Report on the Two-Day Webinar On

Access to Reproductive Justice

Date: 23.05.2020 & 24.05.2020

Compiled & Edited by
Shaoni Mukherjee

HRLN

HUMAN RIGHTS LAW NETWORK

Reproductive Rights Initiative

INDEX

AGENDA

DAY 1		
Time	Session	Speaker
12:00- 12:20	Welcome Note	Colin Gonsalves, Senior Advocate, Supreme Court of India; Founder, HRLN
12:20-1:00	Right to Contraceptive Information and Services: Access and Affordability	Jasmine, Hidden Pockets Collective, Bangalore Zahra Andalucia, Social Activist, London
1:00- 1:15	Discussions	
1:15- 02:15	COVID 19 – Sexual and Reproductive Health and Rights during the Pandemic	Prabina Bajracharya, Centre for Reproductive Rights, Nepal Purna Srestha, Centre for Reproductive Rights, Nepal Adv. Meenaz Kakalia, Maharashtra
2:15–2:30	Discussions	
2:30 – 3:15	Two-Child Norms and the Policies enforced by the government	Leena Uppal, MAMTA, Delhi Sarita Barpanda, HRLN, Delhi
3:15 – 3:30	Discussions	
3:30- 4:15	Forced Sterilization: Devika Biswas PIL and Coercive Hysterectomies	Adv. Rajni Soren, Chhattisgarh Adv. Deepak Kr. Singh, Bihar
4:15- 4:30	Discussions	
4:30- 4:45	Summarizing DAY 1	

DAY – 2		
12:00 – 12:45	Denial of Abortion Services and the MTP Act	Rupsa Mallik, CREA, Delhi Dr Suchitra Dalvie, Asia Safe Abortion Partnership, Mumbai Adv. Sneha Mukherjee, Delhi
12:45 – 1:00	Discussions	
1:00 – 1:45	Obstetric Violence	Dr Nabin Pati, White Ribbon Alliance, Odisha YK Sandhya, Sahayog
1:45- 2:00	Discussions	
2:00- 2:45	Child Marriage and Adolescent Friendly health care services	Manak Matiyani & Shruti Arora, The YP Foundation Adv. Afreen Khan, Maharashtra Sabin Srestha, FWLD, Nepal
2:45- 3:00	Discussions	
3:00- 3:45	Using Law to Enforce Indian Public Health Services	Adv. Sauradeep Dey, Assam Adv. J. Hillson Angam, Manipur
3:45- 4:00	Discussions	
4:00- 4:45	Maternity Benefits and the Food Security Act	Adv. Debasmita Ghosh, Assam Shaoni Mukherjee, Delhi
4:45- 5:00	Discussion	
5:00- 5:15	Summarizing Day 2 & Concluding Remarks	

Eminent Speakers who graced the event:

Colin Gonsalves:
Colin Gonsalves is a designated Senior Advocate of the Supreme Court of India and the founder of Human Rights Law Network (HRLN). He specializes in human rights protection, labour law and public interest law. He has been awarded Right Livelihood Award for the year 2017 for "his tireless and innovative use of public interest litigation over three decades to secure fundamental human rights for India's most marginalised and vulnerable citizens."[1] Considered a pioneer in the field of public interest litigation in India,[2] he has brought several cases dealing with economic, social and cultural rights. Most of these cases, decided by the Supreme Court, have been set as precedents.

Jasmine, Hidden Pockets Collective:
Jasmine is a self-declared young feminist activist, who uses her legal training to improve the sexual and reproductive health rights of women and girls in India. She has worked on a range of issues around disability, HIV/AIDS, and comprehensive sexuality education. Jasmine has been part of the activist work at the local, national and international levels, actively participating in coalitions which aim to being a sex positive voice to SRHR discussions. She is one of the founders of Hidden Pockets which maps SRHR services using a patient experience framework.

Zahra Andalucia:
Zahra has worked on a range of issues, including access to contraception, unsafe abortion, child marriage, Rohingya refugees, and gender-based violence. She co-wrote and edited HRLN's recent publication on child marriage, which featured research in several different states. Recently, along with a team she visited eleven Rohingya refugee camps across Delhi and Haryana to document reproductive health violations taking place, which was then compiled into a comprehensive report and submitted to the Supreme Court of India as evidence adjoining a petition.

Prabina Bajracharya, Centre for Reproductive Rights, Nepal:
Prabina is a human rights lawyer with extensive experiences on human rights analysis, advocacy and capacity building. Since 2017, she has been working with the Centre for Reproductive Rights and is responsible for leading the Centre's capacity building work in Asia. The major initiatives she is leading includes judicial engagement in Nepal, spearheading partnership with National Judicial Academy; and coordinating South Asia Reproductive Justice and Accountability Initiatives (SARJAI).

Leena Uppal, MAMTA:
Leena is the Assistant Director at MAMTA, Health Institute for mother and Child. She is a senior professional with ten years of experience in development sector project planning,

implementation and management; capacity building at large scale; Monitoring and Evaluation; Health System Strengthening, Resource mobilization; Networking and partnership. Excellent reputation for resolving problems and driving overall operational improvements.

Sarita Barpanda, Senior Director, Reproductive Rights Initiative, HRLN

She has been working in the development sector for last twenty-five years, and has wide ranging experience in the field Sexual Reproductive Health and Rights, HIV/AIDS, Public health Population Development, Gender justice, Human Rights at State, national and international level. She has worked in State Government of Orissa and Government of India in various capacities. She was Country Programme Adviser for Interact Worldwide 2005-12, an UK based organization that primarily focussed on Reproductive and Sexual Health across continents. Sarita is one among few development experts who combines a strong micro-research with macro Policy and programmes. She is passionate about her work and has provided technical support and knowledge to European Union, DFID, Government of India.

Rupsa Malik

Rupsa Malik is the Director of Programmes and Innovation, CREA. She is responsible for developing and implementing CREA's strategic initiatives.

Dr Suchitra Dalvie

She is the MD, MRCOG Coordinator, the Asia Safe Abortion Partnership as well as an Independent Researcher, Sexual and Reproductive Health and Human Rights, Consultant

Dr Y.K. Sandhya

She is the Assistant Coordinator of SAHAYOG, an organization that works on youth and women's sexual reproductive health and rights in the northern state of Uttar Pradesh in India. Dr. Sandhya has been trained in social medicine and community health from Jawaharlal Nehru University. She has experience of working on sexual reproductive health and rights and plays a significant role in advocating with Officials of the Ministry of Health and Family Welfare, the Secretariat of the Parliamentary Standing Committee of Health and Family Welfare and the National Human Rights Commission.

Shruti Arora

She is a feminist activist with extensive experience in facilitating youth leadership for social change. Her work has focused on sexuality rights, gender justice, violence prevention, and Sexual and Reproductive Health and Rights awareness.

Advocates and Activists from HRLN

Adv. Sneha Mukherjee, Delhi, HRLN

Adv. Rajni Soren, Chhattisgarh, HRLN

Adv. Deepak Kr. Singh, Bihar, HRLN
Adv. Meenaz Kakalia, Mumbai, HRLN
Adv. Afreen Khan, Mumbai, HRLN
Adv. Sauradeep Dey, Assam, HRLN
Adv. J Hillson Angam, Manipur, HRLN
Adv. Debasmita Ghosh, Assam, HRLN.
Shaoni Mukherjee, Delhi, HRLN

Day 1:

Sarita Barpanda, Senior Director of Reproductive Rights Initiative of HRLN welcomed the participants.

Colin Gonsalves, the founder of Human Rights Law Network and Senior Counsel Supreme Court of India, laid an overview of the current situation where he emphasized that it is going to be a very difficult and frightening situation for women especially with regards to accessing their sexual and reproductive health and rights also women rights in general. This webinar not only concentrates on saying how gloomy and difficult the situation is and the new deprivations women are facing due to the outbreak but will also focus on a way forward. He spoke of the hardships the women are facing due to the lockdown: Women are giving birth on the roads, pregnant women walking 1000 of miles to reach their home state. The state is just a mere spectator to these extreme levels of brutality. The simple solution was to just provide trucks. He was disappointed at the conditions of the Hospitals: Health care system collapsed, decline in health services, the public hospitals stopped admitting people and converted their wards for COVID affected patients.

The other upsetting aspect was the absolute collapse of the Public Distribution System especially the food distribution system collapsed. Anganwadi centres and mid-day meals services stopped. The thousands of migrant workers would not have to leave if the PDS system had functioned properly.

Through the point of view of Public Interest Litigation, the courts have also failed in recognizing and fending for the people. The courts have primarily been unresponsive. The High Courts of Karnataka and Kerala has been exceptionally good, mostly the courts have been disappointing. The high Courts of Delhi and Mumbai were not very good in giving orders. So, when it comes to women's rights, Courts have been mostly numb, so recognition and achieving Sexual and Reproductive Health and Rights is going to be a tough struggle.

HRLN has been an advocate of reproductive rights since a long time. After a long-drawn struggle, we have reached somewhere with regards to SRHR. HRLN has done about 100- 120

cases for the courts to amend the MTP Act and increase the cap from 20 weeks to 24 weeks. We are nowhere near to absolute right of women for terminating of pregnancies. Similar is the case for forced sterilization, hysterectomies and child marriage, it is difficult to convince courts to rule in favour and get it implemented.

He requested the participants to not only speak of the problem but formulate an action plan to end the crisis.

Session 1 – Right to Contraceptive Information and services: Access and Affordability

Speakers: Jasmine, Hidden Pockets and Zahra Andalucia, London

Right to Contraceptive Information and Services: Access and Accessibility***:*** Women's and adolescents' right to contraceptive information and services is grounded in basic human rights. The Programme of Action of the International Conference on Population and Development recognized "the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice." Additionally, the Committee on the Rights of the Child has indicated that "States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV and the prevention and treatment of sexually transmitted diseases (STDs).

Jasmine:
Jasmine and her organization provide abortion services by linking young clients with service providers. It has been extremely tough to work as circumstances changed with the lockdown. They had devised a helpline number called WhatsApp Careline in four languages – Hindi, Malayali, English and Kannada. During the pandemic outbreak, the demand of the women and adolescents changed. The guidelines of the pandemic in India did not mention anything whether abortion services were essential services or not. Since most of the hospitals were not admitting patients other than ones affected with COVID – 19, it was hard to refer people to hospitals as mobility was a key concern. Many clinics were also shut. Panic was around access to contraceptives like condom, pills as well. This led to a number of unwanted pregnancies as well as unsafe abortions. The Apollo Hospitals were the only ones who were providing these pills. But not everyone could travel to this hospital during the Pandemic. There was no clarity with regards to sanitary napkins also. The concept of Tele- medicines could have been very effective but no-one was sure whether they would include contraceptives and medicines for safe abortion. The relief package introduced by the Government does not mention anything about sexual and reproductive health and rights.

Zahra:
Zahra also added her inputs on Contraceptive Information and Services in India. She started with explaining the access to a wide range of both spacing and limiting methods of

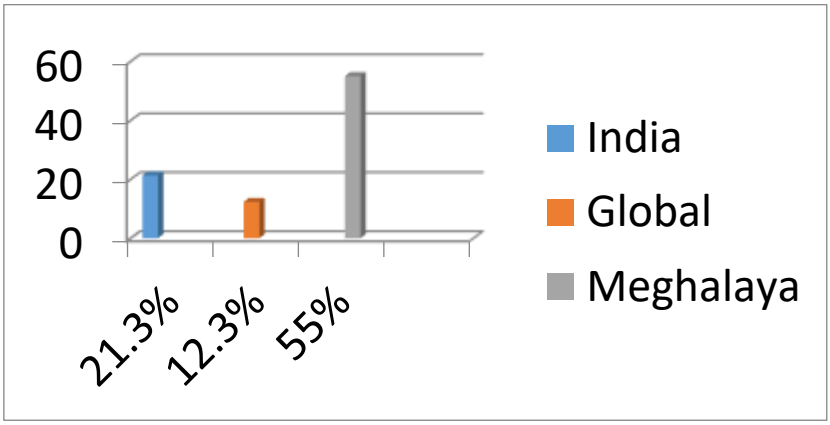
contraception, awareness of how different forms of contraception work and their side effects and the access to information regarding the availability and variety of contraception

HRLN Fact Finding Prior to PIL: The Role of ASHAs in the Delivery of CIS

- ASHAs have a lack of adequate training and are therefore spreading misinformation regarding CIS
- Incentive payments driving promotion of female sterilization
- There is a shortfall of almost 350,000 ASHA workers
- CIS is not being delivered in many poor, rural communities
- Unmet need for CIS is increasing rather than decreasing

She mentioned about what the National Health Mission's Plan Regarding CIS

- 'Family planning services would be utilized as a key strategy to reduce maternal and child morbidities and mortalities in addition to stabilizing population'
- 'All states would be encouraged to focus on promotion of spacing methods, especially Intra-Uterine Contraceptive Devices (IUCDs)'
- 'Male involvement including male sterilization would be promoted'
- 'Distribution of contraceptives at the doorstep through ASHAs and other channels will be actively promoted'
- 'Improved family planning service delivery including access, availability and quality of services; counselling services through dedicated counsellors; improved technical competence of the providers and increased awareness among the beneficiaries would be ensured



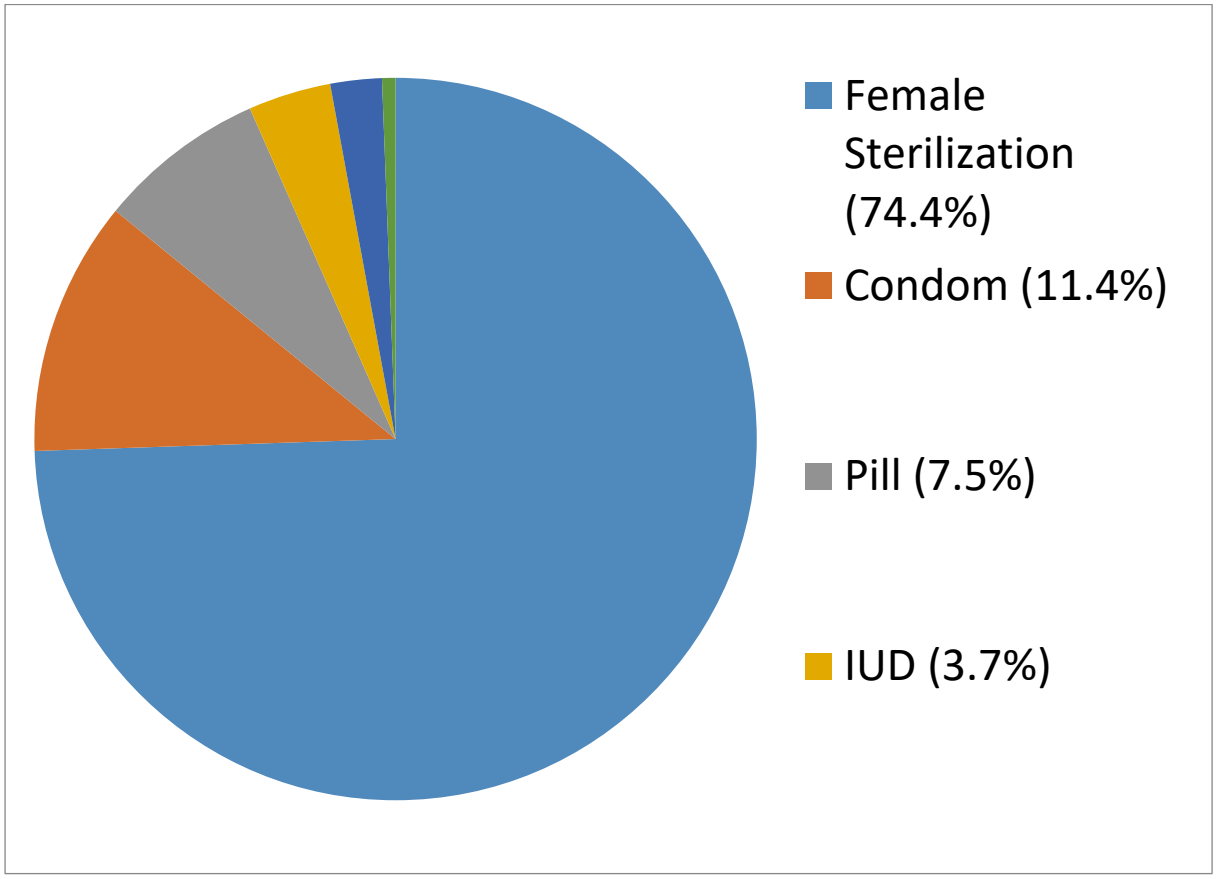
Consequences of a lack of CIS in India

- Unwanted Pregnancy
- Adolescent Pregnancy
- Unsafe Abortion
- Sexually Transmitted Diseases
- Maternal Mortality

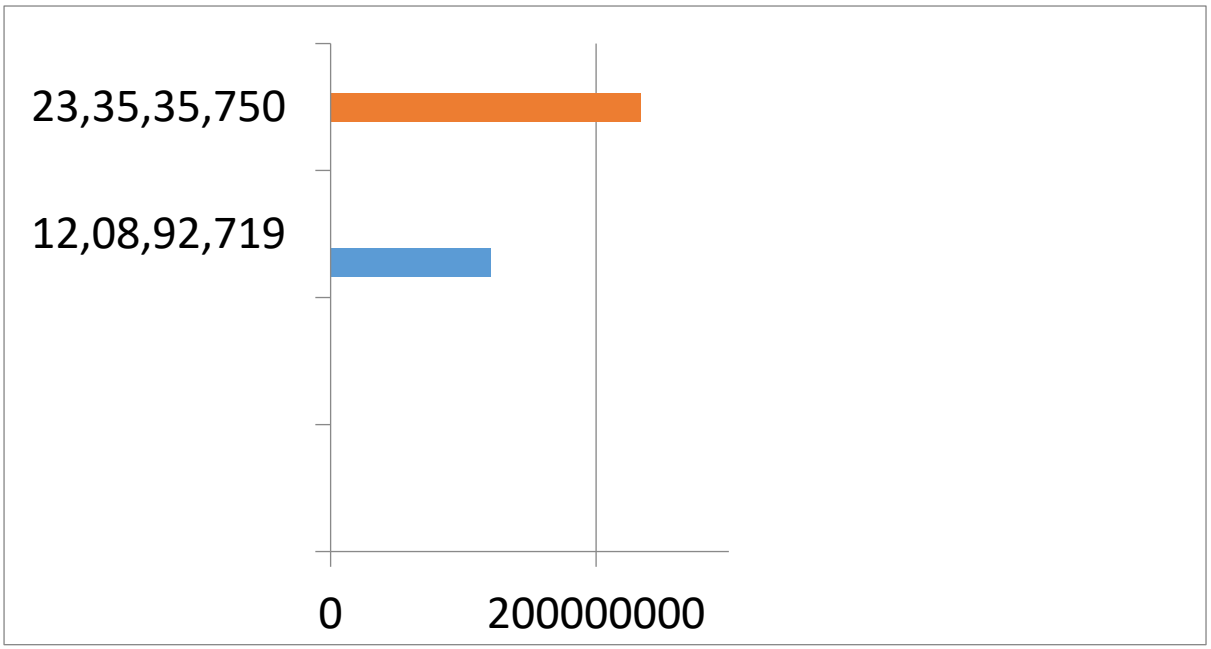
- Infant Death

Methods of Contraception Available in India

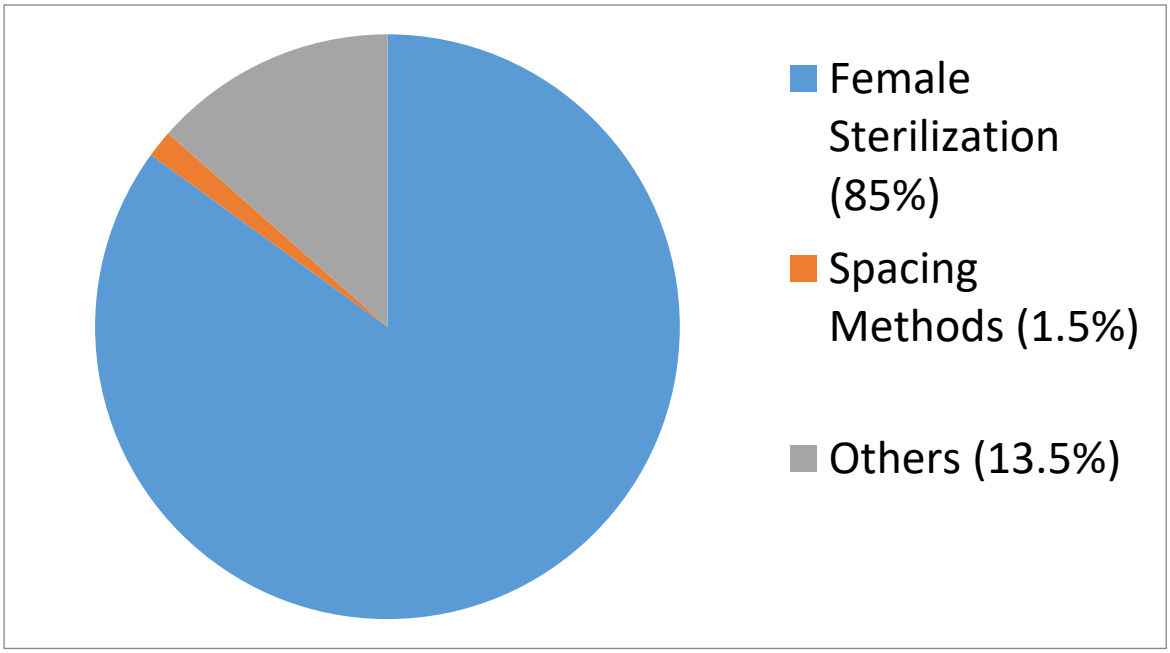
- OCPs
- ECPs
- Condoms
- IUDs
- Male Sterilization
- Female Sterilization



India's Pledged Budget vs. Actual Budget



Expenditure (%)



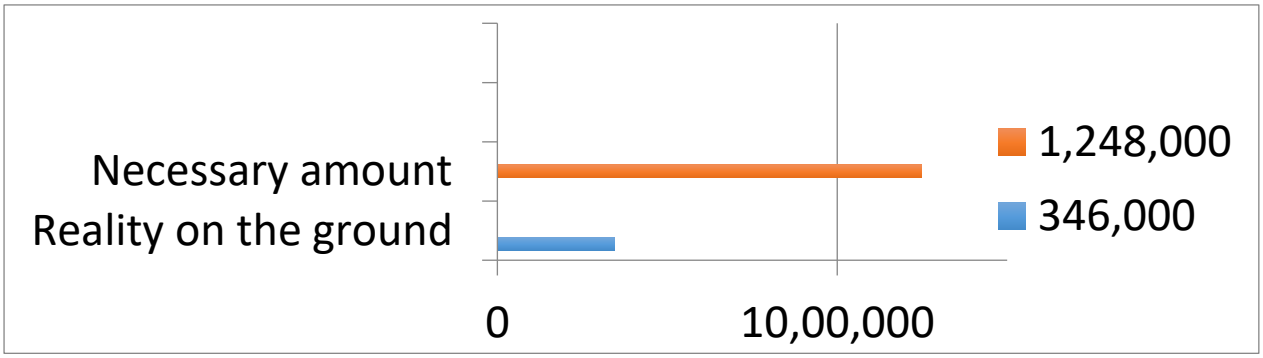
Supply of Contraceptives: The ASHA Doorstep Delivery Service and Supply at PHCs and SCs

- The Government of India is supposed to supply contraceptives such as condoms, OCPs and ECPs for free at Primary Health Centres (PHCs) and Sub-Centres (SCs)
- In 2011, the Ministry of Health and Family Welfare rolled out a scheme to improve access to CIS by having Accredited Social Health Activists (ASHAs) deliver a variety of contraceptives at the doorstep of households. This initiative was piloted in 233 districts in 17 states with a view to roll it out across the nation

Reality:

- Assam: Essential drugs under the RMNCH+A Matrix not available, ASHA drug kits in short supply
- Chhattisgarh: Emergency Contraceptive Pills not available in most facilities
- Haryana: OCPs and ECPS have not yet been received by the state in the current year due to budget constraints
- Jharkhand: Counselling on spacing methods at SC or PHCs level is non-existent
- Karnataka: Continues to target permanent methods instead of spacing methods with a focus on female sterilization
- Maharashtra: Family Planning counselling services are not taking place across facilities or during outreach visits
- Meghalaya: Home Delivery of contraceptives by ASHAs is almost non-existent and their knowledge and skills on the topic is poor
- Odisha: ECPs were not available at most of the facilities, and knowledge of ECPs amongst staff was poor
- Uttarakhand: Shortages/stock-outs of essentials such as condoms was seen in many facilities visited

Shortfall of ASHA Workers (1 worker per 1000 people)



The Petition: Bihar Voluntary Health Association v UOI (2018)

- HRLN and BVHA recently filed a PIL in the Supreme Court demonstrating that both the Central Government and all State Governments and Union Territories have failed to address and ensure adequate access to CIS, citing high levels of unmet need, budget cuts, population control rather than reproductive rights based approaches, and disproportionate focus on female sterilization as evident shortfalls
- We focus on the results of these shortfalls: high maternal mortality rates and infant mortality ratios, adolescent pregnancy, STI/Ds, coercive sterilization, and unsafe abortion
- Legal Focuses- Indian Constitution
    - Article 15 – Right to Equality
    - Article 21 – Right to Life

CEDAW

- Article 14(2)(b) – rural access to adequate health care facilities, including information, counselling and services in family planning
- Article 16(e) – 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

Prayers of the Petition

- Our prayers order and direct the Central and State Governments to:
  - Comprehensively roll out the ASHA doorstep delivery service across the nation, with a full basket supply of contraceptives
  - Address the shortfall of approximately 346,000 ASHA workers
  - Ensure entire basket range of contraceptives are available at all public health care centres
  - Bring down the unmet need from 21.3% to a negligible rate within the next 5 years
  - Bring the Family Planning Budget in line with the pledges made the London Family Planning Summit and in the Family Planning Vision 2020 Initiative
  - Launch a drive promoting male sterilization as a safe, simple and reversible procedure in a move away from female sterilization, an invasive, irreversible procedure
  - Address the significant imbalance between female and male sterilization
  - Launch a drive encouraging condom usage in order to promote safe sex and reproductive rights
  - Implement a mass media campaign to raise awareness regarding CIS

Sneha Mukherjee, an advocate who is representing the case on behalf of HRLN at the Supreme Court elaborated on the case. However, it has been rather disappointing from the Court's end that we still haven't been able to achieve a good and progressive order yet.

Discussions:

Jasmine: Abortion for adolescents. POSCO complicates it. Sarita added that we should talk about sexual intimacy among young adolescents and educate people about it. There should be the inclusion of sex education and the concepts like consent, sex in the school curriculum. Adolescent sexual health services are still not considered a priority despite the mandate of National Rural Health Mission. She also additionally spoke of what should be included under Sexual and Reproductive Health and Rights, like we never talk about Consumables and products like condoms and pills etc. Nayanika, an activist from Kolkata asked an extremely pertinent question with regards to women and cyclone affected areas of WB & Odisha. Relief package proposed by the Government of West Bengal does not include anything about SRHR. Since she has worked with migrant labours of Sunderbans, West Bengal, she observed that there is a cycle of domestic Violence, child birth and abundance that a woman goes through.

The husband comes back home after 7 -8 months, he has no source of livelihood and income, so his frustration contributes to domestic violence, marital rape and unwanted pregnancies. And during this outbreak, the level of loss of livelihood must be extremely high contributing to high cases of unwanted pregnancies and violence against women.

Session 2: COVID 19 – Sexual and Reproductive Health and Rights during the Pandemic

Speakers: Prabina Bajracharya, Centre for Reproductive Rights Nepal and Adv. Meenaz Kakalia, Maharashtra

Prabina started the conversation and put upfront the global perspective. COVID -19 has not only been disastrous from women in India but globally women have been affected. She viewed Sexual and Reproductive health and Rights from the human rights perspective and government accountability. A number of policies and case order upheld the fact that Violation of reproductive rights equals to violation of human rights. States are obligated to provide quality care and not erode during these testing times. The Government of every country is accountable and they have to answer the citizens if health care systems is not in place, if they are unable to cater to the demands of the situation. Committees like CEDAW and other working committees have pushed the government in the midst of the crisis that Right to health is a basic imperative and the guidelines should be reinforced. They should also focus their concerns towards the poor and marginalized, LGBTIQ committee, women, adolescents, infants, low income groups for whom it is even hard to access quality health care. Rights of such people should be at the focus of the Government initiatives and relief packages. Control of COVID-19 approaches should be inclusive equitable, gender sensitive, intersectional and pro individual. Services should not be disrupted because of the pandemic. It is the government duty to provide them at the right time.

Taking a cue from other speakers, she adds abortion and post abortion care is a human right. WHO and other working groups emerging during emergency points out that in order to protect maternal mortality and morbidity, abortion care is very significant and a basic human right. Drugs f0r abortion falls under essential medicines. With reference to Contraceptive Information and services, counselling is crucial, even in such harsh situations, complete information should be provided who are accessing contraceptives.

The pandemic has severe implications when it comes to providing quality maternal care. However, WHO guidelines clearly mention that breast feed and safe delivery should be ensured. However, it has been estimated that violations and denials of services will increase. There will be long lasting implications on the global context too. In a study recently on 132 low- and middle-income countries, it has been estimated that 10 % reduction in use of contraceptives maternal and infant mortality will increase and travel restrictions will lead to many unsafe abortions and unwanted pregnancy.

As she is from Nepal, she gave an idea of the conditions in Nepal. The legal framework is comprehensive and interim guidelines had SRHR had a priority. Despite the positive measures, denial and deprivation is high. She narrated a few incidences – a hospital turned away the pregnant patient because the woman belonged to a containment zone. CRR had to intervene for safe delivery of the child and mother. Big government hospitals turned their maternity wards into COVID patient for indefinite period of time. The 1st casualty was a 29-years old, woman. She was admitted to a Government hospital and had procured a normal delivery. But tragedy struck and she died within 10 days. This shows that women are not receiving the additional care required during this period of time. Prabina points out to Pakistan where police and parliament are curtailing abortion rights.

Government it seems is using COVID to curtail women's rights. But we cannot let that happen. The Government has to fulfil international guidelines and ensure women's safety and rights. Taking the discussion forward, Sarita adds, the Pandemic is causing a high rate of morbidity which is not being recognized by any government. Women always have to bear the burnt for every circumstance.

Meenaz shared her own experience as an advocate working on women's rights. She points out that there is an estimate of 1.4 million unwanted pregnancies and 9 lacs unsafe abortions that are going to take place. Anyway, abortion accessibility is difficult in India, the outbreak has made situations more challenging. Health care centres are not available and if available, mostly non-functional. As travelling is restricted, it becomes difficult for women to access abortion services. Not just abortion, women who are pregnant has to go through an awful lot for check-ups and care. Getting admitted is also problematic as prices for a COVID test is high as 4500.

Access to courts have been another hardship. Due to the shutting down of courts and constant delays, formation of Medical committee and informing the court whether it will be allowed takes ample amount of time. Courts are not functioning regularly. Termination gets late. Hospitals are the centre and they are turned into COVID wards. The Maharashtra Unit is thinking of filing a PIL fast tracking cases for abortion.

Meenaz also noticed that during the first phase of the lockdown the number of women who wanted to access abortion was less, but with the third and fourth lockdown, there has been a spur in the number of cases. Sarita added there are women who are unable to access abortion because there is a shortage of money. Meenaz adds that pills are available but get a permission from a place registered under section 4 of the Act. Due to travel restrictions, this becomes ever more difficult.

Session 3: Two child norms and the policies enforced by the Government

Speakers – Sarita Barpanda, HRLN and Leena Uppal, MAMTA

Sarita Barpanda:

Since 1951, India has seen its population almost quadruple from 360 million to 1.2 billion people, making it the second most populated nation in the world, after China. Despite this, the fertility rate of Indian women has actually decreased by more than half over the last 40 years – falling from 4.97 children born to a woman in her lifetime during 1975-80 to 2.3 for the current period of 2015-20. However, due to the phenomenon of 'demographic momentum' – a tendency for growing populations to continue growing after a fertility decline because of their young age distribution – it will take until at least 2050 for India's population growth to stabilise. Deemed an 'explosion', the substantial growth in population is used as a scapegoat and a largely tepid excuse for almost every problem in India – especially issues surrounding poverty and poor public health facilities.

The two-child norm is seen as an antidote to India's 'population explosion'. Based on a largely misconstrued assumption that poor people living in rural areas and slums have more children, which is ironic given that these are the populations continually denied access to quality, affordable family planning services, the government formulated an idea based on China's highly controversial one-child policy: a two-child norm. This is a policy that would impose punitive disincentives on those who have more than two children. This method targets those intending to run in *panchayat* (local government) elections by disqualifying potential candidates who have more than two children. The hope is that citizens will look at their local government figures as role models, and in turn limit the amount of children they have.

Some Indian states have gone even further to push the two-child agenda, by denying the third child access to public health facilities and education in government schools, confiscating ration cards, and cutting off pregnant women's access to a range of maternity benefits and schemes once they are pregnant with their third child. These measures obviously disproportionately affect poor people, with poor women in particular being disadvantaged. To date, Rajasthan, Andhra Pradesh, Odisha, Maharashtra, Gujarat, Uttarakhand, and Bihar have two-child policies in place, ranging in their degrees of punitive outcomes when breached. As of September 2017, Assam became the eighth state to effect a two-child policy, with possibly the most punitive measures yet – barring anyone with more than two children from running for any kind of elections, holding a government job, or being eligible for government schemes and entitlements, such as nutritional entitlements for pregnant women who are below the poverty line. In October 2017, Jharkhand also announced its intention to follow the two-child norm with regard to eligibility in elections. All of the aforementioned states have high levels of impoverished communities from scheduled castes and tribes, and have bad records with regards to female literacy and school drop-out rates.

Under the two-child policy, parents are cut off from crucial schemes and entitlements that help to alleviate the circumstances of the most deprived people in India. This compounds the problems faced by those poor and uneducated communities, who often have very little access to contraceptive information and services. The two-child norm also contradicts India's commitment to rights-based family planning and fails the self- stated goal of moving away from target-driven, incentive-based population control tactics, as expressed at the Cairo Conference in 1994 and codified in the National Population Policy 2000. This policy specifically identified as its overriding objective the improvement in the quality of lives, and made reference to the need to address unmet needs for contraception. The policy does not mention targets, disincentives, or policies relating to the number of children one can have.

Nevertheless, a Supreme Court blunder has had extremely harmful effects on the poor and marginalised communities of several states of India. When a two-child norm approach was adopted in Haryana, barring those with more than two children from running in *Panchayat* elections, those who were disqualified filed a petition against the State of Haryana, known as *Javed vs. State of Haryana* (2003). The parties before the court failed to explain and assess the complexities of population, family planning, reproductive rights, and bodily autonomy in a nuanced manner, leading to a judgment that relied heavily on obsolete, disproven, obscure and controversial statements regarding notions of population 'explosions.' It quoted research dating back to the 1960s that labelled population growth as 'more dangerous than a Hydrogen bomb', failed to note India's sharp decrease in population growth rate from 1991 – 2001, briefly mentioned the disadvantages that the two-child norm would impose on women and poor people in general, and featured a glaring absence of any Indian population experts, who were unanimous in their view that the impact of the two-child norm on women and the poor would be 'immediate and severe.' The resulting judgment was misleading and misunderstood and led to several states taking on the two-child norm and disqualifying candidates from running in local elections. Research conducted in Odisha, Rajasthan, Haryana and Madhya Pradesh demonstrates that this directly led to the desertion of wives by aspiring local politicians, the seeking of unsafe abortions, giving up children for adoption, and the initiation of new marriages by male elected members to escape punitive measures.

The first problem is increasing population and disproportionate increase in produce. The second problem is the government’s lack of proper distribution of produce. Post the reduction of the 1921 death rate, the second phase started. This phase was characterized by high birth rates and low death rates. There is a myth and misconception that to ensure that the number of poor does not increase, the population needs to reduce. China’s fertility rate was comparable to Kerala’s total fertility rate in 1951. This was due to the prohibition of child marriages, a good education and health services. It is unfair to impose state policies on families which forces the families to abandon their third child. Further, as per the national population policy the woman and her womb must be protected. The woman should have the

flexibility to decide the number of children she wants. Subsequently, the children should receive a good quality of life. The Population policy should benefit mother and child and the choice should lie with the mother.

Unfortunately, that is not the case. Many states have initiated the two child norm. Bihar, Orissa and Himachal Pradesh have passed orders that persons with more than two children cannot contest in the local elections. Many organizations have stood up against such order. For example, in the JSY maternity benefit scheme the services will only be provided for the first child. This showcases that the government is attempting to incentivize people towards the two child norm.

After the Supreme Court's Judgement in Javed's case set a bad precedent thereby encouraging the state governments to propose laws in consonance with the two child norm. The two child norm has had a serious impact on women. Women face double edged challenge, decision making in reproduction has not been in women's hands and yet they suffered the consequences of the implementation of the norm directly (as candidates) or indirectly (as spouse of those disqualified). Women were even abandoned by their husbands because they wanted to stand for the elections. We filed a petition in the Supreme Court to direct the government to not go through with the two child norm. The Supreme Court came out with a very strong judgement that at the interest of the nation population control is required. The judges weren't willing to listen to the arguments that could have changed the course of the judgement.

Population growth in the past few years is the lowest the country has ever seen. Ration cards are also distributed keeping in mind the no. of children a family has. If you have up to two children then you will get the red card. People can't hold positions in the government if they have more than two children. Because of this provision no poor person with more than two children can stand for elections. If we look at the data about 80% of the people will be disqualified. A study was done in Punjab and about 21.6% Dalit and 45% women are there where the children are more than two in the family. This norm is coercive, and many countries have banned it, but it is still prevalent in India. We therefore wish to challenge it in the High Court. Most affected are the poor Dalit, tribal and the OBC women.

Leena Uppal:

After Sarita set the tone, Leena took the discussion forward. She started with speaking about the National Population Policy. When the National Population Policy came up it brought along with it some terms like population control, population stabilization, small family and 2 children. But along with-it choice was also one term that came into being.

The Government's Goal was to reduce MMR and IMR through population control. But the evidences say otherwise. She will share with us the report on the effect on Population policy in the four states where it was implemented.

The RKSK program is a very detailed policy program but the implementation is extremely poor. There has never been much discussion of reproductive rights no information of rights We have reproductive choices as a prime requirement for our country development but the government won't take it seriously. No conversation or information of when to marry, when to have children and what are the implication of having whatever number of children, men taking decisions on behalf of women. There is no intersectionality of programs and policies which is a major concern. There is a huge Life cycle disconnect, no intersectionality programs and policies and no justice for women.

Barriers in uniformity and consistent use of contraception: wider environment level which restrict this. Issue of mobility, economic independence, becoming a leader, strategic needs should be taken into consideration. But Government look at women as reproductive machines and not as individuals. Assam has come up with it already and UP is the next state to be targeted.

Session 4: Forced Sterilization & Coerced Hysterectomies

Speakers: Adv. Deepak Kr. Singh, Bihar and Adv. Rajni Soren, Chhattisgarh

Deepak

How family planning has always concentrated on female sterilization. Male sterilization is about (.3) and female sterilization is about (36) condom usage a mere 5.9% and the focus has been on coercive sterilization.

In 2012, Human Rights Law Network and petitioner Devika Biswas filed the landmark public interest litigation petition *Devika Biswas v. Union of India & Ors* in the Supreme Court. This petition concerned the highly coercive, target-driven sterilization camps that were taking place in the State of Bihar and across India. These camps rounded up impoverished women, typically from Scheduled Castes and Tribes, and sterilized them in barbaric and highly unsanitary conditions, without their consent. This practice formed part of the Government of India's oppressive 'family planning' programme, which was leaning towards population control methods rather than practices that enabled reproductive autonomy.

In January, 2012, a sterilization camp was conducted in the Arharia district of Bihar, sterilizing 53 women within 2 hours in unhygienic and cruel conditions. This camp was organized in a government school by Jai Ambe Welfare Society, and authorized by Bihar state. The respective public interest litigation petition highlighted the oppressive practices employed by the state to achieve sterilization targets, which was discouraged by the National Population

Policy 2000, which had championed reproductive health and autonomy. It also mainstreamed the notion of sterilization being viewed as a 'population control and stabilization measure' by the healthcare personnel rather a way of safeguarding a woman's reproductive rights. The petition sought monetary compensation, directions for safety of patients, and guidelines for terms of operations amongst other things.

In a Govt. School in Bihar, at 2 am in the night around 53 women underwent sterilization procedure. The women largely belonged to the SC/ST community. It was found that the procedures followed violated the guidelines that were given after the Ramakant Rai vs. Union of India case. After the procedure the women were given painkillers, and later the same night the place was vacated. Instead of being questioned on their actions the doctors were instead appraised. Devika Biswas thus carried out a fact finding and filed a case in the Supreme Court of India. The Speaker in conclusion emphasized on the need to understand how important such judgements are that have brought a change in the guidelines of the government and she feels that as activists and lawyers that are aware about this it's our duty to make people aware about such judgements and the kind of impact it has.

Rajni Soren:

She spoke of the Bilaspur sterilization death cases which were also a part of the Devika Biswas case. Sterilization of 83 women, of which 15 women died. The fact-finding reports show that young women died who had not undergone any counselling on spacing methods
The first interaction with women and health workers was they came to get them sterilized.

There is also a notion that women from tribal communities are always approached for sterilization as supposedly they will have more children. Despite Devika Biswas Case order, the deaths are still continuing. Chhattisgarh as a state faces another problem that women are compensated as per the old Family planning indemnity scheme.

Regarding Hysterectomies, a Medical procedure of removing the uterus from the body. It is used not just for not pregnancy complications but for other gynaecological issues. The RSBY insurance scheme covered hysterectomies. Reports that Chhattisgarh has conducted a lot of hysterectomies to cash in the insurance scheme, also uterus were removed using the scare tactics. Hysterectomies are once again on the rise after 2018. In reports it has been found that under Ayushman Bharat hysterectomy is quite high. This should be included in our petition pending in the Supreme Court

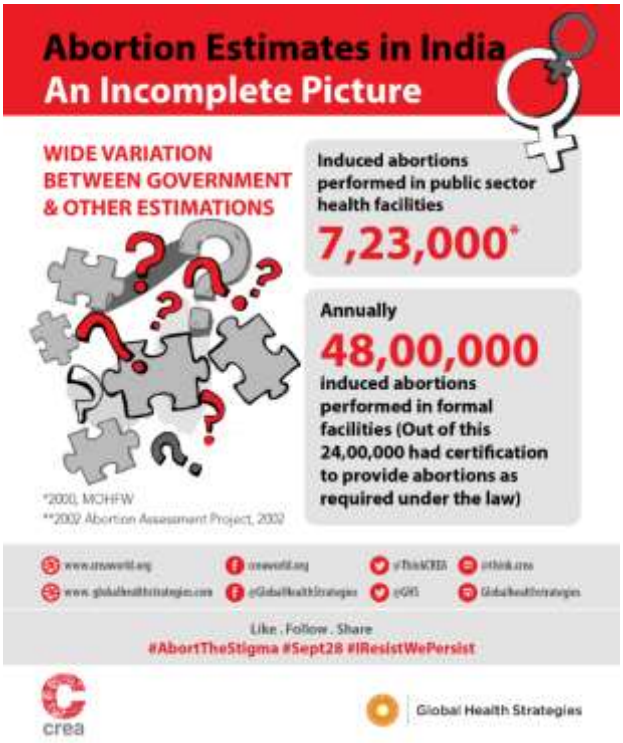
Another incident, of the women from the Sugarcane fields who had to undergo forced hysterectomy in Satara, Maharashtra. Migrant women workers were forced to go through hysterectomies if they have complications and had to visit doctors.

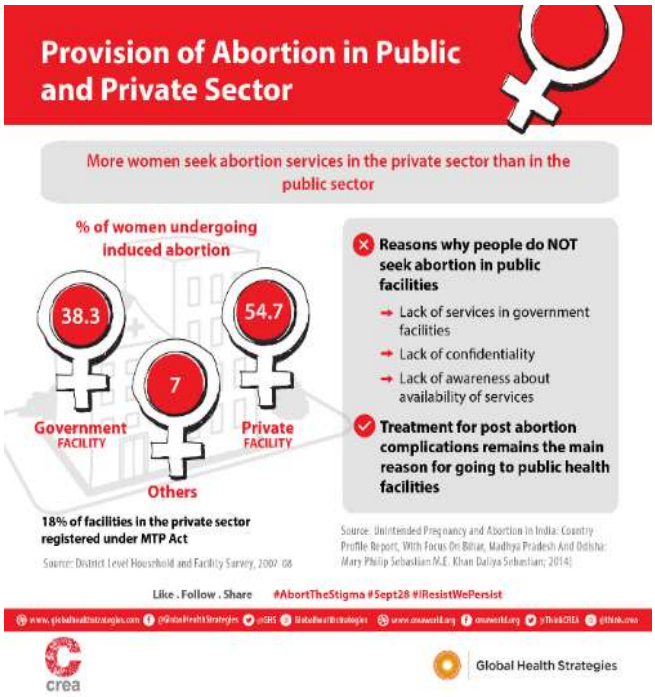
Day 2

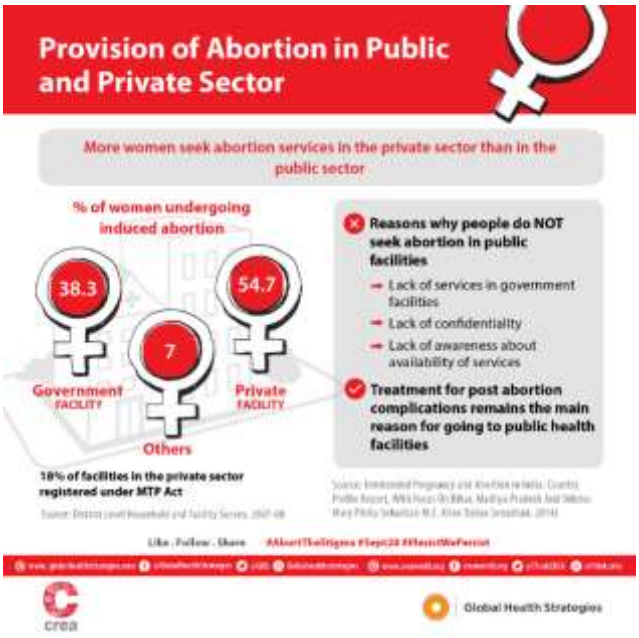
Session 1: Denial of Abortion Services and the MTP Act

Speakers: Rupsa Mallik, CREA, Delhi, Dr Suchitra Dalvie, Asia Safe Abortion Partnership, Mumbai and Adv. Sneha Mukherjee, Delhi

Rupsa started her presentation and the presentation slides were quite self-explanatory.







Please access the full webinar by subscribing to HRLN's page
DAY 1 (https://www.youtube.com/watch?v=FOhrEf6tZwQ&t=9668s)
DAY 2 (https://www.youtube.com/watch?v=2FKJmwO7xVQ&t=12489s)

Dr Suchitra Dalvie

Abortion Facts in India

• More than 15 million unwanted pregnancies are terminated every year in India for various reasons.

• Most women are married and seek abortions to limit the size of their family.

• Other common reasons are to increase the spacing between births or to protect their health in cases where underlying medical conditions would be worsened by pregnancy or childbirth.

• Among married adolescents obtaining abortions in Maharashtra, more than half (53%) reported having an abortion because their previous child was too young.

Guttmacher Study Report (2017)

• Estimate

• 15-6 million abortions occurred in India in 2015

• 22% were obtained in health facilities

• 73% were Medication Abortion pills done outside of health facilities

MTP Act 1971

• The Medical Termination of Pregnancy Act, 1971 (Act Na 34 of 1971) An Act to provide for the termination of certain pregnancies by registered medical practitioners and for matters connected therewith or incidental thereto. Notwithstanding anything contained in the Indian Penal Code 45 of 1860).

Explanation 1. where my pregnancy and by the pregnant woman to have been caused by rape, the anguish caused by each pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

• Explanation 2.-Where any pregnancy occurs as a result of failure of any device or method used by any married woman on her husband for the purpose of the the number of children, the anguish caused by such unwanted pregnancy be presumed to constitute a grave injury to the mental health of the pregnant woman. In determining whether the continuance of pregnancy would involve such risk of injury to the health as mentioned in sub-section, account may be taken of the pregnant woman's actual or reasonably foreseeable event.

Despite this-

56% abortions in India are unsafe 13 women die in India every day due to unsafe abortions • More than 80 per cent of women do not know that abortion is legal in India

Indian Penal Code, 1860
312-316. Causing miscarriage
Whoever voluntarily causes a woman with child to marry all such miscarriage be not caused in good faith for the purpose of saving the Wife of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both and, if the woman be quick with child, all the punished with imprisonment of either description for a term which may extend to seven years, and also be able to fine.

Explanation. A woman who causes herself to miscarry, is within the meaning of this section.

The POCSO Act, 2012

• The Protection of Children from Sexual Offences Act, 2012 defines a child as any person below the ape of 18 years and provides protection to all children under the age of 18 years from the offences of sexual assault sexual harassment and pornography

The PCPNDT Act
• The PCPNOT Act (1994 amended 2003) bans prenatal sex determination • It does not say anything about what one does after that. So a woman who has found out that she is pregnant

with a male foetus and goes home and continue the pregnancy is also guilty under the Act. This is also sex selection. Estimates based on sex ratios at birth in the NFHS-2 suggest that about 8% of induced abortion nationwide may have been done for sex-selective reasons.

Questions about the proposed MTP Act Amendments:

• Do the proposed amendments bring about a shift in power from the doctor/healthcare provider to persons who do not want to continue the pregnancy?
• Do they increase women's autonomy and agency?
• Do they decriminalize abortions?
• Do they ensure that no women is turned away or forced into an unsafe abortion or into containing a pregnancy that is rated?
• Do they increase public sector access and government accountability?
• Do they improve private sector regulation?
• Do they provide for better access to Medical Abortion Pills?
• Do they ensure that all government hospitals are providing the full range of abortion services including second trimester abortions and without any coercion for contraception?

Positives:
• Married woman and husband any woman or her partner (even better would be pregnant person and their partner)
• Up to 20 weeks only one RMP
• Up to 24 weeks for special categories of women which will be defined in the amendments to the MTP Rules and would include Vulnerable women' including survivors of rape, victims of incest and other vulnerable women.

Case Study:
A woman employed as a housemaid who sought safe abortion services from a private doctor. This was her sixth pregnancy, after previously giving birth to one son and two daughters and undergoing two induced abortions. Her husband remained opposed to the use of contraception. Initially, she had sought medical termination of pregnancy through a government hospital but was denied because of procedural delay, especially the non-availability of an ultrasonography report consequent to a lack of proof of identity (ie, the AADHAAR card) (none of which are required by the law). She finally sought the services of an unqualified private physician. Consequently, she was required to seek treatment for bleeding from the dispensary staff at a government hospital. We note that many such incidents occur in our daily practice but remain unnoticed and undocumented.
On September 19, 2016, the division bench of the Bombay High Court passed a landmark Judgement recognising the absolute right of women to abortion. If a woman does not want to continue her pregnancy, then forcing her to do so represents a violation of the woman's bodily integrity and aggravates her mental trauma, which would be deleterious to her mental

health, • The pregnancy takes place within the body of the woman and has profound effect on her health, mental well-being and line. The woman alone should have the right to control her own body, fertility and motherhood chokes.

Supreme Court Judgement

In a landmark judgement in Indian history, in August 2017, the Supreme Court on Thursday unanimously that the right to privacy is a fundamental right of every Indian citizen. The nine-judge bench constituted by Chief Justice JS Khehar ruled that the right to privacy and dignity is intertwined with the right to life and Liberty. "A woman's freedom of choice whether to bear a child or abort her pregnancy are areas which fall in the realm of privacy," said Justice Chelameswar.

Unless we shift the socio cultural patriarchal underpinnings of the rationale to control women's reproduction (compulsory and unpaid reproductive labour) and women's role s permanently consenting sexual partners within the framework of matrimony. It is difficult to move beyond laws which are paternalistic. We need to be our focus within the gender and politics if we are to be able to move towards abortion as a right of the pregnant person over their own body at any conditions.

Session 2: Young People's Access to Health Services Insights and Strategies for Action

Speakers: Shruti Arora, YP Foundation

Shruti:

UNPACKING 'ADOLESCENT AND YOUTH-FRIENDLY SERVICES': FACIILITY-LEVEL INDICATORS

- Waiting time to avail the services
- Cost for accessing the services
- Information displayed around SRH services
- Identification documents asked for provision, delay or denial during service access
- Timing and duration of availability of services at the facility
- Privacy and confidentiality
- Availability of referral links
- Availability of service provider of the same gender
- Insistence on knowing marital status
- Insistence on guardian /parental consent
- Respect and sensitivity by the service providers
- Provision of comprehensive information by service providers
- Provision of SRH commodities and kits
- Feedback mechanism within the facility

INSIGHTS

- Mandatory reporting under POCSO Act is a barrier for adolescents
- Paying attention to unmarried young women and LGBT community's needs
- Young boys are likely to report the quality of services better
- Important to mainstream youth-friendliness in the service provision
- Allocated budget for RKSK in Delhi in 2016-17: 53.7 Lakh. Budget utilised: 11.20% of allocated budget on facility based services and adolescent health trainings

STRATEGIES FOR ACTION

- Building district, state, national-level coalitions
- Capacitating counsellors, frontline health workers, medical service providers etc.
- Budgetary analysis
- Telephonic counselling and tele-medicine for SRH needs during the COVID-19 pandemic

Session 3: Obstetric Violence

Speakers: Sarita Barpanda, HRLN and YK Sandhya, Sahayog

Sarita:

The term 'obstetric violence' was originally coined in Venezuela, in the International Journal of Gynaecology and Obstetrics. It is defined as 'the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.'[1]

Expanding this definition, one can look to what is termed 'disrespectful and abusive care' or 'D&A', especially during childbirth and maternal care. The White Ribbon Alliance notes that D&A constitutes 'interactions or facility conditions that local consensus seems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified', and can generally manifest in seven ways: as 'physical abuse; sexual abuse; verbal abuse; stigma and discrimination; failure to meet professional standards of care (i.e. lack of informed consent and confidentiality, painful

[1] Perez D'Gregorio, R. (2010). Obstetric violence: a new legal term introduced in Venezuela, *International journal of Gynaecology and Obstetrics*: 111(3), 201-202.

examinations and procedures or failure to provide pain relief, and neglect and abandonment); poor rapport between women and providers; and health systems constraints.'[2]

Across India, Human Rights Law Network has documented instances of obstetric violence through fact-finding missions and subsequently filed petitions. Instances have included healthcare professionals slapping and beating women when they cry out in pain during childbirth, verbally abusing them by screaming at them, treating patients appallingly or negligibly due to their Caste or Tribal status, imprisoning women in the hospital if they cannot pay specific fees, and touching them in invasive and sexually charged ways (e.g. vaginal penetration) with no prior warning or consent.

YK Sandhya:
In the last 15 years respectful care focus has finally been on reduction of maternal mortality reduction through institutional deliveries. Institutional delivery is important but at the same time quality of care is significant. However, service providers brutality, neglect after admission due to their caste or religion is also visible in hospitals across India. This brutality, the neglect and violence are addressed to women who are poor, are tribal or Dalit or is a Muslim or is from a low-income category. The care givers are powerful as they are knowledgeable, these behaviours are Manifestation of power. Sandhya and her organization have been for long documenting these kinds of mistreatment by service care providers which has also led to systemic maternal deaths.

HRLN has been representing the case of Salenta in the High Court of Allahabad. She was a woman from one of the vulnerable communities, and neglect by the doctors let to the formation of fistula in her uterus. After struggling for 10 long years, the Court gave a striking order where the health care centres of UP are to be reviewed and arrangements should be made to make them better. Salenta's case is just one of the many incidences. Sandhya recalls one incident from 2017 where the woman named Reshma was a victim of mistreatment and neglect by the doctors and nurses. And at the end, not only was the child dead but she lost her life too.

Sandhya also added that women share their painful experiences of institutional deliveries with other women from the community. They get scared when it comes to visiting hospitals. So not only does it affect maternal health, infant health also is at risk now due to deliveries by unskilled nurses. This is a phenomenon globally addressed. Studies show that better behavior helps in preventing maternal deaths. Community engagement along with health care workers is also one way of promoting maternal health.

[2] White Ribbon Alliance, *Disrespect and Abuse in Childbirth and Respectful Maternity Care,* available online at https://www.whiteribbonalliance.org/wp-content/uploads/2018/01/6422_RMC-DA-Brief-Final.pdf, accessed 29th May 2018.

Session 4: Child marriages

Speaker: Adv. Afreen Khan, Maharashtra

Afreen focused her discussion on the petition filed by HRLN in prohibition of child marriages in India.

Society for Enlightenment and Voluntary Action and Anr. v Union of India and Ors. 2017
This public interest petition was filed to demonstrate that neither the Union of India nor any of the States/UTs have any intention to implement the provisions of the Prohibition of Child Marriage Act, 2006 as a result of which the level of child marriages in India remains approximately at the level it was during independence. It framed child marriage as a violation of a girl's right to life, right to personal liberty (Article 21), right to education (Article 21 A) right to health, and the right to equality and non-discrimination (Articles 14 and 15).

The petition relied on primary qualitative research conducted on the issue of child marriage in the states of Bihar, Odisha, Assam, Uttarakhand, Chhattisgarh and Haryana, as well as secondary desk-research utilizing both Government and international non-governmental organization data.

Relevant excerpts of the petition include:

'The population in India is increasing at a rate of 8%. However, the rate of child marriage is decreasing by a mere rate of 1% per year. This is reflective of the States inaction on the issue and is essentially an infective decline, highlighting the lack of enforcement of the Act brought in place with the intent to eradication of child marriage.'

'Specifically noting the importance of Section 16 of the PCMA which calls for the implementation of Child Marriage Prohibition Officers to both prevent and address child marriage, The Law Commission Report No. 205, on the Proposal to Amend the Prohibition of Child Marriage Act, and other allied laws, 2008, summarized: *"The Act lays emphasis on the prohibition of child marriages by providing for the appointment of Child Marriage Prohibition Officers by the State Governments and gives powers to these Officers to prevent and prosecute solemnization of child marriages and to create awareness on the issue. However without the required financial allocations these Officers in most of the states have not been appointed."'*

'In order to eradicate child marriage, there needs to be an understanding of the dynamics and complexity of the issue. Some of the deficiencies in the current law are outlined in the report and can be summarised as follows:

I. The Child Marriage Protection Officers are not adequately equipped, trained and sensitised for dealing with child marriage.

II. Enforcement officers are not aware of their roles and responsibilities under

the PCMA, 2006 therefore making them ill equipped to prevent child marriages.'

The petition prayed for a range of orders and directions for the Central and State Governments to be obliged to follow. The most pertinent prayers are outlined below:

a) Issue a writ of mandamus or any other appropriate writ, order or direction to all the Chief Secretaries of the States and the Administrators of the Union Territories as well as the Director Generals of Police to ensure that the Collectors and the Superintendents of Police in all the Districts of India forthwith take active steps to prevent child marriages from taking place in their respective jurisdictions;

b) For an order directing all the Chief Secretaries of the States and the Administrators of the Union Territories to identify the officials who failed to prevent child marriages in their jurisdictions and to institute departmental proceedings against them and impose punishment in accordance with law;

c) For an order directing all States/UTs to appoint exclusive Child Marriage Prohibition Officers under section 16 of The Prohibition of Child Marriage Act, 2006 for every district, and by notification invest these officers with police powers as set out in section 16(3) of the Act, and to display the contact details of such officers on an exclusive child marriage website;

d) For an order directing all chief secretaries of States and Union Territories to direct their District Magistrates in the state to prevent solemnisation of mass child marriages on certain days such as Akshaya Trutiya in accordance with section 13(4) of the Act;

e) For an order directing chief secretaries of States and Union Territories to direct the Superintendents of Police throughout India to prosecute all such persons, by whatever designation called, who solemnise child marriages;

f) For an order directing all States and Union Territories to ensure that the Collectors and Superintendents of Police of all the districts in the country, identify all child brides within their jurisdictions and thereafter ensure that the child bride receives entirely at government expense, comprehensive, modern and free of charge education, health services, food and nutrition as well as substantial compensation for herself and her children;

g) For an order directing all States and Union Territories to disclose on affidavit the number of child marriages taking place district wise, the number of prosecutions and their end results and the number of child marriages prevented.

Upon approaching the court with the original petition detailed above, the Supreme Court judges directed HRLN's lawyers to return to the court with more contemporary data regarding the amount of child marriages taking place, as well as the number of CMPOs and their functions. A notable difficulty in this was the fact that there is such a stark lack of clear, reliable data that has been updated in the past few years regarding child marriage. Additionally,

Government data and international NGO data often contradict one another.

As a result of this dilemma, HRLN elected to send Right to Information Requests (RTIs) to all states and union territories of India, as well as the Central Government, requesting information on the amount of child marriages that have been reported but not necessarily taken to the police (hence the absence of NCRB data), as well as the number of CMPOs and their functions. The responses varied; many state departments simply transferred the RTIs onto other departments, but the responses that were received were telling. Of note was the fact that it is now evident that the only State in the entirety of India that has CMPOs who function *only* as CMPOs (rather than having additional charges). All other States and UTs had District Collectors, Child Protection Officers – even *tax officers* – working as CMPOs. The duty of the CMPO is therefore relegated to nothing more than an additional charge – hence no wonder the implementation of the PCMA is poor.

In addition to this, we found that despite the highest number of child marriages being registered in a police station in 2016 as per NCRB were in Tamil Nadu (55 cases), Karnataka (51 cases) and West Bengal (41 cases), the State of Tamil Nadu in its RTI response reflected over 1000 instances of child marriage in Chennai alone. This demonstrates a severe disconnect in cases arising and their subsequent reportage to the police, and further demonstrates that CMPOs are not effectively working to refer such cases to the police, which they are inclined to do.

All of the above information was compiled into an additional affidavit, which was then filed as a rejoinder to the original petition in 2018. In July 2018, the Union Government responded to the additional affidavit, expressing concern that child marriage was a continuing practice but noting that it had reduced due to their methods. However, they made no response to the evidence that had clearly arisen through the RTI responses. HRLN is now moving to respond to the claims made by the Central Government.

Session 5: Using law to enforce Indian Public Health Standards

Speakers: Adv. Sauradeep Dey, Assam & Adv. Hillson J. Angam

The Indian Public Health Standards is the basic minimum standards of services that any health care agency or provider has to adhere to. Standards have been set for all the types of Health centres – Primary Health Centre, Community Health Centres, Sub-centres and district hospitals. There standards are referral for planning and development of health care centres. There are two kinds of services- Desired level of services and essential/ basic minimum services. With reference to the fact-findings HRLN has conducted, the health centres don't even meet the minimum basic standards.

Recent report shows that there is a 61% shortage of staff especially non availability of gynaecologists and obstetricians. There is an unequal distribution of patients. The sole

purpose of having a 3-tier system was that none of the health centre in particular would have to feel the pressure and that people can access health care at their own community level. But what we have been observing is that the PHCs, CHCs and Sub-centres are almost non-functioning and that they refer all their patients to the District Hospital. It then becomes difficult for the District hospital to cater to the needs of the people.

Some significant cases filed in the High Court of Guwahati. Both the cases have been disposed off with good directions. 1st case – Kanaklata health centre had only 30 beds as opposed to 50 beds. The pregnant women and other patients were lying on the floor due to shortage of beds. The high court increased the number of beds to 81 and asked the state to look into the hygiene of the hospital. They also directed that if there is an additional requirement, more beds should be installed. Radiologist, dermatologists and other staffs should be appointed. Another case was a district in Assam without a blood bank. There was no provision for blood storage as well. The High Court not only ordered to install a blood bank but also asked the hospital to upgrade the other services too according to IPHS.

Hillson practices in the court of Manipur and has done some outstanding cases to promote maternal health. Manipur Unit filed a petition for inspection of all health care centres for which a committee should be formed. Ultimately a committee was formed and a status report was submitted. The case on the Primary Health Centre in Senapati also received good orders. The construction pf the new building started in 2012 but it was stalled for the next 8 years. The court ordered that Construction has to be completed within 6 months.

Manipur Unit has filed a number of PILs in the high Court on upgradation of infrastructure of hospitals and health care centres, Shortage of manpower, appointment of Ayush doctors, etc. also PIL on referral services for pregnant women should be free.

Session 6: Maternity Benefit Initiatives in India and its impact

Speakers: Adv. Debosmita Ghosh & Shaoni Mukherjee, HRLN

National Rural Health Mission (previously known as National Health Mission) was envisaged to promote institutional deliveries conducive towards facilitating safe motherhood and reduce out of pocket expenses. Rolled out all across India since 2005. The primary goal was to ensure universal access to equitable, affordable, and quality health care services.

The goal was to ensure and:

a. Reduce MMR to 1/1000 live births
b. Reduce IMR to 25/1000 live births
c. Reduce TFR to 2.1 4.
d. Prevention and reduction of anaemia in women aged 15–49 years

e. Prevent and reduce mortality & morbidity from communicable, non-communicable; injuries and emerging diseases

The National Health Mission in order to ensure that institutional delivery increases and safe delivery is promoted across the nation. Various incentives and entitlements were rolled out to promote safe motherhood programmes. Some of the key initiatives which were rolled out were:

A. Janani Suraksha Yojana- cash incentive of up to Rs.1400 depending upon the state

B. Janani Shishu Suraksha Karyakram- provision for free services like free medicines, free and cashless delivery, Free C-Section, Free drugs and consumables, free diagnostics, free ambulance services etc

C. Pradhan Mantri Matru Vandana Yojana- all pregnant women of 19 years of age and above were eligible for conditional cash transfer benefits of ₹5,000 in three instalments. After the implementation of National Food Security Act, the amount has been revised to ₹6,000, ₹ 5000 under PMMVY and ₹ 1000 from JSY

D. MAMATA Scheme in Odisha- ₹5000 in two instalments to mothers above 19 years of age

E. MAMONI Scheme in Assam ₹1000 Cash assistance to mothers in two instalments

Under the Integrated Child Development Scheme, the mother is also entitled to the following services.

This includes the role of Anganwadi centres, AWW and ASHA workers

- Supplementary Nutrition
- Pre-school non-formal education
- Nutrition & health education
- Immunization
- Health check-up and
- Referral services

Observations from Fact Finding Visits -

- Although this detailed and comprehensive framework is put in place, when it comes to implementation, it does not meet the standards
- No timely disbursement of incentives
- Although institutional deliveries have increased by number not still there is a long way to go
- Lack of free services and entitlements
- Non- functional Anganwadi centres
- Lack of documentation of high-risk cases of pregnancy
- Cases of out of pocket expenditure
- Laxmi Mandal vs Deen Dayal Harinagar Hospital Writ Petition © 8853/2008
- Petition on the systemic failure resulting in denial of benefits to mothers below the poverty line (BPL) during their pregnancy.

Leading Case

- Drawing on international law Justice Muralidhar underlined that women have the right to control their body and decide when they wish to conceive. The Court also pointed out that women carry the burden of poverty in that they have to prove their BPL status when trying to access health facilities and accordingly ordered that "no pregnant women be denied access to medical treatment regardless of her social economic status".
- The Court underlined that the cases demonstrated a complete failure of the public health system and a failure in implementation of Government Schemes, including the National Maternity Benefit Scheme (NMBS), Integrated Child Development Scheme (ICDS) and Janani Soraksha Yojana (JSY) - a scheme designed to reduce maternal and neo-natal mortality by encouraging institutional delivery for poor pregnant women.

HRLN has by far in the last 5 years filed more than 150 cases across India for mothers to receive the benefits. Some courts have been extremely prompt, and some courts despite giving good directions, failed at the level of implementation. Debosmita also discussed about the cases filed in Assam as it still sits in the number one spot for highest maternal mortality.

Action Plan

Issues	Point person
Right to Contraceptive Information and Services: Access and Affordability	Adv. Tenzin, Delhi
COVID 19: Impact on Reproductive Healthcare services	Adv. Sneha Mukherjee, Delhi
Two-Child Norms and the Policies enforced by the government	Assam Unit, Adv. Ankita Wilson, Delhi and Leena Uppal, MAMTA
Forced Sterilization: Devika Biswas PIL and Coercive Hysterectomies	Adv. Rajni Soren, Chhattisgarh
Denial of Abortion Services and the MTP Act	Adv. Meenaz Kakalia, Maharashtra Adv. Sneha Mukherjee, Delhi Rupsa Malik, CREA
Obstetric Violence	YK Sandhya, Sahayog
Child Marriage and Adolescent Friendly health care services	Adv. Deepak Kr. Singh, Bihar along with YP Foundation
Using Law to Enforce Indian Public Health Services	Manipur Unit Adv. Sauradeep Dey, Assam Adv. Shanno Khan, Madhya Pradesh
Maternity Benefits and the Food Security Act	All States Adv. Deepak Kr. Singh, Bihar to coordinate
Violation Cases	UP Team – Ali and Danish

*Working Groups to be created