTH SURVEY (NFHS-3) 2005-06: INDIA [hereinafter NFHS-3] *Key Findings* (2007) at 4, *available at*: http://www.nfhsindia.org/nfhs3_national_report.html
- ²³ *India Report to CESCR* (2007), *supra* note 15, para. 482.
- ²⁴ *Id.*, para. 477.
- ²⁵ UNITED NATIONS POPULATION FUND (UNFPA), STATE OF THE WORLD POPULATION REPORT 2006 95-96 (2006), *available at* www.unfpa.org/swp/2006
- ²⁶ WHO, MATERNAL MORTALITY IN 2005, *supra* note 12 at 18, “Is the Fifth MDG Achievable?” (Reduction of MMR to 25% of 1990 levels by 2015 would require an annual reduction of 5.5% every year after 1990. It is clear that even based upon the state party’s self-reporting, this rate of change has not occurred, as India has instead achieved only a 1% decline per year.)
- ²⁷ Ministry of Health and Family Welfare, *Health Indicators of Uttar Pradesh*, RHS BULLETIN, Mar. 2006, *available at* <http://mohfw.nic.in/NRHM/State%20Files/up.htm>
- ²⁸ Ministry of Health and Family Welfare, *Health Indicators of Rajasthan*, RHS BULLETIN, Mar. 2006, *available at* <http://mohfw.nic.in/NRHM/State%20Files/raj.htm>
- ²⁹ Deeti Ray, *Maternal Mortality: Women at Risk*, SOCIETY FOR THE STUDY OF PEACE AND CONFLICT, Jul. 2006, *available at* http://www.sspconline.org/article_details.asp?artid=art86
- ³⁰ Civil Society Meeting with Paul Hunt: Special Rapporteur on the Right to Health; Delhi, India, Dec. 1, 2007 [hereinafter Civil Society Meeting with Paul Hunt], from a report by Prasanta Tripathy, EKJUT, *full text of meeting available at*: <http://www.chsj.org/pages/events/civil-society-meeting-with-un-special-rapporteur-on-the-right-to-health.php>
- ³¹ NATIONAL DEVELOPMENT COUNCIL, PLANNING COMMISSION, TENTH FIVE YEAR PLAN (2002-2007), vol. 11, ch. 2.11, para. 2.11.41 *available at* <http://planningcommission.nic.in/plans/planrel/fiveyr/10th/default.htm>. Anemia should be of special importance to the state given that women are more predisposed to suffer from anemia in India than are men, yet as its correlation to maternal morbidity and mortality shows, it disproportionately endangers women.
- ³² *Concluding Observations of CEDAW: India* (2007), *supra* note 8, para 41.
- ³³ Nirmala Murthy & Alka Barua, *Non-medical Determinants of Maternal Death in India*, 6 J. HEALTH MGMT 47 – 61 (2004) (“Most ‘death cases’ belonged to high-risk age groups, had high parity (3+), were socially disadvantaged, had not received prenatal care and advice to go to hospital...Delay in care was also because of lack of transport facilities, inappropriate referrals or poor emergency preparedness of referral facilities. Data suggested that about half the deaths could have been avoided if the health system had been alert and accessible.”)
- ³⁴ UN Millennium Project, Task Force on Child and Maternal Mortality, cited by UNFPA, *Maternal Mortality in 2005 Fact Sheet*, *available at*: http://www.unfpa.org/swp/2005/presskit/factsheets/facts_rh.htm#ftn10.
- ³⁵ Jishnu Das, Jeffrey S. Hammer & Kenneth L. Leonard, *The Quality of Medical Advice in Low-Income Countries* (Jan. 1 2008) World Bank Policy Research Working Paper No. 4501 *available at* <http://ssrn.com/abstract=1089272> (“The relationship between poverty in the area that the doctor practices in and his or her competence stands out. In India, Indonesia, and Tanzania, doctors in poorer areas are less competent than those in richer areas.” P. 16)
- ³⁶ WHO, RECOMMENDED INTERVENTIONS FOR IMPROVING MATERNAL AND NEWBORN HEALTH WHO/MPS/07.05 at 2 (2007) [hereinafter WHO, RECOMMENDED INTERVENTIONS] *available at* http://whqlibdoc.who.int/hq/2007/WHO_MPS_07.05_eng.pdf
- ³⁷ NFHS-3, *supra* note 22, at 4.
- ³⁸ *Id.* at 186, tbl. 8.3.
- ³⁹ *Id.* at 12; WHO, RECOMMENDED INTERVENTIONS, *supra* note 36, at 4.
- ⁴⁰ *India Report to CESCR* (2007), *supra* note 15, para. 250.
- ⁴¹ *Id.*, para. 565.
- ⁴² WHO, MATERNAL MORTALITY IN 2005, *supra* note 12, at 18.
- ⁴³ *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), *Combined second and third periodic report of State parties, India*, Oct. 19, 2005, para. 7, U.N. Doc. CEDAW/C/IND/2-3 [hereinafter *India Report to CEDAW* (2005)]
- ⁴⁴ Paul Hunt Remarks, Delhi, 2007, *supra* note 18

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- ⁴⁵ Civil Society Meeting with Paul Hunt, *supra* note 30, from a report by Francis Raj.
- ⁴⁶ WHO, MATERNAL MORTALITY IN 2005, *supra* note 12, at 5
- ⁴⁷ Dileep Mavalankar, Kranti Vora & M. Prakasamma, *Achieving Millennium Development Goal 5: is India serious?* 86 BULLETIN OF THE WORLD HEALTH ORGANIZATION 241-320 (2008) available at <http://www.who.int/bulletin/volumes/86/4/07-048454/en/index.html> [hereinafter Mavalankar et al., *Achieving MDG 5*]
- ⁴⁸ UNITED NATIONS DEVELOPMENT PROGRAM (UNDP), HUMAN DEVELOPMENT REPORT (2007).
- ⁴⁹ *India Report to CESCR (2007)*, *supra* note 15, paras. 483, 484; Paul Hunt Remarks, Delhi, 2007, *supra* note 19.
- ⁵⁰ Government of India, Union Budget 2008 – 2009 [available at <http://indiabudget.nic.in/ub2008-09/bag/bag4-2.htm>]
- ⁵¹ In 2007 India's GDP surpassed 1 trillion US Dollars, or approximately 41 trillion Rupees. In the 2008-2009 budget, combined spending on the Ministry of Health and Family Welfare, the Department of Health and Family Welfare, the Department of Health Research and the Department of Ayurveda, Naturopathy, Yoga, etc., equaled approximately 326.48 billion Rupees, approximately .07 % of GDP. [Government of India, Union Budget 2008 – 2009 (available at <http://indiabudget.nic.in/ub2008-09/bag/bag4-2.htm>)]
- ⁵² UNDP, HUMAN DEVELOPMENT REPORT 2007, *supra* note 48.
- ⁵³ Paul Hunt Remarks, Delhi, 2007, *supra* note 18.
- ⁵⁴ Nazmul Chaudry et al, *Missing in Action: Teacher and Health Worker Absence in Developing Countries*, 20 J. ECON. PERSPECTIVES 91-116 (2006) (cited by Shanta Devarajan, Chief Economist, South Asia Region, World Bank)
- ⁵⁵ Abhijit Banerjee, Angus Deaton & Esther Duflo, *Wealth, health, and health services in rural Rajasthan*, 94 AMER. ECON. REV., Papers and Proceedings 326-330, available at http://www.princeton.edu/~rpds/downloads/banerjee_deaton_wealthhealth.pdf
- ⁵⁶ Das, et al., *supra* note 35.
- ⁵⁷ *Id.*
- ⁵⁸ Murthy and Barua, *supra* note 33.
- ⁵⁹ Paul Hunt Remarks, Delhi, 2007, *supra* note 18.
- ⁶⁰ Civil Society Meeting with Paul Hunt, *supra* note 30, comments by Asha Kilaru (Bilaku Trust) on Karnataka state.
- ⁶¹ Mavalankar, *Achieving MDG 5*, *supra* note 47.
- ⁶² *Id.*
- ⁶³ *India Report to CESCR (2007)*, *supra* note 15, para. 246.
- ⁶⁴ NFHS-3, *supra* note 22
- ⁶⁵ *India Report to CESCR (2007)*, *supra* note 15, para. 214.
- ⁶⁶ NFHS-3, *supra* note 22, at 4 (“The median age at first marriage among women is 17.2 years...Almost half (46%) of women age 18-29 got married before the legal minimum age of 18.”)
- ⁶⁷ Murthy and Barua, *supra* note 33 (“Most ‘death cases’ belonged to high-risk age groups, had high parity (3+), were socially disadvantaged...”)
- ⁶⁸ Civil Society Meeting with Paul Hunt, *supra* note 30, from a report by Sangeeta Mourya of SAHAYOG..
- ⁶⁹ *Id.*
- ⁷⁰ *India Report to CESCR (2007)*, *supra* note 15, para. 247.
- ⁷¹ “The first main cause/factor in maternal mortality in Uttar Pradesh is the informal demand for money...Out of 68 cases documented in Uttar Pradesh, 32 were asked for informal payments...Many health care providers demand money for services and women don't get JSY, despite the fact that maternal health services are free according to NRHM.” Dr. Bulbul Sood (WRAI), reporting at Civil Society Meeting with Paul Hunt, *supra* note 33; “The implementation of JSY was different for low-performing and high-performing states. Often, the JSY order does not trickle down to the community level. Also, even when you have the JSY payment, women have to make lots of payments to the health care system, and sometimes they even have to pay money to get the JSY money.” Civil Society Meeting with Paul Hunt, *supra* note 30.
- ⁷² Civil Society Meeting with Paul Hunt, *supra* note 30.
- ⁷³ *India Report to CESCR (2007)*, *supra* note 15, para. 565; Paul Hunt Remarks, Delhi, 2007, *supra* note 18.
- ⁷⁴ “The status of deliveries, which are attended by qualified persons and in institutions, are showing improvements.” *India Report to CESCR (2007)*, *supra* note 15, para. 481.
- ⁷⁵ Paul Hunt Remarks, Delhi, 2007, *supra* note 18. (“In many cases, the range and quality of services in those [public] facilities has been seriously neglected...The focus has become increasing institutional delivery—but institutional delivery is not a proxy for access to life-saving care (EmOC)...What is the point of getting pregnant women to go to facilities which do not have the services the women need?”)
- ⁷⁶ *India Report to CESCR (2007)*, *supra* note 15, para 493; Nazmul Chaudry et al, *Missing in Action: Teacher and Health Worker Absence in Developing Countries*, J. ECON. PERSP. 91-116, vol 20, No. 1. 2006 (cited by Shanta Devarajan, Chief Economist, South Asia Region, World Bank); See also Das, et al., *supra* note 35.
- ⁷⁷ *India Report to CESCR (2007)*, *supra* note 15, para. 493.
- ⁷⁸ *Id.*, para. 252.
- ⁷⁹ *Id.*, para. 253.
- ⁸⁰ WHO, INTEGRATED MANAGEMENT OF PREGNANCY AND CHILDBIRTH (IMPAC), BIRTH AND EMERGENCY PREPAREDNESS IN ANTENATAL CARE 2 (2006), available at http://www.who.int/making_pregnancy_safer/publications/Standards1.9N.pdf (“Outcome indicators: - the proportion of births at which a skilled attendant is present. – the proportion of births at which a birth companion, designated by the woman, is present. – the proportion of women who recently gave birth whose delivery took place where planned. – transport is available to referral facilities.”)

- ⁸¹ Quazi Islam, WHO, *Making Pregnancy Safer in Least Developed Countries: The Challenge of Delivering Available Services*, UN CHRON. No. 4, 2007, available at http://www.who.int/making_pregnancy_safer/publications/un_chronicle_mdg5.pdf
- ⁸² ICESCR, *supra* note 1, art. 10.
- ⁸³ *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Bolivia*, 21/05/2001, UN Doc E/C.12/1/Add.60, ¶ 23; **Mexico**, 08/12/1999, UN Doc. E/C.12/1/Add.41, ¶ 43; **Morocco**, 01/12/2000, UN Doc. E/C.12/1/Add.64, ¶ 53; **Nepal**, 24/09/2001, UN Doc. E/C.12/1/Add.66, ¶ 32; **Panama**, 24/09/2001, U.N. Doc. E/C.12/1/Add.55, ¶ 37; **Senegal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.62, ¶ 47.
- ⁸⁴ *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Nepal*, 24/09/2001, UN Doc. E/C.12/1/Add.66, ¶ 32; **Paraguay**, 28/05/96, UN Doc. E/C.12/1/Add.1, ¶ 16; **Peru**, 16/05/97, UN Doc. E/C.12/1/Add.1/14, ¶ 16.
- ⁸⁵ According to India's National Family Health Surveys (NFHS-1 conducted 1992-1993, NFHS-3 conducted 2005-2006)
- ⁸⁶ *India Report to CESCR* (2007), *supra* note 15, para. 567.
- ⁸⁷ Consortium for Emergency Contraception in India, All India Institute of Medical Sciences (AIIMS) *Introduction of Emergency Contraception in India*, (Sunecta Mittal) at http://aiims.edu/aiims/events/Gynaewebsite/ma_finalsite/drmittal.html
- ⁸⁸ According to the WHO, unsafe abortion "causes approximately 13% of all maternal deaths and approximately 20% of the overall burden of maternal death and long-term sexual and reproductive ill health." WHO, UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2003, 5th ed. (2007) available at http://who.int/reproductive-health/publications/unsafeabortion_2003/ua_estimates03.pdf [hereinafter WHO, UNSAFE ABORTION 2003]
- ⁸⁹ Abortion Assessment Project – India, Research Summaries and Abstracts (Dec 2, 2004) at 7 [hereinafter Abortion Assessment Project]
- ⁹⁰ WOMEN OF THE WORLD SOUTH ASIA: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES, CENTER FOR REPRODUCTIVE RIGHTS (EDS) 2004 at 103 [citing CENTRE FOR DEVELOPMENT AND POPULATION ACTIVITIES (CEPDA), ADOLESCENT GIRLS IN INDIA CHOOSE A BETTER FUTURE: AN IMPACT ASSESSMENT (2001)]
- ⁹¹ "Where contraception is inaccessible or of poor quality, many women will seek to terminate unintended pregnancies, despite restrictive laws and lack of adequate abortion services." Matthews Mathai, *Preventing Unsafe Abortion in India*, INDIAN J. MED. RESEARCH Aug. 2005, available at: http://findarticles.com/p/articles/mi_qa3867/is_200508/ai_n15704668; See also WHO, UNSAFE ABORTION IN 2003, *supra* note 88.
- ⁹² See WHO, UNSAFE ABORTION 2003, *supra* note 88, at 30 ("Countries with both legal and unsafe abortions contributed only small numbers of deaths from unsafe abortion, except India, where large numbers of unsafe abortions reportedly take place.")
- ⁹³ Abortion Assessment Project, *supra* note 89, at 46.
- ⁹⁴ M.E. Khan et al., *Availability and Access to Abortion Services in India: Myth and Realities* (2001) [hereinafter Khan, *Availability and Access to Abortion Services in India*] [available at http://www.iussp.org/Brazil2001/s20/S21_P10_Barge.pdf]
- ⁹⁵ Abortion Assessment Project, *supra* note 89, at 17.
- ⁹⁶ WHO, UNSAFE ABORTION 2003, *supra* note 88, at 4.
- ⁹⁷ *India Report to CEDAW* (2005) *supra* note 43, para. 41.
- ⁹⁸ Khan, *supra* note 94.
- ⁹⁹ *Id.*
- ¹⁰⁰ Consortium on National Consensus for Medical Abortion, AIIMS, *Current status of abortion in India* (Sharad Iyengar) at http://aiims.edu/aiims/events/Gynaewebsite/ma_finalsite/report/1_1_1.htm
- ¹⁰¹ Abortion Assessment Project, *supra* note 89, at 17.
- ¹⁰² Khan, *Availability and Access to Abortion Services in India*, *supra* note 94.
- ¹⁰³ Consortium on National Consensus for Medical Abortion, AIIMS, *Current status of abortion in India*, *supra* note 100.
- ¹⁰⁴ *Concluding Observations of CEDAW: India* (2007), *supra* note 8, para. 41.
- ¹⁰⁵ See e.g. *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Finland*, 01/12/2000, UN Doc E/C.12/1/Add.52, ¶ 31; **Italy**, 23/05/2000, UN Doc E/C.12/1/Add.43, ¶ 31; **Philippines**, 07/06/1995, UN Doc. E/C.12.1995/7, ¶ 20; **Republic of Korea**, 21/05/2001, U.N. Doc. E/C.12/1/Add.59, ¶ 26.
- ¹⁰⁶ Consortium on National Consensus for Medical Abortion, AIIMS, *Current status of abortion in India*, *supra* note 100.
- ¹⁰⁷ Abortion Assessment Project, *supra* note 89, at 18.
- ¹⁰⁸ See *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Belgium*, 09/05/96, UN Doc. A/51/38, ¶ 181; **Indonesia**, 14/05/98, UN Doc. A/53/38, ¶ 284(c); **Turkey**, 12/08/97, UN Doc. A/52/38/Rev.1, ¶¶ 184, 196.
- ¹⁰⁹ *India Report to CESCR* (2007), *supra* note 15, para. 326-327.
- ¹¹⁰ *India Report to CESCR* (2007), *supra* note 15, para. 326.
- ¹¹¹ *India Report to CEDAW* (2007), *supra* note 43, para. 22.
- ¹¹² See e.g., Paton v. United Kingdom, App. No. 8416/78, 3 Eur. H.R. Rep. 408 ¶¶ 7-9 (1980) (Eur. Comm'n H.R.); *R.H. v. Norway*, decision on admissibility, App. No. 17004/90, Eur. Comm'n H.R. (1992); *Boso v. Italy*, App. No. 50490/99, Eur. Comm'n H.R. (2002); *Vo v. France*, App. No. 53924/00, Eur. Ct. H.R. (2004).
- ¹¹³ See *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Cameroon*, 08/12/1999, UN Doc. E/C.12/1/Add.40, ¶ 25; **Mauritius**, 31/05/94, UN Doc. E/C.12/1994/8, ¶ 15; **Mexico**, 08/12/99, UN Doc. E/C.12/1/Add.41, ¶ 29; **Nepal**, 24/09/2001, UN Doc. E/C.12/1/Add.66, ¶ 32; **Panama**, 24/09/2001, UN Doc. E/.112/1/Add.64, ¶ 20; **Poland**, 16/06/98, UN Doc. E/C.12/1/Add.26, ¶ 12; **Senegal**, 24/09/2001, UN Doc. E/C.12/1/Add.62, ¶ 26.
- ¹¹⁴ *India Report to CESCR* (2007), *supra* note 15, paras. 329, 567.

¹¹⁵ POPULATION COUNCIL, SANDHYA BARGE, ET AL., FORMAL AND INFORMAL ABORTION SERVICES IN RAJASTHAN, INDIA: RESULTS OF A SITUATION ANALYSIS (2004), available at http://www.popcouncil.org/pdfs/abortion_analysis_india.pdf

¹¹⁶ Consortium for Emergency Contraception in India, All India Institute of Medical Sciences (AIIMS) *Introduction of Emergency Contraception in India*, *supra* note 87.

¹¹⁷ Medical Termination of Pregnancy Act, 1971, Act No. 34 of 1971, as amended by Act No. 64 of 2002.

¹¹⁸ *India Report to CESCR* (2007), *supra* note 15, para. 567.

¹¹⁹ See *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Cameroon*, 08/12/1999, UN Doc. E/C.12/1/Add.40, ¶25; *Mauritius*, 31/05/94, UN Doc. E/C.12/1994/8, ¶ 15; *Mexico*, 08/12/99, UN Doc. E/C.12/1/Add.41, ¶ 29; *Nepal*, 24/09/2001, UN Doc. E/C.12/1/Add.66, ¶ 32; *Panama*, 24/09/2001, UN Doc. E/112/1/Add.64, ¶ 20; *Poland*, 16/06/98, UN Doc. E/C.12/1/Add.26, ¶ 12; *Senegal*, 24/09/2001, UN Doc. E/C.12/1/Add.62, ¶ 26.

¹²⁰ See *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Cameroon*, 08/12/99, UN Doc. E/C.12/1/Add.39, ¶15; *Paraguay*, 28/05/96, UN Doc. E/C.12/1/Add.1, ¶ 16.

¹²¹ Susheela Singh et al., *Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care*, Alan Guttmacher Institute and UNFPA (2004).

¹²² “In 2000 the contraceptive prevalence rate (CPR) among married women was 48.3%. Contraceptive use in India is characterized by the predominance of ... female sterilization... [and] negligible use of contraceptives among both married and unmarried adolescents” WHO, Southeast Asia Regional Office (SEARO), *India and Family Planning: An Overview* (2003) [hereinafter WHO SEARO, *India and Family Planning*] available at http://www.searo.who.int/LinkFiles/Family_Planning_Fact_Sheets_india.pdf. WHO SEARO reports that **total** ‘unmet need’ in 2003 was **15.8%**, but a **30%** rate of unmet need among women desiring **non-permanent** means of contraception, such as young and adolescent women; the NFHS-3 reports that ‘unmet need’ is only 13%, but acknowledges that “unmet need for family planning varies greatly by state, from 5 % in Andhra Pradesh to 35 % in Meghalaya... more than 20 % unmet need in Nagaland, Jharkand, Bihar, and Uttar Pradesh.” NFHS-3, *supra* note 22, at 35.

¹²³ “It is estimated that if all unwanted births were prevented, India’s TFR would drop to replacement level fertility.” As it stands now, India already has over 1 billion people and is on track to have a population of over 2 billion within the 21st century. WHO SEARO, *India and Family Planning*, *supra* note 123.

¹²⁴ *India Report to CEDAW* (2005), *supra* note 43, paras. 74 – 75.

¹²⁵ DEPARTMENT OF FAMILY WELFARE, MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA, NATIONAL POPULATION POLICY (2000), para. 7 [hereinafter National Population Policy (2000)].

¹²⁶ *Id.*, para. 6. See also NHRC Declaration, at 1-2 (“Note with concern that population policies framed by some State Governments reflect in certain respects a coercive approach through use of incentives and disincentives which in some cases are violative of human rights. This is not consistent with the spirit of the National Population Policy.”); A. R. Nanda, *Indian Population Policy: An Overview*, Colin Gonsalves, *Two Boy Norm: State Governments Poised to Blunder*, in COERCION VERSUS EMPOWERMENT: PERSPECTIVES FROM THE PEOPLE’S TRIBUNAL ON INDIA’S COERCIVE POPULATION POLICIES AND TWO-CHILD NORM (Shruti Pandey et al. eds., Human Rights Law Network, India), at 14-17, 18-19.

¹²⁷ NFHS – 3, *supra* note 22, citing that amongst married women, 44% do not use any method of contraception, 3% use the withdrawal method and 5% use the rhythm method.

¹²⁸ *Id.*

¹²⁹ Policies that punish women and men for having more than a certain number of children are inherently coercive. One policy in the state of Haryana was upheld by India’s Supreme Court in *Javed v. State of Haryana*, and prohibits those with three or more children from running for or holding public office.

¹³⁰ *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept 5-13, 1994, principle 8, UN Doc. A/CONF.171/13/Rev.1 (1995). (Principle 8: “Reproductive health-care programmes should provide the widest range of services **without any form of coercion.**”)

¹³¹ There are no specific statutes to make sure that contraceptives are distributed equitably and that information is provided about their efficacy, safety, potential side effects, and proper use. WOMEN OF THE WORLD SOUTH ASIA, *supra* note 19, at 83.

¹³² “In 2000 the contraceptive prevalence rate (CPR) among married women was 48.3%.” WHO *Fact Sheet, Family Planning: India*.

¹³³ NFHS – 3, *supra* note 22, at 6.

¹³⁴ NFHS – 3, *supra* note 22, at 6.

¹³⁵ *India Report to CEDAW* (2005), *supra* note 43, para. 250.

¹³⁶ *India Report to CESCR* (2007), *supra* note 15, para. 247.

¹³⁷ Petition, Ramakant Rai & Health Watch U.P and Bihar v. Union of India, W.P. (Civ.) No. 209 of 2003, at A-1 (Supreme Court of India, 2003)

¹³⁸ See COERCION VERSUS EMPOWERMENT: PERSPECTIVES FROM THE PEOPLE’S TRIBUNAL ON INDIA’S COERCIVE POPULATION POLICIES AND TWO-CHILD NORM (Shruti Pandey et al. eds., Human Rights Law Network, India) (2006).

¹³⁹ Consortium for Emergency Contraception in India, AIIMS, *Profile and perceptions of EC users and providers: AIIMS experience* (Sunceta Mittal) at http://www.aiims.ac.in/aiims/events/Gynaewebsite/ec_site/report/1_3_3.htm

¹⁴⁰ Reva Tripathi et al., *Emergency contraception: knowledge, attitude, and practices among health care providers in North India.*, 29 J OBSTET GYNAECOL RES.142-6 (2003).

¹⁴¹ “In 2000 the contraceptive prevalence rate (CPR) among married women was 48.3%. Contraceptive use in India is characterized by the predominance of ... limited use of male-/couple-depended methods...” WHO SEARO, *India and Family Planning*, *supra* note 123.

¹⁴² *Concluding Observations of the Committee on the Elimination of Discrimination against Women: India*, 22nd Sess., 419th to 421st mtg., para. 78, U.N. Doc. A/55/38 (1999) [hereinafter *Concluding Observations of CEDAW: India* (1999)].

¹⁴³ *Id.*, para. 56.

¹⁴⁴ On access to family planning information as related to the right to health, see *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Cameroon*, 08/12/99, UN Doc. E/C.12/1/Add.39, ¶15; *Paraguay*, 28/05/96, UN Doc. E/C.12/1/Add.1, ¶ 16. On access to family planning generally, see *Armenia*, 08/12/99, UN Doc. E/C.12/1/Add.39, ¶ 15; *Dominican Republic*, 12/12/97, UN Doc. E/C.12/1/Add.16, ¶ 15; *Dominican Republic*, 06/12/96, UN Doc. E/C.12/1/Add.6, ¶ 22; *Honduras*, 21/05/2001, UN Doc. E/C.12/1/Add.57, ¶ 27; *Poland*, 16/06/98, UN Doc. E/C.12/1/Add.26, ¶ 12; *Saint Vincent and the Grenadines*, 02/12/97, UN Doc. E/C.12/1/Add.21, ¶ 12. On affordability see *Armenia*, 08/12/99, UN Doc. E/C.12/1/Add.39, ¶ 15; *Poland*, 16/06/98, UN Doc. E/C.12/1/Add.26, ¶ 12.

¹⁴⁵ CESCR Gen. Comment 16, *supra* note 6, para. 7: “Guarantees of non-discrimination and equality in international human rights treaties mandate both de facto and de jure equality. De jure (or formal) equality and de facto (or substantive) equality are different but interconnected concepts. Formal equality assumes that equality is achieved if a law or policy treats men and women in a neutral manner. Substantive equality is concerned, in addition, with the effects of laws, policies and practices and with ensuring that they **do not maintain, but rather alleviate, the inherent disadvantage** that particular groups experience.”

¹⁴⁶ CESCR Gen. Comment 16, *supra* note 6, para. 7.

¹⁴⁷ CESCR Gen. Comment 14, *supra* note 3, para 16

¹⁴⁸ See World Health Organization (WHO), *Adolescent Pregnancy: Issues in Adolescent Health and Development*, at 13 (2004), [hereinafter WHO, *Adolescent Pregnancy*].

¹⁴⁹ See Joint United Nations Programme on HIV/AIDS (UNAIDS), *Impact of HIV and Sexual Health Education on the Sexual Behavior of Young People: a Review Update* at 27 (1997).

¹⁵⁰ *Concluding Observations of the Committee on the Rights of the Child: India*, 35th Sess., para. 61(c), CRC/C/15/Add.228 (2004).

¹⁵¹ CEDAW Committee, General Recommendation 15, *Avoidance of Discrimination Against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)*, U.N. Doc. A/45/38 at 81 (1990).

¹⁵² *India Report to CESCR* (2007), *supra* note 15, para. 214.

¹⁵³ NFHS-3, *supra* note 22.

¹⁵⁴ Saroj Pachauri and K.G. Santhya, *Contraceptive Behaviours of Adolescents in Asia: Issues and Challenges*, WHO [available at http://www.who.int/reproductive-health/publications/towards_adulthood/17.pdf (last visited Oct. 25, 2007)]; see also INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES (IIPS), NATIONAL FAMILY HEALTH SURVEY (NFHS-2) 1998-1999.

¹⁵⁵ NFHS-3, *supra* note 22, at 5.

¹⁵⁶ Sue Alford et al., *Science & Success in Developing Countries: Holistic Programs that Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections* 13 ADVOCATES FOR YOUTH 28 (2005).

¹⁵⁷ Deborah Rogow & Nicole Haberland, *Sexuality and Relationships Education: Toward a Social Studies Approach*, 5 SEX EDUCATION 333–344 (2005).

¹⁵⁸ *India Report to CESCR* (2007), *supra* note 15, paras. 215, 268, 326.

¹⁵⁹ *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries*, Advocates for Youth (2005) [available at <http://www.advocatesforyouth.org/PUBLICATIONS/growingupglobal/index.htm> (last visited Sept. 25, 2007)].

¹⁶⁰ *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Armenia*, 08/12/99, UN Doc. E/C.12/1/Add.39, ¶ 15; *Bolivia*, 21/05/2001, UN Doc E/C.12/1/Add.60, ¶ 43; *Cameroon*, 08/12/99, UN Doc. E/C.12/1/Add.39, ¶45; *Honduras*, 21/05/2001, UN Doc. E/C.12/1/Add.57, ¶¶ 27, 48; *Mexico*, 08/12/99, UN Doc. E/C.12/1/Add.41, ¶ 43; *Poland*, 16/06/98, UN Doc. E/C.12/1/Add.26, ¶ 20; *Ukraine*, 31/08/2001, UN Doc. E/C.12/1/Add.65, ¶ 31.

¹⁶¹ CESCR, Gen. Comment 14, *supra* note 3, para. 16.

¹⁶² *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Cameroon*, 08/12/99, UN Doc. E/C.12/1/Add.39, ¶ 45; *Honduras*, 21/05/2001, UN Doc. E/C.12/1/Add.57, ¶ 27; *Ukraine*, 31/08/2001, UN Doc. E/C.12/1/Add.65, ¶ 31.

¹⁶³ See e. g., *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Bolivia*, 21/05/2001, UN Doc E/C.12/1/Add.60, ¶ 43; *Mexico*, 08/12/99, UN Doc. E/C.12/1/Add.41, ¶ 43; *Senegal*, 24/09/2001, UN Doc. E/C.12/1/Add.62, ¶ 47.

¹⁶⁴ In response to pressure from NGOs, women’s activists, and the 1994 Programme of Action of the International Conference on Population and Development, India’s government, in 1996, reoriented its entire approach to population and family planning away from targets and towards an approach based in women’s needs and rights. See National Population Policy (2000), *supra* note 125; see also Leela Visaria, et al., *From Family Planning to Reproductive Health: Challenges Facing India*, INT’L FAMILY PLANNING PERSPECTIVES, Vol 25 Supp. Jan. 1999.

¹⁶⁵ *Javed v. State of Haryana*, A.I.R. 2003 S.C. 3057

¹⁶⁶ *Javed*, *supra* note 165, paras. 2, 5, 66.

¹⁶⁷ NATIONAL POPULATION POLICY (2000), *supra* note 125, para. 6. See also NATIONAL HUMAN RIGHTS COMMISSION, MINISTRY OF HEALTH AND FAMILY WELFARE & UNFPA, DECLARATION ADOPTED AT THE NATIONAL COLLOQUIUM ON POPULATION POLICY, DEVELOPMENT AND HUMAN RIGHTS (2003) at 1-2 available at <http://www.nhrc.nic.in/Publications/PopulationP.pdf> (“Note[s] with concern that population policies framed by some State Governments reflect in certain respects a coercive approach through use of incentives and disincentives which in some cases are violative of human rights. This is not consistent with the spirit of the National Population Policy.”)

¹⁶⁸ *Javed*, *supra* note 165, para. 65.

¹⁶⁹ *Javed*, *supra* note 165, paras. 18, 20.

¹⁷⁰ *Javed*, *supra* note 165, at introduction.

¹⁷¹ *Javed*, *supra* note 165, at para. 63.

¹⁷² Nirmala Buch, *Law of Two-Child Norm in Panchayats: Implications, Consequences and Experiences*, ECON. & POL. WKLY 2422 (Jun. 2005) at 2429.

¹⁷³ Buch, *Law of Two-Child Norm in Panchayats*, *supra* note 172.

¹⁷⁴ Buch, *Law of Two-Child Norm in Panchayats*, *supra* note 172; see also Rita Sarin, *Two-Child Norm and Political Participation of Women in Marginal Communities*; Jagmati Sangwan, *State Overview: Haryana* in COERCION VS. EMPOWERMENT, *supra* note 127, at 40, 73-75.

¹⁷⁵ CENTER FOR REPRODUCTIVE RIGHTS & AVANI MEHTA SOOD, LITIGATING REPRODUCTIVE RIGHTS: USING PUBLIC INTEREST LITIGATION AND INTERNATIONAL LAW TO PROMOTE GENDER JUSTICE IN INDIA 66 (2006) (citing interview by A. Sood with Dr. A.R. Nanda, Executive Director, Population Foundation of India, New Delhi, India, Mar. 7, 2006)

¹⁷⁶ CENTER FOR REPRODUCTIVE RIGHTS AND AVANI SOOD, LITIGATING REPRODUCTIVE RIGHTS, *supra* note 175 at 67 (citing interview by A. Sood with Justice J.S. Verma, former Chief Justice, Supreme Court of India and former Chair, National Human Rights Commission, New Delhi, India, Mar. 29, 2006).

¹⁷⁷ Ghosh v. Ghosh (2007) 2004 S.C. 151 at 1, in which appellant Samar Ghosh claimed that his wife subjected him to mental cruelty because she instructed him not to interfere with her career, refused to bear him a child, demanded that he stay away from her daughter from a previous marriage, and “ration[ed] . . . emotions in the area of love, affection, future planning and normal human relations”; the appellant also complained that his wife failed to care for him when he suffered a prolonged illness, refused to live with or cook for him, thus forcing him to take meals outside the house, and “stopped sharing bed with him without any justification” [*Ghosh v. Ghosh* at 3] Although the *Ghosh* Court allowed that there is no single, comprehensive definition of “mental cruelty,” and that “[t]he concept . . . is bound to change with the passage of time,” [*Ghosh* at 23] the Court listed fourteen instances of human behavior that “may lead to mental cruelty.” [*Ghosh* at 23-24] Three of the most troubling enumerations included: “. . . a **wife undergo[ing] vasectomy or abortion** without medical reason or **without the consent or knowledge of her husband[,]**” and the “[u]nilateral decision or **refusal to have intercourse** for a considerable period without there being any physical incapacity or valid reason . . . [or] **to not to have a child from the marriage . . .**” [*Ghosh* at 24] Disturbingly, the Supreme Court betrays its own ignorance of women’s reproductive health by referring to women obtaining a “vasectomy”, a procedure solely conducted on men.

¹⁷⁸ CESCR Gen. Comment 16, *supra* note 6, para. 5.

¹⁷⁹ *Id.*, para. 19.

¹⁸⁰ *India Report to CESCR* (2007), *supra* note 15, para. 217.

¹⁸¹ A Delhi district court recently granted a divorce in *Chand v. Devi*, based, in part, on a respondent wife’s abortion, allegedly obtained without her husband or his parents’ consent. Not only did the *Chand* court align with *Ghosh*, but it failed to take issue with the assertion that the respondent should have obtained her in-laws’ consent to obtain an abortion. The Court also commented on the respondent’s inability to report the purported medical reason for her abortion. As such, the *Chand* court impliedly affirmed that women should be required to obtain consent from both their husbands and their husband’s family to have an abortion, and provide medical explanations for the procedures on demand. In the end, both the *Ghosh* and the *Chand* courts accord **greater weight to husbands’ interest in their wives reproductive capacities and sexualities, than to women’s reproductive rights and autonomy.**

¹⁸² CESCR Gen. Comment 16, *supra* note 6, para. 29.

¹⁸³ See *Concluding Observations of the CEDAW Committee: Indonesia*, 14/05/98, UN Doc. A/53/38, ¶ 284(c), **Turkey**, 12/08/97, UN Doc. A/52/38/Rev.1, ¶ 196.

¹⁸⁴ WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS (2003).