UNITED NATIONS **A**

General Assembly

Distr.
GENERAL

A/HRC/11/NGO/32
2 June 2009

ENGLISH ONLY

HUMAN RIGHTS COUNCIL
Eleventh session
Agenda item 3

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

Written statement* submitted by the Asian Legal Resource Centre (ALRC), a non-governmental organization in general consultative status

The Secretary-General has received the following written statement which is circulated in accordance with Economic and Social Council resolution 1996/31.

[22 May 2009]

* This written statement is issued, unedited, in the language(s) received from the submitting non-governmental organization(s).

INDIA: Rights to health and food - destined to die because of neglect

Four-year-old Chhotu and his sister, six-year-old Sagar, died from malnutrition induced ailments in 2008. Chhotu died in August and Sagar in September. Chhotu had diarrhoea and weight-loss, whereas Sagar was suffering from a respiratory infection at the time of death. Both children were also suffering from acute malnutrition when they died.

The children's family belongs to a tribal community, living in Mohalkhari village, in Khalwa Block, Khadwa district of Madhya Pradesh state in India. The family had no resources to provide the children with sufficient food. To make matters worse, the heavy rain destroyed their crops and contaminated water sources rendering them unhygienic to use and spreading waterborne diseases in the village.

Chhotu and Sagar are two of the sixty-two children that died of malnutrition associated ailments in Khalwa Block in 2008. Of the sixty-two children who died, the Asian Legal Resource Centre (ALRC) reported the death of forty-three children to the authorities. According to the reports made available to the ALRC, and submitted to the Supreme Court of India, more than 125 children, aged below five years, died from various ailments arising out of malnutrition in four districts in Madhya Pradesh state since May 2008. These districts are Satna, Sheopur, Shivpuri and Khandwa.

It is estimated that there are 33,000 malnourished children under the age of five in Madhya Pradesh state. This amounts to 60 percent of the total child population of the state. The report published by the National Family Health Survey in 2009 confirms this. The World Bank report released in April, 2009 confirms that Madhya Pradesh is the worst state in India concerning child health, followed by Bihar and Jharkhand. The Global Hunger Index 2008 published by the International Food Policy Research Institute illustrates that India is comparable with Yemen and Timor-Leste, having the highest prevalence of underweight children under the age of five. More than 40 percent of the children in this age group in the country are underweight.

The ALRC, and its sister concern, the Asian Human Rights Commission (AHRC), have written to the government on several occasions expressing concern about the lack of prompt government action concerning malnutrition among the children during the past 12 months. Yet, the government has done nothing sensible and sustainable to save the lives of the remaining children, even in Khalwa Block. For instance, two-year-old Sumantra, a girl whose Mid Upper Arm Circumference, measures 94 millimetres and weighs merely 5.5 kilograms is currently living in Chadida village of Khalwa Block and is suffering from acute malnutrition. Sumantra’s family belongs to the tribal community.

When reports regarding the deaths of malnourished children were published, the state government of Madhya Pradesh conducted health profiling of the children in parts of that state. The children were brought to the Nutrition Rehabilitation Centres in Khandwa district. Approximately 1,000 children of the district were examined. All children diagnosed as suffering from Severe Acute Malnourishment (SAM) were expected to be treated with a combination of Ready to Use Therapeutic Food (RUTF), popularly known as Plumpy'nut, and nutritious diet including milk and eggs. For the treatment, the children were expected to stay for a fortnight at the centres.

Sumantra was taken to the ad-hoc centre set-up at Roshni village in October 2008. In spite of her poor health, Sumantra was sent back home after four days. It is suspected that the doctors are under instruction from the state administration to send the children off without completing the treatment to show that not many children are suffering from malnutrition. This suspicion is arguably confirmed by the subsequent reaction of the state government. When reports of malnutrition among the children in the state were reported, the State Health Minister called a press conference, in which the Minister accused human rights organisations of spreading false information concerning child health in the state.

The government is not in a position to properly assess the exact state of malnutrition among the children. There is no coherent and integrated method practiced in the country identifying malnourishment, particularly of children. For example, the medical team dispatched by the government identified only four children in the villages, Hardua and Nakjhir of Satna district, as suffering from severe acute malnutrition while the Child Care Centre (Anganwadi Centre) records show that eight children are malnourished. Five out of them were sent to the Nutrition Rehabilitation Centre for treatment.

Public health institutions follows different assessment criteria to identify malnourishment. Some institutions use the weight against the age method whereas others use Mid Upper Arm Circumference for assessment. The non-coherence of measurement at different health institutions results in data corruption. Another loophole in the emergency relief program is that the programme only treats the severely malnourished children and there is no further treatment or follow-up once the children are discharged from the emergency centre. This lack of follow-up renders the programme unsuccessful since a child is released from the centre to the care of poverty-struck parents, who cannot afford to continue providing nutritious food to the child.

Additionally, if a child is diagnosed as not being severely malnourished but moderately malnourished, the child would not be provided with treatment. This practice overlooks the fact that a moderately malnourished child is in fact proceeding into the state of severe malnourishment, a condition that could eventually kill the child. In other words, only those children, who at the time of examination are diagnosed as severely malnourished can expect treatment. Thus, the preventive nature of the entire programme is undermined.

While the centre is expected to provide high quality nutrition which costs about USD 40 for a malnourished child, the other facilities in the centre are lacking. The centre at the district hospitals only provides twenty beds. Since most centres have to treat often more than twenty children, the children are intentionally misdiagnosed as not requiring assistance and sent away from the hospitals. In addition, the centres lack basic facilities like clean drinking water and sanitation, rendering the centres unsafe for medical treatment.

The Anganwadi Centre is the lowest unit in the chain of public health institutions under the Integrated Child Development System. As it is often the only health centre accessible to a poor villager, problems at Anganwadis often results in complete denial of medical services to a child requiring treatment. Most of the Anganwadis in the country are non-functional, or the services provided are arbitrarily denied to certain sections of society owing to caste-based discrimination. Health workers who are from the upper caste groups tend to discriminate against children and mothers from the low caste groups and tribes.

Many small villages do not have an Anganwadi. The children living in small and remote villages are often more exposed to malnutrition than others. Understaffing and a lack of facilities in Anganwadis, particularly those in remote and tribal villages, results in the denial of proper medical check-ups and vaccination for children.

Many of the deceased children were first registered as 'malnourished' at the Anganwadi. Since some centres do not have their own buildings, the children have to be taken to the residence of a health worker. Many centres do not have even a weighing scale and lack medicine kits.

The Supreme Court of India, in an order, has set standards for the capacity of Anganwadis. The Court has directed the government that a health worker should take care of a minimum of 40 children whereas the maximum number is set to 80 children. However, only one health worker and one helper are available for each centre. This is not sufficient, given the fact that most Anganwadis will have to take care of more than a hundred children. For example, in the case of Uchhehra Block in Satna district, there are 152 Anganwadis covering 21,380 children. The Court in an order issued in 2008 has also directed that the involvement of private sector businesses must be avoided in the primary health sector. However, the government is increasingly resorting to the privatisation of the health sector, for instance by employing private contractors to supply food and medicine to the Centres, a process that is laden with corruption.

The government often denies the deaths of children from malnutrition. The repeated practice is to first deny the opportunity for an autopsy to be carried out following a death and then to issue a public statement through the office of the concerned District Magistrate that the death was not from malnutrition. Illiteracy of the parents, their poverty, religious practices and the remoteness of the villages prevents the real cause of death from being exposed.

In addition to the Supreme Court of India, the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, after his mission to India in 2007 said *"[r]ural and disadvantaged areas are those most likely to be without a provider in public facilities."*[1] Concern regarding the consistent and widespread denial of the right to health linking it with the right to food has been expressed by the UN Special Rapporteur on the right to food. The Rapporteur said that *"...despite these impressive gains, household-level food security has not been achieved, levels of malnutrition, undernourishment and poverty remain very high and there are signs that hunger and food insecurity have increased since the second half of the 1990s. Nearly 2 million Indian children die every year as a result of serious malnutrition and preventable diseases. Nearly half suffer from moderate or severe malnutrition, with 47 per cent of children underweight and 46 per cent stunted in their growth. This is one of the highest levels of child malnutrition in the world, higher than most countries in Sub-Saharan Africa. Malnutrition is most severe amongst children in rural areas but is also high in urban areas. Nearly a third of children (30 per cent) are born underweight, which means that their mothers are themselves underweight and undernourished."*[2]

Further, the Child Rights Committee in its concluding observations on India has expressed that *"...the Committee is concerned at high maternal mortality, and very high levels of low birth weight and malnutrition among children, including micronutrient deficiencies, linked to the lack*

[1] A/HRC/7/11/Add.4
[2] E/CN.4/2006/44/Add.2

of access to prenatal care and, more generally, limited access to quality public health care facilities, insufficient numbers of qualified health workers, poor health education, inadequate access to safe drinking water and poor environmental sanitation. This situation is exacerbated by the extreme disparities faced by women and girls, especially in rural areas."[3]

In spite of all these efforts, India still tends to ignore and avoid the responsibility to protect, promote and fulfil the right to health of its citizens, particularly children. This negation of duty appears to be intentional, consistent and widespread in nature.

In this context, the ALRC request the Human Rights Council to:

1) Encourage the Government of India to set up properly functioning Child Care Centres, Primary Heath Centres and district hospitals throughout the country;

2) Have the Indian government provide assurances and proof that the operation of the Nutrition Rehabilitation Centres is effective;

3) Urge the government to comply without default to the orders issued by the Supreme Court of India regarding the right to health.

- - - - -

[3] CRC/C/15/Add.115