Nations Unies A/HRC/14/NI/11

Assemblée générale

Distr. générale
4 juin 2010
Français
Original: anglais

Conseil des droits de l'homme
Quatorzième session
Point 3 de l'ordre du jour
Promotion et protection de tous les droits de l'homme, civils, politiques, économiques, sociaux et culturels, y compris le droit au développement

Informations communiquées par la Commission nationale indienne des droits de l'homme*

Note du secrétariat

Le secrétariat du Conseil des droits de l'homme a fait tenir ci-jointe la communication présentée par la Commission nationale indienne des droits de l'homme** reproduite conformément à l'article 7 b) du règlement figurant dans l'annexe de la résolution 5/1 du Conseil des droits de l'homme, qui dispose que la participation des institutions nationales des droits de l'homme s'exerce selon les modalités et les pratiques convenues par la Commission des droits de l'homme, y compris la résolution 2005/74 du 20 avril 2005.

* Institution nationale des droits de l'homme à laquelle le Comité international de coordination des institutions nationales pour la promotion et la protection des droits de l'homme a accordé le statut d'accréditation «A».

** La communication est reproduite en annexe telle qu'elle a été reçue, dans la langue originale seulement.

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Annexe

Statement of the National Human Rights Commission of India

National Human Rights Commission – India's Views on UN Special Rapporteur's Preliminary Note Concerning the Issue of Rights to Health in India

1. The health of a nation is an essential component of development, vital to the nation's economic growth and stability. Women are significant contributors to the growing economy and children are assets of the future. Almost 50% of India's population consists of women. For growth to be truly inclusive, it is imperative to guarantee a minimal level of health care for this segment of the population so as to ensure their protection, well-being, development, participation and empowerment.

2. Ever since India achieved independence, it has built up a vast health infrastructure and health personnel at primary, secondary and tertiary care in public, voluntary and private sectors through its Five Year Plans, policies, schemes and programmes. As a result, there have been considerable achievements over the last six decades to improve health standards, such as life expectancy, child mortality, infant mortality and maternal mortality. Nonetheless, due to persistent discrimination against women and girls, especially in rural areas and among those who are illiterate, India continues to grapple with high maternal mortality rate (MMR) and increasing rates of anaemia and malnutrition among women across the country. According to National Family Health Survey-3, incidence of anaemia has risen from 49.7% to 57.9% in pregnant women and from 51.8% to 56.2% in ever-married women within a period of seven years (1998-99 to 2005-06). This has raised anaemia among children by 5 percentage points (to 79.2%) and is also partially responsible for the high MMR. Maternal mortality has a direct correlation with lack of accessibility to health care facilities including access to emergency obstetric care (EmOC). Paucity of resources and age old discriminatory practices deny large number of women access to good nutrition and care before, during, and after child birth, thus increasing their mortality. Only 22% of mothers consume Iron Folic Acid (IFA) tablets for 90 days or more, and less than half of them receive three antenatal care visits. As many as 51.7 % births take place without assistance from any health personnel. Practices such as female foeticide also affect women's health, as they are forced to go through multiple pregnancies and abortions.[1] This combined with the low proportion of institutional deliveries is a grave cause of concern. This reinforces that rapid expansion of skilled birth attendants and EmOC is needed to reduce maternal mortality in India. Other than this, the existing drawbacks in the public and private health system need to be looked into. For example, the provision of infrastructure in various States across the country is based on population norms rather than habitations leading to issues of accessibility, acceptability and utilization. The gap between requirement and availability of human resources at various level of health care is wide and where they are available, the concerned affected women-provider interactions are beset with many problems. Similarly, the cost of services in the private sector makes it unaffordable for the poor and the underprivileged women to make use of the obtainable

[1] Eleventh Five Year Plan (2007-2012), Social Sector, Volume II, Planning Commission, Government of India.

facilities. Many small private providers have poor knowledge base and tend to follow irrational, ineffective, and sometimes even harmful practices for treating women. Bulk of the qualified medical practitioners and nurses are subject to self-regulation by their respective State Medical Councils under central legislation. In practice, however, regulation of these professionals is weak and non-existent. The overall health system also lacks a real and working process of monitoring, evaluation and feedback.

3. India has committed to meeting the Millennium Development Goals (which focuses on maternal health) and has ratified many international conventions including the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). Right to health is a fundamental right under the Constitution of India. The Constitution has also made special provision for women and children. Accordingly, the vision of the on-going Eleventh Five Year Plan (2007-2012) is to end the multifaceted exclusions and discriminations faced by women, in particular those who are more vulnerable than others. The road map for this has already been made in the 2001 National Policy for Women and the 2005 National Rural Health Mission (NRHM). The NRHM was launched to achieve the goals set under the National Health Policy and the Millennium Development Goals. One of the monitorable targets of the Eleventh Five Year Plan is to reduce MMR from 3.01 to 1 per 1000 live births.[2] The Plan recognizes the gender dimension of health problems and seeks to address the issues of women's survival and health through a life cycle approach. Making ordinary and vulnerable women partners in their own health care is an underpinning of women's health in the Eleventh Plan. The challenge is to create an enabling environment with information, services and health programme for women to exercise their rights and choices. The Eleventh Plan would also focus on health needs of the urban poor by launching the National Urban Health Mission (NUHM). The NRHM along with NUHM will form *Sarva Swasthya Abhiyan.*

Role of NHRC-India

4. The NHRC-India has consistently taken the view that the right to a life with human dignity, enshrined in the Constitution, must result in the strengthening of measures to ensure that the people of this country, and particularly those belonging to economically disadvantaged sections of society, have access to better and more comprehensive health facilities.

5. It was to widen and deepen its own understanding of the issues involved and to promote the view that the right to an adequate level of health-care was essential to a life with dignity, that NHRC-India constituted a Core Advisory Group on Health. The Core Group has dealt with many issues concerning women and was specifically requested to prepare a Plan of Action for bringing about systemic improvements in the health delivery system of the country. In keeping with its broad objective to give greater practical meaning to right to health care, it organized a workshop on 'Health and Human Rights with Special Reference to Maternal Anaemia' in April 2000. The report of the workshop was considered in-depth by the Commission, which upon formulating its own recommendations forwarded it to the concerned authorities for appropriate action.

6. In the year 2004, the NHRC in collaboration with *Jan Swasthya Abhiyan* (People's Health Movement -- a Network of 1,000 NGOs working in the health sector) organized public hearings on 'Right to Health Care' in five regions (Northern, Southern, Western, Eastern and North-Eastern) of the country followed by one at the National level in New Delhi. During the day-long public hearings, selected cases/instances, wherein individuals or groups including women, who had suffered denial of health care and had not received

[2] *Ibid, p.185.*

mandated health care from a public or private health provider were presented. In these public hearings, the Commission brought victims, NGOs and concerned authorities on the same platform, which helped in the resolution of individual problems, identification of systemic problems and forging of partnerships. More than 1,000 victims from marginalized sections presented their testimonies. It also included affected women, some of whom came in person or were represented by their families. Their complaints were redressed by the Commission and the concerned authorities. In addition, the National Action Plan to Operationalize the Right to Health Care was proposed. Detailed recommendations on 'Right to Health Care' were made in the National Action Plan to the Ministry of Health and Family Welfare, Government of India, State Governments and Union Territories, NHRC, State Human Rights Commissions (SHRCs) and health service networks. The recommendations of Regional Public Hearings and National Action Plan were communicated to all States/Union Territories.

7. The issue of female foeticide and infanticide has also been examined in detail by NHRC, India. It confirmed the persistence of patterns of discrimination against the girl child, both before and after birth, despite the constitutional vision, which under Article 14 expressly proclaims equality before the law, and under Article 15 unequivocally prohibits discrimination on grounds of religion, race, caste, sex or place of birth. Analyzing the 'Human Rights Dimension of Census 2001', it also called for a concerted effort to end the misuse of sex-determination tests that had encouraged the evil practice of female foeticide, for it not only violated the right to life but happened to be one of the worst possible forms of discrimination based on sex. Prior to this, commenting on the proceedings and recommendations made by the CEDAW Committee before which the Government of India had presented its Country Report, the Commission made its own recommendations concerning the steps that the Government should take to end gender discrimination.

8. Recognizing the crucial linkages between population policy, development and human rights, the issue of female foeticide and infanticide was indirectly touched upon again when the Commission organized a Colloquium on this subject in 2003 and in the Declaration adopted therein emphasized that this practice should be done away with. All these efforts have undoubtedly resulted in sharp decline -- nation wide – in the sex ratio of child population in the age group 0-6 years. That ratio fell from 945 in 1991 to 927 in 2001.

9. As regards the issue of availability of manpower in remote parts of the country, NHRC-India organized a meeting with Medical Council of India, Indian Nursing Council and the Ministry of Health and Family Welfare (Government of India) in August 2007. In this meeting it was decided that to overcome the shortage, one year rural posting be made compulsory for the MBBS students. The views of NHRC-India on the issue of compulsory rural attachment were conveyed to the Sambasiva Rao Committee constituted by the Union Ministry of Health and Family Welfare to look into this issue. The Committee has recommended that instead of extending the internship for another year to do the rural posting, one year rural work shall be made mandatory for candidates who want to do post-graduation. They will be appointed by the respective State Governments on contract basis for one year. The Commission has also recommended to the Ministry of Health & Family Welfare that one year rural posting should be made mandatory not only for those who want to do their post-graduation but others also, that is, including those who do not want to do their post-graduation.

10. The fact that the Government of India under NRHM modified the National Maternity Benefit Scheme to Janani Suraksha Yojana (JSY) to promote institutional delivery, it has to take two critical factors into account. One being that India does not have the institutional capacity to cater to large number of women giving birth each year, and the other being that around half of all maternal deaths occur outside of delivery, during pregnancy, abortions and postpartum complications. If institutions are pre-occupied with

handling the huge numbers of normal childbirths, there will be inevitable neglect of life-threatening complications faced by women. They will be compelled to vacate beds in the shortest time. Consequently, complications during pregnancy and after childbirth will not be given attention. Second, JSY money sometimes does not reach hospital on time, and as a result, poor women and their families do not receive the promised money. This reality needs to be looked into by the Government. Other than this, the Government of India should ensure that States/Union Territories like Uttar Pradesh, Uttarakhand, Assam and Madhya Pradesh, which have very high MMRs need to improve their performance with regard to progressive States/UTs like Maharashtra, Tamil Nadu and Kerala. The need of the hour is to develop systems that comprehensively address the health needs of women. Till the time the existing health system is overhauled, it is the view of the Commission that emphasis should be laid on 'training' whereby the knowledge and skills of existing manpower like health workers/functionaries and doctors working at the grassroots is upgraded so that they are able to protect the rights of affected women.