



May 10, 2007

Pre-Sessional Working Group of the Committee on Economic, Social and Cultural Rights

Re: Supplementary information on India

Dear Working Group Members:

Reproductive health and rights receive broad protection under the International Covenant on Economic, Social and Cultural Rights (the Convention). Article 12(1) recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”¹ When interpreting the right to health, the Economic, Social and Cultural Rights Committee (the Committee), in General Comment 14, has explicitly defined this right to “include the right to control one’s health and body, including sexual and reproductive freedoms.”² Articles 2(2) and 3 guarantee all persons the rights set forth in the ICESCR without discrimination, specifically as to “sex, social origin or other status.”³ In line with the spirit of this provision, the Committee has characterized the duty to prevent discrimination in access to health care as a “core obligation” of the state.⁴

Through this letter, the Center for Reproductive Rights⁵ would like to draw the attention of the Pre-Sessional Working Group to three issues of concern that implicate women’s reproductive rights in India — unsafe abortion, maternal mortality and the failure to ensure universal access to contraception — and propose questions for inclusion in the official list of questions transmitted to the government of India, prior to the formal reporting session. Contextual information has been provided in brief to enable the working group to assess the need for an official response in each case.

A. UNSAFE ABORTION

Each year, an estimated 6.7 million abortions are performed in places other than registered and government recognized institutions, often in unhygienic conditions or by untrained individuals.⁶ The majority of women who undergo unsafe abortion procedures are low-income and rural based. Such procedures are inherently risky, and consequently, account for half of all maternal deaths of women aged fifteen to nineteen.⁷ Obstacles to accessing safe services include: (1) inconsistent and prohibitive costs;⁸ (2) lack of trained providers and adequate equipment;⁹ and (3) poor access to facilities.¹⁰

In the past, the Committee has expressed deep concern over the relationship between high rates of maternal mortality and unsafe abortions.¹¹ The Indian government’s report to the Committee discusses efforts to reduce “illegal and unhealthy” abortion,

specifically through the implementation of a Reproductive and Child Health programme, which is considering introducing manual vacuum aspiration—a less invasive abortion technique widely available in many other countries—in eight states.¹² An intervention of this scale is not an adequate response to a problem that exists nationwide and often results in death. A high incidence of unsafe abortion is indicative of the government’s failure to protect women’s health. As a result of government neglect, women seeking to terminate their pregnancies have been forced to put their reproductive health and lives at risk.

Questions:

- 1. What steps are being taken by the government to protect women from pregnancy related death and morbidity due to unsafe abortion and to expand access to safe and affordable abortion services?**
- 2. What steps are being taken to introduce and ensure the implementation of safeguards protecting the privacy and confidentiality of patients to enable women to access services without fear of discrimination and stigma?**
- 3. What steps are being taken to ensure that measures to curb sex-selective abortion do not undermine access to abortion on legal grounds and divert public attention and resources from the continuing problem of abortion related deaths?**

B. MATERNAL MORTALITY

Maternal deaths due to complications in pregnancy and childbirth are among the leading causes of death of women in India: maternal mortality accounts for 15% of all deaths of women of reproductive age.¹³ The government contends in its periodic report that the country’s rate of maternal mortality has decreased from 437 per 100,000 live births (1992-93) to 407 per 100,000 live births in 1998.¹⁴ Meanwhile, NGO estimates of maternal death are significantly higher than the government’s data. For example, the UNFPA State of the World Population Report (as of March 2006) estimates that there are 540 maternal deaths for every 100,000 live births.¹⁵

Considering the existing structural barriers to healthcare, widespread poverty, and the persistence of discriminatory practices against women and girls such as early marriage and son preference, the goal of reducing the maternal mortality ratio to 2 per 1,000 live births by 2007 and 1 per 1,000 live births by 2012—as outlined in the government report¹⁶—appears unattainable. In its report to the Committee, the Indian government acknowledges that State governments’ lack of resources has led to “unacceptably high” mortality and morbidity rates.¹⁷

The Committee has consistently expressed concern to States parties about the high rates of maternal mortality,¹⁸ which the Committee views as a violation of the right to health. Article 10 of the Convention grants special protection to pregnant women before and after delivery. A high maternal mortality rate is indicative of the

government's failure to ensure the proper protection of maternal health as envisaged under international law.

Questions:

- 1. How does the government propose to realize in practice its state policy goals of reducing maternal mortality in India? Where does accountability lie within the government for the persistent failure to meet the official targets for reducing the maternal death rate?**
- 2. Has the government considered introducing appropriate regulations and mechanisms to monitor, investigate, and punish the occurrence of maternal deaths due to medical negligence and discrimination in health care facilities, especially among low-income women from rural areas?**

C. ACCESS TO FAMILY PLANNING SERVICES

India launched an official family planning program in 1952, yet more than fifty years later, universal access to contraceptive methods and services remains a dream: fewer than half of all married women between 15 and 49 years of age use a modern method of contraception.¹⁹ In addition, access to emergency contraception is not ensured to women and girls who experience unwanted pregnancy as a result of sexual abuse in the form of rape or incest. The fact that nearly fifty women are raped every day in India²⁰ underscores the need for a comprehensive and gender-sensitive approach to women's reproductive health.

Furthermore, the most widely known and used modern method of contraception in India is female sterilization,²¹ an indication of the unavailability of a full range of family planning options that should include the broad range of temporary methods available to women worldwide. A public interest case brought in the Supreme Court of India in 2004 exposed abuses by public health officials in several states who coerced women to undergo sterilization through the performance of sub-standard and unsafe sterilization procedures, resulting in failed procedures and even death.²² The Supreme Court of India has issued interim orders directing state governments to take immediate steps to regulate health-care providers who perform sterilization procedures, and to compensate women who suffer complications due to sub-standard practices and the relatives of victims who may die from botched operations. Unfortunately, these orders have not been fully implemented by the government.

This Committee has consistently commented on the need for access to contraception and family planning information and services²³ and has framed lack of such access as a violation of the right to health.²⁴ The government's failure to ensure that women and girls can universally access the widest possible range of family planning methods, information and services without discrimination, coercion, and violence, constitutes a denial of their reproductive rights.

Questions:

1. **How does the government plan to fulfill the goal of establishing universal access to family planning information and services, including access to emergency contraception for women and girls who need it?**
2. **What steps are being taken to create safeguards to protect individual women against coercion and violence in access to family planning information and services?**

We hope the Working Group takes this information under consideration while formulating the list of questions for the government. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Very truly yours,



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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), 999 U.N.T.S. 3 (*entered into force* Jan. 3, 1976), art. 12(1) [hereinafter Economic, Social and Cultural Rights Covenant].

² Committee on Economic, Social and Cultural Rights, Gen. 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].

³ Economic, Social, and Cultural Rights Covenant, *supra* note 1, at art. 2(2).

⁴ CESCR Gen. Comment 14, *supra* note 2, at para. 19.

⁵ The Center for Reproductive Rights (formerly the Center for Reproductive Law and Policy) is a nonprofit legal advocacy organization dedicated to promoting and defending women's reproductive rights worldwide. See <http://www.reproductiverights.org/about.html>.

⁶ ABORTION ASSESSMENT PROJECT—INDIA, RESEARCH SUMMARIES AND ABSTRACTS 7 (December 2, 2004) [hereinafter ABORTION ASSESSMENT PROJECT—INDIA].

⁷ WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES—SOUTH ASIA 103 (Center for Reproductive Rights ed., 2004) [hereinafter WOMEN OF THE WORLD SOUTH ASIA].

⁸ ABORTION ASSESSMENT PROJECT—INDIA, *supra* note 6, at 46.

⁹ WOMEN OF THE WORLD SOUTH ASIA, *supra* note 7, at 87.

¹⁰ ABORTION ASSESSMENT PROJECT—INDIA, *supra* note 6, at 17.

¹¹ CENTER FOR REPRODUCTIVE RIGHTS & UNIVERSITY OF TORONTO PROGRAMME OF REPRODUCTIVE AND SEXUAL HEALTH LAW. BRINGING RIGHTS TO BEAR: AN ANALYSIS OF THE WORK OF UN TREATY MONITORING BODIES ON REPRODUCTIVE AND SEXUAL RIGHTS 153 (2002) [hereinafter BRINGING RIGHTS TO BEAR]. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. See e.g., **Cameroon**, 08/12/99, U.N. Doc. E/C.12/1/Add.40, ¶ 25; **Mauritius**, 31/05/94, U.N. Doc. E/C.12/1994/8, ¶ 15; **Mexico**, 08/12/99, U.N. Doc. E/C.12/1/Add.41, ¶ 29; **Nepal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.66, ¶ 32; **Panama**, 24/09/2001, U.N. Doc. E/C.12/1/Add.64, ¶ 20; **Poland**, 16/06/98, U.N. Doc. E/C.12/1/Add.26, ¶ 12; **Senegal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.62, ¶ 26.

¹² *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 (CESCR Committee), paras. 329, 567, U.N. Doc. E/C.12/IND/5 [hereinafter *India Report*].

¹³ WOMEN OF THE WORLD SOUTH ASIA, *supra* note 7, at 84.

¹⁴ *India Report*, *supra* note 12, at para. 477.

¹⁵ UNFPA STATE OF THE WORLD POPULATION REPORT 95-96 (2006), *available at* <http://www.unfpa.org/swp/2006>.

¹⁶ *India Report*, *supra* note 12, at para. 558.

¹⁷ *Id.* at para. 482.

¹⁸ BRINGING RIGHTS TO BEAR, *supra* note 11, at 118. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Argentina**, 08/12/99, U.N. Doc. E/C.12/1/Add.38, ¶ 24; **Bolivia**, 21/05/2001, U.N. Doc. E/C.12/1/Add.60, ¶ 23; **Cameroon**, 08/12/99, U.N. Doc. E/C.12/1/Add.40, ¶ 25; **Dominican Republic**, 12/12/97, U.N. Doc. E/C.12/1/Add.16, ¶ 15; **Dominican Republic**, 06/12/96, U.N. Doc. E/C.12/1/Add.6, ¶ 22; **Gambia**, 31/05/94, U.N. Doc. E/C.12/1994/9, ¶ 16; **Mali**, 21/12/94, U.N. Doc. E/C.12/1994/17, ¶ 13; **Mexico**, 08/12/99, U.N. Doc. E/C.12/1/Add.41, ¶ 29; **Mongolia**, 01/09/2000, U.N. Doc. E/C.12/1/Add.47, ¶ 15; **Morocco**, 01/12/2000, U.N. Doc. E/C.12/1/Add.55, ¶ 29; **Nepal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.66, ¶ 32; **Panama**, 24/09/2001, U.N. Doc. E/C.12/1/Add.64, ¶ 20; **Paraguay**, 28/05/96, U.N. Doc. E/C.12/1/Add.1, ¶ 16; **Peru**, 16/05/97, U.N. Doc. E/C.12/Add.1/14, ¶ 16; **Senegal**, 24/09/2001, U.N. Doc. E/C.12/1/Add.62, ¶ 26; **Solomon Islands**, 14/05/99, U.N. Doc. E/C.12/1/Add.33, ¶ 22.

¹⁹ WOMEN OF THE WORLD SOUTH ASIA, *supra* note 7, at 69.

²⁰ U.S. Department of State, Country Reports on Human Rights Practices – 2005 (March 8, 2006), *available at* <http://www.state.gov/g/drl/rls/hrrpt/2005/61707.htm>.

²¹ WOMEN OF THE WORLD SOUTH ASIA, *supra* note 7, at 82.

²² *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).

²³ BRINGING RIGHTS TO BEAR, *supra* note 11, at 131. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Armenia**, 08/12/99, U.N. Doc. E/C.12/1/Add.39, ¶ 15; **Cameroon**, 08/12/99, U.N. Doc. E/C.12/1/Add.40, ¶ 25; **Dominican Republic**, 12/12/97, U.N. Doc. E/C.12/1/Add.16, ¶ 15; **Dominican Republic**, 06/12/96, U.N. Doc. E/C.12/1/Add.6, ¶ 22; **Honduras**, 21/05/2001, U.N. Doc. E/C.12/1/Add.57, ¶ 27; **Paraguay**, 28/05/96, U.N. Doc. E/C.12/1/Add.1, ¶ 16; **Poland**, 16/06/98, U.N. Doc. E/C.12/1/Add.26, ¶ 12; **Saint Vincent and the Grenadines**, 02/12/97, U.N. Doc. E/C.12/1/Add.21, ¶ 12.

²⁴ *Id.* This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. *See* **Cameroon**, 08/12/99, U.N. Doc. E/C.12/1/Add.40, ¶ 25; **Paraguay**, 28/05/96, U.N. Doc. E/C.12/1/Add.1, ¶ 16.