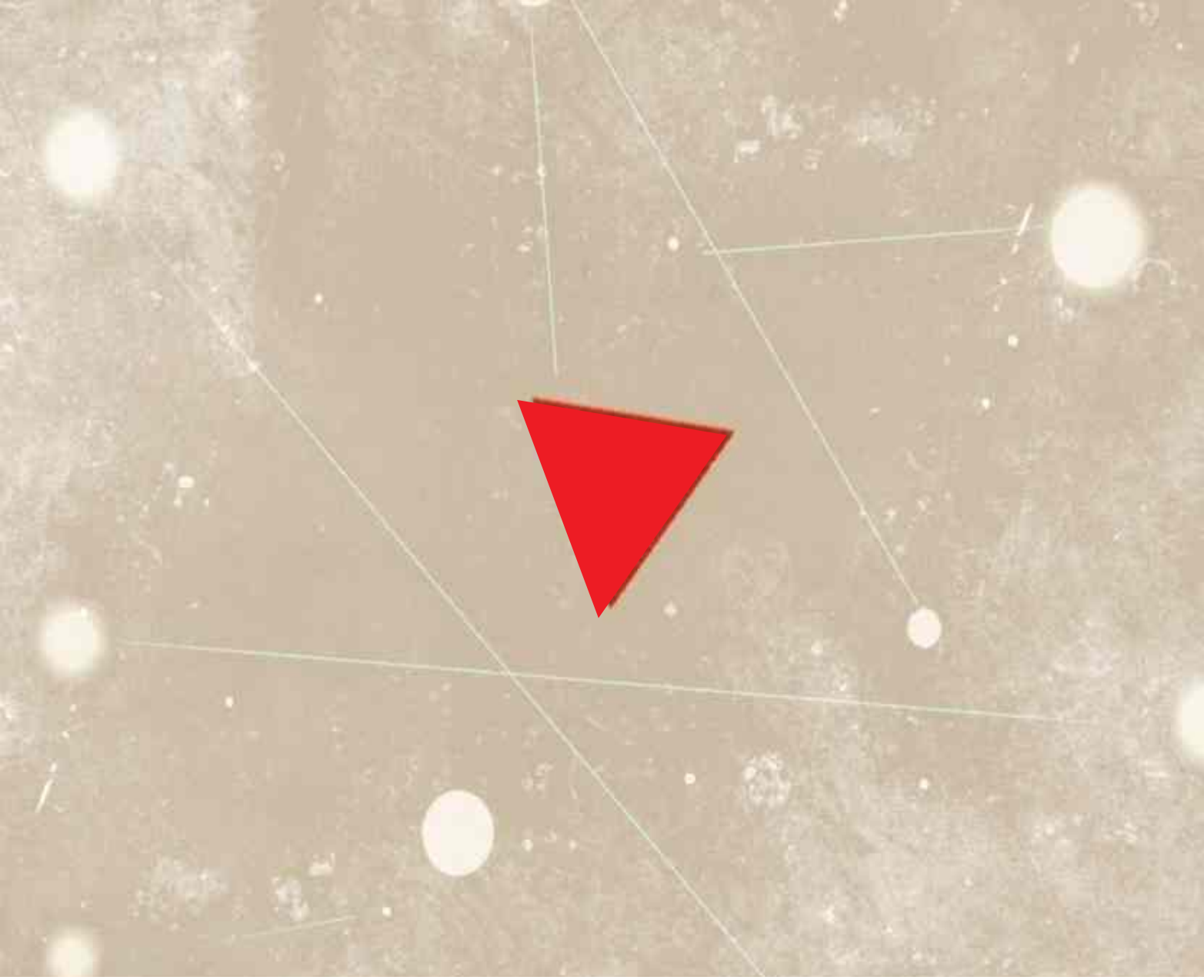

Voices From the Field: Access to Contraceptive Services and Information in the State of Haryana, India

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Voices From the Field: Access to Contraceptive Services and Information in the State of Haryana, India

Centre for Health Law, Ethics and Technology
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Centre for Health Law, Ethics and Technology

The Centre for Health Law, Ethics and Technology (CHLET) at Jindal Global Law School (JGLS) undertakes research on issues related to healthcare from a developing world perspective on social justice. CHLET adopts a multidisciplinary approach and focuses particularly on access to drugs, health and sexuality, sexual minority rights, reproductive rights, realization of a constitutional right to health, implication of advancement in technology on access to healthcare and anti-discrimination law and policy relating to contagious diseases in India and abroad.

CHLET seeks to foster informed dialogue among various stakeholders including policymakers, lawyers, activists, and the medical industry and profession. Through this dialogue, CHLET is dedicated to advancing the entrenched constitutional right to health irrespective of race, caste, ethnicity, national origin, disability, gender or poverty. Implementation of the right to health has distinct challenges in the Indian context. In this and other areas, CHLET aims to use its position within JGLS to engage in global-domestic research, dialogue, negotiation and, when necessary, the judicial system to achieve systemic reforms that advance social justice and equity in the many dimensions of healthcare.

In countries like India that grapple with inadequate delivery of basic healthcare, a response to these new challenges is hindered by systemic problems. Access to healthcare in India is compromised by poor infrastructure, cultural attitudes and practices, poverty and low levels of education, deficient resources, and the lack of effective legislation and policies on health related issues.

CHLET is in a unique position to tackle these complexities because it bridges the Global North and the Global South. Alliances are already being drawn for collaborations with research centers in India and globally to conduct joint research projects, enabling a unique transnational conversation on an issue that is unmistakably transnational in nature.

Last, in order to find effective solutions to pressing health challenges, it is imperative to merge theory and practice. CHLET is in an exceptional position to focus on both theoretical as well as empirical study on global health law and sexuality issues by building an academic as well as a civil society network.

Acknowledgements

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Foreword

This report published by the Centre for Health Law, Ethics and Technology (CHLET), a research centre at the Jindal Global Law School of O.P. Jindal Global University, is an important step in developing strong research capacities within academic institutions that is socially relevant and transformative. It is essential that universities use their intellectual resources with a view to advancing research in areas that are critical in shaping the contemporary social and political discourse.

In recent times, access to contraceptive services and information has been recognized as a fundamental right. However, it is fraught with various social, cultural, and financial barriers which prevent women from exercising their right. This study by the CHLET is an important initiative that highlights multiple stakeholder perspectives and provides for a human rights assessment of the economic, social, and cultural barriers that impede women in the state of Haryana from realizing their fundamental right to contraceptive services and information. In this process, it violates women's fundamental right to bodily autonomy and human dignity. The study arrives at important conclusions noted here including, but not limited to: women have a limited range of contraceptive services; women have limited access to contraceptive information; and healthcare suffers from poor facilities and infrastructure. Most importantly, it highlights the need for states to ensure gender equality and gender justice.

In November 2012, the UN Population Fund formulated a report entitled: "By Choice, not by Chance: Family Planning, Human Rights and Development," which underscored the importance of contraception and family planning. The report observed that there is an immediate need to ensure access to contraception in several countries, including Zimbabwe, Malawi, Rwanda, Iran, Bangladesh, and Tajikistan, and India. Further, the report has also recognized the efforts of these countries to bring a change in the existing situation of access to reproductive rights to the various stakeholders. These are important milestones in the global efforts to uphold the fundamental right to access contraception by women. It is useful to observe that the Committee on the Rights of the Child has indicated that *"State 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)."*

The study reinforces the importance of the constitutional rights to life, health and contraceptive access by women, and the immediate need for the state to formulate and

implement policies that uphold such rights. Countries, especially India, need to recognize that access to contraceptive services and information is of utmost importance for the empowerment of women and the realization of their rights, autonomy, and human dignity.

I congratulate the authors of the report, Professor Dipika Jain and Ms. Natassia Rozario for their passion, commitment, and dedication to pursue this research. I appreciate the admirable work of the student researchers and other scholars who have helped in the publication of this report. This project is an endeavor between the Centre for Heath Law, Ethics and Technology at JGLS, with support from the Center for Reproductive Rights, New York. I would like to acknowledge their contribution and in particular their encouragement and support to this research. I sincerely hope that this study paves the way for more initiatives that will bring together academics and practitioners to pursue rigorous research on various issues of contemporary relevance in law and society and contribute towards social transformation.

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Contents

Glossary**

Abortion: Termination of pregnancy. An abortion can occur either spontaneously (called a spontaneous abortion or miscarriage), or it can be brought about by intervention (called an induced abortion). It is with this last meaning that the word is generally used.

Adolescence: The period between sexual maturity at puberty and the attainment of adult social status; psychosocial development during the teenage years.

AIDS (Acquired Immunodeficiency Syndrome): The stage at which an individual's immune system is weakened by HIV to the point where he or she may develop any number of diseases or where a laboratory test shows his or her immune system to be severely damaged.

Anganwadi centers: Community centers where Anganwadi workers provide child- and maternal-health and education services.

Anganwadi workers: Workers trained by the government to deliver basic child- and maternal-health and education services.

ANM (Auxiliary Nurse Midwives): ANM are government paid health workers who provide free maternal and childcare services within a sub center area.

Antenatal care: Health care given to women during pregnancy, also referred to as prenatal care.

ASHA (Accredited Social Health Activist): They are appointed in every village and act as a link between the community and the public health system. The qualifications prescribed are that only a woman can be an ASHA worker and she should be literate from the same village and within the age group of 25-45 years. She may be married, widowed or divorced. They are selected through a rigorous selection process involving various village and district level authorities. ASHA workers get special training to acquire the necessary knowledge and skills for performance of her spelled out roles. ASHA workers get performance-based incentives for spreading awareness and promoting universal immunization. These ASHA workers will be empowered with drug kits to deliver first- contact health care. ASHA workers play an active role in creating awareness and satisfying the demands of the deprived sections of the society, who find it difficult to access healthcare services. They counsel women on birth-preparedness, the importance of a safe delivery, and also help them promote good health practices.

Barrier methods: Barrier methods of contraception prevent pregnancy by physically or chemically blocking the entrance of sperm into the uterine cavity. Some, particularly condoms, help to protect against sexually transmitted infections, including HIV infection. Barrier methods include cervical caps, condoms, diaphragms, female condoms, spermicides and sponges.

Birth control: Birth control is the use of any practice, method, or device to prevent pregnancy from occurring in a sexually active woman. Also referred to as family planning, pregnancy prevention, fertility control, or contraception; birth control methods are designed either to prevent fertilization of an egg or implantation of a fertilized egg in the uterus. Birth control may be irreversible or reversible. Birth control methods include hormonal, barrier, natural family planning, abstinence and abortion.

Calendar method: (sometimes called the rhythm method) A method of contraception or body awareness which uses records of previous menstrual cycles to predict the fertile period. The first fertile day is calculated by subtracting 18 days from the first day of menstruation of the shortest menstrual cycle; the last fertile day is calculated by subtracting 11 days from the longest cycle.

Cairo Conference: The United Nations International Conference on Population and Development (ICPD) was held from 5-13 September 1994 in Cairo, Egypt. During this two week period world leaders, high ranking officials, representatives of non-governmental organizations and United Nations agencies gathered to agree on a Programme of Action.

Cairo Programme of Action: Programme of Action of the United Nations International Conference on Population and Development (ICPD): The consensus document was adopted by 179 nations participating in the International Conference on Population and Development. First inter-governmental agreement to explicitly define "reproductive rights".

Condom: A sheath of thin material (usually latex, but also made of polyurethane, a non-latex product for those who are allergic to latex) that covers either the male's penis (male condom) or the female's vagina and cervix (female condom) to help prevent conception and/or transmission of infection during intercourse.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979): International treaty codifying states' duties to eliminate discrimination against women. Has provisions related to reproductive health and rights issues.

Convention on the Rights of the Child (1989): International treaty upholding the human rights of children. It is the most widely ratified treaty in the world.

Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (1984): Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984): The Convention against Torture entered into force in 1987. It defines torture and requires states parties to take legislative, administrative, judicial and other measures to combat torture in all territories under its jurisdiction, barring war and conflict as a justification for torture at any time. The Treaty Monitoring Body formed pursuant to the Convention to monitor states parties' compliance is the Committee against Torture.

Counseling: A process of communication by which a person is helped to identify her or his sexual and reproductive health needs and make the most appropriate decisions about how to meet them. Counseling is characterized by an exchange of information and ideas, discussion and deliberation free of bias, coercion, violence, inaccurate information, and judgment, in a safe, confidential space, which is respectful, accessible and private.

Diaphragm: A dome-shaped rubber cup with a flexible rim which covers the cervix during intercourse to reduce the chance of pregnancy.

Dual protection: Dual protection is protection against both unintended pregnancy and sexually transmitted infections, including HIV. For sexually active individuals, a latex or polyurethane condom is the only device that is effective for dual protection. Dual protection can also be achieved by using condoms with another method of contraception.

Emergency contraceptive (EC): Sometimes called the "morning after pill," EC prevents pregnancy after unprotected sex via a course of hormonal contraceptive pills taken in one- or two-dose regimens. Note the difference between medical abortion, which ends an already established pregnancy, and emergency contraception, which prevents pregnancy. EC is most effective if taken within 24 hours after unprotected sex; however, it can be effective for up to five days.

Family planning: The conscious effort of couples or individuals to plan for and attain their desired number of children and to regulate the spacing and timing of their births. Family planning is achieved through contraception and through the treatment of involuntary infertility.

Female condom: A soft, loose-fitting polyurethane sheath which is placed inside the vagina to reduce the risk of STI transmission and unplanned pregnancy.

Healthy sexuality: Healthy sexuality is a positive and life affirming part of being human. It includes knowledge of self, opportunities for healthy sexual development and sexual experience, the capacity for intimacy, an ability to share relationships, and comfort with different expressions of sexuality including love, joy, caring, sensuality,

or celibacy. Our attitudes about sexuality, our ability to understand and accept our own sexuality, to make healthy choices and respect the choices of others, are essential aspects of who we are and how we interact with our world.

Hormonal contraception: Systemic methods of contraception based on a progestagen combined with an oestrogen, or a progestagen alone. The methods of delivery include pills (oral contraceptives), injectables and implants. All these methods are reversible. Pills (two types): Combined oral contraceptives (COCs) contain synthetic oestrogen and progestagen. They can be monophasic, i.e. a fixed concentration of hormones throughout 21 days of the 28-day menstrual cycle, or multiphasic, with two (biphasic) or three (triphasic) variations of concentration throughout the cycle. Progestagen-only pills (POPs) contain only a progestagen, in a smaller dose than in COCs. Injectables are longer lasting than oral contraceptives.

HIV (Human Immunodeficiency Virus): The Human Immunodeficiency Virus (HIV) is a retrovirus that infects cells of the immune system, destroying or impairing their function. As the infection progresses, the immune system becomes weaker, and the person becomes more susceptible to infections. The most advanced stage of HIV infection is Acquired Immunodeficiency Syndrome (AIDS). It can take 10-15 years for an HIV-infected person to develop AIDS; antiretroviral drugs can slow down the process even further. HIV is transmitted through unprotected sexual intercourse (anal or vaginal), transfusion of contaminated blood, sharing of contaminated needles, and between a mother and her infant during pregnancy, childbirth and breastfeeding.

Hysterectomy: Surgical removal of the uterus.

Implants: Regarding contraception, they are a set of silicone capsules containing synthetic progesterone that are inserted in the upper arm as a means of birth control. They can be worn for a few years.

Information, education and communication: A program to ensure that clients or potential clients of sexual and reproductive health services are given the means to make informed decisions about childbearing and about their sexual and reproductive health. Information involves generating and disseminating general and technical information, facts and issues, in order to create awareness and knowledge. Education whether formal or non-formal, is a process of facilitated learning to enable those learning to make rational and informed decisions. Communication is a planned process aimed at motivating people to adopt new attitudes or behaviour.

Informed choice: Voluntary decision by a client to use, or not to use, a contraceptive method (or accept a sexual and reproductive health service) after receiving adequate information regarding options, risks, advantages and disadvantages of all available methods. The exercise of both the right of access to family planning and the right to make informed and responsible decisions about childbearing requires full knowledge

of the benefits, purposes and practice of family planning, access to services and the personal, familial and societal consequences of individual reproductive behaviour.

International Covenant on Civil and Political Rights (ICCPR) (1966): International treaty protecting individuals' civil and political human rights. The U.S. has both signed and ratified the ICCPR.

International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966): This treaty, together with the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights, constitute the International Bill of Human Rights. In accordance with the Universal Declaration, the Covenants recognize that the ideal of free human beings enjoying civil and political freedom and freedom from fear and want can be achieved only if conditions are created whereby everyone may enjoy his civil and political rights, as well as his economic, social and cultural rights.

International Convention on the Elimination of All Forms of Racial Discrimination: International treaty upholding individuals' human rights to be free of discrimination on the basis of race.

ICPD Programme of Action: Consensus document adopted by nations participating in the International Conference on Population and Development. This was the first explicit intergovernmental agreement that explicitly recognized reproductive rights and their basis in established human rights.

IUD (Intra-Uterine Device): A long-term, reversible method of contraception, involving the insertion into the uterus of a small flexible device of metal/plastic/hormonal materials.

Male Condom: A thin latex, polyurethane or natural membrane sheath placed over the glans and shaft of the penis to prevent unintended pregnancies. Latex and polyurethane condoms also reduce the risk of STI transmission.

Maternal morbidity: Illness or disability in women caused directly or indirectly by factors relating to pregnancy, childbirth, or the puerperal (post-delivery) period.

Maternal mortality: Deaths of women caused directly or indirectly by factors relating to pregnancy, childbirth, or the puerperal (post-delivery) period.

Medical abortion: Medical abortion is a safe and effective non-surgical method of terminating early pregnancy using certain medications taken orally or through injections. There are currently two methods of medical abortion: mifepristone, formerly known as RU-486, and methotrexate. Both drugs must be used in combination with misoprostol in order to stimulate uterine contractions, which aids in expelling the fertilized egg. Note the difference between medical abortion, which

ends an already established pregnancy, and emergency contraception, which prevents pregnancy.

Microbicide: The word 'microbicides' refers to a range of different products that share one common characteristic: the ability to prevent the sexual transmission of HIV and other sexually transmitted infections (STIs) when applied topically. A microbicide could be produced in many forms, including gels, creams, suppositories, films, or as a sponge or ring that releases the active ingredient over time. Some of the microbicides being investigated prevent pregnancy and some do not.

Miscarriage: The termination of a pregnancy before the foetus is viable, as a result of natural causes (not medical intervention).

Modern Methods of Contraception: Modern Methods of Contraception include female sterilization, male sterilization, and pills, IUDs, injections, implants, male condoms, female condoms and diaphragms, interalia.

Oral contraceptives (OCs or OCP): Pills containing synthetic estrogen and progesterone that are taken every day to prevent pregnancy. Also known as the birth control pill, or just 'the pill'.

Pregnancy: The state of carrying a developing embryo or fetus within the female body. This condition can be indicated by positive results on an over-the-counter urine test, and confirmed through a blood test, ultrasound, detection of fetal heartbeat, or an X-ray. Pregnancy lasts for about nine months, measured from the date of the woman's last menstrual period (LMP). It is conventionally divided into three trimesters, each roughly three months long.

Reproductive health: Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations and not merely counseling and care related to reproduction and sexually transmitted diseases.

Reproductive Rights: Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programs in the area of reproductive health, including family planning.

Safe sex: Any sexual practice that aims to reduce the risk of unintended pregnancy and of passing HIV (and other sexually transmitted infections) from one person to another. Examples are non-penetrative sex or sex with a latex or polyurethane barrier. During unsafe sex, fluids that can transmit HIV and other STIs (semen, vaginal fluid or blood) may be introduced into the body of the sex partner.

Sex education: Basic education about reproductive processes, puberty, sexual behaviour, etc. Sex education may include other information, for example, about contraception, protection from sexually transmitted infections and parenthood.

Sexual and Reproductive Health (SRH) Services: Defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health.

Sexual health: The integration of the somatic, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love and thus the notion of sexual health implies a positive approach to human sexuality and the purpose of sexual health care should be the enhancement of life and personal relations and not merely counselling and care related to reproduction and sexually transmitted diseases.

Sexual rights: The right to have control over and decide freely and responsibly on matters related to one's sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

STIs (Sexually Transmitted Infections): (sometimes called sexually transmitted diseases or STDs) They are caused by bacteria or viruses and often acquired through

sexual contact. Some STIs can also be acquired in other ways (i.e. blood transfusions, intravenous drug use, and mother-to-child transmission). The term 'STI' is slowly replacing 'STD' (sexually transmitted disease) in order to include HIV infection. Most STIs, like HIV, are not acquired from partners who are obviously ill, but rather through exposure to infections that are asymptomatic or unnoticeable at the time of transmission.

Sterilization: The sterilization procedure blocks either the sperm ducts (the vas deferens) or the oviducts (fallopian or uterine tubes) to prevent the sperm and ovum from uniting.

Traditional Methods of Contraception: Traditional Methods of Contraception include periodic abstinence and withdrawal, interalia.

Universal Declaration of Human Rights (1948): UN human rights instrument at the foundation of modern international human rights law. The UDHR is not a treaty. It was adopted as a U.N. General Assembly Resolution in 1948 and is now regarded as legally binding in all U.N. member states.

Unmet Need: The World Health Organization defines unmet need to be those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child.

Vasectomy: Vasectomy is a permanent method of contraception for men. It is a simple operation that makes a man's semen free of sperm by blocking the tubes that normally carry sperm to mix with seminal fluid. Vasectomy is one of the few methods that allow men to take personal responsibility for contraception. It is highly effective and does not affect sexual performance or masculinity.

Executive Summary

The Centre for Health Law, Ethics, and Technology (CHLET) at Jindal Global Law School (JGLS) presents this report on the right to contraceptive services and information for women in Haryana, India. The primary objective is to delineate whether the state of Haryana is fulfilling its obligations to provide women with access to contraceptive services and information. It presents findings from a multi-stakeholder analysis and human rights assessment of the various policy, social, and cultural barriers that impede women in Haryana from realizing their fundamental right to contraceptive services and information. By conducting both a multi-stakeholder analysis and a human rights assessment, this report provides a nuanced depiction of the policy, economic, social, and cultural barriers to contraception. This analysis also contributes to a deeper understanding of the state's obligation to ensure the right to contraceptive services and information.

The report is divided into two sections. The first section describes the state of access to contraception in India, the first country in the world to make family planning part of its official policy. This section outlines the current trends in contraceptive use among women in India. It then provides a brief historical sketch of India's family planning programs from its inception in 1952 through the Emergency Period up until today. The historical backdrop cautions against taking the target based approach of the Emergency Period, which imposed flagrantly coercive and punitive measures to curb population growth. India's history of family planning also brings into prominence the importance of taking a rights based approach to family planning, one that is centered on empowering women and takes into account the various structural impediments hindering a woman from exercising autonomy around decisions about her reproductive health. This section then describes the complex web of factors that influence contraceptive usage and access for women in India, including socioeconomic development and health infrastructure, gender dynamics and inequities, education, son preference, and other factors, including caste and tribe association, socioeconomic status, and age.

The second section, the main feature of this report, presents findings from a multi-stakeholder analysis on whether the state of Haryana is fulfilling its obligations to provide access to contraceptive services and information to the women of Haryana. The study centered on three questions: (1) Is Haryana implementing its policies around contraception and how is the state implementing its policies? (2) Are women able to enjoy their right to access contraceptive information and services? (3) What are the main policy, economic, social, and cultural barriers to contraceptives services and information that women face? Focusing on five districts in Haryana, we

conducted semi-structured qualitative personal interviews with a diverse group of key stakeholders, including married women, unmarried women and adolescents, ASHA workers, healthcare workers in government hospitals, and pharmacies and medicine shops.

The multi-stakeholder analysis and human rights assessment paint a rich and vivid picture of the state of access to contraception for women in Haryana. It reveals that women in Haryana are unable to realize their right to contraceptive services and information. The findings of the report demonstrate that:

- Haryana's policies push for sterilization over other temporary and reversible methods that are crucial for women to be able to time and space their pregnancies, resulting in women facing a lack of access to the full range of contraceptive methods;

- The quality of government contraceptive services is poor;

- Women have limited access to contraceptive information and education, resulting in serious misconceptions about contraceptives and depriving women of the ability to make fully informed decisions about contraceptive methods;

- Healthcare facilities are in a poor condition, have limited functioning hours, and may impose restrictions that limit contraceptive access such as providing contraceptive counseling in only postpartum wards and HIV/AIDS counseling rooms;

- Healthcare providers and ASHA workers have little knowledge of all range of contraceptives and thus are unable to counsel women appropriately; and

- Women face significant social and cultural barriers to contraceptive service and information, including stigma concerning the use of contraceptives, particularly among unmarried and adolescent women, and lack of autonomy in reproductive health related decision making.

These findings implicate women's basic rights to health, life, equality and non-discrimination, reproductive self-determination, privacy, freedom from torture and cruel, inhuman, or degrading treatment, and to enjoy the benefits of scientific progress. These fundamental rights are protected under the Indian Constitution, Indian Supreme Court and High Court jurisprudence, and international treaties to which India is a party.

The government of Haryana must take steps to fulfill its obligation to provide women with comprehensive access to contraceptive services and information. Specifically, the government of Haryana should (1) create and implement family planning policies that provide comprehensive information on the full range of contraceptive methods,

rather than singularly push sterilization, and focus on providing the information and means to make educated, autonomous reproductive health related decisions; (2) ensure that a full range of contraceptives, which include female condoms and diaphragms, are made accessible and available to women; (3) improve the quality of contraceptive services and information by training health workers and ASHA workers and by ensuring that contraceptives are not sold past the expiration; and (4) provide sexual and reproductive health information to women and young girls. Ultimately, access to contraceptive services and information is a human right. The government must take steps to ensure that women can fully enjoy their right to contraceptive services and information, which is essential to their health, agency, well-being, citizenship, and basic human dignity.

Introduction

1

Access to contraceptive services and information is a human right and a basic need, essential to women's life, health, autonomy, well-being, and active participation in society.[1] This report focuses on a woman's right to contraceptive services and information in the northern state of Haryana, India. It presents findings from a multi-stakeholder analysis of the various policy, social, and cultural barriers that impede women in Haryana from realizing their right to contraceptive services and information.

States are obligated to respect, protect, and fulfill the right to contraceptive services and information because it is a human right that derives protection from several internationally recognized human rights, including the right to life; right to the highest attainable standard of health; right to determine the number, spacing, and timing of one's children; right to privacy; right to equality and non-discrimination; right to sexual and reproductive information and education; right to enjoy the benefits of scientific progress; and right to be free from torture and cruel, inhuman, or degrading treatment.[2]

Ensuring a woman's right to contraceptive information and services is a necessary precondition for governments to fulfill their legal obligation to ensure women's enjoyment of their other human rights without discrimination. Contraceptive information and services enable women to make fundamental decisions about their bodies and reproductive capacity, and are vital to a woman's dignity, privacy, autonomy, equality, and reproductive self-determination.

Contraceptive services and information are also crucial to preventing unintended pregnancies, risky pregnancies, unsafe abortions, as well as HIV and STIs; all of which not only endanger a woman's life and health, but also preclude women from being active members of society. Unfortunately, women around the world are denied the right to access contraceptive services and information. The situation is particularly acute

in developing countries where 99 percent of maternal deaths occur.[3] In 2012, of the 1520 million women of reproductive age in developing countries,[4] approximately 222 million of them have an unmet need for contraception.[5]

It is estimated that in 2012, 80 million unintended pregnancies took place in the developing world, resulting in 30 million unplanned births, 10 million miscarriages, and 40 million abortions,[6] 56 percent of which were unsafe.[7] In developing countries where abortion is severely restricted, there is an extremely high risk of unsafe abortion.[8] Additionally, lack of contraceptive accessibility exposes women to the risk of HIV and other STIs.[9]

"It is estimated that India carries one of the highest global burdens of maternal health issues in the world, accounting for 19 percent of all global maternal deaths."

Globally, women represent about half of all people living with HIV, and young women aged fifteen to twenty-four are most vulnerable to HIV, with infection rates twice as high as in young men.[10] Moreover, without access to contraception, women are less able to pursue educational and professional opportunities and are more likely to suffer from diminished economic security and autonomy in their households.[11]

The situation in India is no less dire. It is estimated that India's unmet need for family planning is around 28 million, which accounts for roughly 10 percent of the global unmet need.[12] It is estimated that India carries one of the highest global burdens of maternal health issues in the world, accounting for 19 percent of all global maternal deaths.[13]

In order to fully understand the main barriers to contraception, the Centre for Health Law Ethics and Technology (CHLET) at Jindal Global Law School (JGLS) conducted a multi-stakeholder analysis and human rights assessment of access to contraception in the northern Indian state of Haryana. This report discusses the results of our study.

This report will first delineate the situation in India, describing the trends in contraceptive use, national policies addressing family planning and contraception, and the major factors influencing contraception usage and access. It will then present the findings and analysis from our case study on access to contraceptive services and information for women in Haryana.

The report will provide a rich depiction of barriers to contraception. The lack of access to contraceptive services and information by women is due to a complex web of interrelated factors and its assessment requires a wide spectrum of perspectives from varied stakeholders. Second, the findings of this report on contraceptive access will provide useful insights to the main barriers faced by women in accessing contraceptive services and information, which must be addressed for women to have control over their sexuality and reproduction and is essential for women's bodily integrity and autonomy. Finally, this report will contribute to a deeper understanding of the state's obligation to ensure the right to contraceptive services and information that is vital to women's health, agency, well-being, citizenship, and basic human dignity.

The Situation in India

2

This section describes the state of access to contraception in India, the first country in the world to adopt an official family planning policy. It first outlines the current trends in contraceptive use among women in India. It then offers a brief historical overview of India's family planning program from its inception in 1952 through the Emergency Period up until today. India's history of family planning cautions against taking the target based approach of the Emergency Period, a period marked by draconian and coercive population control policies. The report highlights the importance of taking a rights based approach to family planning, one that is centered on empowering women and considers the various structural impediments hindering a woman from exercising autonomy in taking decisions about her reproductive health. This section then describes the panoply of factors that influence contraceptive usage and access for women in India, including socioeconomic development and health infrastructure, gender dynamics and inequities, education, son preference, and other factors, including caste and tribe association, socioeconomic status, and age.

A. Trends

The main source of data in this section is the National Family Health Survey (NFHS), a large scale household survey conducted in a representative sample spread across India.[14] Three rounds of NFHS have been conducted in 1992-93, 1998-99, 2005-06.[15]

Contraceptive use: According to NFHS-3 (2005-06), 56 percent of currently married women use contraception, which is 48 percent higher than reported in the previous survey NFHS-2 (1998-1999).[16] Female sterilization is the main form of contraception, comprising two-thirds of total contraceptive use and 77 percent of modern method use.[17] Eighty-one percent of women undergo the operation before they reach thirty years of age.[18] The predominant reliance on sterilization suggests that women lack access to a full range of contraceptive methods.[19]

Within India, there are significant disparities in access. For example, the contraceptive prevalence rate is 11 percent lower in rural areas than in urban areas. Among urban and rural women, however, the prevalence of female sterilization, male sterilization, and traditional methods is almost the same.[20] Compared to rural areas, urban areas have a higher prevalence of modern short term and reversible longer term methods, such as oral contraceptive pills, intrauterine devices (IUDs), and condoms.[21] Condom use varies dramatically among states, with modern use contraceptive prevalence rates among married women at nearly 67 percent in Andhra Pradesh and at 37.2 percent in Assam.[22]

Unmet Need for Family Planning: The World Health Organization defines unmet need to be "those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child."[23] According to NFHS-3 data, 13 percent of married women have an unmet need for family planning, which is 16 percent lower than reported in NFHS-2 data.[24] Unmet need in NFHS-3 varies tremendously among states. For example, the unmet need among married women in Andhra Pradesh is 5 percent, whereas the unmet need among married women in Meghalaya is 35 percent.[25]

Unplanned Births, Unsafe Abortions, and Maternal Mortality: Twenty-one percent of all pregnancies that resulted in births are unplanned.[26] Although the *Medical Termination of Pregnancy Act 1971* provides for legal abortion in a range of circumstances, about 20,000 Indian women die annually as a result of unsafe abortions.[27] Unplanned pregnancies, unsafe abortions, miscarriages and complications during pregnancy have all contributed to India's maternal mortality ratio. India has a maternal mortality ratio of 212 per 100,000 live births, which accounts for 19 percent of all global maternal deaths.[28]

"More recently developed and marketed contraceptives are less known among women. Forty-nine percent of women know about injectables, 8 percent know about female condoms, and 11 percent know about emergency contraception."

Knowledge of Family Planning: NFHS-3 data suggests that knowledge of contraception is universal, meaning that nearly all (98 percent) women in India know about at least one type of contraceptive method.[29] However, women's breadth of knowledge is limited, and the majority of the women are unlikely to be aware of the full range of contraceptive choices.[30] Women are more likely to know about sterilization than modern non-permanent methods.[31] For example, roughly 97 percent of women know about sterilization, whereas only about 61 percent of women know about modern spacing methods promoted by the government (pills, IUDS, and condoms).[32] More recently developed and marketed contraceptives are less known among women.[33] Forty-nine percent of women know about injectables, 8 percent know about female condoms, and 11 percent know about emergency contraception.[34] The limited range of knowledge that women have in India compromises their ability to exercise autonomy over their fertility. Women have different needs for contraceptives and these needs change over time. Women may want to delay pregnancy or may decide to have children far enough apart to avoid higher risk pregnancies. They may also want to accommodate other life goals or realities. In this context, women need to use temporary (short or non-permanent longer term) methods like pills and IUDs. Thus, women must know about a wide range of contraceptive options if they are to exercise autonomy over their fertility.

Sources of Family Planning: Eighty-four percent of women were sterilized in government facilities, mainly in government or municipal hospitals.[35] In contrast, most women had their IUD insertions in a private medical facility.[36] The private medical sector also is the most common source for both pills and condoms.[37]

B. National Family Planning and Reproductive Health Programs

1. Brief History

In 1952, India became the first country in the world to make family planning part of its official policy.[38] Initially, the government took a cautious approach to family planning and regarded it as a mechanism to improve maternal and child health rather than a method of population control.[39] Over time, however, the primary focus of the program shifted, placing more emphasis on reaching certain demographic goals and specific targets for population control.[40] These targets were set for states by the Central government.[41] The states would then pursue measures to reach them, usually relying heavily on sterilization.[42]

The target approach became extremely coercive during the Emergency Period (1975-1976).[43] Indira Gandhi, the Prime Minister at the time, declared "We must now act decisively, and bring down the birth rate speedily too. We should not hesitate to take steps which might be described as drastic."[44] Calling for a "frontal attack on the problems of population,"[45] the National Planning Policy of 1976, among its many measures, allowed state legislatures, in exercise of their own powers, to pass legislation for compulsory sterilization.[46] Responding to the call for action, state governments zealously promulgated draconian family planning policies and set ambitious sterilization quotas, which often exceeded the targets set by the Central government.[47] It is estimated that between 1967-77, 8.2 million people were sterilized,[48] millions were harassed by government officials adamant on implementing sterilization programs, and possibly hundreds, died from these measures.[49] These coercive family planning policies resulted in a severe backlash and significant damage to the government's reputation.[50] Following the Emergency Period, the Central government took steps to reassure the public that its family planning policies were voluntary in nature.[51] Nonetheless, the government was still preoccupied with taking a target oriented approach and promoted the use of incentive payments, which in some cases violated women's rights.[52]

The 1990s saw a dramatic shift in family planning policies in India, inspired by the International Conference on Population and Development (ICPD) in 1994 and the Beijing Women's Conference in 1995.[53] For the first time at the ICPD, a consensus was reached concerning population and development issues among countries, including India.[54] The ICPD successfully adopted a Programme of Action, which asserted "the aim of family-planning programs must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods."[55] The Programme of Action constituted a paradigm shift in thinking and action on population issues globally, promoting the idea that implementing education, development, and women child welfare programs is a better way to lower family size than the use of punitive disincentives.[56] As a signatory to the Programme of Action, India agreed to shift from

its old model of family planning to a rights based and target free approach.[57] In 1996, India committed itself to a target free approach to family planning, where health workers' caseloads would be determined by needs identified at the community level, rather than being centrally assigned.[58]

2. Current Policies and Programs

Currently, India does not have a single, cohesive policy or program governing family planning and access to contraceptives. Several overlapping policies and initiatives address issues related to family planning and contraception. These policies are discussed below:

a. National Population Policy

In 2000, India adopted the National Population Policy (NPP), which is managed and monitored by the National Commission on Population.[59] The NPP espouses the principles of the ICPD and "affirms the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive healthcare services, and continuation of the target-free approach in administering family planning services."[60] The NPP articulates several objectives to be reached by 2010.[61] Among these objectives is to attain universal access to contraception, information/ counseling, and services for fertility regulation.[62] The NPP also sets among its goals, increasing the accessibility of reproductive health care, empowering women, improving school attendance among girls, and promoting the delayed marriage of women, not younger than eighteen and ideally older than twenty.[63] Unlike in the past, the NPP does not include punitive disincentives to curb population growth.[64]

Unfortunately, several states have enacted policies discordant with the spirit of the NPP and have established punitive disincentives to curtail population growth including Haryana.[65] Most notably, a number of states have adopted laws restricting parents from participating in local government elections if they have more than two children.[66] Referred to as the Two Child Norm (TCN), these laws have been extended to proscribe entry into public service and deny benefits of development and welfare programs.[67] In the 2003 case *Javed v. State of Haryana,*[68] the Supreme Court upheld the TCN law in Haryana.[69] There, the Court rejected the claim that the TCN law violated the National Population Policy,[70] and instead praised the law as being "salutary and in the public interest," the public interest goal being population control.[71] The Court based its decision on the assumption that women already have the ability to control their fertility.[72]

b. National Rural Health Mission

In 2005, as part of its strategy to improve reproductive health, the Central government of India launched the National Rural Health Mission

(NRHM).[73] Focused on eighteen states with the worst health outcomes, the overarching goal of the NRHM is to "improve the availability of and access to quality healthcare by people, especially for those residing in rural areas, the poor, women, and children."[74] Several targets and strategies of the NRHM are directed towards improving reproductive health. For example, a specific objective of the NRHM is to reduce the maternal mortality ratio to 100 per 100,000 live births by 2012, a goal which India has failed to reach.[75] To meet its objective of reducing maternal deaths, the NRHM subsumed the Reproductive Child Health (RCH) Program,[76] which is a national program directed towards maternal and child health and relies upon the promotion of contraceptives and spacing among its strategies.[77]

A central feature of the NRHM is the "Accredited Social Health Activist" (ASHA), who promotes women and children to use health services in each village.[78] Among their many tasks, ASHA workers play a crucial role in implementing the family planning strategies of the NRHM, namely by providing counseling and distributing contraceptives.[79] The NRHM places an ASHA worker in every village of 1,000.[80] The NRHM guidelines also emphasize the importance of training ASHA workers, suggesting that an ASHA worker should have twenty-three days of training that takes place over five episodes and that training should be a "continuous" process.[81] Under the NRHM, ASHA workers are not paid a fixed salary but rather are paid based on an incentive scheme.[82] For example, the NRHM suggests compensating ASHA workers Rs. 150 for "motivation for tubectomy" and Rs.250 for "motivation for vasectomy/NSV."[83]

Several evaluations made by citizens groups, government entities, UNFPA, and the Comptroller and Auditor General (CAG) expose that the NRHM is falling short on several levels and is not delivering adequate and quality care to the population that it seeks to serve.[84] Reports have criticized the NRHM for corruption, and its inadequate training of health workers.[85] One report provided examples where woman were not receiving the counseling on contraceptives to which they were entitled under the NRHM.[86]

"The NRHM guidelines also emphasize the importance of training ASHA workers, suggesting that an ASHA worker should have twenty-three days of training that takes place over five episodes and that training should be a "continuous" process."

c. Twelfth Five Year Plan

Launched in 1951, the National Planning Commission is charged with setting five year plans that determine the government's major policy objectives and economic strategies over a five year period.[87] India is transitioning from its Eleventh to its Twelfth Five Year Plan.[88] The Twelfth Five Year Plan is subtitled "Faster, Sustainable, and More Inclusive Growth," and places emphasis on the inclusion of women in policies aimed at improving India's economic growth.[89] With regards to family planning, the Twelfth Five Year Plan mentions the importance of spacing methods and making contraceptives accessible to the population through government funding.[90]

d. National Family Welfare Program

The National Family Welfare Program (NFWP) is run by the Ministry of Health and Family Welfare. Launched in 1951, NFWP has followed different approaches according to each of the five year plans. Since October 1997, the services and interventions under the NFWP and the Child Survival and Safe Motherhood Program (CSSM) have been integrated with RCH.[91] According to the most recent annual report (2011-2012), the NFWP is devoted to "the twin objectives of promoting reproductive health and population stabilization within the wider context of sustainable development."[92]

The NFWP emphasizes the provision of a wide basket of contraceptive choices, including condoms, oral contraceptives, IUDs, emergency contraceptives, and permanent methods (e.g., vasectomy, laparoscopic sterilization, and minilap).[93] However, while the NFWP encourages the use of different types of spacing methods, it also heavily promotes sterilization.[94] The NFWP continues to run sterilization camps in states with high fertility rates and encourages NSV.[95] Additionally, the NFWP compensates those who have undergone sterilization for lost wages and also provides insurance in cases of deaths, complications, and failures following sterilization.[96]

"The NFWP continues to run sterilization camps in states with high fertility rates and encourages NSV."

e. National AIDS Control Program

Under this program, the government promotes condom use to prevent HIV/AIDS. The National AIDS Control Program (NACP) provides free government condoms and subsidized commercial brands of condoms.[97] The NACP has launched several innovative initiatives to promote condom use, including condom vending machines and the social marketing of female condoms.[98]

f. National Essential List of Medicines

The Indian Ministry of Health and Family Welfare has compiled a list of essential medicines, "those medicines that satisfy the priority healthcare needs of majority of the population."[99] Under the national government's policy, the medicines in the National List of Essential Medicines (NLEM) should be available at affordable costs and with assured quality.[100] The primary purpose of NLEM is to promote the rational use of medicines considering three important aspects; cost, safety, and efficacy.[101] The NLEM lists hormonal contraceptives (pills), IUDs, and barrier methods (which include only male condoms) among the contraceptive methods to be considered essential medicines.[102]

The World Health Organization (WHO) also has assembled a model list of essential medicines, which is more comprehensive than India's list. The

WHO list includes all of the contraceptive methods listed on the NLEM, as well as injectable hormonal contraceptives, implantable contraceptives, and diaphragms.[103]

g. Sterilization Guidelines

After the Supreme Court ruling in *Ramakant Rai & U.P. and Bihar Health Watch v. Union of India*,[104] which addressed the abhorrent conditions in which sterilization operations were being conducted in Uttar Pradesh, Bihar, and Maharashtra, the Government of India developed extensive guidelines for sterilization in 2006.[105] The 2006 guidelines address the eligibility of providers, the physical requirements of clients about to undergo a sterilization procedure, the clinical process (including providing clients with counseling and obtaining informed consent), post-operative care, and the procedures to be followed during complications related to the sterilization procedure.[106] The guidelines stress the importance of obtaining informed consent and providing counseling.[107] The guidelines state that "clients must be informed of all the available methods of family planning and should be made aware that for all practical purposes this operation is a permanent one" and "clients must make an informed decision for sterilization voluntarily."[108]

C. Socio-Cultural Factors Influencing Women's Contraceptive Access and Usage

In India, contraceptive access and usage is influenced by a complex web of factors including socioeconomic development and health infrastructure, gender dynamics and inequities, education, son preference, and other factors, including caste and tribal association, socioeconomic status, and age.

In India, higher socioeconomic development is strongly linked to higher contraceptive use and lower fertility rates.[109] Research conducted across the world has supported the "demographic transition theory," which posits that fertility rates decline when improvements are made to standard of living, public health programs, educational development, and technology and medicine.[110] One study investigating the regional variety in fertility among Indian states found that more socioeconomically developed states—those with higher levels of modernization, health, education, and family planning services—experienced lower fertility rates.[111] Additionally, experts have highlighted that the reproductive health needs of women will not be improved in the absence of stronger socioeconomic development and improved health infrastructure.[112]

Gender dynamics and inequities influence contraceptive decision-making.[113] Gender inequities manifest in the belief that men should control women's sexuality and their ability to bear children.[114] Women's reliance upon family planning and contraceptives dispels this sense of control.[115] In qualitative studies, men expressed their concern that

they would “lose their role as head of the family,” “their partners will become promiscuous or adulterous,” and “they will be ridiculed by other members of the community.”[116] One often cited study found that regional differences in fertility in India are strongly correlated with a region's degree of patriarchy, defined to be a set of "social institutions that favor men in the allocation of resources and power and deny women the opportunity to be self supporting, thereby making them dependent on male relatives for survival."[117] Those regions with a stronger patriarchy—as measured by marriage patterns, discrimination against women, and the economic productivity of women —generally had higher levels of fertility.[118] Gender inequities are particularly intense in situations of domestic violence and child marriage.[119] In the case of child marriage, girls are in danger of suffering from power inequities and not being able to exercise autonomy in marriage. The UN Special Rapporteur on Violence Against Women,[120] the Human Rights Council,[121] the CEDAW Committee,[122] and the Committee on the Rights of the Child[123] have all condemned the practice of child marriage and have highlighted the devastating health risks associated with it. Global estimates also reveal that there is a high unmet need for contraception among girls in child marriages.[124] Gender inequities also translates into domestic violence. One study on domestic violence and contraceptive use among rural women in India found that women who suffered physical violence from their husbands were significantly less likely to use contraception and more likely to have an unwanted pregnancy.[125]

Research has highlighted the importance of education, particularly of women, in reducing the fertility rates in developing countries.[126] According to a seminal study conducted over thirty years ago, mass education is the most effective way to reduce fertility rates in a population.[127] It increases the cost of raising children and alters the nature of family economies.[128] Research has continued to demonstrate a palpable negative relationship between education and fertility, paying close attention to the education levels of women.[129] Studies focused on India in particular highlight the importance of literacy levels and the education of women in reducing fertility levels.[130] These studies elucidate how contraceptive use is not just influenced by the education level of an individual woman but also the education level of the overall community.[131] For example, women living in communities where other women are educated tend to use contraception more.[132]

In India, the preference for male children is also a compelling factor in contraceptive decision-making.[133] One human rights fact-finding mission in the Indian state of Gujarat found that families preferred sons because of their capacity to do agricultural work and the family's belief that sons could support their parents later in life, while girls could not because they needed to leave their homes to live with their in-laws when they got married.[134] In India, the number of sons in a family influences a woman's decision to use contraception and what type of contraception to use.[135] Women who already have sons are more likely to seek out contraceptive methods and have a higher usage of sterilization.[136] On the other hand, women who do not have sons either do not use contraception or rely upon reversible contraception.[137]

In addition to the above factors, several other variables have been associated with contraceptive use, including caste and tribe status, poverty, and adolescence. In terms of caste and tribe, contraceptive prevalence is lowest among those considered to be from backwards and scheduled castes (48 percent use contraception) compared to those who do not belong to scheduled castes, scheduled tribes, or other backward classes (62 percent use contraception).[138] In terms of economic status, poor women use contraception less. Women living in households in the lowest wealth quintile have a contraceptive prevalence rate of 42 percent, whereas those living in highest quintile have contraceptive prevalence rate of 68 percent.[139] And in terms of age, contraceptive prevalence is lowest among women between fifteen to nineteen years old; 13 percent of married girls and 14.1 percent of sexually active unmarried girls reported currently using some method of contraception.[140] The categories of low caste status, poverty, and adolescence each have also been associated with high maternal mortality rates, suggesting that these categories are not merely ways to stratify data, but also major determinants of access to reproductive healthcare and family planning services.[141] Women who belong to these categories have less access to healthcare and family planning services, and thus are exposed to a higher risk of unintended pregnancies, unsafe abortions, and complications during pregnancy, all of which lead to a higher probability of a suffering from a pregnancy related death.[142]

In the light of above discussion, it is clear that ensuring a target driven approach to family planning fails because women's access to contraception requires addressing women's inequality in society. To fulfill a woman's right to contraceptive services and information, India must address gender inequality and other intersecting forms of discrimination such as caste, race, and class. The most successful way for India to improve contraceptive access is to accompany health system reform with empowering of women, improving women's socioeconomic development and education, and advancing of the importance of the girl child.

Case Study: Access to Contraceptive Services and Information in Haryana

3

This section evaluates whether the government of Haryana is fulfilling its obligations to respect, protect, and fulfill the right to contraceptive services and information for women. Although Haryana is not the worst state in terms of reproductive health outcomes, we selected Haryana for our case study because several of Haryana's policies are concerned with targets, emphasize sterilization, and rely upon punitive disincentives, all of which are antagonistic to a rights based approach to family planning. Furthermore, statistics from national surveys suggest that women in Haryana face serious barriers to contraception and that sharp gender inequities exist in the state. For example, Haryana has a high unmet need for contraception among married women (8.3 percent),[143] and a high maternal mortality ratio (153 per 100,000 live births), indicating that many women do not have access to family planning and reproductive healthcare.[144] Haryana also has the lowest sex child ratio of any state in India, with only 830 girls for every 1,000 boys in the 0-6 age group, suggesting that many couples in Haryana have a strong preference for sons.[145] Moreover 41.4 percent of women in Haryana are married before the legal age of eighteen, which creates perilous situations for these women because they are in danger of suffering from sharp power inequities within marriage, which threatens their autonomy to make decisions about their fertility.[146] Taken together, both the policies and statistics signal that women in Haryana face serious impediments to access contraceptive services and information and that many of their basic human rights are in jeopardy.

This section first provides an overview of the trends of contraceptive use in Haryana. Second, it reviews the various overlapping polices related to contraception in Haryana. This review visibly demonstrates that many of Haryana's contraception related policies contradict the target free approach of the NPP and are more concerned with population control than taking a rights based approach to family planning. Third, we discuss our methodology and findings from 168 married women, 120 unmarried women, seventeen ASHA workers, eleven healthcare workers, and ninety-one pharmacies and medicine shops. Finally, we provide our multi-stakeholder analysis and human rights assessment of access to contraceptive services and information for women in Haryana. We conclude that Haryana is failing in its obligations to respect, protect, and fulfill the right to contraceptive services and information for women.

A. Trends

General Demographic Data: The state of Haryana has a population of 25,353,081 (male, 13,505,130; female, 11,847,951).[147] Women generally have a lower education

status than men in the state with 40 percent of women receiving no education (compared to 19 percent of men with no education) and only 8.7 percent of women receiving education of over twelve years (14.3 percent men).[148] Roughly 60.4 percent of women are literate, compared to approximately 83.4 percent of men.[149] Women also have lower rates of employment than men.[150] About 23.1 percent of married women were employed in the past twelve months of the NFHS-3 survey being conducted, whereas 83.7 percent of married men in the same age group were employed in the past twelve months of the survey being conducted.[151]

Contraceptive Use: According to NFHS-3 data, 63.5 percent of married women are using contraception, and 58.3 percent are using modern methods. Of the married women using modern methods, nearly two thirds of them were sterilized, 18.8 percent used condoms, 1.2 percent were married to men who were sterilized, and the remaining 9.4 percent used other spacing methods, including pills, IUDs, injectables, and condoms.[152] A 2008 study among Muslim women in Haryana found that nearly 35 percent of research participants were using contraceptive methods. Out of the total protected females, 61 percent were using spacing methods and 39 percent were using terminal methods.[153]

"According to 2011 Indian Census data, Haryana has the lowest sex- child ratio of any state, with only 830 girls for every 1,000 boys in the 0-6 age group."

Unmet Need for Contraceptives: Among married women, Haryana's total unmet need for contraception is 8.3 percent (3.1 percent for spacing and 5.2 percent for limiting).[154]

Sex-Child Ratios: According to 2011 Indian Census data, Haryana has the lowest sex-child ratio of any state, with only 830 girls for every 1,000 boys in the 0-6 age group.[155]

Total Fertility Rate: Haryana has a fertility rate at 2.3 (2.0 in urban areas, and 2.5 in rural areas), which is close to the national fertility rate (2.5).[156]

Maternal Mortality: Haryana has a maternal mortality ratio of 153,[157] which is lower than the national maternal mortality ratio (212 per 100,000 live births)[158] but still much higher than the MDG 2015 goal set for India, which is to reduce the maternal mortality ratio to 109 per 100,000 live births.[159]

Knowledge of Family Planning: According to NFHS-3 data, married women in Haryana have varied awareness about different contraceptive methods, with the greatest awareness about female sterilization at 96.2 percent (male sterilization, 82.4 percent; pills, 90.2 percent; IUDs, 84.5 percent; injectables, 46.1 percent; male condoms, 85.4 percent; female condoms, 4.9 percent; emergency contraception, 12.8 percent).[160] A more recent 2011 study on contraceptive practices among 250 couples in Haryana also found that women had uneven knowledge about different types of contraceptive methods, with the greatest awareness about female sterilization at 92 percent (male sterilization, 79.6 percent; oral pills, 90.4 percent; IUDs, 82.4 percent; injectables, 39.2 percent; condoms, 84 percent; female condoms, 2.8 percent; emergency contraception, 10.8 percent).[161]

Sources of Family Planning: According to NFHS-3 data, 90.1 percent of women were sterilized in government hospitals and 49.4 percent of women had their IUD insertions at public facilities, whereas only a small percentage of women obtained their pills (22.4 percent) and condoms (15.6 percent) from the public sector.[162]

B. Haryana's Policies and Initiatives

Haryana has several policies and initiatives that address family planning and contraception. Many of the initiatives push for sterilization and are target based, which are discordant with the 2000 National Population Policy, which purports to be committed to a more holistic approach to family planning.

The health budget estimate for the Health Department, Haryana during the year 2010-11 was Rs. 202.00 crores. The budget estimate for the year 2011-2012 was Rs. 234.64 crores.[163]

1. Haryana State Population Commission

In 2000, the Haryana State Commission on Population (HSCP) was constituted under the National Population Commission.[164] At a 2000 conference among several state population commissions, the Haryana Director of Health Services summarized HSCP's strategies and objectives for population stabilization in Haryana.[165] Many of which focused on sterilization and disincentives rather than spacing methods, which are dissonant with the goals of the NPP.

At the 2000 conference, the Director of Health Services said that the HSCP persuaded couples with two or more children to seek terminal methods of contraception, but encouraged other couples to seek any method of their choice.[166] As a way to promote male participation in family planning, the government introduced the NSV program and trained doctors in seventeen districts to conduct the procedure.[167] They also promoted the one child norm, as well as spacing of children and the birth of the girl child.[168] Haryana additionally gave monthly incentives of Rs. 500 per month to couples who underwent sterilization procedures upon the birth of their first child or second child provided both the children were girls.[169]

The Director of Health Services further explained that Haryana has a scheme of incentives and disincentives for promoting the small family norm.[170] Incentives included providing all family welfare services free of cost; compensating those who underwent sterilization; and providing maternity leave for up to 180 days for government employees with less than two children; allowing leave benefit for men who have undergone sterilization; and offering abortion leave for government employees.[171] Disincentives included not providing maternity leave to female government employees who had more than two children.[172] Additionally, under the 1994 Panchayat Act, a person with more than two children cannot contest elections.[173] This law was upheld by the Supreme Court in *Javed v. State of Haryana.*[174]

"As a way to promote male participation in family planning, the government introduced the NSV program and trained doctors in seventeen districts to conduct the procedure."

2. Family Welfare Program, Haryana

The NFWP is run by the Central government, and the government of Haryana is charged with implementing the NFWP in the state according to the Central government guidelines.[175] Much like Haryana's other family planning programs, the Haryana FWP is antagonistic to the objectives and strategies of the NPP. The Haryana FWP also pushes for sterilization above other contraceptive methods and set targets. The Haryana FWP provides the following table of targets and achievements for contraceptive use among its population:[176]

Method	Target for the year 2010-2011	Proportionate Target	Achievement During the month (June, 2010)	Cumulative Achievement (June, 2010)	%age Achievement
Sterilization	120000	30000	8520	23626	78.8
IUD	230000	57500	14668	43758	76.1
C.C. Users	395000	98750	10537	37490	38.0
O.P. Users	80000	20000	4555	15387	76.9

Although the lowest target is set for sterilization, the Haryana FWP places emphasis on permanent methods as a way to curb population growth.[177] Haryana seeks to reach a total fertility rate of 2.1.[178] To meet this end, it has several new initiatives, all of which involve permanent methods.[179] None involve modern temporary methods or spacing.[180] The new initiatives include vasectomy and tubectomy camps.[181] The government has planned and implemented hundreds of vasectomy and tubectomy camps in district hospitals, sub-divisional hospitals, community health centers, and primary health care centers. In 2009-2010, 336 NSV camps were planned and 273 were held; 1092 tubectomy camps were planned and 892 were held.[182] The government also has planned for static fixed day tubectomy and vasectomy operations to be held at district hospitals, sub-divisional hospitals, and selected community and primary health care centers.[183] Additionally, the Haryana FWP has set aside a separate sterilization budget, which has been earmarked to give Rs. 600 to persons of scheduled caste, scheduled tribe, or below poverty level who have undergone tubectomy.[184] All others will receive Rs. 250 for having undergone a tubectomy procedure.[185]

3. Haryana AIDS Control Society

The Haryana AIDS Control Society (HACS) was established as per the guidelines of the National AIDS Control Organization (NACO) and is the main HIV/AIDS control program for Haryana.[186] Among its activities, HACS promotes the use of condoms to protect against HIV/AIDS.[187] It also conducts several education campaigns to raise awareness around HIV/AIDS, including through newspapers, radio, televisions, street plays, posters, pamphlets, booklets, advocacy workshops, meetings, functions, and outreach camps.[188] HACS also runs a school education program and red ribbon

clubs.[189] The school education program is directed at children in classes ninth to twelfth and sensitizes them to various issues of HIV/AIDS.[190] The program reached 4500 schools in 2006-07 and 2250 schools in 2007-08.[191] The red ribbon clubs are geared towards sensitizing college students on various aspects of HIV/AIDS through seminars and workshops.[192] The clubs are run in twenty government colleges and eighty-two private colleges.[193]

4. National Rural Health Mission, Haryana

The National Rural Health Mission (NRHM) is a Central government program that is implemented at the state level. The Haryana NRHM encourages a holistic approach to family planning by strengthening the health infrastructure and advancing community participation. However, it also heavily promotes sterilization.

Several of the initiatives are geared towards taking a comprehensive approach to family planning. According to Haryana NRHM's most recent progress report, 13,096 ASHA workers have been hired to work throughout the state.[194] In order to reduce maternal and child deaths and stabilize the population, the Haryana NRHM plans to "expand facilities capable of providing contraception."[195] Additionally, the Haryana NRHM has set up a system of mobile health units that, among its functions, provides family planning services like IUD insertion, condoms, emergency contraceptives, and oral pills.[196]

However, in implementing the NRHM, the Haryana government continues to push for sterilization as the primary method of contraception.[197] In the most recent Haryana NRHM progress report, the only targets set for contraception are those set for sterilization; none were set for temporary and spacing methods.[198] Between 2006-2010, a total of 31,700 male sterilizations were performed and 231,000 female sterilizations were performed.[199] See chart below:[200]

Services	06-07	07-08	08-09	09-10	Total
Male Sterilization	9,700	9,800	10,000	2,200	**31,700**
Female sterilization	55,000	71,000	77,000	28,000	**231000**

5. Essential Drug List

The government of Haryana guarantees that essential medicines will be available and supplied free of cost to all out-patient department/casualty patients and deliveries in all government-run health facilities in the state.[201] By providing these medicines free of cost, the Haryana government policy goes one step further than the Indian government policy, which only states that these medicines should be affordable. Included on Haryana's essential list of medicines are IUDS, pills, and condoms.[202]

In sum, a review of the policies demonstrates that many of Haryana's family policy strategies are dissonant with the target free approach of the NPP. Although several of

Haryana's policies encourage temporary and spacing methods, the push is largely towards sterilization. Furthermore, the state relies upon punitive disincentives to curb population growth, most notably the Two Child Norm.

C. Methodology

The primary objective of this study is to examine whether Haryana is fulfilling its obligations to provide women with access to contraceptive information and services. This study focuses on three questions: (1) Is Haryana implementing its policies around contraception and how is the state implementing its policies? (2) Are women able to enjoy their right to access contraceptive information and services? (3) What are the main policy, economic, social, and cultural barriers to contraceptive services and information that women face? Through a multi-stakeholder analysis, we conducted semi-structured qualitative personal interviews with key stakeholders, including married women, unmarried women and adolescents, ASHA workers, health care workers in government hospitals, and public and private pharmacies and medicine shops (hereinafter referred to as pharmacies). Participation in the study was voluntary in nature and informed consent was taken from all participants. The study focused on five districts in Haryana: Panipat, Sonipat, Kurukshetra, Kaithal, and Mewat. The lead researchers along with six research assistants conducted interviews in Hindi and English. Researchers were fluent in both languages. When conducting interviews, researchers relied upon a semi-structured questionnaire. Researchers field tested a pilot questionnaire. A re-pilot was conducted to test the questionnaire after amendments and changes were made to the questionnaire. Two hundred and eighty-eight women (married and unmarried) were interviewed from the five districts.

Interviews were also conducted with ASHA workers in each district, health officials from one government hospital in each district, and ninety-one owners and employees from pharmacies in all five districts.

Lead researchers and research assistants prepared careful field notes, which was the main mode of recording the interviews since some participants were uncomfortable with video or audio recordings.

For the analysis, we transferred the responses from the interviews with each stakeholder into a grid. In total, we created five grids, one grid per stakeholder. Most of the questions in the survey generated binary responses (a “yes” or “no” response). For these questions, we were able to quantify the responses. Some of the responses to the questions were narratives. In those cases, and where we could, we converted the narratives into a binary response and incorporated them into the grids. We also included those narratives that were particularly vivid and contributed to our understanding of access to contraception in Haryana into the findings, as provided in the next section.

This analysis has a number of limitations. We were unable to interview men and their perspectives are thus not included in this analysis. Many ASHA workers were absent

on days that we visited their district, and thus we interviewed more ASHA workers from some districts than in others. Some healthcare workers were also non-cooperative and thus the analysis does not fully capture their perspectives. Additionally, we did not collect data on socioeconomic status, caste, or religion as this was outside the scope of the analysis. This analysis cannot be used to describe how these factors influence both access and usage of contraception. Finally, the analysis is based on self-report data.

Despite these limitations, however, this analysis is valid and reliable and provides a nuanced depiction of the state of access to contraception among women in Haryana. By taking a multi-stakeholder analysis, we were able to corroborate stakeholder perspectives against each other. The findings also are consonant with NFHS-3 data and other studies investigating contraceptive access and usage among women in India broadly and in Haryana specifically. Furthermore, we sampled a large group of stakeholders from five districts to capture a wide range of perspectives. Finally, the findings provide a deeper and richer understanding of contraceptive access and usage among women in Haryana by taking a multi-stakeholder analysis that synthesizes varied perspectives. National household surveys and other studies only consider data from married and unmarried men and women but do not consider the perspectives of ASHA workers, healthcare workers, and pharmacies. These perspectives are also crucial to understanding fully the state of contraceptive access and usage among women in Haryana.

To protect the anonymity and confidentiality of the stakeholders, their names have not been used in this report. We also did not identify them by the district where they belonged.

D. Findings

1. Married Women

In this study, 168 married women between the ages of eighteen and sixty were interviewed in five districts of Haryana. We conducted interviews either in their homes or at *Anganwadis* (community centers where workers provide child and maternal health and education services.). The average age of the women was 30.5 years. The average age at the time of their marriage was 18.2 years. Fifty-four women were married at age eighteen or younger, twelve of whom were married between the ages of nine to thirteen. The average number of children per woman was two to three children.

Main Findings:

Contraceptive Prevalence: A significant number of the women (57.7 percent) said that they had never used contraception.

Stigma: One married woman described the stigma associated with buying condoms,

If I go to the pharmacist and buy contraceptives every now and then, people might talk behind my back. They might think that I enjoy sex and that I am shameless.

Awareness: A fair percentage of married women (45.2 percent) said that they did not know about diaphragms or female condoms. In the conversations with married women about modern contraceptive methods, only a small percentage mentioned copper T (11.3 percent), condoms (9.5 percent), and pills (2 percent).

Receiving Information: Many married women (52.4 percent) commented that they did not receive information or counseling about contraception at the government hospitals. Of those who were told about contraception in hospitals, they reported receiving information mainly in the HIV/AIDS counseling room. Most of these women reported that they only received information about copper T or sterilization.

Sterilization: Several women (47.6 percent) said that they were aware of sterilization camps, and 17.2 percent said they had visited a sterilization camp. They had also accessed sterilization facilities in the government or private hospitals. A few women said that they underwent sterilization procedures because their husbands would not use condoms.

One woman recounted her experience of her husband undergoing a sterilization procedure. She described the painful consequences of sterilization as being an irreversible procedure that permanently deprives couples of the option having another child,

I was returning from the market when I came to know that my husband got sterilized. He did not consult me and now that I want to have another child as one of my two children had passed away, I cannot.

Seeking Care: A majority of the women (94.6 percent) said that they never went to a health consultancy before pregnancy, and approximately 66 percent never met with an ASHA worker. About 4 percent said that the ASHA worker was either inaccessible or there was no ASHA worker available in their village. Of the roughly 32 percent (53 women) who said that they saw an ASHA worker, twelve expressed dissatisfaction towards the ASHA workers. The rest either found the ASHA worker to be good or very good.

Where to Seek Care: Approximately 59 percent said that they preferred to seek care from a private hospital. These women said that they would prefer their delivery either in a private hospital or at their home. They described the quality of health services and care in government hospitals to be dismal. Women also preferred to go to private facilities for condoms. As one of the married women said,

I do not use government condoms. Government condoms are not easily available and their quality is questionable.

Misconceptions: There were misconceptions about reversible contraceptive methods that made women skeptical about using these methods. For example, one woman said,

"Copper T is not safe. It might cause bleeding." Another woman said, "*I have heard that Copper T is not safe and can travel to other parts of the body like my brain or heart. I am scared to use it."* Two other woman said that they "*were afraid to use Copper T*" because they had heard that *"a woman's Copper T had gone into her stomach and caused infection."*

Son Preference: Several women reported that they did not use contraception immediately after they got married and avoided using contraception until they had a male child. For example, one married women said,

We also believe in spacing of children but we do not use any contraceptive methods unless we have a son. If my first born is a boy, I will be happy to use contraception to avoid further pregnancy. I would not want another child.

2. Unmarried Women

We interviewed 120 girls between the ages of sixteen to twenty-four in post high school graduate college settings. The average age of the girls was 19.7 years old.

Main Findings:

Views on Contraception as a Health Issue: Nearly 58 percent of unmarried women view contraception as a health issue, and 8 percent had no idea whether it was a health issue.

Access to Care: Eighty-five percent of unmarried women said that there was no healthcare facility at their university. Four said that they only had a medicine dispensary on campus. One of the girls said,

We would like to have sex education and health related workshops on campus. We would also welcome health facilities on campus. There is nothing wrong in knowing about one's well-being. There are only posters on campus but we have never had a counselor on campus.

Awareness: Nearly 86 percent expressed the view that they did not know about the full range of contraceptives available, but 54 percent said that they had knowledge about sterilization. A majority of the unmarried women (72.5 percent) did not know about the government's free condom scheme.

Sex Education: Ninety percent of unmarried women said they did not receive sex education, either by way of conference, seminar, or camp. They identified that their main sources of information on contraception were TV, books, friends, movies, and posters. The internet was the primary source of contraceptive information at one university, where many women were pursuing a masters degree in computer science. Many of the women at this university were aware of contraception. Although they were not aware of the full range of contraceptive methods, they were familiar with the popular ones.

Access to Contraception: About 91 percent of unmarried women said that they felt socioeconomic barriers to contraception, and 10 percent commented that they did not feel they could talk freely about contraception. Four of the women specifically remarked that they did not want to talk about contraception because of the ensuing discrimination or stigma they would face. One of the girls said,

Knowledge about contraception means that you have engaged in premarital sex hence I am scared to read or talk about contraception.

3. ASHA Workers

Seventeen ASHA workers were interviewed. Their working experience ranged from one month to six years. We were unable to interview a large number of ASHA workers in these districts because their *Anganwadis* were closed during our multiple visits to them.

Main Findings:

Training of ASHA Workers: The training of the ASHA workers varied. Five of the ASHA workers said that they had received training multiple times. Five others, however, said that they received either no or delayed training. Three ASHA workers who had been working for a month said they received no training, and one ASHA worker said that she had been working for three months without any training. Another ASHA worker said that in her five years of working, she only received training after five months of work and never received any other training after that. Further, ASHA workers were required to do multiple tasks including administering polio vaccines to children, providing prenatal care for women, and motivating women to deliver in government hospitals among others. Distributing contraception and telling women about their contraceptive options were not high on their priority lists.

Fixed Salary: Seven ASHA workers complained about not having a fixed salary. One of the ASHA workers said,

We get only Rs. 400 per month that gets spent for transport for the meeting for ASHA workers .

Another ASHA worker said,

We are stuck between the government and the villagers. Here we cannot provide them with proper care due to lack of training and the government does not provide us with training. There is no motivation to work in this field. I will quit if I do not get proper pay soon.

Working Conditions: Only one district provided ASHA workers with a separate room to work. The other districts did not provide a separate room for work and lacked an adequate supply of condoms. ASHA workers in these districts worked from the

Anganwadi, many of which were closed during our multiple visits to them. Most of the ASHA workers were very unhappy with their working conditions, which they described to be not only unsatisfactory but hostile as well. One of them said,

When we take pregnant women for deliveries to the hospitals, there is no place for us to stay during night, and the hospital staff is extremely rude. We do not get paid on time and have to go to the officials several times before we receive our payment. Further, in case of mishaps during delivery, the village people and family of the women blame ASHA workers. Recently, an ASHA worker was beaten up by the family members because the delivery in the hospital was unsuccessful.

Doctors in the Hospital: Two ASHA workers complained about the doctors in a hospital. One said*, "The doctor is rude, not well-trained for performing sterilization operation. Many women had suffered with swollen stitches, post sterilization operation."*

ASHA Workers' Observations about their Female Clients: Some ASHA workers said that most women were not interested in using contraception, and that they relied on their husbands to use contraception. Another ASHA worker said that most women are scared to use copper T.

ASHA Workers Encouraging Sterilization over Other Contraceptive Methods: Several ASHA workers mentioned that they motivated women to undergo sterilization after two children. Since they were given monetary incentives for promoting sterilization, some ASHA workers said that they usually promoted sterilization as the most effective method of contraception. One ASHA worker said that she knew about different types of contraceptives (IUDs, condoms, oral contraceptives) and would distribute them at the *Anganwadi*. She, however, only recommended sterilization. She received Rs. 150 per sterilization and Rs. 250 per delivery.

4. Healthcare Workers

Eleven healthcare workers were interviewed, including four gynaecologists, one primary care doctor, one counselor, one AIDS counselor, one supervisor, and two ANMs (auxiliary nurse midwives). There were varying levels of cooperation to participate in the study based on district.

Main Findings:

Sterilization: According to the three doctors interviewed at a government hospital, sterilization is the preferred method of contraception by women. Copper T was the second most preferred method. One doctor estimated that 20 percent of women prefer copper T. She also mentioned that while some women would like to try temporary spacing methods, their mothers-in-law and husbands usually stopped them from

pursuing this option. One doctor stated that women underwent sterilization procedures only after they had had two or three children. Some doctors also mentioned that free sterilization camps were organized once a week, which were run by a family planning officer and ASHA workers. All the healthcare workers interviewed in all districts said that they always took consent of their patients before administering the sterilization procedure. One of the healthcare workers mentioned that she specifically focused on motivating married women to undergo sterilization procedures.

Lack of Diaphragms and Female Condoms: All government hospitals that we visited had a dedicated family planning and counseling ward where contraception was meant to be distributed free of cost. During the conversation with the healthcare workers in the districts, none of these wards stocked diaphragms or female condoms and were not even aware of this contraceptive method. All of them stocked male condoms, contraceptive pills, (given on prescription only) and IUDs. We managed to obtain free condom samples from all the wards in four districts except one. Also, the civil government hospital pharmacy in one district did not sell condoms. A staff worker at the civil government hospital said that they did not sell condoms because these were freely available in the AIDS counseling ward and the postpartum ward (special ward for family planning and pregnant ladies and child care).

The Use of Copper T: A healthcare worker in the postpartum ward said that, "*After delivery, many women are motivated to use copper T."* In contrast, another healthcare described the reluctance of women to use copper T. She said,

Most of them were scared and reluctant to use a copper T because they thought it was a needle.

Despite these reservations, however, she mentioned that copper T was the second most preferred and recommended contraceptive after sterilization.

Stigma Around Condoms: Many of the healthcare workers spoke about the stigma surrounding contraception, which discouraged women from talking about it. Most healthcare workers said that women were extremely reluctant to talk about contraceptives and usually whispered in their ears if they wanted contraceptives. According to a doctor in Sonipat, there is no counseling provided to women because the women are reluctant to speak about contraception. If a patient was in need of family counseling, the patient usually would be sent to the HIV/AIDS counselor.

5. Pharmacies and Medicine Shops

We surveyed ninety-one pharmacies, both government and private, in all five districts.

Main Findings:

Availability of Contraceptives: Most pharmacies had condoms (98.9 percent of pharmacies) and birth control pills (90.1 percent) in stock. However, most did not carry injectables (90.1 percent) or female condoms (96.7 percent).

Knowledge and Information: Based on conversations with employees at pharmacies, there appeared to be a limited range of knowledge on contraception. The employees working at pharmacies were mostly aware of male condoms, oral contraceptives, and IUDs.

Few Women Buying Contraceptives: Seventy-five percent of the pharmacies said that women did not buy contraceptives from their shop and had never seen a woman purchase a contraceptive in the last ten years. A pharmacy in one district stated that roughly 10-20 percent women visited their store to purchase pills, and another pharmacy claimed that no woman had ever approached them for contraceptives.

Selling after the Expiration Date: Only the government pharmacies were giving out contraceptives for free. Some private pharmacies were selling government subsidized condoms, which are supposed to be distributed free of cost in government hospitals. For example, in one of the districts, the expiration date on the box had passed. The employee at the pharmacy struck off the date of manufacturing on the box and sold the box of condoms.

Lack of Diaphragms and Female Condoms: Two out of ninety-one pharmacies (2 percent) had stocked diaphragms and female condoms in the past. None of them had a current stock of diaphragms and female condoms. They had stopped stocking diaphragms for lack of demand. Two pharmacies had sold them previously but they did not have stock on that particular day.

Prescription Requirement: Except for government pharmacies, most of the pharmacies (72.5 percent) did not require prescriptions for pills. In one district surveyed, however, two of the pharmacies required a prescription for oral pills.

"Two out of ninety-one pharmacies (2 percent) had stocked diaphragms and female condoms in the past. None of them had a current stock of diaphragms and female condoms."

E. Multi-stakeholder Analysis and Human Rights Assessment of the Right to Access Contraceptive Services and Information in Haryana

The study reveals that women in Haryana are denied access to the full range of contraceptives, as well as to the information and means to make decisions about their fertility for a plethora of reasons. First, Haryana's policies place a singular focus on sterilization over short term and reversible spacing methods. Second, failures and inefficiencies within Haryana's healthcare system hinder women from realizing their right to contraceptive services and information. Healthcare workers are also not trained on the full range of contraceptives. These systemic failures and inefficiencies compromise the availability, accessibility, acceptability, and quality of contraceptive services and information in Haryana. Third, Haryana fails to provide sexual and reproductive health education to women. As a result of the lack of information and education on contraception, women have misconceptions about contraceptives leading to fear of using certain methods and disuse of contraceptives even when they are at risk of unintended pregnancy. Finally, women face significant social and cultural barriers to contraceptive information and services, including stigma

surrounding use of contraceptives, particularly for unmarried women, as well as lack of autonomy in decision-making as a result of pressure from husbands or in-laws.

These findings evince that women in Haryana are unable to enjoy their basic right to health, right to life, right to equality and non-discrimination, right to reproductive self-determination, right to privacy, right to be free from torture, and cruel, inhuman or degrading treatment; and the right to enjoy benefits of scientific progress.[203] These fundamental rights are protected under the Indian Constitution, Indian Supreme Court and High Court jurisprudence, and international treaties to which India is a party, namely the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Convention on the Rights of the Child (CRC).[204] They also find support in Indian policies and international consensus agreements, namely the ICPD.[205] Moreover, the UN's Millennium Development Goals (MDGs), which India has integrated into its national policy, include universal access to reproductive health among its goals (Target 5b), which also means universal access to contraception.[206]

Under a human rights framework, Haryana has an obligation to respect, protect, and fulfill the right to contraceptive information.[207] The duty to respect requires that Haryana does not directly interfere with enjoyment of the right.[208] For example, Haryana should not restrict access and the availability of spacing methods by pushing sterilization over other forms of temporary contraception. The duty to protect requires Haryana to prevent third parties from interfering with the right to contraceptive services and information.[209] For instance, Haryana must ensure that pharmacies do not provide contraceptives of poor quality. Finally, the duty to fulfill requires that Haryana adopts the necessary legislative, administrative, budgetary, judicial and promotional measures towards the full realization of the right to contraceptive services and information.[210] Thus, through its policies and programs, Haryana must provide women with access to contraception and the means and information to make fully informed decisions about their fertility and reproductive health.

The section below analyzes the various perspectives of the stakeholders in the study within the context of both Indian constitutional and international human rights law. It elucidates how Haryana is in violation of its obligations under a human rights framework to respect, protect, and fulfill the right to contraceptive services and information. It specifically focuses on (1) Haryana's policies that push for sterilization and the failure to ensure access to the full range of contraceptive methods; (2) the unavailability of contraceptive services and information; (3) the poor quality of contraceptive services and information; (4) limited access to education and information on contraception; and (5) cultural and social barriers to contraception.

1. The Push for Sterilization & the Failure to Ensure Access to the Full Range of Contraceptives

Haryana's policies push for sterilization over other contraceptive methods. In 2000, the Haryana State Population Commission openly stated that it motivates couples with more than two children to seek terminal contraceptive methods.[211] In implementing the NRHM and the NFWP, the Haryana government continues to emphasize sterilization over other measures.[212] Under the NRHM, ASHA workers get monetary incentives for encouraging couples to undergo sterilization.[213] All of the new initiatives listed under Haryana's Family Welfare Program involve permanent methods, including setting up tubectomy and vasectomy camps.[214] Most of the ASHA workers and healthcare workers confirmed that sterilization camps were being organized in the districts on a continuous basis and the ASHA workers were given financial incentives to motivate men and women for sterilization. The Haryana FWP has also set aside a sterilization budget, which has been earmarked to give RS. 600 to persons of scheduled caste, scheduled tribe, or below poverty level who have undergone tubectomy.[215]

a) Violation of the Right to Information and the Grave Implications for Other Rights

Haryana's emphasis on sterilization suppresses the information available to women on contraception, which creates precarious conditions for women to realize their human rights. These policies that push for sterilization not only endanger a woman's rights to information, but also other basic human rights, including the rights to health, life, and reproductive self-determination.[216] Although the Indian Supreme Court has yet to recognize a right to contraceptive information or sex education, the Court has acknowledged a basic right to information.[217] Further, international human rights law protects the right to contraceptive information and sex education. Article 10(h) of CEDAW declares, "States Parties shall . . . ensure . . . [a]ccess to specific educational information to help ensure the health and well-being of families, including information and advice on family planning."[218] The CEDAW Committee, which monitors compliance with CEDAW, also has posited, "women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services" so that they can make informed decisions about the contraceptive methods that is most appropriate for them.[219] The Economic, Social, and Cultural Rights Committee (ESCR), which monitors the ICESCR, has also stated in General Comment 14 that education and information on sexual and reproductive health are central components of the right to health.[220]

The conversations with multiple stakeholders reveal that women are not given comprehensive information about the full range of contraceptive methods. ASHA workers mentioned that they only tell couples about

sterilization because they get monetary incentives for motivating couples to seek permanent methods of contraception. Consequently, women are not sufficiently aware of their contraceptive options. Among the married women in the study, 86 percent said that they did not know about the full range of contraceptives.

The chilling effect that these policies have upon access to information has severe adverse implications for the right to life, right to health, right to reproductive self-determination, right to be free from torture and cruel, inhuman or degrading treatment, the right to equality and non-discrimination, and the right to enjoy the benefits from scientific progress.[221] Specifically, policies that push for sterilization hamper the realization of these other rights because they result in some women not being aware of temporary methods or believing that such methods are unsafe, unavailable or inaccessible.

"ASHA workers mentioned that they only tell couples about sterilization because they get monetary incentives for motivating couples to seek permanent methods of contraception"

b) Violation of the Rights to Life & Health

The Indian Constitution recognizes the right to life (Article 21)[222] as a fundamental right, and the Court has broadly interpreted the right to life to mean a life with dignity.[223] Under Article 21, the Court has expanded the right to life with dignity to encompass the right to health.[224] Furthermore, the right to life and health are both recognized under international instruments to which India is a party, including the ICCPR,[225] ICESCR,[226] CEDAW,[227] and CRC.[228]

Under General Comment 14, both accessibility and availability are critical aspects of the right to health.[229] To fully enjoy their right to health, women must be both aware of and have access to a full range of contraceptive choices. Not all contraceptive methods are appropriate for all women. Therefore, women must have access to and information about a wide range of contraceptive methods in order to make autonomous decisions about their reproductive health.[230] Moreover, by not having comprehensive and adequate information, women are unable to make fully informed choices about their health and about when and if they want to have children, all of which make women vulnerable to being coerced into sterilization. These circumstance compromise the acceptability component of the right to health.[231] According to General Comment 14, "all health facilities, goods and services must be respectful of medical ethics and culturally appropriate," which means that they also must be "sensitive to gender and life-cycle requirements" and "designed to respect confidentiality . . . of those concerned."[232] The CEDAW Committee has also explained the acceptability component as follows; "acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her

dignity, guarantees her confidentiality, and is sensitive to her needs and perspectives."[233]

Furthermore, if women are only informed about sterilization and are not aware of other less invasive and temporary and reversible methods, women who do not want to undergo sterilization may decide not to use contraception altogether, which exposes them to the risk of unintended pregnancies and in turn, increases their likelihood of having an unsafe abortion and experiencing complications during pregnancy, all of which make women more vulnerable to death during pregnancy. The Special Rapporteur on the Right to Health and several Treaty Monitory Bodies, including the CEDAW Committee and the Committee on Economic, Social and Cultural Rights, have expressed concern about the high incidence of pregnancy related deaths in India.[234]

c) Violations of the Rights to Reproductive Self-Determination & Privacy

Haryana's policies that push for sterilization endanger a woman's right to reproductive self-determination and privacy. The Indian Supreme Court has addressed reproductive health issues in cases of failed sterilization,[235] and forced sterilization.[236] Several high courts, most notably the Delhi High Court in *Laxmi Mandal v. Deen Dayal Harinagar Hospital and Ors*,[237] have issued rulings recognizing reproductive health, specifically maternal health, as a fundamental right in cases of maternal mortality.[238] International human rights law also affords protection to reproductive self-determination, specifically in its provisions protecting the right to determine the number and spacing of children(CEDAW, Art. 16(1) and the right to privacy (ICCPR art. 17(1), CRC 16 (1).[239]

Haryana's policies presume that sterilization is the only option that women need and deny women access to information on other contraceptive methods. In order to make fully informed decisions about their reproductive health, women need to have information about a wide range of contraceptive choices because not every contraceptive method is appropriate for every woman. Thus, Haryana's policies that stifle information on contraception preclude women from enjoying their right to reproductive self-determination and their right to privacy to make decisions about their own fertility.

d) Violation of the Right to be Free from Torture and Cruel, Inhuman or Degrading Treatment

Additionally, the push for sterilization can lead to instances of coercive sterilization, which threaten a woman's right to be free from torture and cruel, inhuman or degrading treatment.[240] The recent report by Special

Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment emphasizes that involuntary sterilization amounts to torture.[241] In 2007, the Supreme Court in *Ramakant Rai v. Union of India*.[242] specifically held that international human rights law protects the rights of women to have access to voluntary sterilization services free of coercion, discrimination, and violence.[243] Without being fully aware of other contraceptive methods, women who undergo sterilization are doing so without informed consent, which constitutes coercion. Being coerced into sterilization can have long lasting physical and psychological effects, permanently stripping women of their reproductive capabilities and causing severe mental distress. Unfortunately, in India, there have been numerous instances of coercive sterilization that have been reported in the media.[244]

e) Violation of the Right to Equality & Non-discrimination

Haryana's policies also prevent women from fully realizing their right to equality and non-discrimination. Article 14 and 15 of the Indian Constitution protects equality as a fundamental right.[245] The Supreme Court has described gender equality as one of the "most precious Fundamental Rights guaranteed by the Constitution of India."[246] International human rights law instruments, namely the ICCPR,[247] CEDAW,[248] and CRC,[249] also guarantee the rights of equality and non-discrimination. Paying women to undergo permanent sterilization is inherently coercive and violates women's fundamental rights as protected by international human rights law. The push for sterilization also has a disproportionate impact on women compared to men, having a greater adverse effect on their autonomy and ability to freely make decisions about their reproductive health. Without the ability to fully enjoy their right to reproductive freedom, women cannot fully participate in society and are more vulnerable to exploitation and abuse.

f) Violation of the Right to Enjoy the Benefits of Scientific Progress

Moreover, Haryana's policies preclude women from realizing their right to enjoy the benefits of scientific progress.[250] Because of policies that emphasize sterilization, women are less aware of other modern reversible methods of contraception, most notably female condoms and diaphragms, and they cannot take advantage of these methods.

In sum, by creating and enforcing policies that push for sterilization over other temporary methods, Haryana is violating its duties under a human rights framework. Specifically, these policies violate Haryana's obligations to respect the right to contraceptive services and information. Polices that heavily promote sterilization directly interfere with the right to contraceptive services and information by compromising the availability of temporary spacing methods and suppressing the information available to

women on contraception. The push for sterilization also contravenes with Indian policies, most notably the NPP and the 2006 Sterilization Guidelines. The NPP promotes the principles of the ICPD, which recognizes "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."[251] The 2006 Sterilization Guidelines further emphasize the importance of informed consent during sterilization procedures and ensuring that women are aware of the full range of contraceptive information.[252]

2. Unavailability of Contraceptive Services and Information

Contraceptive services and information are unavailable in Haryana. Although most pharmacies had condoms and birth control pills, they did not carry other methods of contraception like diaphragms and female condoms. Conversations with healthcare workers in the five districts revealed that none of the family planning wards in government hospitals stocked diaphragms and female condoms. Additionally, the free government condoms were only available in postpartum wards and HIV/AIDS counseling centers. Moreover, ASHA workers, who are pivotal to the implementation of the government's family planning policies, were not accessible and available in every village. The interviews suggested that the absence of ASHAs in certain villages is largely due to the hostile conditions in which ASHAs work. They are not paid a fixed salary and are required to complete multiple tasks without adequate training. As a result, many of them lose motivation and are unproductive.

The lack of availability of a wide range of contraceptive methods obviously violates the availability component of the right to health.[253] Moreover, under General Comment 14, ensuring access to the WHO list of essential medicines is a core obligation of the right to health. The WHO list includes a wide range of contraceptive methods considered essential, including hormonal contraceptives (pills), IUDs, and barrier methods, injectable hormonal contraceptives and implantable contraceptives.[254] The NLEM, however, is a much more limited list, which only includes three types of contraceptives and does not include female condoms and diaphragms.[256] It is imperative to amend this list to include all range of contraceptives that have been proven to be medically safe and effective. Easy availability of female condoms and diaphragms will aid the process of safe sex and access to reversible and effective contraception. Moreover, by expanding the NLEM to include other types of contraceptives, namely diaphragms and female condoms, there can be wide spread social benefits. In the study, doctors, pharmacists and women were mostly aware of only the three methods of contraception listed in the NLEM. If more types of contraception were recognized by the NLEM, there might be greater awareness of a wider range of contraception and spacing methods, in particular. In turn, temporary spacing methods may become the preferred mode of contraception over sterilization, which would better ensure a human rights approach to family planning.

The lack of availability and accessibility of AHSA workers in certain villages also violates the right to health.[257] Not only does it compromise the availability and accessibility components of health, it also violates a core obligation of states under the right to health. Governments, under General Comment 14, must ensure "the right of access to health facilities, goods, and services on a non-discriminatory basis, especially for vulnerable and marginalized groups"[258] and "the equitable distribution of all health facilities, goods, and services."[259] Under the NRHM, ASHA workers are a critical component of expanding services to poor and vulnerable groups.[260] Moreover, ASHA workers are key actors in the delivery of family planning services and counseling to this population.[261] By failing to ensure that ASHA workers are available and accessible in villages, poor women living in those villages are less able to access government family planning services.

In addition to the right to health, lack of availability of contraceptive services and information has wide-ranging human rights implications. The right to life[262] is threatened because of the vital role that contraception plays in preventing maternal mortality. The rights to reproductive self-determination[263] and to enjoy the benefits of scientific progress[264] are challenged because women are not fully able to take advantage of modern spacing methods to control their own fertility. Moreover, the right to equality and non-discrimination[265] is endangered because women bear the burden of the consequences resulting from lack of access to adequate contraceptive service and information. Their autonomy is more restricted and their reproductive health is more impacted by inadequate contraceptive services.

Under a human rights framework, Haryana is in breach of its obligations to fulfill the right to contraceptive services and information by not ensuring the availability of a full range of contraceptive methods and the availability of ASHA workers. Moreover, by not providing a full range of contraceptive methods, Haryana is preventing the Indian government from meeting its overall national goals of universal access to contraception, as reflected in the objectives of the NPP and the Indian government's commitments to the MDGs.[266]

3. Poor Quality of Contraceptive Service and Information

The conversations with multiple stakeholders highlighted that quality of contraceptive services is deficient. In addition, healthcare workers appeared to be poorly trained. Several ASHA workers said that they had not received training, received training only after several months of being on the job, or received training infrequently. In the conversations, there were reports of doctors not being well trained and disrespectful to female patients. Moreover, the employees at the pharmacies or healthcare workers in the family planning wards of government hospitals were not aware of the full range of contraceptives, most notably diaphragms and female condoms. ASHA workers and healthcare workers at hospitals also did not tell women about all of their contraceptive options and did not provide adequate family planning counseling.

General Comment 14 asserts that quality is an essential component of the right to health, requiring that healthcare goods services are "medically appropriate and of good quality."[267] The poor training of health workers and the selling of contraception beyond the expiration date both compromise the quality of care.

Inadequately trained healthcare workers not only threaten quality of care, but also other essential components of the right to health. Without proper training, both the availability and accessibility of contraceptive services and information are compromised. Additionally, without proper training, healthcare services and goods are unlikely to meet the acceptability requirement of the right to health, which ensures that healthcare services and goods commensurate with a woman's needs and perspectives. Indeed, as the findings demonstrate, rarely did doctors, ASHA workers, and other healthcare providers offer adequate family planning counseling, which is essential to ensure that a woman uses the contraceptive method that is most appropriate to her needs and perspectives about how she wants to manage her fertility, which may be influenced heavily by both cultural and religious factors.

In addition to the right to health, the deficient training of healthcare workers and the poor quality of contraception seriously endangers other fundamental rights. The right to life[268] is in peril when healthcare workers are inadequately trained, leading to inappropriate care and counseling, which in turn, can lead to fatal consequences in extreme cases. The right to equality and non-discrimination[269] is also jeopardized because the deficit quality of contraceptive services has a greater adverse impact upon women than men.

By failing to ensure quality contraceptive services and information, the government of Haryana is in non-compliance with its duties under the human rights framework. Haryana is in violation of its duty to respect the right to access contraceptive services and information because it is allowing third parties, namely pharmacies and medical shops, to sell contraceptives that have expired, which interferes with a woman's right to access contraception that is of good quality. Moreover, Haryana is in violation of its duty to fulfill its obligations under the right to provide contraceptive services and information by failing to train ASHA workers. The failure to train ASHA workers also contravenes with the NRHM guidelines, which emphasize the importance of training ASHA workers.[270]

4. Limited Access to Contraceptive Information and Education

The interviews with adolescent girls and women revealed that they are not fully aware of the full range of contraceptive methods. None of the young girls in the study had access to sex education in their schools. Moreover, hospitals either provided no or inadequate information on family counseling to women. ASHA workers also did not provide sufficient information to women about family counseling. The misconception of women regarding some contraception such as copper T also indicates that information and education on contraception is severely lacking and insufficient in Haryana.

"The misconception of women regarding some contraception such as copper T also indicates that information and education on contraception is severely lacking and insufficient in Haryana."

The failure to provide information on contraception is a violation of Haryana's duty to fulfill the right to contraceptive services and information. Among both India and Haryana's contraceptive policies, scant attention is paid to sexual and reproductive health information. HACS lists some HIV/AIDS awareness activities among its strategies and the NPP lists access to information among its objectives. The other policies and initiatives, however, are largely silent when it comes to the provision of sexual and reproductive health information and education.

As previously mentioned in other sections, sexual and reproductive health information is essential to a woman realizing several basic human rights, including the right to life, right health, right to reproductive self-determination, right to be free from torture, cruel, inhuman, and degrading treatment, right to equality and non-discrimination, and right to benefit from scientific progress.[271] In terms of the right to equality and freedom from non-discrimination, both women and men are adversely impacted by the lack of information on contraception, but women are more impacted and their rights are more vulnerable to abuse. Without adequate information, young women are less prepared for their sexual and reproductive lives, leaving them susceptible to coercion, abuse and exploitation, as well as to an increased risk of unintended pregnancy, unsafe abortion, maternal mortality, HIV/AIDS, and other sexually transmitted infections. All of which have grave implications for their right to health, right to life, right to reproductive self-determination, the right to enjoy the benefits of scientific progress, and the right to be free from torture and other cruel, inhuman or degrading treatment.[272]

5. Social and Cultural Barriers

The interviews revealed that woman in Haryana face palpable social and cultural barriers to contraceptive services and information. Women were extremely reticent to discuss the topic and to purchase contraception. Among the conversations with unmarried women, a majority of them, 91 percent of them said that they felt social and cultural barriers to contraception. Some of these women said that they did not feel that they could talk about contraception because of the fear of discrimination and stigma that could result. Most healthcare workers interviewed said that women were extremely reluctant to talk about contraception and usually whispered it in their ears if they wanted contraceptives. And a majority of the pharmacies surveyed, 75 percent, also said that women never came to the shop to buy contraception.

These social and cultural barriers to contraception have a profound impact on human rights, impinging upon a women's right to health,[273] right to life,[274] right to reproductive self-determination,[275] right to information,[276] and ability to enjoy the benefits of scientific progress.[277] They also seriously preclude women from realizing their right to equality and non-discrimination[278] because these barriers only further deepen gender divides and inequities by enfeebling women from exercising autonomy over

their reproductive health, which in turn hinders their ability to actively participate in society and engage in their own academic and professional pursuits.

The provision of sexual and reproductive health information and education, which falls under Haryana's duty to fulfill the right to contraceptive services and information, is a potent tool to eradicate social and cultural barriers. As the Special Rapporteur on the Right to Health has posited,

> As a tool for empowerment and means to critically examine gender inequalities and stereotypes, comprehensive education and information also becomes a way of eroding deeply entrenched systems of patriarchy; such systems perpetuate violations of women's rights, including their right to health. Providing women with knowledge and skills relating to their sexual and reproductive health, related education and information enhances their freedom in making informed health related decisions, and promotes their equal participation in society.[279]

In the case of Haryana, sexual and reproductive information would remove social and cultural barriers to contraception and would create ripe conditions to empower women. Through sexual and reproductive information and education, women would have more knowledge about a wide range of contraceptive method and therefore would be able to exercise more autonomy over their own reproductive health choices, which is critical especially in situations of gender inequities in marriage. This issue is particularly concerning in Haryana, which has the lowest child sex ratio of any state in India and where child marriage is prevalent.[280] Furthermore, with greater knowledge, women would also be more comfortable to discuss the topic of contraception, which would further promote greater societal awareness of and dialogue around contraception. This in turn would promote the acceptance of contraception as an essential need and ensure progress towards the goals of the NPP and the ICPD, which recognize access to contraceptive services and information as a basic human right.

Concluding Observations

The findings from the multi-stakeholder analysis and human rights assessment demonstrate that women in Haryana are unable to enjoy their basic right to contraceptive services and information, which precludes them from realizing their other rights, including the right to health, right to life, right to reproductive self-determination, right to equality and non-discrimination, right to enjoy benefits of scientific progress, and right to be free from torture and cruel, inhumane or degrading treatment.

In Haryana, women are unable to enjoy their basic right to contraceptive services and information for a variety of reasons. Policies push for sterilization over temporary spacing methods and emphasize population control over a rights based approach. The range of contraceptive service and information available to women is limited. ASHA workers are unavailable and inaccessible in some villages, which is largely due to the hostile conditions in which they work. Pharmacies sell contraceptives past the expiration date. Women do not have access to adequate sexual and reproductive health education and information. And women face incredible social and cultural barriers to contraception.

The government of Haryana must take steps to respect, protect, and fulfill the right to contraceptive services and information for women. Specifically, the government of Haryana should 1) create and implement family planning policies that provide comprehensive information on the full range of contraceptive methods, rather than singularly push for sterilization, and focus on providing the information and means to make educated, autonomous reproductive health related decisions; 2) ensure that a full range of contraceptive methods, which include female condoms and diaphragms, are made accessible and available to women; 3) improve the quality of contraceptive services and information by training health workers and ASHA workers and by ensuring that contraceptives are not sold past the expiration date; and 4) provide sexual and reproductive health information to women and young girls.

In conclusion, access to contraceptive services and information is a human right and a basic need. The government must take steps to assure that women can fully enjoy their right to contraceptive services and information, which is essential to realization of their basic human rights.

Notes

* This report does not represent the views of the Fulbright program or the U.S. Department of State.

** Sexual Health Centre, Lunenburg County, *Sexual and Reproductive Health Glossary*, http://www.lunco.cfsh.info /sexual-reproductive-health-glossary/glossary-A-B.html#a.

Reproductive Health Glossary of Terms, http://www.medicinenet.com/reproductive_health/glossary.htm.

Centre for Reproductive Rights, *Legal Glossary*, http://reproductiverights.org/en/node/339.

Ministry of Home and Family Welfare Department Government of India. http://mohfw.nic.in/ NRHM/asha.htm.

World Health Organization, http://www.who.int/topics/hiv_aids/en/.

World Health Organization, https://apps.who.int/rht/documents/FPP94-3/fpp943.htm#What%20is %20vasectomy

Centre for reproductive Rights, Maternal Mortality in India, www.reproductiverights.org/sites/ crr...net/files/ .../MM_update_FINAL.pdf.

1. *See infra* note 2.
2. The right to life is protected under the following relevant international treaties: International Covenant on Civil and Political Rights, art. 6(1), Dec. 16, 1966, G.A. res. 2200A (XXI) [hereinafter ICCPR] ("Every human being has the inherent right to life. This right shall be protected by law."); Convention on the Rights of the Child, art. 6(1), U.N. Doc. A/44/49 (1989) [hereinafter CRC] ("States Parties recognize that every child has the inherent right to life."). The right to the highest attainable standard of health is protected under the following relevant international treaties: International Covenant on Economic, Social and Cultural Rights, art. 12(1), Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR] (mandating that "States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. . . realization of this right shall include those necessary for [t]he prevention, treatment and control of epidemic, endemic, occupational and other diseases; The creation of conditions which would assure to all medical service and medical attention in the event of sickness."); Convention on the Elimination of All Forms of Discrimination against Women, art. 12(1), U.N. Doc. A/34/46 (1979) [hereinafter CEDAW] ("States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."); CRC, art. 24(1) ("States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. The right to determine the number and spacing of one's children is protected under: CEDAW, art. 16(1) ("States Parties shall . . . ensure, on a basis of equality of men and women . . .(e) [t]he 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."). The right to privacy is protected under: ICCPR, (art. 17(1) ("No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home. . . "); CRC 16(1) ("No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home. . . ."). The right to equality and non-discrimination is protected under: ICCPR, art. 2(1) ("Each State Party to the present Covenant undertakes to respect and to ensure to all individuals . . . the rights recognized in the present Covenant, without discrimination of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.); ICESCR, art. 2(2) ("The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."); CEDAW, arts. 1,3 ("[T]he term 'discrimination against women' shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field … [and] States Parties shall take in all fields . . . all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men."); CRC, art. 5 ("States Parties shall respect the responsibilities, rights and duties of parents, or where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention."). The rights to sexual and reproductive health information: CEDAW, art. 10(h) ("States Parties shall . . . ensure . . . [a]cess to specific educational information to help ensure the health and well-being of families, including information and advice on family planning."). The right to enjoy the benefits of scientific progress: ICESCR, art. 15.1 ("The States Parties to the present Covenant recognize the right of everyone: . . . b) To enjoy the benefits of scientific progress and its applications . . . ."). The right to be free from torture or cruel, inhuman, or degrading treatment: ICCPR, art. 7 ("No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.").
3. World Health Organization, *Fact Sheet No. 348: Maternal Mortality* (May 2012), http://www.who.int/mediacentre /factsheets/fs348/en/index.html. (last visited Feb. 18, 2013).
4. SUSHEELA SINGH & JACQUELINE E. DARROCH, ADDING IT UP: COSTS AND BENEFITS OF CONTRACEPTIVE SERVICES-ESTIMATES FOR 2012, 4-5 (Guttmacher Institute & United Nations Population Fund, 2012) [hereinafter ADDING IT UP].
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6. *Id.* at 14.
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8. CENTER FOR REPRODUCTIVE RIGHTS & UNITED NATIONS POPULATION FUND, THE RIGHT TO CONTRACEPTIVE INFORMATION AND SERVICES FOR WOMEN AND ADOLESCENTS 9 (2010) [hereinafter THE RIGHT TO CONTRACEPTIVE INFORMATION AND SERVICES].
9. *Id.*
10. UNAIDS, WOMEN OUT LOUD: HOW WOMEN LIVING WITH HIV/AIDS WILL HELP THE WORLD END AIDS 9-10 (2012), http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/ 20121211_Women_Out_Loud_en.pdf (February 18, 2013).

11. THE RIGHT TO CONTRACEPTIVE INFORMATION AND SERVICES , *supra* note, at 8 (describing the negative consequence of lack of access to contraception).
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16. INTERNATIONAL INSTITUTE OF POPULATION SCIENCES AND MACRO INTERNATIONAL, NATIONAL FAMILY HEALTH SURVEY, (NFHS-3) 2005-2006, India 120-121(vol. 1 2007), http://www.measuredhs.com /pubs/pdf/ FRIND3/FRIND3-Vol1%5BOct-17-2008%5D.pdf (last visited Feb. 18, 2013) [hereinafter NFHS-3].
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19. *Id.*
20. *Id.* at 120-121.
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22. *Id.* at 126.
23. World Health Organization, Unmet Need for Family Planning Definition, http://www.who.int/reproductivehealth /topics/family_planning/unmet_need_fp/en/index.html (last visited Feb. 18, 2013).
24. *Id.* at 157-160.
25. *Id.* at 157-160.
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28. WHO, MATERNAL MORTALITY 1990-2010: WHO, UNICEF, UNFPA AND THE WORLD BANK ESTIMATES 1 (2012), http://whqlibdoc.who.int/publications/2012/9789241503631_eng.pdf; OFFICE OF REGISTRAR GENERAL, SAMPLE REGISTRATION SYSTEM, MATERNAL & CHILD MORTALITY RATES AND TOTAL FERTILITY RATES (July 7, 2011), http://censusindia.gov.in/ vital_statistics/SRS_Bulletins/MMR_release_ 070711.pdf (last visited Feb. 18, 2013).
29. NFHS-3, *supra* note 16, at 111-113
30. *Id.*
31. *Id.*
32. *Id.*
33. *Id.*
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39. *See* Santhya, *supra* note at 38, at 2-3 (outlining India's history of family planning).
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41. *See id.*
42. *See id.*
43. *See supra* note 38.
44. *See* Panandiker & Umashankar, *supra* note 38.
45. *See* Santhya, *supra* note 38, at 2-3.
46. *See* Usha Tandon et al., *Family Planning in India: A Study of Law and Policy* 2, http://paa2010.princeton.edu /papers/101217.
47. *See* Gwatkin, *supra* note 38, at 39-40 (describing the response of Indian states to national family planning policies of the Emergency Period).
48. *See* Gwatkin, *supra* note 38, at 48.
49. *See id.* at 29.
50. Santhya, *supra* note 38, at 2-3.
51. *See id.*
52. *See id.*
53. *See id.*
54. *See id.*

55. Program of Action of the International Conference on Population and Development, Cairo, Egypt, Sept. 5–13, 1994, ch. VII, para. 7.12, U.N. Doc. A/CONF.171/13/ Rev.1 (1995) [hereinafter ICPD Program of Action].
56. Santhya, *supra* note 38, at 5.
57. *See id*.
58. *See id.*
59. National Commission on Population*, Historical Perspectives*, http://populationcommission.nic.in/hp.htm (last visited Feb. 18, 2013) (stating that the commission has the mandate "to review , monitor and give direction for implementation of the National Population Policy with the view to achieve the goals set in the Population Policy.").
60. National Commission on Population, *Introduction*, http://populationcommission.nic.in/npp_intro.htm. (Last visited Feb. 18 , 2013).
61. National Population Commission, *Objectives*, http://populationcommission.nic.in/npp_obj.htm (last visited Feb. 18, 2013) (listing the objectives of the NPP).
62. *Id.*
63. National Population Commission, *Objectives*, http://populationcommission.nic.in/npp_obj.htm (listing the objectives the NPP) (last visited Feb. 18, 2013); National Population Commission, Strategic themes, National Population Commission, *Objectives*, http://populationcommission.nic.in/npp_obj.htm (discussing women's empowerment as a strategic theme) (last visited Feb. 18, 2013); Santhya, *supra* note 38, at 5 (delineating the objectives of the NPP).
64. Santhya, *supra* note 38, at 5 (noting that the NPP is a marked contrast to previous policies that focused on disincentives).
65. Santhya, *supra* note 38, at 5 (demonstrating how state policies are subverting the goals of the NPP).
66. *Id.*
67. *Id.*
68. Javed v. State of Haryana (2003) 8 S.C.C. 369, para 31. ("The torrential increase in the population of the country is one of the major hindrances in the pace of India's socio-economic progress. Everyday, about 50,000 persons are added to the already large base of its population. The Karunakaran Population Committee (1992-93) had proposed certain disincentives for those who do not follow the norms of the development model adopted by the national public policy so as to bring down the fertility rate. It is a matter of regret that though the Constitution of India is committed to social and economic justice for all, yet India has entered the new millennium with the largest number of illiterates in the world and the largest number of people below the poverty line. The laudable goals spelt out in the directive principles of State policy in the Constitution of India can best be achieved if the population explosion is checked effectively. Therefore, population control assumes a central importance for providing social and economic justice to the people of India.").
69. *Id.*
70. *Id.*
71. *Id.*
72. *Id.*
73. *See generally* MINISTRY OF HEALTH AND FAMILY WELFARE, NATIONAL RURAL HEALTH MISSION DOCUMENT, http://www.mohfw.nic.in/NRHM/Documents/Mission_Document.pdf (last visited Feb. 18, 2013).
74. *Id.*, Preamble.
75. MINISTRY OF HEALTH AND FAMILY WELFARE, NATIONAL RURAL HEALTH MISSION: FRAMEWORK FOR IMPLEMENTATION 2005-2012 at 10,http://www.mohfw.nic.in/NRHM/Task_grp/Decentralised_Planning_and_Financial_Guidelines.pdf. (last visited Feb. 18, 2013).
76. National Rural Health Mission, *Frequently Asked Questions*, http://jknrhm.com/Guideline/Frequently_Asked_Question.pdf (last visited Feb. 18, 2013) (noting that NRHM has subsumed several national programs, including RCH-II, to improve service delivery and efficiency).
77. R.C. Gulati, *Presidential Address, Indian Association For the Study of Population*, 27th Annual Conference 1-2 (10-12 February 2005) (last visited Feb. 18, 2013) (noting that the RCH-I reflected the shift in the Indian Government's family planning policies from those approaches focused on targets and disincentives towards approaches promoting spacing methods).
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79. *Id.* (enumerating the duties of the ASHA worker, which include distributing contraceptives and family planning counseling).
80. *Id.* (delineating how ASHA workers should be assigned per village).
81. *Id.* (stressing the importance of training ASHA workers).
82. *Id.* (describing the performance-based incentives that the ASHA workers receive).
83. National Rural Health Mission, *Performance based Payments to ASHA workers*, http://www.mohfw.nic.in/NRHM/Documents/Performance_based_payment_to_ASHAs.pdf (last visited Feb. 18, 2013) (suggesting how much an ASHA worker should be compensated for different activities).
84. *See e.g.* CENTRE FOR HEALTH AND SOCIAL JUSTICE, REVIEWING TWO YEARS OF NRHM, OCTOBER 2007: CITIZENS REPORT (2007) http://www.chsj.org/uploads/1/0/2/1/10215849/citizenreport-2007.pdf (last visited Feb. 18, 2013) (identifying many of the limitations and criticisms of the NRHM); COMPTROLLER AND AUDITOR GENERAL OF INDIA (CAG), REPORT NO. 8 - PERFORMANCE AUDIT OF NATIONAL RURAL HEALTH MISSION (NRHM) - MINISTRY OF HEALTH & FAMILY WELFARE (MOHFW), Executive Summary, xi (2009), http://saiindia.gov.in/cag/union-audit/report-no-8-performance-audit-national-rural-health-mission-ministryhealth-family-welfa (last visited Feb. 18, 2013). *See also*, CENTER FOR REPRODUCTIVE RIGHTS, 2011 UPDATE ON MATERNAL MORTALITY IN INDIA 10-11 (2011) (summarizing the evaluations and reports on the NRHM).
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86. CENTER FOR HEALTH AND SOCIAL JUSTICE, REVIEWING TWO YEAR OF NRHM, *supra* note 84, at 111 http://www.chsj.org/uploads/1/0/2/1/10215849/citizenreport-2007.pdf (describing instances where women are not given contraceptive information, which can lead to fatal consequences).

87. The Union Cabinet approved the Twelfth Five Year Plan on October 4, 2012, and the National Development Council approved the Twelfth Five Year Plan on December 20, 2012. See the following articles: *National Development Council approves 12th Five Year Plan*, INDIAN EXPRESS (December 27, 2012), http://www.indianexpress.com/news/national-development-council-approves-12th-five-year-plan/1051012/0; Government Approves 12th Five Year Plan, TIMES OF INDIA (October 4, 2012), http://timesofindia.indiatimes.com/business/india-business/Government-approves-12th-five-year-plan/articleshow/16672927.cms.
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90. PLANNING COMMISSION, GOVERNMENT OF INDIA, DRAFT OF THE TWELFTH PLANNING COMMISSION 2012-2017 14, 30-31 (vol. 2 2012) (mentioning a basket of contraceptives among a list of public health interventions to be provided and funded by the government and emphasizing the importance of spacing).
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105. *See* MINISTRY OF HEALTH & FAMILY WELFARE, MANUAL FOR FAMILY PLANNING INSURANCE SCHEME 3, 4 (2009), http://mohfw.nic.in/WriteReadData/l892s/FPIS%202005%20manual-15916277.pdf (last visited Feb. 18, 2013) (discussing the Supreme Court orders to government for ensuring the enforcement of sterilization guidelines).
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108. *See id.* at 4.
109. Ravindra Amonker & Gary Brinker, *Reducing Fertility in India*, 33 (2) INT'L J. SOC. FAM. 327,344-46 (2007) [hereinafter Reducing Fertility in India] (observing that in India, more socioeconomically developed states experienced lower fertility rates). Other studies have investigated the relationship between health infrastructure and reproductive in models investigating the salience of community-level influences rather than individual-level influences on reproductive health. See for example: Alok Bhargava et al., *Healthcare Infrastructure, Contraceptive Use and Infant Mortality in Uttar Pradesh, India* 3(3) ECON & HUM. BIOLOGY 388, 388-404; Rob Stephenson & Amy Ong Tsu, *Contextual Influences on Reproductive Health Service Use in Uttar Pradesh, India* 33(4) STUDIES IN FAMILY PLANNING 309, 309-320 (2002).
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119. CENTER FOR REPRODUCTIVE RIGHTS, MATERNAL MORTALITY IN INDIA 33 (2008) (positing that age of marriage is a "crucial determinant of equality in marriage" and illustrating the untoward health consequences of child marriage).
120. Report of the Special Rapporteur on Violence Against Women, Ms. Radhika Coomaraswarny, Cultural practices in the family that are violent towards women, para 56 UN Doc E/CN 4./2002/83 (2002) ("She will have to submit to sex with an older man and her immature body must endure the dangers of repeated pregnancies during childbirth.").
121. Human Rights Committee, *Concluding Observations: India*, para. 88, U.N. Doc CCPR/C/79/Add.81 (1997))(expressing serious concern about the failure of India to implement legislation proscribing child marriage).
122. Committee on the Elimination of Discrimination Against Women, *General Recommendation 21, Equality in Marriage and Family Relations (13th Sess. 1994) in Compilation of General Recommendations Adopted by Human Rights Treaty Bodies*, art. 16(1) (e) para.36 U.N. Doc HR/GEN/Rev/5 (2001) (Rejecting arguments in support of girls getting married younger than eighteen because of the associated health risks).
123. Committee on Rights of the Child, General Comment 4, para 31, U.N. Doc CRC/GC/2003/4 (2003) (elucidating the connection between child marriage and high infant and maternal mortality rates); Committee on the Rights of the Child, Concluding Observations: India, para. 90, U.N. Doc. CRC/C/15/ Add.228 (2004) (articulating concern over the very high number of forced and child marriage in India and commenting that it "can have a negative impact on their, health, education, and social development.").
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127. *See generally*, John Caldwell, *Mass education as a Determinant of the Timing of Fertility decline*, 6 POPULATION DEVELOPMENT R. 225, 225-255 (1980).
128. *See id.*, 227-231 (delineating the mechanisms in which mass education contributes to fertility declines).
129. *Reducing Fertility in India*, *supra* note 109, at 331 (2007) (summarizing the research on the connection between education and fertility rates).
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133. *See generally,* Human Rights Watch, *India: Target-Driven Sterilization Harming Women* (July 12, 2012) http://www.hrw.org/news/2012/07/12/india-tar get-driven-sterilization-harming-women[hereinafter India: Target-Driven Sterilization Harming Women]; Anuja Jayaraman et al., *The Relationship of Family Size and Composition To Fertility Desires,* 35(1) INT'L PERSPECTIVES SEXUAL & REPRODUCTIVE HEALTH 29-38 (2009) (delineating the impact of son preference on contraceptive use in India and other parts of Asia); Prahbhjot Malhi & Jegat Jerath, *Is Son Preference Constraining Contraceptive Use in India?* 18(2) GURU NANAK J. SOC, 77, 77-92 (1997) (summarizing the research conducted on son preference in various parts of the world).
134. *India: Target-Driven Sterilization Harming Women, supra* note 133 (describing son preference in Gujarat).
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138. NFHS-3, *supra* note 16, at 122- 23 (observing the positive effects of wealth on contraceptive use).
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22. INDIA CONST. art. 21.

223. Francis Coralie Mullin v. Union Territory of Delhi, (1981) 1 S.C.C 608, para. 8
("We think that the right to life includes the right to live with human dignity and all that goes along with it, namely, the bare necessaries of life …Of course, the magnitude and content of the components of this right would depend upon the extent of the economic development of the country, but it must, in any view of the matter, include the right to the basic necessities of life and also the right to carry on such functions and activities as constitute the bare minimum expression of the human-self.").

224. Consumer Education and Research Centre v. Union of India, (1995) 3 S.C.C. 42, para. 24 ("The right to health to a worker is an integral facet of meaningful right to life, to have not only a meaningful existence but also robust health and vigour without which worker would lead life of misery. . . Therefore, it must be held that the right to health and medical care is a fundamental right under Article 21 read with Articles 39(*e*), 41 and 43 of the Constitution and make the life of the workman meaningful and purposeful with dignity of person. Right to life includes protection of the health and strength of the worker and is a minimum requirement to enable a person to live with human dignity."); C.E.S.C. Limited and Ors. v. Subhash Chandra Bose and Ors, (1992) 1 S.C.C. 441, paras. 30, 32 (reflecting on the protections afforded to the right to health under international law and asserting that " [i]n the light of Articles 22 to 25 of the Universal Declaration of Human Rights, International Convention on Economic, Social and Cultural Rights, and in the light of socio-economic justice assured in our Constitution, right to health is a fundamental human right to workmen); Bandhua Mukti Morcha v. Union of India and Ors., (1984) 3 S.C.C. 161, para. 10 ("This right to live with human dignity enshrined in Article 21 derives its life breath from the Directive Principles of State Policy and particularly clauses (*e*) and (*f*) of Article 39 and Articles 41 and 42 and at the least, therefore, it must include protection of the health and strength of workers, men and women, and of the tender age of children against abuse, opportunities and facilities for children to develop in a healthy manner and in conditions of freedom and dignity, educational facilities, just and humane conditions of work and maternity relief.").

225. ICCPR, *supra* note 2, art. 6(1).

226. ICESCR, *supra* note 2, art. 12(1).

227. CEDAW, *supra* note 2, art. 12(1).

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235. State of Haryana v. Smt. Santra, (2000) 5 S.C.C. 182, paras. 36, 41 (providing remedies for a failed sterilization on the basis of medical negligence and population control rather than on recognition of reproductive rights and constitutional rights claims).

236. Ramakant Rai v. Union of India, 15 S.C.C. 645 (directing States to set up measures to regulate the safety of sterilization procedures and observing that "it is apparent that there is no uniformity with regard to the procedures nor the norms followed for ensuring that the guidelines laid down by the Union of India in this regard are being followed.").

237. Laxmi Mandal v. Deen Dayal Harinagar Hospital and Ors, W.P.(C) 8853/2008, para. 2 ("These petitions are essentially about the protection and enforcement of the basic, fundamental and human right to life under Article 21 of the Constitution. These petitions focus on two inalienable survival rights that form part of the right to life: the right to health (which would include the right to access and receive a minimum standard of treatment and care in public health facilities) and in particular the reproductive rights of the mother.").

238. *Id.*

239. ICCPR, *supra* note 2, art. 17(1); CRC, *supra* note 2, 16(1).

240. D.K. Basu v. State of West Bengal, (1997) 1 S.C.C 416, para. 13 ("Reaffirming that the internationally recognized prohibition against torture stating that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."); Arvinder Singh Bagga v. State of Uttar Pradesh, (1994) 6 S.C.C 565, para. 4 (considering the meaning of the definition of torture and expanding it to include more than just physical torture); Sube Singh v. State of Haryana and Ors., AIR 2006 SC 1117). See also ICCPR, *supra* note 2, art. 7.

241. Juan Mendez, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, para. U.N. Doc. A/HRC/22/53(2013).

242. Ramakant Rai v. Union of India, 15 S.C.C 645 (2007).

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244. *See e.g.*, Gethin Chamberlain, *UK aid helps to fund forced sterilization of India's poor* (April 15, 2012),http://www.guardian.co.uk/world/2012/apr/15/uk-aid-forced-sterilization-india (last visited Feb 18, 2013) (revealing how aid money from the U.K helped pay for a controversial program that has led to miscarriages and even deaths after botched operations; Human Rights Watch, *India: Target-Driven Sterilization Harming Women* (July 12, 2012), http://www.hrw.org/news/2012/07/12/india-target-driven-sterilization-harming-women (describing the "coercive environment" in which sterilization takes place in India). (last visited Feb 18, 2013)

245. Arati Durgaram Gavandi v. Managing Director, Tata Metaliks Limited and Ors., 2008(6) BomCR1, para. 10. (.."The provisions of the Constitution recognize gender equality as a fundamental right. Gender equality in all its dimensions is a basic human right which is recognized by and embodied in the provisions of the Constitution. The broad sweep of the human right to gender equality traverses every facet of the position of a woman in society.". . .).
246. Apparel Export Promotion Council v. Chopra, (1999) 1 S.C. C. 759, para 26 (emphasizing the importance of the fundamental to gender equality). See also Vishaka v. State of Rajasthan, (1997) 6 S.C.C 241, para. 14, 16 (affirming that the Indian Constitution guarantees gender equity and elaborating "the meaning and content of the fundamental rights guaranteed in the Constitution of India are of sufficient amplitude to encompass all the facets of gender equality" . . and explaining that .the court has a duty to protect fundamental rights, including gender equality, under Article 32 of the Indian Constitution).
247. ICCPR, *supra* note 2, art. 2(1).
248. CEDAW, *supra* note 2, arts. 1,3.
249. CRC, *supra* note 2, art. 5.
250. ICESCR, *supra* note 2, art. 15(1).
251. ICPD Program of Action, *supra* note 55, para. 7.2.
252. *See generally*, Ministry of Health and Family Welfare, Standard for Female and Male Sterilization Services (2006) http://mohfw.nic.in/NRHM/RCH/guidelines/Standard_for_female_male_sterilization_services_ final.pdf. (last visited Feb 18, 2013).
253. General Comment 14, *supra* note 220, para. 43(d).
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257. General Comment 14, *supra* note 220, para. 12.
258. General Comment 14, *supra* note 220, para. 43 (a)
259. General Comment 14, *supra* note 220, para. 43 (e)
260. National Rural Health Mission, *About Asha*, http://mohfw.nic.in/NRHM/asha.htm#abt (last visited Feb 18, 2013) (delineating how ASHA workers should be assigned per village).
261. National Rural Health Mission, *About Asha*, http://mohfw.nic.in/NRHM/asha.htm#abt (last visited Feb 18, 2013) (enumerating the duties of the ASHA worker, which include distributing contraceptives and family planning counseling).
262. ICCPR, *supra* note 2, art. 6(1); CRC, *supra* note 2, art. 6(1).
263. CEDAW, *supra* note 2, art. 16(1); ICCPR, *supra* note, 2(1). CRC, *supra* note 2, art. 16(1).
264. ICESCR, *supra* note 2, art. 15(1).
265. ICCPR, *supra* note 2, art .2(1); ICESCR, *supra* note 2, art. 2(2); CEDAW, *supra* note 2, arts.1,3; CRC, *supra* note, art.5.
266. *See supra* note 62 (highlighting that one of the NPP's goals is to provide universal access to contraception and *supra* note 206 (highlighting that one of the MDG's goals is to provide universal acess).
267. General Comment 14, *supra* note 219, para 12.
268. ICCPR, *supra* note 2, art. 6(1); CRC, *supra* note 2, art. 6(1).
269. ICCPR, *supra* note 2 art. 2(1); ICESCR, *supra* note 2, art. 2(2); CEDAW, *supra* note 2, arts.1,3; CRC, *supra* note, art. 5.
270. National Rural Health Mission, *About Asha*, http://mohfw.nic.in/NRHM/asha.htm#abt (stressing the importance of training ASHA workers) (last visited Feb. 18, 2013).
271. *See supra* note 2, (enumerating the International Treaties protecting fundamental rights).
272. *Id.*
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274. ICCPR, *supra* note 2, art. 6(1); CRC, *supra* note 2, art. 6(1).
275. CEDAW, *supra* note 2, art. 16 (1); ICCPR, *supra* note 2, art 17(1); CRC, *supra* note 2, art 16(1).
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277. ICESCR, *supra* note 2, art. 15(1).
278. ICCPR, *supra* note 2, art. 2(1); ICESCR, *supra* note 2, art. 2(2); CEDAW, *supra* note 2, arts.1,3; CRC, *supra* note 2, art.5.
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Annexure – I

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