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I. Introduction

These comments have been prepared by the Center for Reproductive Rights\(^1\) in support of a petition submitted to the High Court of Judicature at Patna, in the matter of *Centre for Health and Resource Management v. The State of Bihar & Others* (2008). The petition urges the government to ensure safe institutional deliveries and to fulfill the service guarantees provided for in the National Rural Health Mission’s Framework for Implementation by upgrading hospitals, sub-centers, and other health facilities in the state.\(^2\) The petition also urges the government to ensure that all health facilities in the state be made fully functional to meet with Indian Public Health Standards. Furthermore, the petition appeals to the government to ensure that all health facilities are available to everyone without discrimination and free of charge to persons below the poverty line.\(^3\)

These comments are based on key provisions contained in international human rights treaties, relevant jurisprudence produced by treaty monitoring bodies, and the comments by the Special Rapporteur on the right to the highest attainable standard of health. The purpose of this memo is to lend support to the aforementioned petition by establishing India’s obligations to ensure the right to survive pregnancy and childbirth as a human right as recognized under international law. Article 51(c) of the Indian constitution directs the state to “foster respect for international law and treaty obligations.”\(^4\) The Supreme Court of India has stated that Indian courts should incorporate international laws and norms in their decisions where there is no inconsistency between international and domestic legal norms.\(^5\) Furthermore, international legal obligations apply at the state level and actions of local and state level governments that are inconsistent with such international human rights obligations amount to failure by the national government to fulfill its human rights obligations.\(^6\)

\(^1\) The Cornell International Human Rights Clinic provided research assistance in the preparation of this memorandum.

\(^2\) Petition, Centre for Health and Resource Management v. The State of Bihar, at 38 [hereinafter Petition].

\(^3\) Id. at 38–40.

\(^4\) *India Const.* art 51, § c.

\(^5\) Vishaka v. State of Rajasthan, AIR 1997 SC 3011 (noting, in creating sexual harassment policies based on *CEDAW*, that international conventions and norms could be “used for construing the fundamental rights expressly guaranteed in the Constitution of India which embody the basic concept of gender equality in all spheres of human activity” and justifying the use of international law in its decision stating that “[i]t is now an accepted rule of judicial construction that regard must be had to international conventions and norms for construing domestic law when there is no inconsistency between them and there is a void in the domestic law”). Additionally, the Bangalore Principles (1988) indicate that it is appropriate for national courts to consider international law obligations of the State even if they have not been specifically adopted through legislation by the State. Bangalore Principles, Principle 7, available at www.chr.up.ac.za/hr_docs/african/docs/other/cwn1.doc.

II. The Center’s Interest in the Case

The Center for Reproductive Rights is a non-profit legal advocacy organization based in New York, N.Y., USA, dedicated to defending and promoting women’s reproductive rights worldwide. The International Legal Program, in collaboration with women’s rights organizations and advocates around the world, documents violations of reproductive rights, monitors laws concerning reproductive health care, advocates at the United Nations and litigates in regional human rights fora. The Center has filed memoranda of support in maternal mortality cases in India, including in Sandesh Bansal v. Union of India & Ors, W.P. No. 9061/2008 and in Snehalata Singh v. The State of Uttar Pradesh and Others, W.P.No. 14588/2009. The Center has also recently authored a publication on the right to survive pregnancy and childbirth entitled Maternal Mortality in India: Using International and Constitutional Law to Promote Accountability and Change; a copy is included in this submission for the Court’s reference.

This case has significant implications for the basic human rights of women in India, and more specifically, their right to survive pregnancy and childbirth, which includes their rights to life, liberty and security, freedom from cruel, inhuman and degrading treatment, health, equality and non-discrimination, and the right to reproductive self-determination. These rights are guaranteed by international human rights treaties to which India is a party, including the International Convention on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The Indian national government, and derivatively the Bihar state government, have the obligation to protect and guarantee these rights and thus must also guarantee and protect the right to survive pregnancy and childbirth.

III. Jurisdiction

7 G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (entered into force Mar. 23, 1976) (acceded to by India April 10, 1979) [hereinafter ICCPR]. Article 6(1) guarantees the right to life, article 9(1) provides for the right to liberty and security, article 2 guarantees right to equality and non-discrimination, article 7 provides for the right to be free from cruel, inhuman and degrading treatment or punishment, and article 17.1 guarantees right to privacy, which is part of the right to reproductive self-determination.


10 See infra Part III.
International law establishes judicial responsibility to ensure respect for human rights and mandates that there be remedies for violations of international human rights. Various international human rights instruments, including the Universal Declaration of Human Rights, the ICCPR and the CEDAW, expressly guarantee the right to a remedy if rights are violated.

Article 51(c) of the Constitution obligates the Government of India to uphold international law and respect the provisions of international treaties. The Supreme Court has declared that the Constitution must be interpreted in light of international treaties to which India is party and in conformity with international law. As per the doctrine of incorporation, “the rules of international law are incorporated national law and considered to be part of domestic law, unless they are in conflict with an Act of Parliament.” This doctrine implies that the provisions of international treaties that India has ratified are part of the law of the land if there is no apparent conflict between the two. Treaty provisions that support the right to survive pregnancy and childbirth as a human right can be found in constitutional guarantees of the rights to life, health and equality, and non-discrimination. Hence, the responsibility to protect and implement human rights established through international law that support the right to survive pregnancy extends to state governments, including the State Government of Bihar, which are responsible for the implementation of fundamental rights and health policies in the state including the NRHM and the IPHS.

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12 Id. art. 8 (“Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted [her] by the constitution or by law.”).

13 ICCPR, supra note 7, art. 2(3). The ICCPR states:
   (a) To ensure that any person whose rights or freedoms as . . . recognized [in the Covenant] are violated shall have an effective remedy notwithstanding that the violation has been committed by persons acting in an official capacity;
   (b) To ensure that any person claiming such a remedy shall have the right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;
   To ensure that the competent authorities shall enforce such remedies when granted.

14 CEDAW, supra note 9, art. 12 (“States Parties . . . undertake: (c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination . . . .”).

15 This right is also enshrined in the Convention on the Elimination of Racial Discrimination (CERD). See Convention on the Elimination of Racial Discrimination (CERD), art. 6, 21 Dec. 1965; entered into force 4 Jan. 1969, 660 U.N.T.S. 195 (“States Parties shall assure to everyone within their jurisdiction effective protection and remedies, through the competent national tribunals and other State institutions, against any acts of racial discrimination which violate [her] human rights and fundamental freedoms contrary to this Convention, as well as the right to seek from such tribunals just and adequate reparation or satisfaction for any damage suffered as a result of such discrimination.”).

16 INDIA CONST. art 51, § c (stating that India must “(c) foster respect for international law and treaty obligations in the dealings of organized peoples with one another”).


18 Id.
The ICCPR calls upon States parties “to develop the possibilities of judicial remedy” for people whose rights are violated, and to enforce such remedies when granted. In addition, CESCR declares that appropriate measures to implement the ICESCR may include judicial remedies, especially with regard to non-discrimination. CESCR has also stated that “[i]n general, legally binding international human rights standards should operate directly and immediately within the domestic legal system of each State party, thereby enabling individuals to seek enforcement of their rights before national courts and tribunals.” CESCR has expressed that violations of the right to health can also occur through the omission or failure of States to take necessary measures arising from legal obligations. Violations through acts of omission include the failure to take appropriate steps towards the full realization of everyone’s right to the enjoyment of the highest attainable standard of physical and mental health.

CESCR also establishes that the obligation to “fulfill the right to health” requires that the State party adopt judicial measures towards the full realization of the right to health.

The CEDAW Committee recommends “strengthen[ing] implementation and monitoring” of laws, “acting with due diligence to prevent and respond to [violations],” and sanctioning responsible parties. CEDAW requires State parties to “establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination.” The CEDAW Committee has stated that the duty of States parties to ensure, on a basis of equality of men and women, access to health-care services, information and education implies an obligation to respect, protect and fulfill women's rights to health care. States parties have the responsibility to ensure that legislation and

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19 ICCPR, supra note 7, art. 2(3).
23 Id. ¶ 33.
25 CEDAW, supra note 9, art. 2(c).
executive action and policy comply with these three obligations. They must also put in place a system that ensures effective judicial action.\textsuperscript{26}

The CEDAW Committee has further established that, “the duty to fulfill rights places an obligation on states parties to take appropriate . . . judicial . . . measures to the maximum extent of their available resources to ensure that women realize their rights to healthcare.”\textsuperscript{27}

Similarly, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has underscored that monitoring and accountability are integral features of the right to health and can help reduce maternal mortality.\textsuperscript{28} Under the right to health, State parties are obligated to ensure accountability of various stakeholders, including health-care providers, local health authorities, national governments, international organizations, and civil society.\textsuperscript{29} The Special Rapporteur has emphasized the role of courts and tribunals in ensuring access to health care specifically in the context of maternal mortality.\textsuperscript{30}

\section*{IV. Legal Issue}

The legal issue here is whether the state government of Bihar’s failure to effectively take steps to improve maternal health care despite high maternal mortality and morbidity ratios violates key provisions of international law as enshrined in the ICCPR, the ICESCR, and the CEDAW, and whether, by this failure, the government of Bihar has violated India’s obligations under international law.

\section*{V. Discussion}

A State party’s failure to take steps to improve maternal health care and effectively address maternal mortality violates numerous international legal obligations, as recognized by major international human rights treaties. We note that a failure of a State to address maternal mortality violates the right to survive pregnancy, which is a basic human right that is supported by numerous rights. The state of Bihar deviates from international law obligations to which India is bound by failing to provide these protections.


\textsuperscript{27} Id.

\textsuperscript{28} Report of the Special Rapporteur, \textit{supra} note 99, ¶ 28(d).

\textsuperscript{29} Id.

\textsuperscript{30} See id.
A. Failure to address maternal mortality violates the right to survive pregnancy.

The right to survive pregnancy and childbirth is a basic human right supported in the international right to life; the right to liberty and security; the right to freedom from cruel, inhuman and degrading treatment; the right to health; the right to equality and non-discrimination; and the right to reproductive self-determination. These rights, which together form the right to survive pregnancy and childbirth, are guaranteed by international human rights treaties, including the ICCPR, ICESCR, and the CEDAW. These rights are also recognized in regional human rights treaties, national constitutions, and domestic legislation of many countries. The State of Bihar has failed to fulfill India’s treaty obligations to provide these rights and has failed to protect women’s right to survive pregnancy and childbirth.

Maternal deaths are largely preventable, and governmental failure to take effective steps to ensure survival of pregnancy indicates a breach of the right to life. The right to health does not guarantee perfect health for all people, but it does include a binding obligation on the part of states to ensure access to health care. Such access must be provided without discrimination on grounds of sex or socioeconomic background. To ensure the equal enjoyment of the rights to life and health, governments are obligated to respond to the specific health needs of men and women and to take affirmative steps to ensure that sexual and reproductive health care is accessible and available to all women. Failure to ensure access to health services that only women need results in inequality and discrimination.

The State of Bihar has the fourth highest maternal mortality ratio (MMR) in the country. Women are dying due to systemic failures in the health care system, including the high cost of health care, the lack of qualified medical staff in rural areas, the lack of appropriate transportation, as well as cultural and social barriers that deny women

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31 ICCPR, supra note 7.
32 ICESCR, supra note 8.
33 CEDAW, supra note 9.
34 See CESC Gen. Comm. 14, supra note 22, ¶ 34.
35 Human Rights Committee, General Comment 14, art. 6, 23d Sess., ¶ 8 (1984) in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 139 (2003). The Human Rights Committee has stated: The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

Id.
37 CEDAW, supra note 9, art. 12(1).
39 Petition, supra note 2, at 5.
effective and adequate access to health care.\textsuperscript{40} International treaty obligations firmly establish that these systemic failures constitute violations of human rights and the state of Bihar must address them immediately. Furthermore, international law obligates the judiciary to ensure the protection and enforcement of human rights by providing legal remedies for violations of basic fundamental and human rights.

1. The State of Bihar deviates from international human rights treaty provisions protecting the right to life.

   a. The Indian government has an affirmative international legal obligation to protect life by adopting effective measures to protect the health and life of pregnant women.

   The right to life has been accorded the highest protection by all major human rights treaties signed and ratified by India. The ICCPR provides that “[e]very human being has the inherent right to life,” which “shall be protected by law,” and that “[n]o one shall be arbitrarily deprived of his life.”\textsuperscript{41} Likewise, the UDHR states that “everyone has the right to life, liberty and security of person.”\textsuperscript{42}

   International guarantees of the right to life obligate states not merely to refrain from arbitrary killings but to take measures to safeguard individuals from arbitrary and preventable losses of life.\textsuperscript{43} The HRC has declared that governments have the affirmative duty to protect the right to life and to assure that it is guaranteed.\textsuperscript{44} Furthermore, this government duty includes measures to protect women against the unnecessary loss of life related to pregnancy and childbirth or its mismanagement.\textsuperscript{45} Governments are expected to understand the right life in broad terms\textsuperscript{46} and take positive measures to “increase life expectancy.”\textsuperscript{47} This positive obligation to protect life by adopting positive measures to protect health is especially necessary in the case of a pregnant woman because article 25 of the UDHR explicitly states that “motherhood and childhood are entitled to special care and assistance.”\textsuperscript{48} Fulfilling this obligation entails taking measures to ensure that health

\textsuperscript{40} Id. at 20.
\textsuperscript{41} ICCPR, \textit{supra} note 7, art. 6(1).
\textsuperscript{42} Universal Declaration, \textit{supra} note 11, art. 7.
\textsuperscript{43} Id. ¶ 1.
\textsuperscript{44} Id. ¶ 5.
\textsuperscript{47} Id. ¶ 5.
\textsuperscript{48} Universal Declaration, \textit{supra} note 11, art. 25.
services are accessible as well as maintaining and reporting data on pregnancy- and childbirth-related deaths of women.

International law interprets the right to life broadly. General Comment 6 of the Human Rights Committee (HRC) states that “[t]he right to life has been too often narrowly interpreted. The expression ‘inherent right to life’ cannot be properly understood in a restrictive manner and the protection of this right requires that states adopt positive measures.” Thus, the right to life includes more than merely the right to be alive, and the state has an affirmative duty to protect life in a broader sense of the word.

Treaty-monitoring bodies (TMBs) such as the HRC and the CEDAW Committee have repeatedly expressed concern over high ratios of maternal mortality and have

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50 HRC General Comment 28, supra note 45, at ¶ 10.


52 Id.

explicitly recognized maternal mortality as a violation of women’s right to life.\(^{54}\) The CEDAW Committee has specifically called for protection of women’s right to life by taking measures to prevent maternal mortality, including by “ensuring full and timely access of all women to emergency obstetric care.”\(^{55}\) Similarly, the HRC made the following recommendation to a State party after noting its high ratio of maternal mortality: “So as to guarantee the right to life, the State party should strengthen its efforts . . . in ensuring the accessibility of health services, including emergency obstetric care. The State party should ensure that its health workers receive adequate training.”\(^{56}\)

b. The state government of Bihar deviates from India’s international treaty obligations by its failure to adopt effective measures to protect the health and lives of pregnant women in Bihar.

The state government is not taking effective measures in Bihar to protect pregnant women against arbitrary and preventable losses of life. For example, the MMR in Bihar is 371 maternal deaths per 100,000 live births,\(^ {57}\) which is higher than the national average of 301 maternal deaths per 100,000 live births.\(^ {58}\) In fact, of the fifteen states surveyed in the National Family Health Survey,\(^ {59}\) Bihar is the state with the fourth highest MMR in India.\(^ {60}\) Although trends indicate that Bihar’s MMR is decreasing (400 in 2001 to 371 in 2003), declines in Bihar have been slower than other comparable states, such as Orissa’s declining MMR (427 in 2001 to 358 in 2003).\(^ {61}\) Because the state government fails to effectively adopt and implement mechanisms and policies to reduce Bihar’s MMR, it fails to take steps to protect women against the unnecessary loss of life related to pregnancy and childbirth. Thus, Bihar deviates from India’s obligations to guarantee and protect the right to life.

In addition to the state government’s failure to reduce the unacceptably high maternal mortality ratios in Bihar, the state government is failing to protect women against unnecessary loss of life by failing to ensure that necessary health care and services are accessible. For example, highly anemic women are much more likely to


\(^{57}\) Petition, supra note 2, at 15.

\(^{58}\) Id.

\(^{59}\) CENTER FOR REPRODUCTIVE RIGHTS, MATERNAL MORTALITY IN INDIA (2008), 11.

\(^{60}\) Id.

experience prolonged labor, abnormal deliveries, and death during labor. In Bihar, anemia causes 26% of maternal deaths. This number is far above the national average of 19% of maternal deaths attributable to anemia. In fact, anemia prevalence has increased from 46% to 60% in Bihar.

Anemia is easily diagnosed during antenatal check-ups and easily treated with iron and folic acid tablets. According to survey results in the Bettiah region of West Champaran District of Bihar, however, iron and folic acid tablets had been unavailable in one health center for a period of eighteen months. As a result, the state government has effectively denied pregnant women necessary treatment that has been proven to easily treat anemia and prevent the increased risk of complications during pregnancy and unnecessary maternal deaths, which deviates from India’s obligation to protect life.

Obstructed labor is another common cause of maternal mortality and morbidity. Deaths from obstructed labor are preventable if obstructed labor is detected in time through antenatal care and dealt with by skilled practitioners or through Caesarean sections where necessary. Obstructed labor accounts for a much higher percentage of maternal deaths in Bihar (24%) than it does in India on average (9.5%). These data show that existing state government plans are not effective in Bihar at targeting and curbing preventable causes of maternal mortality. By failing to effectively address these preventable and treatable common causes of maternal death in Bihar, the state government has deviated from India’s duty to take steps to effectively protect and promote pregnant women’s right to life.

2. The State of Bihar deviates from international human rights treaty provisions protecting the right to liberty and security.

   a. The Indian government is obliged to protect the right to liberty and security.

   International treaty law establishes state party responsibility to protect human liberty and security, which is essential for ensuring the right to life and a safe, dignified existence. The UDHR and the ICCPR both state that “[e]veryone has the right to liberty and security of person.” Accordingly, this “right shall be protected by law, and no one shall be arbitrarily deprived of his life.” States parties must provide protection “against
violence or bodily harm, whether inflicted by government officials or by any individual group or institution” to promote the right to security of the person.73

The right to liberty and security requires states to provide health services if the lack of services will jeopardize the liberty and security of the person.74 The Inter-American Commission of Human Rights (IACHR) has recognized that providing basic health needs is part of the right to personal security. The IACHR observed that:

The essence of the legal obligation incurred by any government . . . is to strive to attain the economic and social aspirations of its people by following an order that assigns priority to the basic needs of health, nutrition and education. The priority of the “right to survival” and “basic needs” is a natural consequence of the right to personal security.75

Additionally, the development of the right to liberty and security has been recognized by legal experts to be “one of the strongest defenses of individual integrity in the reproductive and sexual health care context.”76

b. The state of Bihar deviates from India’s obligation to protect the right to liberty and security.

The state of Bihar has failed to implement health services and provide conditions necessary for safe motherhood, and as a result, Bihar has deviated from India’s obligation to protect women’s right to liberty and security of the person. For instance, the state of Bihar has failed to effectively adopt and implement measures to address the lack of adequate equipment, medicine, and services.77 Additionally, Bihar’s health facilities lack proper equipment such as beds, machines to measure blood pressure, and scales.78 The state government’s failure to address the maternal mortality ratio and provide accessible health services during pregnancy and after child birth implicates women’s right to liberty and security.79

3. The State of Bihar has failed to abide by international human rights treaty provisions protecting the right to freedom from cruel, inhuman and degrading treatment.

73 See ICESCR, supra note 8, art. 5(b).
76 COOK & DICKENS, supra note 74, at 30.
77 Petition, supra note 2, at 34.
78 Id.
79 See Cook et al., supra note 75, at 161.
a. The Indian government must protect the right to freedom from cruel, inhuman, and degrading treatment.

Several international human rights treaties recognize the right to freedom from cruel, inhuman, and degrading treatment. The UDHR and ICCPR establish that “[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”

In addition, international treaties obligate States parties to actively prevent these acts. States parties must “protect both the dignity and the physical and mental integrity of the individual,” and they have a positive obligation toward persons who are particularly vulnerable. Furthermore, States parties have a duty to “afford everyone protection through legislative and other measures as may be necessary.” Consequently, the national government must improve maternal health care whether the harm is inflicted by people acting in their official capacity, outside their official capacity or in a private capacity.

In situations in which a government’s refusal to provide essential health services may have constituted a violation of freedom from inhuman and degrading treatment, courts and international human rights bodies have applied this right to require states to provide essential health services in the sexual and reproductive context. The HRC provides that the purpose of this provision is to “protect both the dignity and the physical and mental integrity of the individual” and that it “relates not only to acts that cause physical pain but also to acts that cause mental suffering to the victim.” Thus, a State party could be held liable for violating its duty to protect the life and dignity of pregnant women if it fails to ensure access to essential obstetric care, because the physical and mental anguish resulting from the denial of such care could constitute inhuman treatment.

b. The state government of Bihar deviates from India’s obligation to protect pregnant women’s right to freedom from cruel, inhuman, and degrading treatment by failing to ensure access to essential obstetric care in Bihar.

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80 Universal Declaration, supra note 11, art. 5; ICCPR, supra note 7, art. 7.
81 See Human Rights Committee, General Comment No. 20 to the International Covenant on Civil and Political Rights (Art. 7), 44th Sess., ¶ 2 in Compilation of General Comments and General Recommendations Adopted by the Human Rights Treaty Bodies, UN Doc. HRI/GEN/1/Rev.1. at 30 (1992) [hereinafter HRC, Gen. Comment 20].
83 Human Rights Committee, General Comment No. 21, Replaces general comment 9 concerning humane treatment of persons deprived of liberty (Art. 10) 44th Sess., ¶ 3, UN Doc. HRI/GEN/Rev.6 at 153 (2003).
84 Id.
85 Id.
87 HRC, Gen. Comment 20, supra note 81.
88 Id. ¶ 5.
89 Cook et al., supra note 75.
The state government of Bihar’s failure to effectively reduce high maternal mortality ratios and to provide essential obstetric care in Bihar deviates from India’s duty to protect women’s right to freedom from cruel, inhuman and degrading treatment. Specifically, the state government has failed to address shortages of gynecologists and obstetricians, inadequate health facilities, and the lack of skilled birth attendants to assist in home-based deliveries, which contribute to Bihar’s weak essential obstetric care services.90 The government of Bihar has also failed to adequately promote institutional deliveries by trained health care personnel as well as the benefits of antenatal, prenatal and postnatal care.91 The lack of basic reproductive services, including emergency and other essential obstetric care, contributes dramatically to maternal deaths.92

Many maternal deaths arise from preventable health complications, and Bihar’s failure to address this issue also deviates from India’s obligation to protect the right to freedom from cruel, inhuman, and degrading treatment. The state government of Bihar has caused mental and physical trauma to women by denying them minimum standards of essential medical treatment, which also may be considered cruel, inhuman and degrading treatment. For example, there is evidence of doctors mistreating patients, leaving patients lying on floors without access to rooms, and denying treatment outright to women.93 The state government’s failure to ensure essential maternal health services during pregnancy and after childbirth, which leads to unnecessary physical pain and mental anguish, deviates from established women’s rights and amounts to cruel, inhuman, and degrading treatment.

4. The State government of Bihar deviates from international human rights treaty provisions protecting the right to health.

   a. The Indian government must protect the right to health, which is a comprehensive right that extends to maternal health, including the underlying determinants of reproductive health.

The right to health is “a fundamental human right indispensable for the exercise of other human rights.”94 The ICESCR establishes that “[e]very human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.”95 The right to health encompasses “the right to control one’s health and body, including sexual and reproductive freedom.”96 International law requires states to promote women’s right to health by providing access to “a full range of high quality and affordable health care, including sexual and reproductive services.”97 In addition to being physically accessible and affordable, services must be widely available, provided in a

90 Petition, supra note 2, at 2.
91 Id.
92 Id. at 18.
93 Id. at 36.
95 Id. art. 12.1.
96 Id. ¶ 8.
97 Id. ¶ 21.
manner acceptable to women, and of high quality.\textsuperscript{98} States must also remove any barriers that deny women access to sexual and reproductive health services, information, and education.\textsuperscript{99} The CESCR interprets the right to health as an inclusive right extending to “the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.”\textsuperscript{100}

In his report on maternal mortality worldwide, the former Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health stated that the right to the highest attainable standard of health “entitles women to services in connection with pregnancy and the post-natal period, and to other services and information on sexual and reproductive health.”\textsuperscript{101} Specifically, these entitlements oblige states to provide key technical interventions for the prevention of maternal mortality, including access to a skilled birth attendant, emergency obstetric care, education and information on sexual and reproductive health, safe abortion services where not against the law, and other sexual and reproductive health-care services.\textsuperscript{102}

Additionally, the former Special Rapporteur has emphasized that the right to health “should also be understood more broadly as an entitlement to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all.”\textsuperscript{103} This entitlement is of special importance in the case of maternal mortality.\textsuperscript{104} To prevent maternal mortality, a priority intervention for states is to ensure functioning primary health-care systems, “from community-based interventions to the first referral-level facility at which emergency obstetric care is available.”\textsuperscript{105}

CEDAW requires State parties to “ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”\textsuperscript{106} The CEDAW Committee has issued a General Recommendation that discusses the nature of state obligations in relation to the right to health care during pregnancy and childbirth. Noting the “risk of death or disability from pregnancy-related causes” women face because they lack the funds to obtain or access the necessary services, which include antenatal, maternity and post-partum services, the CEDAW Committee states that it “is the duty of States parties to ensure women’s right to safe motherhood and emergency

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\textsuperscript{98} \textit{Id.}
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\textsuperscript{100} CESCR Gen. Comm. 14, \textit{supra} note 22, at ¶ 11.
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\textsuperscript{102} \textit{Id.}
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\textsuperscript{103} \textit{Id.} ¶ 14.
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\textsuperscript{104} \textit{Id.}
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\textsuperscript{105} \textit{Id.} ¶ 16.
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\textsuperscript{106} CEDAW, \textit{supra} note 9, art. 12.
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obstetric services and they should allocate to these services the maximum extent of available resources.” 107

b. Maternal health is a core obligation.

The CESCR states that although the ICESCR provides for the progressive realization of the right to health and acknowledges limits to available resources, it also imposes certain “core obligations” that are to take immediate effect. 108 Maternal health care has been deemed a core obligation, including pre- and post-natal care; access to health facilities, goods and services without discrimination, especially for vulnerable or marginalized groups; and equitable distribution of all health facilities, services and goods. 109 Other immediate obligations in relation to the right to health include the duty to take “deliberate, concrete and targeted steps” towards fulfilling the right to health110 and to “give effect to the relevant legal duties,” including through domestic legal, administrative and other appropriate remedies.111 The CESCR describes core obligations as duties “to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care.”112 Actions or omissions violating the core obligations constitute serious violations of the right to health.113 As the CESCR emphasizes, “a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations . . . which are non-derogable.”114 In this context, the provision of maternal health care and non-discriminatory access to maternal health services constitute absolute and unqualified obligations of States.

Hence, even under the progressive realization analysis, states with resource constraints like India are obligated to take steps that are “deliberate, concrete and targeted towards the full realization of the right to health” and cannot abdicate responsibility for their failures by arguing resource constraints. 115 According to the CESCR, a “State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its [right to health] obligations.”116

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107 Id. at ¶ 27; see also id. at ¶17 (“[T]he duty to fulfill rights places an obligation on States parties to take appropriate legislative, judicial, administrative and budgetary, economic measures to the maximum extent of their available resources to ensure that women realize their rights to health care. Studies such as those which emphasize the high maternal mortality and morbidity ratios worldwide . . . provide an important indication for States parties of possible breaches of their duties to ensure women’s access to health care.”).
108 CESCR Gen. Comm. 14, supra note 22, ¶ 44. According to the Special Rapporteur, “progressive realization means that a State is required to be doing better in five years time than it is doing today.” See Report of the Special Rapporteur, supra note 99, ¶ 55.
109 Id. ¶¶ 43(a), 43(e), 44(a).
110 Id. ¶ 30.
113 OHCHR & IBA, supra note 111, at 738.
114 CESCR Gen. Comm. 14, supra note 22, ¶ 47.
115 Id. ¶ 30.
116 Id. ¶ 47.
In addition to the CESCR recognition of maternal health as a core obligation, the international community has recognized maternal mortality reduction as a top priority in other ways as well. In 1994, the International Conference on Population and Development adopted key benchmarks, which have since been reaffirmed in subsequent international meetings, and which India has adopted. These benchmarks state that by 2015, countries with the highest levels of maternal mortality should aim to achieve a maternal mortality ratio of below 75 per 100,000 live births. By 2010, in countries where the maternal mortality ratio is very high, 50% of all births should be assisted by skilled attendants, and by 2015, that figure should be at least 60%. Furthermore, by 2015, all primary health care and family planning facilities should aim to provide, directly or through referral, essential obstetric care. Another key benchmark is to reduce the maternal mortality ratio by three quarters by 2015. The Millennium Development Goals (MDGs) have also set the target of reducing maternal mortality by three quarters by 2015. Furthermore, India committed under the MDGs to lower the MMR to 200 by 2007 and to 109 by 2015; India has already failed to meet the former benchmark.

c. International treaty obligations establish minimum standards for maternal health care.

The CESCR has established a four-pronged standard for the provision of health care, including maternal and reproductive health care: (1) availability, (2) accessibility, (3) acceptability, and (4) quality. These elements are both “interrelated and essential.”

i. Availability

For health services to be available, states parties must provide, in sufficient quantity, functioning public health and health-care facilities, goods and services, as well as programs. “Functioning” should be interpreted to include fully staffed primary health centers which are open for regular business hours and provide for emergency obstetric care. Availability includes adequate provision of underlying determinants of health care, such as safe and potable drinking water and adequate sanitation facilities,
hospitals, clinics, and other health-related buildings, and trained medical and professional personnel receiving domestically competitive salaries. Availability also includes essential drugs, as defined by the World Health Organization Action (WHO) Program on Essential Drugs, including drugs necessary to save women’s lives during pregnancy.

ii. Accessibility

This requirement includes four dimensions: (1) nondiscrimination in services even (and particularly) to the most marginalized sections of the population, (2) physical accessibility of health services and the underlying determinants of health such as potable water and adequate sanitation facilities, (3) economic accessibility (affordability) of health facilities, goods, and services, including underlying determinants of health, and (4) information accessibility, which includes the right to receive information relating to health. The Special Rapporteur has established that accessibility to essential medicines is a fundamental element of the right to health, and a core obligation not subject to progressive realization. Moreover, accessibility requires that health facilities, goods, and services must be provided in a timely manner.

iii. Acceptability

All health facilities, goods, and services must be respectful of medical ethics and be culturally appropriate, as well as being designed to respect confidentiality and be sensitive to gender requirements. This includes ensuring the availability of female providers and doctors where their absence may deter women from seeking health care. According to the CEDAW Committee, “[a]cceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.” As such, the government also has an obligation to prevent coercion in the sexual and reproductive health context.

iv. Quality

Health facilities, goods, and services must be scientifically and medically appropriate and of good quality. This includes requiring skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. Poor quality care is not only a major cause of maternal

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129 Id.
130 Id.
131 Id. ¶ 12(b).
133 ICESCR, supra note 8, ¶¶ 3, 4.
134 Id. ¶ 12(c).
136 Id. ¶ 12(d).
137 Id.
death and complications, but it can lead to the underutilization of maternal health services among pregnant women, especially antenatal care.138

The Committee has emphasized that states are obligated to go beyond merely establishing health care facilities; rather, states parties must ensure that such facilities are functional, affordable, good quality, and take into consideration the need for women to have access to the underlying determinants of health care such as clean water and sanitation. While discussing women’s health, the CESCR has emphasized the need for state parties to provide a full range of high-quality and affordable services, including sexual and reproductive health care services and reiterated the importance of states’ obligation to reduce the risks to women’s health and reduce maternal mortality ratios.139

d. Maternal mortality is inextricably linked to State party violations of the right to health.

The CESCR has consistently expressed concern to state parties about high maternal mortality ratios which the Committee views as constituting a violation of the right to health. The CESCR interprets Article 12(2)(a) of the ICESCR as including the right to maternal, child and reproductive health, which requires states parties to implement measures to “[i]mprove child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.”140

The CESCR has observed that inadequate health and family planning services are one of the primary factors contributing to a high maternal mortality ratio.141 To address this problem, it has recommended that state parties take constructive measures to address the problem, through the review of health policies142 and restrictive legislation143 and the implementation of programs that increase women’s access to comprehensive reproductive health care.144

138 Manju Rani, et al., Differentials in the Quality of Antenatal Care in India, INT’L J. FOR QUALITY IN HEALTH CARE 8 (2007).
140 Id. ¶ 14.
e. The state government of Bihar deviates from India’s obligation to protect the right to health when it fails to ensure the availability, accessibility, acceptability, and quality of health care services, especially maternal health care services, to pregnant women in Bihar.

The state government is failing to provide available, accessible, and acceptable health care services of good quality based on its own determination of the required number of health care facilities in Bihar. Thus, the state of Bihar is not living up to India’s obligation to take positive measures to protect the health and lives of pregnant women in Bihar.

The government of Bihar is ineffective in addressing common causes of maternal mortality because it does not ensure the availability of and access to health care services, which are essential components of India’s obligation to protect the right to health. As the petition in this case states, “[t]he public health facilities providing obstetric and gynecological care . . . are inadequate,” falling below the minimum quality required to meet international health standards. In Bihar, the state government has fallen short of meeting its own benchmarks by failing to provide the number of hospitals, sub-division hospitals, referral hospitals, primary health centers and sub-centers that it has itself deemed necessary to meet the needs of its population. Additionally, as mentioned above, Bihar has an inadequate supply of essential health items like “BP machines, weighing scales, [and] safe delivery kits,” and a shortage of the gynecologists and obstetricians in rural areas. Moreover, Bihar ranks thirty-fifth in the country in providing primary health care infrastructure and reproductive and child health care.

Some basic solutions exist for preventing maternal deaths. Experts believe that these steps could help prevent almost seventy-five percent of all maternal deaths: oxytocin and misoprostol for preventing deaths due to hemorrhage; Caesarean section for preventing deaths due to obstructed labor; family planning and safe abortion services, including medical abortion and manual vacuum aspiration, for preventing deaths due to unsafe abortion; antibiotics for preventing deaths due to sepsis/infection; and magnesium sulfate for preventing eclampsia.

145 See Petition, supra note 2, passim.
147 Petition, supra note 2, at 27.
148 See supra text accompanying notes 133–138.
149 Petition, supra note 2, at 16 (“Although the government requires 38 District Hospitals, only 23 are in place. Of 100 required Sub-division Hospitals only 23 are in place. Of the 800 required Referral Hospitals only 70 are in place. Of the required 2,700 Primary Health Centers only 398 are in place. Of the required 16,000 Sub-centers only 9140 are in place.”).
150 Id. at 27.
151 Id. at 16.
152 FAMILY CARE INTERNATIONAL, FOCUS ON 5: WOMEN’S HEALTH & THE MDGs (Briefing Cards) (unpublished preview copy, on file at CRR), cited in CENTER FOR REPRODUCTIVE RIGHTS, supra note 59.
Early detection of high-risk pregnancies through antenatal check-ups and treatment of complications during birth can reduce the number of maternal deaths, but because inadequate reproductive health care services and facilities exist in Bihar, such prevention and treatment is not possible. According to the National Family Health Survey, 65.7% of women in Bihar do not receive any antenatal care and only 17% have three or more antenatal care visits. Often, women do not receive adequate information or are constrained by cost, distance from medical facilities, permission from their families, and access to family planning services.

Other factors that could lower the ratio of maternal death are also not adequately addressed in Bihar. Only 28.6% of women receive institutional delivery, and only a slightly higher percent of all deliveries, 29.5%, are attended by skilled persons. Similarly, women in Bihar are unlikely to receive postpartum care, which is also essential because the period after birth is critical for women’s maternal survival ratios and studies show that a large number of maternal deaths occur in the post-partum phase.

5. The State of Bihar violates international human rights treaty provisions protecting the right to equality and non-discrimination.

A high maternal mortality ratio is indicative of deeply entrenched discrimination and systematic gender inequality. In fact, “[t]here is no single cause of death and disability for men aged fifteen to forty-four that is close to the magnitude of maternal death and disability.” A State party’s obligation to ensure basic human rights without discrimination, including discrimination against women, has been enshrined in many international human rights documents.

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153 Petition, supra note 2, at 19.
154 See id.
155 See id. at 19–20.
156 Id. at 26.
157 See id. at 21.
159 See CENTER FOR REPRODUCTIVE RIGHTS, supra note 59, at 30.
a. International human rights treaty provisions to which India is State party guarantee the right to equality and non-discrimination.

The ICCPR contains an anti-discrimination provision as well as an equality provision that states that:

[a]ll persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as . . . sex . . . national or social origin . . . birth or other status. ¹⁶²

Similarly, the ICESCR commits states to “undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.”¹⁶³ Furthermore, under the CEDAW, states have a positive obligation to introduce special measures of protection for women during pregnancy.¹⁶⁴ The CEDAW Committee has clearly set out the government’s positive obligation to “ensure women’s right to safe motherhood and emergency obstetric services”¹⁶⁵ and has instructed states to “allocate to these services the maximum extent of available resources.”¹⁶⁶

Because only women can become pregnant, violations of the right to survive pregnancy and the right to maternal health only affect women. Denying health protection that only women need results in inequality and discrimination.¹⁶⁷ The CEDAW Committee has stated that

[m]easures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect, and treat illnesses specific to women. It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women.¹⁶⁸

¹⁶² ICCPR, supra note 7, art. 26.
¹⁶³ ICESCR, supra note 8.
¹⁶⁴ CEDAW, supra note 9, art. 11(2)(a) (prohibition, subject to sanctions, dismissal on the grounds of pregnancy or maternity leave), art. 11(2)(d) (obligation to provide special protection to pregnant women in types of work proved to be harmful to them), art. 12(2) (obligation to ensure appropriate and free where necessary, ante-natal, intra-natal and post-natal services and adequate nutrition during pregnancy and lactation).
¹⁶⁵ CEDAW Comm., Gen. Rec. 24, supra note 26, ¶ 27.
¹⁶⁶ CEDAW, supra note 9, art. 26; see also CEDAW Comm., Gen. Rec. 24, supra note 26, ¶ 27 (stating that “the duty to fulfill rights places an obligation on States parties to take appropriate legislative, judicial, administrative and budgetary, economic measures to the maximum extent of their available resources to ensure that women realize their rights to health care. Studies such as those which emphasize the high maternal mortality and morbidity ratios worldwide . . . provide an important indication for States parties of possible breaches of their duties to ensure women’s access to health care”).
¹⁶⁸ Id. ¶ 11.
Thus, if the national government does not provide appropriate pregnancy-related health services, it violates women’s right to equality and non-discrimination. The CESCR has further elaborated on the right to health and the principles of non-discrimination on the basis of equal treatment by observing that women’s inability to access reproductive health care is discriminatory since it deprives them of their ability to fully enjoy the economic, social and cultural rights on an equal basis with men.169 The HRC notes that women’s equality is essential to their ability to enjoy and exercise all other rights guaranteed by the ICCPR, including the right to life.170

Under the CEDAW, States parties are legally obligated to “condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women.”171 The CEDAW also obliges states parties to “refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation.”172

i. Discriminatory practices and stereotypes

State parties’ obligation to eliminate discrimination in access to health care includes the responsibility to take into account the manner in which “societal factors,” which can vary among women, determine health status.173 Child marriage is one such societal factor that the national government has the legal duty to eliminate. The U.N. Special Rapporteur on Violence Against Women highlighted child marriage as a form of violence against women in part because child marriage jeopardizes girls’ health and lives due to early pregnancy and childbirth.174 The Committee on the Rights of the Child (CRC) has noted with concern the connection between child forced marriage and high maternal and infant mortality ratios.175 Additionally, stereotypes about women as procreators also fall within the “societal factors” that the State party has the duty to eliminate. CEDAW clearly states that “the role of women in procreation should not be a basis for discrimination”176 and guarantees women’s right to control their fertility by requiring State parties to ensure women have “the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.”177

ii. Inequality in marriage and family relations

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170 HRC General Comment 28, supra note 45, at ¶ 2.
171 CEDAW, supra note 9, art. 2.
172 Id. art. 15
173 Id. ¶ 6.
174 Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, Cultural practices in the family that are violent towards women, ¶ 56, U.N. Doc E/CN.4/2002/83 (2002) (“She will have to submit to sex with an older man and her immature body must endure the dangers of repeated pregnancies and childbirth.”).
176 CEDAW, supra note 9, pmbl.
177 Id. art. 16(e).
Equality within marriage is a basic human right. Women must be able to make important decisions about marriage and pregnancy free from violence and coercion, and must be able to protect themselves against major health risks. This right to equality within marriage is set out in the CEDAW, which says that states must “eliminate discrimination against women in all matters relating to marriage and family relations” and in the ICCPR, which obligates States parties to take affirmative measures to ensure equality in marital relationships. According to the CEDAW Committee, eighteen is an appropriate legal age of marriage. Thus, State party failures to prevent child marriage, with its accompanying harms such as the risk of early pregnancy and childbirth, violates the right to equality within marriage.

iii. Vulnerable subgroups of women

Women who are members of low-income and marginalized social groups are among the most vulnerable and disadvantaged. The CEDAW Committee has noted that “special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups.” Further, the CESCR has stated that State parties must ensure “equitable distribution of all health facilities, goods and services” and that these obligations must be met “even in times of resource constraints.” Adolescent girls receive further special protections through the CRC, which obligates States parties to ensure adolescents’ access to comprehensive reproductive health services.

b. The state government of Bihar has deviated from the international obligation to guarantee pregnant women’s and girls’ right to equality and non-discrimination in Bihar.

The Bihar government has failed to protect women’s right to survive pregnancy and their right to maternal health; therefore, it has deviated from India’s duty to guarantee women and girls’ right to equality and non-discrimination because such deviations disproportionately affect women in Bihar. For example, 42.60% of Bihar’s population is below the poverty line, and low-income women are particularly vulnerable to discrimination.

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178 Universal Declaration, supra note 11.
179 CENTER FOR REPRODUCTIVE RIGHTS, supra note 59, at 32.
180 CEDAW, supra note 9, art. 16(1).
181 ICCPR, supra note 7, art. 23(4).
183 Id.; see also CESCR Gen. Comm. 14, supra note 22 (“In particular, States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including . . . minorities . . . to preventive, curative and palliative health services.”).
184 CENTER FOR REPRODUCTIVE RIGHTS, supra note 59, at 33 (citing CESCR, Gen. Comm. 14, supra note 22, ¶ 43(e)).
185 Id. (citing CESCR, Gen. Comm. 14, supra note 22, ¶ 18).
186 Id. (citing Children’s Rights Convention, supra note 161, art. 24(1)).
187 Petition, supra note 2, at 16.
Additionally, the state government has not effectively curbed other societal factors, even certain societal norms prohibited by law, that deviate from India’s obligation to ensure women’s’ and girls’ right to equality and non-discrimination in Bihar. For example, women in Bihar often cannot access any available health care systems because they do not hold decision-making power within the family structure and thus may not get permission to access health care from powerful family decision makers like husbands or mothers-in-law. Furthermore, in Bihar, 51.5% of girls marry below the legal age of marriage. By failing to enforce laws or curb social norms that adversely affect women and girls’ health and lives in Bihar, the state government of Bihar has deviated from India’s duty to guarantee their right to equality and non-discrimination.

6. Bihar has failed to satisfy international human rights treaty provisions protecting the right to reproductive self-determination.

   a. The Indian government must provide women adequate resources to attain reproductive self-determination.

   International guarantees of the right to determine the number and spacing of children and the right to privacy support women’s right to reproductive self-determination. The CEDAW Committee requires States parties to ensure that women have the right to control their fertility and to obtain family planning information, counseling, and services without discrimination. To protect women’s rights to reproductive self-determination in the context of pregnancy, States parties must take holistic approaches toward women’s health. Countries must ensure access to a full range of family planning methods and services; access to safe abortion services; the availability of non-biased, medically accurate information about sexual and reproductive health; and safeguards against violations of confidentiality, privacy, and quality of care.

   Reproductive self-determination further implies the right to be free from all forms of violence, discrimination and coercion that affect a woman’s reproductive or sexual life, such as nonconsensual sex and coercive sterilization. The fulfillment of these obligations is essential for protecting women’s autonomy, bodily integrity, and dignity, which are key attributes of the right to reproductive self-determination. Included in this obligation are measures to protect women and girls against discriminatory practices such as early marriage.

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188 See id. at 20.
189 Id. at 24.
190 CEDAW, supra note 9, art. 16.1.
191 ICCPR, supra note 7, art. 17.1.
192 CEDAW, supra note 9, arts. 10, 12(1).
b. The state government of Bihar has deviated from India’s obligation to provide women adequate resources to attain reproductive self-determination in Bihar.

The state government does not afford women reproductive self-determination in Bihar, even as compared to national averages. For instance, access to reproductive health care information and services is critical to reproductive self-determination. The percentage of women or husbands using any family planning method in Bihar, however, is 31%, which is well below the percentage of all Indian women or husbands who use a family planning method (53%). \(^{194}\) The percentage of women using a modern family planning method in Bihar is even lower (27%). \(^{195}\) Furthermore, Bihar deviates from the national government’s duty to protect women’s and girls’ right to reproductive self-determination by failing to enforce the legal age of marriage. \(^{196}\)

B. Concerns expressed by TMBs and independent experts about maternal mortality in India.

Treaty monitoring bodies (TMBs) and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health have specifically highlighted India’s failure to uphold its obligations under international law to ensure improvement of maternal health and to reduce maternal mortality and morbidity. These obligations stem from the country being a party to major human rights instruments that guarantee to women, the right to life, the right to health, including reproductive health, the right to equality and non-discrimination, the right to be free from cruel, inhuman, and degrading treatment, and the right to liberty and security. TMBs have consistently expressed concern about the high number of maternal deaths in India as a consequence of the lack of access to appropriate maternal health care services and the poor quality of care that undermines the safety of institutional deliveries. The following sections highlight some of these concerns.

1. Concluding Observations of TMBs to India

The CESCR has established a clear link between high ratios of maternal mortality and blatant violations of the right to health. \(^{197}\) In its Concluding Observations to the Government of India in 2008, it expressed deep concern about the state of health care in the country in general and maternal mortality in particular. Notwithstanding the economic growth achieved by India, the CESCR noted how health-care expenditures remained exceptionally low (around one percent of GDP), and that a significant

\(^{194}\) See Petition, supra note 2, at 24.
\(^{195}\) See id.
proportion of the population continues to have limited or no access to basic health services, resulting in alarmingly high ratios of maternal and infant mortality.

In its Concluding Observations to the Government of India in 2008, the CESCR attributed India’s high incidence of maternal mortality mainly to the absence of sex education and the lack of progress in eliminating child marriage. The Committee has urged the government to “expand availability and accessibility of reproductive and sexual health information and services for everyone, and ensure that the educational programmes, including within the school curriculum, as well as services on sexual and reproductive health, are widely available.” The Committee has also emphasized the need for stronger measures to eliminate child marriage.

The CESCR has also expressed concern about India’s position with regard to its legal obligations arising under the ICESCR, specifically, that the realization of the rights it contains are entirely progressive in nature. As discussed, the protection of maternal health is a core obligation, and violations of core obligations are tantamount to the violation of the right to health. The Committee was also concerned that, despite the Indian Supreme Court interpreting the Constitution with a view to achieving justiciability of economic, social, and cultural rights, the ICESCR is not given its full effect in the Indian legal system due to the absence of relevant domestic legislation and the non-implementation of court decisions by state authorities.

The CESCR further observed that all statistical data made available to the Committee was reflective of women being at a disproportionate disadvantage, particularly those women who belong to marginalized groups and are thus unable to enjoy the economic, social, and cultural rights to which they are entitled. The Committee expressed its unease with regard to the high ratio of maternal mortality and the poor quality and availability of health services provided under the universal health care scheme. CESCR attributed this to large-scale privatization of health services, leading to the unavailability of universal coverage and unfortunate consequences for the poorest sections of the population, who are unable to afford private health care.

The CESCR strongly recommended that India increase its expenditure on health care and accord the highest priority to reducing maternal and infant mortality ratios by taking effective measures to successfully implement the National Rural Health Mission. The government could thus ensure the “quality, affordability and accessibility of health services without hidden costs,” especially for disadvantaged and marginalized groups.

198 CENTER FOR REPRODUCTIVE RIGHTS, supra note 59, at 34.
199 Id. (citing CESCR, India, infra note 200, ¶ 37).
201 Id. ¶ 9.
202 Id. ¶ 16.
203 Id. ¶ 37.
204 Id. ¶ 38.
205 Id. ¶ 73.
Although it expressed concern about the poor quality of services provided by the public health care system, CESCR also recommended that the government increase funding for public health and take concrete steps to ensure universal access to primary health care.206

Likewise, the CEDAW Committee has consistently expressed concern about the status of women’s health, particularly the maternal mortality ratio in rural areas, which is among the highest in the world, and inadequacy of services relating to emergency obstetric care.207 In 2007, the Committee specifically noted with concern the high prevalence of “malnutrition; anemia; unsafe abortions; HIV infections” and the “inadequacy of services relating to obstetric family planning.”208 Although acknowledging the programs formulated by the government to improve women’s access to health care and to decrease maternal mortality, the CEDAW Committee also noted the lack of information about the impact of such programs and measures on the ground, the lack of reliable data on the health of women, including on pregnancy-related and non-pregnancy related morbidity and mortality because of which it is unable to monitor progress.209 The CEDAW Committee has strongly urged India to pay closer attention to women’s health, especially in the key areas of pregnancy and non-pregnancy related morbidity and mortality.210 The CEDAW Committee has specifically recommended that India prioritize reducing maternal mortality ratios by ensuring sufficient obstetric care and ensuring that all barriers preventing access to health care services are removed.211 With regard to public health services, the CEDAW Committee noted with concern the privatization of health services and recommended that India focus on balancing the role of public and private health providers to maximize resources and the reach of health services.212

The CERD has observed that members of scheduled castes and tribes are disproportionately affected by infant, child, and maternal mortality and that access to health care facilities is either completely unavailable or substantially reduced in tribal areas.213 The Committee noted the overall poor state of health care in tribal areas, where services are either absent or of a lower quality than in non-tribal areas.214 In this context, the CERD has recommended that the government of India make concerted efforts to ensure equal access to adequate health care facilities and reproductive health services.215 The CERD further identified the dire need for the government to increase the number of health care professionals in the primary health centers and the health sub-centers in the tribal and rural areas.216 Furthermore, the Committee has asked the government to

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206 Id. ¶¶ 73, 78.
208 CENTER FOR REPRODUCTIVE RIGHTS, supra note 59, at 35 (citing CEDAW, India, supra note 207, ¶ 14).
209 See CEDAW, India, supra note 207, ¶ 40.
210 Id. ¶ 41.
211 Id.
212 Id. ¶ 40–41.
213 Id. ¶ 24.
214 CENTER FOR REPRODUCTIVE RIGHTS, supra note 59, at 35.
215 CEDAW, India, supra note 207, ¶ 24.
216 Id.
formally recognize members of tribal groups as entitled to special protection under international law.  

The Committee on the Rights of the Child has also expressed concern about the “very high percentage of early and forced marriages of girls” which the Committee noted “can have a negative impact on their health, education and social development.” The Committee recommended that the government take the following actions: implement legislation prohibiting child marriage; strengthen programs to prevent early marriage; and strengthen reproductive health education and counseling for adolescents and ensure that these services are accessible.  

Finally, the HRC also expressed grave concern about India’s failure to give effect to legislation prohibiting child marriage and emphasized the need for action to “change the attitudes which allow such practices.” In its recommendations to the Government of India in 1997, the Committee urged the government to introduce stronger measures to protect women from “all discriminatory practices, including violence.”  

2. Report of the Special Rapporteur on India’s obligations concerning maternal health

Former Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health Paul Hunt visited India in December, 2007. His mission focused on the issue of maternal mortality with a view to understanding, in the context of the right to the highest attainable standard of health, the steps taken by India to reduce this phenomenon and to make constructive recommendations to reduce the alarming number of maternal deaths in the country.

In his preliminary report, the Special Rapporteur expressed concern about the alarming maternal mortality ratio in India, which he noted as being “shocking for a middle-income country of its stature” and higher than many similarly situated countries such as Brazil, Chile and Egypt. Based on site visits, discussions with NGO

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217 CENTER FOR REPRODUCTIVE RIGHTS, supra note 59, at 35.
218 Id. at 36 (citing Committee on the Rights of the Child, Concluding Observations: India, ¶ 90, U.N. Doc. CRC/C/15/Add.228 (2004)).
219 Id.
221 Id. (citing Human Rights Committee, Concluding Observations: India, ¶ 16, U.N. Doc CCPR/C/79/Add.81 (1997)).
representatives and meetings with government officials, some of the problems with the health system highlighted by the Special Rapporteur in his preliminary report include the following: financial bottlenecks including the underutilization of health budgets; wide variations in the quality of health care; unavailability of emergency obstetric care; emphasis on institutional delivery without sufficient attention to the range and quality of services offered in institutions; the absence of a civil registration system for maternal deaths; and inadequate regulation of public and private health services. The Rapporteur was particularly concerned by the disadvantages that rural women face in access to health care.

Many of the facilities that the Special Rapporteur visited were “dilapidated, ill-equipped and under-staffed,” revealing the lack of institutional preparedness in the public health sector. He noted that health care institutions do not provide adequate life-saving and emergency obstetric care, thereby contributing to maternal deaths among women who seek institutional support at the time of delivery.

The Special Rapporteur has strongly recommended that all state governments immediately introduce an effective registration system, as well as a system for auditing maternal deaths to examine the circumstances under which such deaths occur and to identify the social, economic, and cultural factors that cause them.

VI. Conclusion

The state of Bihar is deviating from international law obligations requiring India to address the systemic violations of women’s rights that are occurring within the state of Bihar, which are resulting in a large number of preventable maternal deaths. Women’s inability to survive pregnancy and childbirth violates a range of indivisible and interdependent human rights enshrined in treaties that India is party to, including the right to life, the right to health, the right to non-discrimination and equality, the right to freedom from cruel, inhuman and degrading treatment, the right to liberty and security, and the right to reproductive self-determination. As suggested under international human rights laws, we request that this court create appropriate judicial remedies for violations of human rights norms.

Respectfully submitted,

Date:

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226 CENTER FOR REPRODUCTIVE RIGHTS, supra note 59, at 36.
227 Id.
228 Preliminary Note, supra note 225, ¶ 11.
229 Id. ¶ 12.
230 Id. ¶ 16.