UNITED
NATIONS

A

General Assembly

Distr.
GENERAL

A/HRC/7/11/Add.4
29 February 2008

ENGLISH ONLY

HUMAN RIGHTS COUNCIL
Seventh session
Agenda Item 3

PROMOTION AND PROTECTION OF ALL HUMAN RIGHTS, CIVIL, POLITICAL, ECONOMIC, SOCIAL AND CULTURAL RIGHTS, INCLUDING THE RIGHT TO DEVELOPMENT

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Preliminary note on the mission to India

Addendum*

* The present note was submitted later than the indicated deadline, in order to incorporate the latest available information on the subject matter. Due to late submission, it is circulated as received.

GE.08-11270

Introduction

1. At the invitation of the Government, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ('right to the highest attainable standard of health' or 'right to health') visited India from 22 November to 3 December 2007.

2. The 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. The Special Rapporteur visited the states of Rajasthan and Maharashtra to engage with the authorities on their approaches to the issue. The Special Rapporteur also discussed maternal mortality with India's central Government in Delhi.

3. During the mission, the Special Rapporteur met with the Minister of Health, Dr Anbunmani Ramdoss, Minister of State for Women and Child Development, Ms Renuka Chowdhury, Minister of State for External Affairs, Mr Anand Sharma, Chairperson of the National Human Rights Commission, Mr Rajendra Babu, a number of senior officials in Rajasthan and Maharashtra as well as officials from the UN County team.

4. The Special Rapporteur is grateful to the Government of India for the invitation to undertake a mission and for the support provided before, during and after the mission.

5. This Note provides some preliminary observations arising from the mission. The Special Rapporteur will submit his mission report to the Human Rights Council in September 2008, and will go beyond the brief observations presented in this Preliminary Note.

Maternal mortality

6. Globally, over 500,000 women die each year in childbirth or during pregnancy, leaving over a million motherless children. Crucially, the great majority of these maternal deaths are preventable.

7. The Special Rapporteur underlines that maternal death is not only a health issue. It is also a human rights issue, relating to - for example - women's rights to life, health, equality and non-discrimination.

8. In India, 100,000 women die yearly in India during childbirth or pregnancy. There is an average of 300 maternal deaths for every 100,000 live births in India, which is higher than in many other middle-income and some low-income countries[1]. Furthermore, in some of the country's states, the situation is considerably worse – for

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[1] Brazil – 110 deaths for every 100,000 live births; Chile - 16; China – 45; Cuba-45; Egypt - 130; Namibia – 210; Sri Lanka – 58 (WHO, UNICEF, UNFPA, World Bank 2005).

instance, in Uttar Pradesh there are over 510 - and in Rajasthan 445 - maternal deaths for every 100,000 live births.

9. Even though the Indian rate of maternal deaths is declining, at the present rate neither India, nor any of its states, will reach their maternal mortality targets for 2015 arising from the Millennium Development Goals (MDGs). Financial bottlenecks, often caused by insufficient absorptive capacity, obstruct India's progress towards achieving its MDGs. In some local authorities, over 50% of the health budget is unutilised.

10. The Special Rapporteur commends and supports the efforts of the Government for introducing policies designed to improve maternal health and reduce maternal deaths. He commends the Government's commitment to increase funds for the public health sector, as well as for establishing the National Rural Health Mission, an ambitious initiative that represents a very significant step in the right direction.

11. However, the Special Rapporteur was concerned about the uneven level of healthcare services in Rajasthan and Maharashtra. During the mission, the Special Rapporteur visited a number of public sector health facilities in both states, from very large hospitals to very small health posts in slums and rural areas. Regrettably, some of these facilities were clearly seriously inadequate: dilapidated, ill-equipped, under-staffed, and offering very low-quality services. However, some other public sector facilities he visited were inspirational: community-supported, well-equipped and staffed by dedicated teams of health and other workers.

12. By adopting various measures, the central and state authorities have successfully managed to increase the number of women delivering babies in public health facilities. In other words, they have increased the demand for services in the public sector. But, in many cases, the range and quality of services offered in those facilities has been seriously neglected. In short, the supply-side has received too little attention. The focus has been on increasing institutional delivery – but institutional delivery does not always provide access to life-saving care, such as emergency obstetric care, and therefore cannot be regarded as a proxy for access to life saving care.

13. It is imperative that the sequencing of reforms ensures a balance between the demand-side and supply-side. Getting pregnant women to go to facilities that do not have the services that they need is not a satisfactory outcome.

14. The Special Rapporteur also found that the authorities are collecting data on the number of institutional deliveries. However, there is little or no data on the crucial issue: access to improved life-saving care which does not appear to be automatically accompanying institutional deliveries as could have been expected.

Registration system and maternal death audits

15. The Special Rapporteur noted with concern that there is no effective, reliable and comprehensive civil registration system for accurately reporting births and deaths in India. There is evidence that women are silently dying in childbirth and during

pregnancy. As many of these deaths are not registered, they remain uncounted and unreported.

16. The Special Rapporteur strongly recommends that all States introduce, as a matter of urgency, a comprehensive, effective registration system, as well as a system of maternal death audits, such as those already in existence in Tamil Nadu and on a pilot basis in Rajasthan. It is of the utmost importance that all the circumstances of maternal deaths are examined in order to find out why the death occurred. A maternal death audit should be a non-judicial review, one that goes beyond medical reasons to identify the social, economic and cultural reasons that led or contributed to the death.

17. The emphasis of the maternal death audits should be on fact-finding rather than fault-finding. In this way, they can help to identify the structural and systemic failures that are leading to women's preventable deaths.

Health workers

18. The Special Rapporteur was concerned about the massive, crippling crisis in India's health workforce. In many areas, life-saving care is unavailable to women giving birth. Rural and disadvantaged areas are those most likely to be without a provider in public facilities. This compels many women either to go without any care at all, or to go to the private sector for life-saving services that should be publicly available for free. Recourse to the private sector impoverishes many women and their families.

19. A human rights approach will call for all health practitioners to contribute to the provision of predictable and sustainable medical care in public facilities in rural and underserved areas. For example, for the life of the present National Rural Health Mission (2005-2012), private practitioners should provide their services to the public authorities for one day a month at governmental rates of pay. In turn, the governmental authorities have a corresponding duty to ensure that such contributions are supported by the necessary facilities and equipment, so that the contributions have maximum impact.

20. However, such arrangements do not provide a long-term solution to a complex, systemic, workforce problem. Therefore, the Special Rapporteur strongly recommends that the Government establish, as a matter of urgency, a high-level, high-profile independent committee to prepare a report on human resources in health, both the public and private sectors, with a particular focus on the needs of rural and underserved areas. The report should be wide-ranging and include the issue of posting and transfers of staff.

National and State Health Commissions

21. The Special Rapporteur notes that, under international human rights law, governments have a binding legal obligation to ensure that third parties, including the private sector, are respectful of individuals' and communities' human rights. Especially in the absence of adequate self-regulation, this requires a State to establish an appropriate, effective, regulatory framework.

22. There are about 1.4 million health practitioners in India. Only about 10% of them are in government service. In other words, the Indian private health sector is enormous. Crucially, it is largely unregulated. Also, to a large extent, the public health authorities act as both provider and regulator, whereas it is clear that these functions should be separated. In other words, the existing monitoring and regulation of both the private and public health sectors is inadequate.

23. Accordingly, the Special Rapporteur recommends that autonomous Health Commissions be established, at the federal and State levels, reporting to their legislatures, to monitor and regulate the private and public health sectors, to ensure that they deliver quality health services to all.

24. Such Commissions need not constrain the health sector but ensure that it operates in a fair and reasonable manner, thereby securing the public's confidence

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