

CENTER FOR REPRODUCTIVE RIGHTS

January 15, 2007

Dear Committee Members:

The Committee on the Elimination of Discrimination against Women (CEDAW Committee)

Re: Supplementary Information on India
Scheduled for review during the CEDAW's 37th Session

This letter is intended to supplement the periodic report submitted by India, which is scheduled to be reviewed by this Committee during its 37th Session. The Center for Reproductive Rights (The Center), an independent non-governmental organization, hopes to further the work of the Committee by providing independent information concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). This letter highlights several areas of concern related to the status of women's reproductive health and rights in India.

Reproductive rights are fundamental to women's health and social equality and an explicit part of the Committee's mandate under CEDAW. The commitment of States Parties to uphold and ensure these rights should receive serious attention. Specifically, the Convention commits States Parties to "ensure... access to specific educational information to help ensure the health and well-being of families, including information and advice on family planning" [Article 10(h)]; "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 relating to family planning" [Article 12(1)]; "take all appropriate measures to eliminate discrimination against women in rural areas in order to assure... access to health-care facilities, including information, counseling, and services in family planning..." [Article 14(2)(b)]; and, to "take all appropriate measure to eliminate discrimination against women in matters relating to marriage and family relations and in particular [to] ensure, on a basis of equality between men and women: ...[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" [Article 16(1)(e)].¹

The Committee's General Recommendation 24 on Women and Health affirms that "access to health care, including reproductive health is a basic right under [CEDAW]"² and is essential to women's health and well being.³ Furthermore, it obligates States Parties to take the following

measures: “report on how public and private health care providers meet their duties to respect women’s rights to have access to health care”⁴; “ensure the removal of all barriers to women’s access to health services, education and information, including in the area of sexual and reproductive health, and, in particular, allocate resources for programmes directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS”⁵; “...reduce maternal mortality rates through safe motherhood services and prenatal assistance”⁶; and finally, “require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice.”⁷ In its General Recommendation 19 on Violence against women, the Committee specifically obligates States Parties to “ensure that measures are taken to prevent coercion in regard to fertility and reproduction.”⁸ Also, according to General Recommendation 21 on Equality in marriage and family relations, States Parties “should resolutely discourage any notions of inequality of women and men which are affirmed by laws, or by... custom.”⁹

The government of India’s combined second and third periodic report discusses efforts made to reduce maternal and infant mortality rates; measures aimed at preventing communicable diseases and HIV/AIDS through health care, education and counseling; the promulgation of state initiatives directed at addressing the adverse sex ratio; and the implementation of policies aimed at encouraging gender equality.¹⁰ In addition, the report discusses important policy measures, such as the adoption of the Reproductive and Child Health Programme and the Family Welfare Programme; the implementation of a National Population Policy; and, the promulgation of the National Policy for the Empowerment of Women.¹¹

Nonetheless, despite key interventions, there are significant shortcomings in the government’s efforts to comply with the Convention, as evidenced by the realities of women’s lives in India. For example, the majority of women do not have the ability to control their fertility due to lack of access to modern contraceptives, lack of information and the prevalence of harmful practices such as child marriage. Furthermore, there is disturbing evidence of coercion in family planning services as a result of state level laws and policies that punish couples for having more than two children. India accounts for a significant proportion of the world’s total number of deaths due to unsafe abortion. While efforts have been made to reduce maternal deaths, the maternal mortality rate in India has not visibly declined and continues to pose a serious threat to the health and lives of adolescents and adult women. Moreover, despite an increase in efforts to prevent HIV/AIDS, today India accounts for the highest number of women between the ages of 15-49 years with HIV/AIDS in the entire region.

We would like to take this opportunity to bring to the Committee’s attention to some issues of concern, which directly affect the reproductive health and lives of women in India:

I. Right to Health Care, Including Reproductive Health Care and Family Planning (Articles 12, 14(2)(b) and (c), and 10(h))

A. Family Planning targets women, neglects rural populations and is tainted by coercion

The Indian government’s Reproductive and Child Health (RCH) Programme, which entered its second phase in 2003, attempts to create awareness about the rights of the population in health

care.¹² RCH seeks to promote contraceptive use and provide a full range of contraceptive methods, including condoms and sterilization.¹³ The RCH Programme also seeks “visibility for men” in providing access to health care.¹⁴ Furthermore, in 2000, India adopted a National Population Policy with the goals of establishing universal access to family planning information, counseling, and contraception, and stabilizing the population growth rate by 2045.¹⁵ The National Population Policy encourages the prioritization of women’s health in family planning and “affirms the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services.”¹⁶ Despite these policy goals, less than half of all married women between 15-49 years of age use a modern method of contraception.¹⁷ Moreover, in recent years, several states have introduced official laws and policies that punish couples for having more than two children by denying them public benefits and even participation in governance. In fact, one such state law which disqualifies men and women with more than two children from running for public office or holding certain positions at the panchayat level was upheld by the Supreme Court of India in *Javed v. State of Haryana* (2003) as constitutional.¹⁸

The most widely known and used modern method of contraception in India is female sterilization.¹⁹ Even though the “No Scalpel Vasectomy Project” was introduced in 1998 to popularize male sterilization, it was only implemented in 20 states.²⁰ As a result, female sterilization accounts for 95% of all sterilizations in India.²¹ This disparity demonstrates that the burden of family planning is borne largely by women. In addition to this reality is the disturbing fact that public health officials in several states have been routinely abusing their ethical obligations and patient’s rights by coercing women to undergo sterilization and through the performance of sub-standard and unsafe sterilization procedures resulting in failed procedures and even death.²² A public interest lawsuit, *Ramakant Rai & Health Watch U.P. and Bihar v. Union of India*, was filed in the Supreme Court in 2003 seeking immediate compliance with the national sterilization guidelines and compensation for victims of abusive practices and while a series of interim orders have been issued which require states to provide insurance and compensation to victims, from a practical standpoint, full compliance has not yet been achieved and violations are continuing.²³

Although governmental policies proclaim to promote access to information regarding contraceptive use, there is no specific statute to ensure the equitable distribution of contraceptives and dissemination of information about their efficacy, safety, potential side effects and proper use.²⁴ Access to contraception continues to be a problem, especially in rural areas. Furthermore, the Department of Family Welfare announced in 2006 that it was introducing Emergency Contraceptive pills into the RCH Programme. However, access to emergency contraception remains severely limited; one study shows that of the fifteen providers, thirteen were in the urban center of New Delhi.²⁵ Until systematic channels for distributing contraceptives and emergency contraception are established by the government, the majority of women will continue to be underserved.

In General Recommendation 19, the CEDAW Committee expressed that “compulsory sterilization or abortion adversely affects women’s physical and mental health...” and that these practices violate the basic right to “decide on the number and spacing of [their] children.”²⁶ In

its previous Concluding Observations to India, this Committee has noted with concern that “family planning is only targeted at women”²⁷ and recognized that “inadequate implementation of laws are serious impediments to the realization of women’s human rights in India.”²⁸ The goal of greater and more equitable access to contraception in India is embodied in official policies, but implementation is sorely lacking.

B. Unsafe abortion

The Medical Termination of Pregnancy Act of 1971 (MTP Act) provides that a pregnancy may be terminated before twelve weeks by a registered medical practitioner, if the practitioner determines that the pregnancy would involve risk to the life of a woman, grave injury to the woman’s physical or mental health, or a substantial risk to fetal development.²⁹ The MTP Act was amended in 2002, specifying the places and persons authorized to perform abortion and providing for penal actions against unauthorized persons performing those abortions.³⁰ However, there is no evidence that these changes have increased access to safe, legal, and affordable abortion services.

An estimated four to six million abortions are performed illegally each year.³¹ Further, it “is estimated that 6.7 million abortions per year are performed in other than registered and government recognized institutions, often by untrained persons in unhygienic conditions.”³² The danger of unregulated and illegal providers is pervasive, with disproportionate effects on rural areas and young women; unsafe abortions account for half of the maternal deaths of women aged fifteen to nineteen.³³ Moreover, studies show that not all registered abortion facilities are fully functional and some have never provided abortion services.³⁴ The primary reason abortion services have not been offered at those facilities is a lack of trained providers and adequate equipment.³⁵ The result is widespread practice by both certified and uncertified (illegal) providers and practitioners who often do not have adequate medical training, do not offer counseling services, and do not ensure the confidentiality of female patients. These factors inhibit women from seeking safe abortion services and force women to put their own lives at risk.

The geographical disparity in the offering of abortion services reinforces poor access to facilities despite the existence of the MTP Act. On average, there are only four medically qualified, though not necessarily certified, abortion facilities per 100,000 people throughout the country.³⁶ Moreover, despite the stringent penalty imposed by the MTP Act for uncertified provision of abortion services, certified and legal abortion facilities account for less than one third of all private abortion facilities.³⁷ The majority of abortion services providers escape accountability by routinely failing to fulfill documentation and reporting procedures, leaving women with no remedy for medical negligence and other violations of their rights as patients and as consumers of services. Social restrictions pose an even greater limitation on access. While the MTP Act does not require spousal consent for women over the age of 18, providers, especially in formal and certified facilities, are known to not provide services to women if they arrive at the facility alone or if the spouse (or a male relative) has not given consent.³⁸

The lack of affordability is another obstacle to accessing safe abortion services. Public (government) hospitals are by default legally authorized to provide abortion services, but

inadequate investment and oversight has led to poor quality of care. As a result, women hesitate to utilize them. Furthermore, services at public facilities are not always free, with states applying disparate costs for services. Often an additional and unregulated fee will be applied depending on the stage of the pregnancy and the location of the facility.³⁹ Meanwhile, services in the private sector can cost eleven times as much as the provision of services in the public sector.⁴⁰ A woman's choice in selecting an abortion facility may become even more difficult when, as discovered in some government hospitals, she can obtain a free abortion only if she consents to a sterilization procedure as well.⁴¹

Although the MTP Act defines "person" and "place" requirements, it does not establish national technical guidelines for safe abortion care.⁴² Since there is no single national law that establishes patients' rights and ethical standards for reproductive services,⁴³ women are left without recourse if they have been denied access to, or injured by, ill-performed abortion services. Moreover, since there is no national database on abortion records or reporting by private or public abortion facilities, monitoring the implementation of safe, legal and affordable abortion services is impossible.

In General Recommendation 21, the CEDAW Committee has emphasized that while a spouse or partner may have potential involvement in the decision to seek an abortion, this service "must not nevertheless be limited by spouse, parent, partner or Government."⁴⁴ In General Recommendation 24, this Committee defines "acceptable services" as 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."⁴⁵ Elsewhere, this Committee has obligated State Parties to "report on how public and private health care providers meet their duties to respect women's rights to have access to health care services . . . and what measures they have taken to ensure timely and affordable access to such services."⁴⁶ Physical and financial access have been found to be the crucial determinants in access to abortion care and services.⁴⁷ In its previous Concluding Observations, this Committee expressed concern that "inadequate allocation of resources for women's development . . . and inadequate implementation of laws are serious impediments to the realization of women's rights in India."⁴⁸

The Indian government in the second and third periodic report, acknowledges only that "many deaths were occurring due to illegally performed abortions," but cites nothing but the imposition of harsher penalties pursuant to the MTP Act as a response to the problem.⁴⁹ The dangers of illegal abortions cannot be prevented until legal abortions are properly financed and made widely available.

C. Maternal mortality has yet to decrease

Maternal deaths due to complications in pregnancy and childbirth are among the leading cause of death of women in India.⁵⁰ Maternal mortality accounts for 15% of all deaths of women of reproductive age.⁵¹ Fewer than half of all women give birth without the assistance of skilled attendants, and most deliveries take place in the home.⁵² While the frequent direct causes of maternal mortality are hemorrhage, anemia or sepsis,⁵³ the responsible factors are poor health care facilities, lack of access to family planning services and safe abortion services, and poor nutrition.⁵⁴ Women in rural areas frequently encounter high risks during pregnancy because of

poor health, unsafe home births, and insufficient access to adequate healthcare.⁵⁵ Maternal health is a serious concern, despite the existence of policies seeking to reduce the maternal mortality rate.

The 2000 National Population Policy (NPP) applies a life-cycle approach to women's health services, based on the principle that women's health needs should be met from the moment they are born, continuing through their childhood, adolescence, and adulthood.⁵⁶ In addition, the NPP contains a specific goal to reduce maternal mortality in India.⁵⁷ The Reproductive Child and Health (RCH) Programme also attempts to reduce maternal mortality by promoting safe deliveries and training birth attendants to conduct clean deliveries.⁵⁸ Furthermore, the Family Welfare Programme adopted a Community Needs Assessment Approach in 1997, which attempts to shift the focus of women's health care from individualized interventions to the holistic and life-cycle approach set forth in the NPP.⁵⁹ Goals of reducing maternal mortality rate from the 1999/2000 rate of 400/100,000 to 100/100,000 by 2012 are iterated in the government's Tenth Five Year Plan.⁶⁰

In past Concluding Observations, the CEDAW Committee has given considerable attention and concern to high maternal mortality rates.⁶¹ The Committee has expressly framed this issue as a violation of a woman's right to life.⁶² Moreover, in General Recommendation 24, this Committee emphasizes that States Parties must "take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care," and that, "studies such as those that emphasize the high maternal mortality and morbidity rates worldwide... provide an important indication for State's parties of possible breaches of their duties to ensure women's access to health care."⁶³ The Committee has recommended that States Parties "reduce maternal mortality rates through safe motherhood services and pre-natal assistance."⁶⁴ Specifically, in the 2000 Concluding Observations for India, this Committee noted its concern that "maternal mortality rates and infant mortality rates are among the highest in the world" and urged the government to "allocate resources from a 'women's right to health' perspective."⁶⁵ Reducing maternal mortality will involve a reduction of economic disparities that exist between urban and rural areas, and a widespread increase in overall access to integrated reproductive health care and services.

Although one of the goals of the NPP is to fully record births and deaths by 2010,⁶⁶ the government still lacks a uniform and functional system for recording deaths in India. Misclassifications and flawed understandings of the definition of maternal death contribute to inaccurate collection of data, as does the underreporting of maternal deaths. Consequently, the maternal death ratio is reported differently by various sources. The government contends in its second and third periodic report that the country's rate of maternal mortality has decreased from 408 per 100,000 live births (1997) to 407 per 100,000 live births in 1998.⁶⁷ Meanwhile the UNFPA State of the World Population Report (as of March 2006) estimates that there are 540 maternal deaths for every 100,000 live births.⁶⁸

Limited governmental budgetary allocations and resources contradict the Indian government's purported goals of seriously reducing maternal mortality; India's health budget in proportion to its GDP is among the lowest in the world.⁶⁹ It is widely known that public health centers are

insufficiently financed resulting in deficits of adequate equipment, training, and supplies. The private health sector is largely unregulated and free of reporting requirements, which allows health care providers to avoid accountability and leaves women without recourse in cases of injury or death. While the government implemented the National Rural Health Mission in 2005, with one of the stated goals being to reduce maternal mortality, the Mission has been criticized by the Consumer Coordination Council of India for lacking data on the technical, operational, and administrative feasibility of implementation in any state.⁷⁰ It is crucial that more strategic efforts be made to reduce maternal mortality rates, as there is no evidence that the maternal mortality rate is decreasing.

II. Information and Education on Sexuality (Articles 10(h), 12)

A. Lack of awareness and education about HIV/AIDS contributes to increasing prevalence of the epidemic

The RCH Programme introduced increased efforts to “address women’s health issues and concerns related to HIV/AIDS, TB, Malaria, Leprosy and other communicable diseases.”⁷¹ The 1999 National AIDS Control Programme focuses on assisting Government with long-term response to HIV/AIDS.⁷² The National AIDS Control Organization (NACO) has recognized the need to prevent discrimination against women with HIV/AIDS and provides counseling for pregnant women with HIV/AIDS.⁷³ Furthermore, state initiatives have encouraged legal resource centers to provide legal representation for health, property and employment cases.⁷⁴

However, there is no separate national legislation on HIV/AIDS that address access to treatment and protection against discrimination,⁷⁵ and a state law such as the 1987 Goa Public Health Act contains provisions for the isolation of persons who are HIV positive.⁷⁶ Lack of information and misconceptions about the disease pose serious obstacles to prevention programs and discourage the utilization of services. The government has yet to successfully implement a national sexual health education program that bridges the information gap and dispels myths about HIV/AIDS. It is widely known that women are particularly vulnerable to infection and discrimination due to their HIV/AIDS status and that their social subordination limits their ability protect themselves by refusing sex or negotiating condom use. In addition to not having access to treatment for HIV/AIDS, there is evidence that women are being denied access to other health services due to their HIV status, putting their reproductive health at great risk. For example, in 2006 when a pregnant woman in Kolkata approached a public hospital for an abortion, she was denied assistance due to her HIV status and told to conduct the procedure upon herself.⁷⁷

In its Concluding Observations, the CEDAW Committee has frequently been concerned with the prevalence of HIV/AIDS and STIs.⁷⁸ The Committee has requested that States Parties use a human rights-based approach to HIV/AIDS.⁷⁹ The Committee has also continuously recommended the use of general prevention measures;⁸⁰ awareness and educational programs;⁸¹ reproductive and sexual health education programs;⁸² and promotion of condom use.⁸³ In General Recommendation 15, the Committee expressed that “programmes to combat AIDS should give special attention to the right and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection.”⁸⁴ In General Recommendation 24, the

Committee explained that “[m]easures to eliminate discrimination against women are considered inappropriate if a health-care system lacks services to prevent, detect, and treat illnesses specific to women.”⁸⁵

The Committee has emphasized the vulnerability of particular groups, who are at a higher risk of contracting HIV/AIDS:⁸⁶ young adults,⁸⁷ trafficked women and girls,⁸⁸ and sex workers.⁸⁹ Particularly, in its 2000 Concluding Observations on India, the Committee expressed concern for the women and girls exploited by prostitution and cross-border trafficking, that “those women are exposed to HIV/AIDS and health risks,” and that “existing legislation encourages mandatory testing and isolation.”⁹⁰ The Committee recommended “inter-state controls and the reintegration of advocacy programs to prevent the exploitation of women and girls in forced prostitution and trafficking.”⁹¹

India has recently become the country with the highest population of people living with HIV/AIDS in the world.⁹² An estimated 5.1 million Indians live with HIV/AIDS, and, while prevalence has stabilized in some states, it is still increasing for at-risk population groups in other states.⁹³ As a result, overall HIV prevalence continues to rise.⁹⁴ It is reported that the rate of HIV/AIDS among Indian women aged 15 to 49 is the highest in all of Asia.⁹⁵

People infected with HIV/AIDS from all income groups tend to prefer private clinics, which typically provide quicker service, better care, and are perceived as more anonymous and confidential than public clinics. However, in 2001, UNAIDS surveyed 37 private clinics and found that 24 refused to accept a patient with HIV/AIDS, 12 accepted them with certain condition, and only 1 was unconditionally accepting.⁹⁶ The UNAIDS survey mentioned above also reported that private clinics subjected pregnant women to mandatory HIV testing, usually without consent.⁹⁷

Women’s vulnerability to infection and subsequent discrimination result from many neglected factors, especially the lack of basic information. Less than half of married women (aged 15 to 49) have even heard of HIV/AIDS.⁹⁸ The deficit in information is particularly dangerous among the demographic of married women, since the significant proportion of new infections are in married women who have been infected by husbands who have frequented sex workers.⁹⁹ This reality underscores the urgent need for the government to implement safe sex programs that empower sex workers to protect themselves against HIV/AIDS.¹⁰⁰ Surveys from 2001 found 30% of street-based sex workers did not know that condoms prevent the spread of HIV.¹⁰¹

Providing information and raising awareness is imperative to empowering all women regardless of age, marital status and profession to protect themselves from infection and the discrimination that follows.

B. As sexual activity increases among adolescents, there is an unmet need for sexual health education

The Committee has often expressed concern over women’s limited access to reproductive health services and information and repeatedly asked State parties to implement sexual education programs.¹⁰² The Committee has connected sexual education to the prevention of HIV/AIDS,¹⁰³

unwanted pregnancies,¹⁰⁴ high rates of teenage pregnancy,¹⁰⁵ and abortion.¹⁰⁶ The Committee has furthermore expressly recognized that young women experience difficulty in obtaining access to reproductive health care.¹⁰⁷ In addition, the Committee has recommended that State parties widely disseminate reproductive health and family planning information.¹⁰⁸

India recently introduced sexual health education into its National Curriculum, which includes segments on raising HIV/AIDS awareness, adolescent education, and life skills.¹⁰⁹ The programs, however, have not been fully implemented and states can choose which topics to cover.¹¹⁰ There has been only one state that has advanced sexual health education programs; and the state with the worst infusion of the AIDS epidemic (Maharashtra) has actually banned AIDS education in public schools.¹¹¹

The government of India is responsible for ensuring the dissemination of reproductive health information to adolescents. India is home to more than 10 million pregnant adolescents and adolescent mothers.¹¹² Due to the continuing practice of child marriage, 1 in 6 Indian girls begin childbearing between the ages of 13 and 19, and less than 10% of married girls, aged 15 to 19, use contraception.¹¹³ Half of maternal deaths for girls aged 15 to 19 are the result of unsafe abortion.¹¹⁴ A public interest lawsuit, Forum for Fact Finding Documentation and Advocacy (FFDA) v. Union of India was filed in 2003 in the Supreme Court of India seeking immediate enforcement of the Child Marriage Restraint Act of 1929 which prohibits child marriage and prescribes punishments for the perpetrators of such marriages.¹¹⁵ The Supreme Court has not issued a final ruling since new legislation, the Prevention of Child Marriage Bill, is being considered by Parliament.¹¹⁶

II. Right to Freedom from Violence and Sexual Exploitation (Articles 1, 3, 5, 6, 12, 15, 16)

A. Increase in violence against women: Rape and Sexual Harassment

In past Concluding Observations, the Committee has expressed concern over many types of sexual violence against women.¹¹⁷ Article 5 of CEDAW requires States parties “[t]o modify the social and cultural patterns of conduct of men and women” in an effort to eliminate prejudices, customs and practices that promote the subordination of women.¹¹⁸ In General Recommendation 19, the Committee confirmed that gender-based violence is a manifestation of discrimination that seriously restricts the ability of women to enjoy rights and freedoms equally with men.¹¹⁹ Gender-based violence was defined by the Committee as “violence that is directed against a woman because she is a woman or violence that affects women disproportionately.”¹²⁰ The Committee found that gender-based violence includes the infliction of physical, mental or sexual harm or suffering.¹²¹ Finally, the Committee emphasized that CEDAW not only regulates acts by the government, or in their names, but also regulates third-party actions.¹²²

While the 2001 National Policy for the Empowerment of Women “commits to address all forms of violence against women”¹²³ and the government of India is in the process of drafting a National Plan of Action,¹²⁴ the incidence of crimes against women has increased.¹²⁵ Particularly, between 1998 and 2003, there has been a 4.6% increase in rape and a 53% increase in sexual harassment.¹²⁶ The Indian Penal Code contains a narrow definition of rape;¹²⁷ marital rapes are

not recognized unless the wife is under the age of 15 or the spouses are living separately.¹²⁸ Courts are also entitled to apply a lesser prison sentence than that which is specified by law.¹²⁹ Furthermore, despite the guidelines against sexual harassment issued by the Indian Supreme Court in *Vishaka v. State of Rajasthan*, the legislative bill on this issue is still pending.¹³⁰

Of particular concern is the infliction of sexual harassment and sexual violence on girls in Indian Schools. In General Recommendation 19, the Committee advised that States should provide “effective complaint procedures and remedies” in order to prevent violence against women.¹³¹ Indian media coverage reflects abuses of female students by teachers and reports that girls have committed suicide in order to escape perpetual violence in schools.¹³² Underreporting of violence is perpetuated by institutional complicity and fear by the victim of social stigma, negative consequences at school, and further abuse. Sexual harassment and violence in schools is pervasive and affects girls regardless of class, race, caste, or region. Uniformly, violence has been shown to peak during their adolescent years.¹³³ The unaddressed violence contributes to “low enrolment [sic] of girls in schools, poor performance at school, high dropout rates, teenage pregnancy, early pregnancy” and increased exposure to HIV/AIDS.¹³⁴ Although the government of India has expressed support for girls’ education and announced its efforts to increase enrollment of girls in school¹³⁵, the failure to introduce formal rules and mechanisms to provide redress to victims of such violence indicates that the government has yet to acknowledge that sexual harassment in educational institutions is a pressing concern. As a complementary measure, it is also important for the government to expand access to emergency contraception to such victims of violence to prevent unwanted pregnancies and suicide deaths.

Over half of the women in India are illiterate (as opposed to one third of males).¹³⁶ Over 10% more men than women enroll in secondary education.¹³⁷ In its 2000 Concluding Observations on India, the CEDAW Committee expressed concern that “the fundamental right to education...has not been realized,”¹³⁸ and that “budgetary allocation for education is still far below India’s commitment.”¹³⁹ The Committee called “upon the Government to make primary and secondary education compulsory by introducing and enforcing relevant regulations.”¹⁴⁰ In light of the challenges faced by young girls in hostile and indifferent school environments, the failure to closely monitor gender-based violence in educational institution prevents the fulfillment of the fundamental right to education as applied equally to both genders.

In 2006, the government vowed to establish a National Commission for the Protection of Children’s Rights¹⁴¹ to protect children’s rights and suggest measures for their implementation; however, whether the Commission will have any practical effect still remains to be seen. The government has not put forth remedies and established formal mechanisms for the harms that are currently being perpetrated and unpunished at educational institutions.

B. Sexual Exploitation: Trafficking

In past Concluding Observations, the CEDAW Committee has continuously expressed serious concern about the failure of State parties to combat trafficking,¹⁴² primarily in the context of sexual exploitation.¹⁴³ The Committee has expressed specific concern in its 2002 Concluding Observations on India that “women and girls are exploited in prostitution and inter-State and cross-border trafficking.”¹⁴⁴ The Committee called upon the government of India to “review

existing legislation on trafficking and forced prostitution and to strengthen law enforcement,” further recommending “the development of bilateral and inter-State controls,” as well as, “the reintegration of advocacy programs to prevent the exploitation of women and girls in forced prostitution and trafficking.”¹⁴⁵

While trafficking is a global phenomenon, it is fueled by poverty and unemployment.¹⁴⁶ South Asia, in particular, is home to the largest number of internationally trafficked individuals per year (150,000).¹⁴⁷ Within the region, India is one of the highest countries of origin and destination of reported trafficking.¹⁴⁸ The geography of India facilitates use of the country as one of the major countries of destination for trafficked women and girls, and also serves as a transit point for trafficking into the Middle East.¹⁴⁹

Article 23 of the Indian Constitution and the Indian Penal Code prohibit and criminalize trafficking.¹⁵⁰ The Immoral Traffic (Prevention) Act (ITPA), amended in 1986, defines “prostitution” as “the sexual exploitation or abuse of persons for commercial purposes.”¹⁵¹ The act does not define “trafficking” or provide for criminal penalties for “trafficking.”¹⁵² As a result, ITPA does not explicitly criminalize all commercial sex work,¹⁵³ but does criminalize prostitution in public places and solicitation, living on the earnings of sex workers and applies penal provisions to traffickers as well.¹⁵⁴ However, enforcement measures (arrest and deportation) most often punish the women sex workers, who are the victims of trafficking and sexual exploitation, rather than the clients or individual traffickers.¹⁵⁵ For those who take up commercial sex work as a profession, the threat of criminal sanctions inhibits them from seeking the reproductive health services that they need.

The Indian government in its report to the Committee has acknowledged that there has been no systematic study of women in prostitution.¹⁵⁶ The government has also not ratified the UN Protocol to Prevent, Suppress and Punish Trafficking in Persons especially Women and Children.¹⁵⁷ The government’s response to the suggestion that Indian laws penalize sexually exploited women rather than the perpetrators has been to consult with the National Law School of India in Bangalore and the National Commission for Women.¹⁵⁸ However, the Committee expressed concern in its 2000 Concluding Observation on India “that the National Commission on Women has no power to enforce its proposals for law reform or intervene to prevent discrimination in the private or public sector.”¹⁵⁹ The Committee additionally noted that “the National Commission and state commissions are not supported by adequate financial or other resources.”¹⁶⁰ As a result, their initiatives may lack the teeth necessary to successfully address the real issues.

Child trafficking, which includes the exploitation of girls for domestic work, is of particular concern in India.¹⁶¹ According to NGO estimates, these young girls are typically recruited between ages 10 and 14.¹⁶² While the Juvenile Justice Act (2000) protects, treats, and rehabilitates juveniles caught in the criminal justice system, including girls¹⁶³, there is no similar legislation directed at caring for children exploited for sex work. The government has taken steps in the right direction by constituting the Central and State Advisory Committee on Child Prostitution (CSACCP), designed “to study the problem and to evolve suitable schemes for their rescue and rehabilitation.”¹⁶⁴ However, the Committee is not responsible for implementing

schemes, acting in a regulatory capacity, or providing for enforcement mechanisms and it is not clear that how will be done.

It is important to note that the Indian Supreme Court has taken a positive step in ordering the compulsory registration of marriages in part with a view to crack down on sham marriages performed for the purpose of facilitating human trafficking.¹⁶⁵ However, the government must now take concrete steps to enforce this order.

We hope that the Committee will consider addressing the following questions to the government of India:

1. How does the government plan to fulfill goal of establishing universal access to family planning information and services? What steps are being taken to address laws and policies introduced by state governments that are inherently coercive and inconsistent with national policy goals and commitments to free and informed consent in family planning?
2. What steps are being taken by the government to protect women from pregnancy related death and morbidity due to unsafe abortion and to expand access to safe and affordable abortion services? What steps are being taken to introduce and ensure the implementation of safeguards protecting the privacy and confidentiality of patients to enable women to access services without fear of discrimination and stigma?
3. How does the government propose to realize in practice its stated policy goals of reducing maternal mortality in India? What procedures and mechanisms does it propose to establish to monitor, investigate and prevent the widespread occurrence of maternal deaths especially in rural areas where the majority of maternal deaths occur?
4. What steps are being taken by the government specifically to enable women and girls, including those who are married, to protect themselves against HIV/AIDS? What measure has the government introduced to prevent discrimination against women with HIV/AIDS? What steps have been taken to prevent mandatory testing of pregnant women for HIV/AIDS and to ensure the protection of confidentiality and privacy in the provision of services?
5. In light of the particular risks faced by adolescents, what steps are being taken by the government to ensure them access to appropriate and reliable information for the protection of their reproductive health and rights? What measures have been taken against states and institutions that have refused to incorporate sexual health education into their curricula in line with its introduction into the National Curriculum? When will the Prevention of Child Marriage Bill be enacted into law and how does the government plan to successfully implement the law?

6. What measures are being taken to address the root causes of sex-trafficking and to protect young women and girl children from the devastating impact of sex work on their reproductive health?

We appreciate the active interest that the Committee has taken in reproductive health and rights and the strong Concluding Observations and General Recommendations the Committee has issued to governments in the past, stressing the need for governments to take steps to ensure their realization. We hope that this information is useful during the Committee's review of India's compliance with the provisions contained in the Convention. A significant amount of information contained in this letter is from our 2005 publication, entitled "Women of the World: South Asia," specifically the chapter detailing laws and policies in India, which can be found online at http://www.reproductiverights.org/pdf/pdf_wowso_india.pdf. If you have any questions or would like further information, please do not hesitate to contact the undersigned.

Very truly yours,

Melissa Upreti
Legal Adviser for Asia
Center for Reproductive Rights
USA

¹ Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 39/46, U.N. GAOR, 34th Sess., Supp. No 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW Convention].

² Committee on the Elimination of Discrimination against Women (CEDAW Committee), General Recommendation 24, *Women and Health*, art. 12, para. 1, U.N. Doc. A/54/38 (Part I) (1999) [hereinafter CEDAW General Recommendation 24].

³ *Id.* at para. 2.

⁴ *Id.* at para. 14.

⁵ *Id.* at para. 31 (b).

⁶ *Id.* at para. 31 (c).

⁷ *Id.* at para. 31 (e).

⁸ Committee on the Elimination of Discrimination against Women (CEDAW Committee), General Recommendation 19, *Violence against women*, para. 24 (m), U.N. Doc. A/47/38 (1992) [hereinafter CEDAW General Recommendation 19].

⁹ Committee on the Elimination of Discrimination against Women (CEDAW Committee), General Recommendation 21, *Equality in marriage and family relations*, para. 44, U.N. Doc. A/49/38 (1994) [hereinafter CEDAW General Recommendation 21].

¹⁰ *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Combined second and third periodic report of State parties, India*, CEDAW Committee, Articles 12, 74-79, U.N. Doc. CEDAW/C/IND/2-3 [hereinafter India Report].

¹¹ *Id.* at 43, 74, 75, 76.

¹² *Id.* at 74.

¹³ WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES—SOUTH ASIA 82 (Center for Reproductive Rights ed., 2004) [hereinafter WOMEN OF THE WORLD SOUTH ASIA]

¹⁴ India Report, *supra* note 10, at 75.

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- 15 WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 82.
- 16 National Population Policy 2000, para. 6. See *also* NHRC Declaration, at 1-2 (“Note with concern that population policies framed by some State Governments reflect in certain respects a coercive approach through use of incentives and disincentives which in some cases are violative of human rights. This is not consistent with the spirit of the National Population Policy.”); A. R. Nanda, *Indian Population Policy: An Overview*; Colin Gonsalves, *Two Boy Norm: State Governments Poised to Blunder*, in COERCION V. EMPOWERMENT, at 14-17, 18-19.
- 17 WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 69.
- 18 Javed v. Haryana, A.I.R. 2003 S.C. 3057.
- 19 WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 82.
- 20 India Report, *supra* note 10, at 10.
- 21 WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 83.
- 22 See COERCION VERSUS EMPOWERMENT: PERSPECTIVES FROM THE PEOPLE’S TRIBUNAL ON INDIA’S COERCIVE POPULATION POLICIES AND TWO-CHILD NORM (Shruti Pandey et al. eds., Human Rights Law Network, India) (2006).
- 23 Ramakant Rai & Health Watch U.P. and Bihar v. Union of India, W.P. (Civ.) No. 209 of 2003, at A-1 (Supreme Court of India, 2003).
- 24 WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 83.
- 25 World Health Organization (WHO), *Guidelines for Administration of Emergency Contraceptive Pills for Medical Officers*, available at http://www.whoindia.org/EN/Section6/Section7/Section300_562.htm (last visited January 9, 2007).
- 26 CEDAW General Recommendation 19, *supra* note 8, at para. 22.
- 27 *Concluding Observations of the Committee on the Elimination of Discrimination against Women: India*, 22nd Sess., 419th to 421st mtg., para. 78, U.N. Doc. A/55/38 (1999) [hereinafter *Concluding Observations of CEDAW: India*].
- 28 *Id.* at para. 56.
- 29 WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 86.
- 30 India Report, *supra* note 10, at 17.
- 31 WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 85.
- 32 ABORTION ASSESSMENT PROJECT – INDIA, RESEARCH SUMMARIES AND ABSTRACTS 7 (December 2, 2004) [hereinafter ABORTION ASSESSMENT PROJECT – INDIA].
- 33 WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 103.
- 34 *Id.* at 87.
- 35 *Id.*
- 36 ABORTION ASSESSMENT PROJECT - INDIA, *supra* note 32, at 17.
- 37 *Id.*
- 38 *Id.* at 18.
- 39 ABORTION ASSESSMENT PROJECT – INDIA, *supra* note 32, at 46.
- 40 *Id.* at 107.
- 41 *Id.* at 83.
- 42 *Id.* at 24.
- 43 WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 81-82.
- 44 CEDAW General Recommendation 21, *supra* note 9, at 22.
- 45 CEDAW General Recommendation 24, *supra* note 2, at 22.
- 46 *Id.* at paras. 14, 21.
- 47 ABORTION ASSESSMENT PROJECT – INDIA, *supra* note 32, at 18.
- 48 *Concluding Observations of CEDAW: India*, *supra* note 27, at 56.
- 49 India Report, *supra* note 10, at 94.
- 50 *Id.* at 80.
- 51 WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 84.
- 52 *Id.* at 85
- 53 *Id.*
- 54 India Report, *supra* note 10, at 80.
- 55 UNICEF, *Building Health and Hope for soon-to-be Mothers in rural India*, May 26, 2004.
- 56 India Report, *supra* note 10, at 10.
- 57 *Id.* at 23.

⁵⁸ *Id.* at 74.

⁵⁹ *Id.* at 75.

⁶⁰ *Id.* at 82.

⁶¹ CENTER FOR REPRODUCTIVE RIGHTS & UNIVERSITY OF TORONTO PROGRAMME OF REPRODUCTIVE AND SEXUAL HEALTH LAW. BRINGING RIGHTS TO BEAR: AN ANALYSIS OF THE WORK OF UN TREATY MONITORING BODIES ON REPRODUCTIVE AND SEXUAL RIGHTS 107 (2002) [hereinafter BRINGING RIGHTS TO BEAR]. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. See e.g., **Antigua and Barbuda**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 260; **Argentina**, 23/07/97, U.N. Doc. A/52/38 Rev.1, Part II, ¶ 304; **Australia**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 397; **Azerbaijan**, 14/05/98, U.N. Doc. A/53/38, ¶ 63; **Bangladesh**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 438; **Burkina Faso**, 31/01/2000 U.N. Doc. A/55/38, ¶ 274; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 61; **Cameroon**, 26/06/2000, U.N. Doc. A/55/38, ¶ 59; **Colombia**, 31/05/95, U.N. Doc. A/50/38, ¶ 612; **Democratic Republic of the Congo**, 01/02/2000, U.N. Doc. A/55/38, ¶ 227; **Dominican Republic**, 14/05/98, U.N. Doc. A/53/38, ¶ 337; **Georgia**, 01/07/99, U.N. Doc. A/54/38, ¶ 111; **Guinea**, 31/07/2001, U.N. Doc. A/56/38, ¶ 128; **India**, 01/02/2000, U.N. Doc. A/55/38, ¶ 78; **Iraq**, 14/06/2000, U.N. Doc. A/55/38, ¶ 203; **Israel**, 21/07/97, U.N. Doc. A/52/38 Rev.1, Part II, ¶ 162; **Kyrgyzstan**, 27/01/99, U.N. Doc. A/54/38, ¶ 136; **Madagascar**, 12/04/94, U.N. Doc. A/49/38, ¶ 244; **Maldives**, 02/02/2001, U.N. Doc. A/56/38, ¶ 142; **Mongolia**, 02/02/2001, U.N. Doc. A/56/38, ¶ 273; **Morocco**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 68; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 129; **Namibia**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 111; **Nicaragua**, 31/07/2001, U.N. Doc. A/56/38, ¶ 300; **Nigeria**, 07/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 170; **Paraguay**, 09/05/96, U.N. Doc. A/51/38, ¶ 123; **Peru**, 08/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 337; **Russian Federation**, 31/05/95, U.N. Doc. A/50/38, ¶ 545; **United Republic of Tanzania**, 06/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 237; **Venezuela**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 236.

⁶² *Id.* This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. See e.g., **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶ 56; **Colombia**, 04/02/99, U.N. Doc. A/54/38, ¶ 393; **Dominican Republic**, 14/05/98, U.N. Doc. A/53/38, ¶ 337; **Madagascar**, 12/04/94, U.N. Doc. A/49/38, ¶ 244.

⁶³ CEDAW General Recommendation 24, *supra* note 2, at para. 17.

⁶⁴ *Id.* at para. 31 (c).

⁶⁵ *Concluding Observations of CEDAW: India*, *supra* note 27, at paras. 78-79.

⁶⁶ India Report, *supra* note 10, at 5.

⁶⁷ *Id.* at 29-30.

⁶⁸ UNFPA STATE OF THE WORLD POPULATION REPORT 95-96 (2006), available at <http://www.unfpa.org/swp/2006>.

⁶⁹ *Id.* at 99.

⁷⁰ National Rural Health Mission (NRHM): *Will it Make a Difference*, Dr. Umesh Kapil, Professor AIIMS.

⁷¹ India Report, *supra* note 10, at 74-75.

⁷² *Id.* at 78.

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 87.

⁷⁶ *Id.*

⁷⁷ Agence France Presse—English, *HIV-positive Indian has to abort her own foetus*, September 1, 2006.

⁷⁸ BRINGING RIGHTS TO BEAR, *supra* note 61, at 160. See e.g., **Antigua and Barbuda**, 12/08/97, U.N. Doc. A/52/38.Rev.1, Part II, ¶ 261; **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶¶ 39, 58; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 59; **Guinea**, 31/07/2001, U.N. Doc. A/56/38, ¶ 130, 136-137; **Guyana**, 31/07/2001, U.N. Doc. A/56/38, ¶¶ 151, 178; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 95, 121; **Namibia**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 79; **Romania**, 23/06/2000, U.N. Doc. A/55/38, ¶ 314; **United Kingdom of Great Britain and Northern Ireland**, 01/07/99, U.N. Doc. A/54/38, ¶ 309; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶ 266.

⁷⁹ *Id.* See e.g., **Egypt**, 02/02/2001, U.N. Doc. A/56/38, ¶¶ 336-337.

⁸⁰ *Id.* See e.g., **Guyana**, 31/07/2001, U.N. Doc. A/56/38, ¶ 179; **Ethiopia**, 09/05/96, U.N. Doc. A/51/38, ¶ 161; **Peru**, 08/07/98, U.N. Doc. A/55/38/Rev.1, ¶ 343; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 96; **Uganda**, 31/05/95, U.N. Doc. A/50/38, ¶ 338.

⁸¹ *Id.* See e.g., **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶ 59; **Burkina Faso**, 31/01/2000, U.N. Doc. A/55/38,

¶ 276; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 60; **Cameroon**, 26/06/2000, U.N. Doc. A/55/38, ¶ 60; **Colombia**, 04/02/99, U.N. Doc. A/54/38, ¶ 346; **Cuba**, 09/05/96, U.N. Doc. A/51/38, ¶ 224; **Dominican Republic**, 14/05/98, U.N. Doc. A/55/38, ¶ 349; **Guyana**, 31/07/2001, U.N. Doc. A/56/38, ¶ 179; **Iraq**, 14/06/2000, U.N. Doc. A/55/38, ¶ 203; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 96; **Uganda**, 31/05/95, U.N. Doc. A/50/38, ¶ 320; **United Republic of Tanzania**, 06/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 214; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶ 267.

⁸² *Id.* See e.g., **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 96; **Uganda**, 31/05/95, U.N. Doc. A/50/38, ¶ 338; **United Kingdom of Great Britain and Northern Ireland**, 01/07/99, U.N. Doc. A/54/38, ¶ 310; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶ 267; **Zimbabwe**, 14/05/98, U.N. Doc. A/53/38, ¶ 160.

⁸³ *Id.* See e.g., **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶ 59; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 60; **Guinea**, 31/07/2001, U.N. Doc. A/56/38, ¶ 131; **Uganda**, 31/05/95, U.N. Doc. A/50/38, ¶ 313; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶ 267.

⁸⁴ Committee on the Elimination of Discrimination against Women (CEDAW Committee), General Recommendation 15, *Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS)*, para (b), U.N. Doc. A/45/38 at 81 (1990).

⁸⁵ CEDAW General Recommendation 24, *supra* note 2, at para. 11.

⁸⁶ BRINGING RIGHTS TO BEAR, *supra* note 61, at 160. See e.g., **Romania**, 23/06/2000, U.N. Doc. A/55/38, ¶ 315.

⁸⁷ *Id.* See e.g., **Cuba**, 09/05/96, U.N. Doc. A/51/38, ¶ 224; **Guyana**, 31/07/2001, U.N. Doc. A/56/38, ¶ 178; **United Kingdom of Great Britain and Northern Ireland**, 01/07/99, U.N. Doc. A/54/38, ¶ 309; **Zimbabwe**, 14/05/98, U.N. Doc. A/53/38, ¶ 147.

⁸⁸ *Id.* at 161. See e.g., **India**, 01/02/2000, U.N. Doc. A/55/38, ¶ 76; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 122; **Peru**, 08/07/98, U.N. Doc. A/55/38/Rev.1, ¶¶ 325-326.

⁸⁹ *Id.* See e.g., **Bolivia**, 31/05/95, U.N. Doc. A/50/38, ¶ 65; **Guinea**, 31/07/2001, U.N. Doc. A/56/38, ¶ 136; **Guyana**, 31/07/2001, U.N. Doc. A/56/38, ¶ 181; **India**, 01/02/2000, U.N. Doc. A/55/38, ¶ 76; **Myanmar**, 28/01/2000, U.N. Doc. A/55/38, ¶ 122; **Nigeria**, 07/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 168; **Peru**, 08/07/98, U.N. Doc. A/55/38/Rev.1, ¶¶ 325-326.

⁹⁰ *Concluding Observations of CEDAW: India*, *supra* note 27, para. 76.

⁹¹ *Id.* at para. 77.

⁹² UNAIDS, 2006 REPORT ON THE GLOBAL AIDS EPIDEMIC 511 (2006), *available at* http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp.

⁹³ UNAIDS, AIDS EPIDEMIC UPDATE 33 (December 2005).

⁹⁴ *Id.*

⁹⁵ UNFPA STATE OF THE WORLD POPULATION REPORT, *supra* note 68, at 95-96.

⁹⁶ UNAIDS, INDIA: HIV AND AIDS-RELATED DISCRIMINATION, STIGMATIZATION AND DENIAL 20 (2001), *available at* http://data.unaids.org/Publications/IRC-pub02/JC587-India_en.pdf.

⁹⁷ *Id.* at 22.

⁹⁸ WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 103.

⁹⁹ UNAIDS, AIDS EPIDEMIC UPDATE, *supra* note 93, at 9.

¹⁰⁰ *Id.* at 34.

¹⁰¹ *Id.*

¹⁰² BRINGING RIGHTS TO BEAR, *supra* note 61, at 137. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. See e.g., **Antigua and Barbuda**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶¶ 258, 267; **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶¶ 56-57; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 62; **Chile**, 09/07/99, U.N. Doc. A/54/38, ¶ 227; **Colombia**, 31/05/95, U.N. Doc. A/50/38, ¶ 608; **Democratic Republic of the Congo**, 01/02/2000, U.N. Doc. A/55/38, ¶ 228; **Dominican Republic**, 14/05/98, U.N. Doc. A/53/38, ¶ 349; **Greece**, 01/02/99, U.N. Doc. A/55/38, ¶¶ 207-208; **Hungary**, 09/05/96, U.N. Doc. A/51/38, ¶ 260; **Jamaica**, 02/02/2001, U.N. Doc. A/56/38, ¶ 224; **Kazakhstan**, 02/02/2001, U.N. Doc. A/56/38, ¶ 106; **Lithuania**, 16/06/2000, U.N. Doc. A/55/38, ¶ 159; **Mongolia**, 02/02/2001, U.N. Doc. A/56/38, ¶ 274; **Nepal**, 01/07/99, U.N. Doc. A/54/38, ¶ 148; **Nicaragua**, 31/07/2001, U.N. Doc. A/56/38, ¶ 303; **Peru**, 08/07/98, U.N. Doc. A/53/38, ¶ 342; **Republic of Moldova**, 27/06/2000, U.N. Doc. A/55/38, ¶ 110; **Romania**, 23/06/2000, U.N. Doc. A/55/38, ¶ 315; **Saint Vincent and the Grenadines**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 147; **Slovakia**, 30/06/98, U.N. Doc. A/53/38/Re v.1, ¶ 92; **Slovenia**, 12/08/97, U.N. Doc. A/52/38/Re v.1, ¶ 119; **Spain**, 01/07/99,

U.N. Doc. A/54/38, ¶ 266; **Uganda**, 31/05/95, U.N. Doc. A/50/38, ¶ 338; **United Kingdom of Great Britain and Northern Ireland**, 01/07/99, U.N. Doc. A/54/38, ¶¶ 309–310; **Uzbekistan**, 02/02/2001, U.N. Doc. A/56/38, ¶¶ 185–186; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶¶ 266–267; **Zimbabwe**, 14/05/98, U.N. Doc. A/53/38, ¶¶ 160–161.

¹⁰³ *Id.* This is supported by the Committee’s Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Dominican Republic**, 14/05/98, U.N. Doc. A/53/38, ¶ 349; **Uganda**, 31/05/95, U.N. Doc. A/50/38, ¶ 338.

¹⁰⁴ *Id.* This is supported by the Committee’s Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶ 56; **Nepal**, 01/07/99, U.N. Doc. A/54/38, ¶ 148.

¹⁰⁵ *Id.* This is supported by the Committee’s Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶¶ 56–57; **Chile**, 09/07/99, U.N. Doc. A/54/38, ¶¶ 226–227; **Greece**, 01/02/99, U.N. Doc. A/55/38, ¶¶ 207–208; **Saint Vincent and the Grenadines**, 12/08/97, U.N. Doc. A/52/38/Rev. v.1, ¶ 147; **United Kingdom of Great Britain and Northern Ireland**, 01/07/99, U.N. Doc. A/54/38, ¶¶ 309–310.

¹⁰⁶ *Id.* This is supported by the Committee’s Concluding Observations to the following countries as cited in this publication. *See e.g.*, **Belize**, 01/07/99, U.N. Doc. A/54/38, ¶¶ 56–57; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 62; **Greece**, 01/02/99, U.N. Doc. A/55/38, ¶¶ 207–208; **Slovakia**, 30/06/98, U.N. Doc. A/53/38/Rev. v.1, ¶ 92; **Slovenia**, 12/08/97, U.N. Doc. A/52/38/Rev. v.1, ¶ 119; **Spain**, 01/07/99, U.N. Doc. A/54/38, ¶ 266.

¹⁰⁷ *Id.* at 105–106. *See e.g.*, **Chile**, 09/07/99, U.N. Doc. A/54/38, ¶ 227; **Greece**, 01/02/99, U.N. Doc. A/54/38, ¶¶ 207–208; **Ireland**, 01/07/99, U.N. Doc. A/54/38, ¶ 186; **Mauritius**, 31/05/95, U.N. Doc. A/50/38, ¶ 211; **Mexico**, 14/05/98, U.N. Doc. A/53/38, ¶ 394; **Nigeria**, 07/07/98, U.N. Doc. A/53/38/Rev.1, ¶ 171; **Paraguay**, 09/05/96, U.N. Doc. A/51/38, ¶ 123; **Peru**, 08/07/98, U.N. Doc. A/55/38/Rev.1, ¶ 341; **Venezuela**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 236; **Zimbabwe**, 14/05/98, U.N. Doc. A/53/38, ¶ 148.

¹⁰⁸ *Id.* at 107. *See e.g.*, **Antigua and Barbuda**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 267; **Burundi**, 02/02/2001, U.N. Doc. A/56/38, ¶ 62; **Colombia**, 04/02/99, U.N. Doc. A/54/38, ¶ 396; **Czech Republic**, 14/05/98, U.N. Doc. A/53/38, ¶ 205; **Finland**, 31/05/95, U.N. Doc. A/50/38, ¶ 390; **Jamaica**, 02/02/2001, U.N. Doc. A/56/38, ¶ 224; **Nicaragua**, 31/07/2001, U.N. Doc. A/56/38, ¶ 303; **Saint Vincent and the Grenadines**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 147; **Slovakia**, 30/06/98, U.N. Doc. A/53/38/Rev.1, ¶ 92; **Slovenia**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶ 119; **Uganda**, 31/05/95, U.N. Doc. A/50/38, ¶ 338; **Zimbabwe**, 14/05/98, U.N. Doc. A/53/38, ¶¶ 160–161.

¹⁰⁹ WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 105.

¹¹⁰ *Id.*

¹¹¹ *Id.* at 114.

¹¹² *Id.* at 103.

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ Forum for Fact Finding Documentation and Advocacy (FFDA) v. Union of India, W.P. (Civ.) No. 212 of 2003 (Supreme Court of India, Apr. 25, 2003).

¹¹⁶ *Id.*

¹¹⁷ BRINGING RIGHTS TO BEAR, *supra* note 61. This is supported by the Committee’s Concluding Observations to the following country as cited in this publication. *See e.g.*, **Romania**, 23/06/2000, U.N. Doc. A/55/38, ¶¶ 306; **Vietnam**, 31/07/2001, U.N. Doc. A/56/38, ¶¶ 258–259.

¹¹⁸ CEDAW Convention, *supra* note 1, at art. 5.

¹¹⁹ CEDAW General Recommendation 19, *supra* note 8, at para. 1.

¹²⁰ *Id.* at para. 6.

¹²¹ *Id.*

¹²² *Id.* at para. 9.

¹²³ India Report, *supra* note 10, at 8.

¹²⁴ *Id.* at 102.

¹²⁵ *Id.* at 7.

¹²⁶ *Id.* at 96.

¹²⁷ *Id.* at 97.

¹²⁸ WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 100.

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- 129 *Id.*
- 130 *Id.* at 102.
- 131 CEDAW General Recommendation 19, *supra* note 8, para. 24 (i).
- 132 *Sexual Harassment: IHRO for Action against Principal*, Tribune News Service, May 28, 2002.
- 133 ActionAid International, *Stop Violence Against Girls in School 4* (2004), available at <http://www.actionaid.org/wps/content/documents/ActionAidViolenceBklt.pdf>.
- 134 *Id.*
- 135 Second Periodic Report of States Parties Due in 2000: India, CRC, paras. 728-1042, U.N. Doc. CRC/C/93Add.5 (2003).
- 136 UNFPA STATE OF THE WORLD POPULATION REPORT, *supra* note 68, at 95.
- 137 *Id.*
- 138 *Concluding Observations of CEDAW: India*, *supra* note 27, at 64.
- 139 *Id.*
- 140 *Id.* at para. 65.
- 141 The Hindu (Online), *Child Rights Protection Panel*, Feb. 2, 2006, available at <http://www.hindu.com/2006/02/02/stories/2006020200651300.htm>.
- 142 BRINGING RIGHTS TO BEAR, *supra* note 61, at 82. This is supported by the Committee's Concluding Observations to the following countries as cited in this publication. See e.g. **Austria**, 15/06/00, U.N. Doc. A/55/38, ¶¶ 228, 239; **Azerbaijan**, 14/05/98, U.N. Doc. A/53/38, ¶ 74; **Bangladesh**, 12/08/97, U.N. Doc. A/52/38/Rev.1, Part II, ¶ 459; **Belarus**, 31/01/2000, U.N. Doc. A/55/38, ¶ 349, 371–372; **Bulgaria**, 14/05/98, U.N. Doc. A/53/38, ¶¶ 243, 256; **China**, 03/02/99, U.N. Doc. A/54/38, ¶¶ 290–291; **China—Hong Kong Special Administrative Region**, 03/02/99, U.N. Doc. A/54/38, ¶¶ 299(c), 326; **Cyprus**, 09/05/96, U.N. Doc. A/51/38, ¶¶ 53, 61; **Denmark**, 12/08/97, A/52/38/Rev.1, ¶ 269; **Dominican Republic**, 14/15/98, U.N. Doc. A/53/38, ¶¶ 333, 346; **Finland**, 02/02/01, U.N. Doc. A/56/38, ¶¶ 303–304; **Georgia**, 01/07/99, U.N. Doc. A/54/38, ¶¶ 101–102; **Germany**, 02/02/00, U.N. Doc. A/55/38, ¶¶ 321–322; **Greece**, 01/02/99, U.N. Doc. A/54/38, ¶¶ 197–198; **India**, 01/02/00, U.N. Doc. A/55/38, ¶¶ 62, 76–77; **Indonesia**, 14/05/98, U.N. Doc. A/53/38, ¶¶ 296, 300, 310; **Kazakhstan**, 02/02/01, U.N. Doc. A/56/38, ¶¶ 97–98; **Kyrgyzstan**, 27/01/99, U.N. Doc. A/54/38, ¶¶ 129–130; **Lithuania**, 16/06/00, U.N. Doc. A/55/38, ¶¶ 152–153; **Mauritius**, 03/05/95, U.N. Doc. A/50/38, ¶ 209; **Mexico**, 14/05/98, U.N. Doc. A/53/38, ¶ 395; **Mongolia**, 02/02/01, U.N. Doc. A/56/38, ¶¶ 265–266; **Myanmar**, 28/01/00, U.N. Doc. A/55/38, ¶¶ 119–120, 121; **Nepal**, 01/07/99, U.N. Doc. A/54/38, ¶¶ 149–150; **Netherlands**, 31/07/01, U.N. Doc. A/56/38, Part II, ¶¶ 198, 211–212; **Nicaragua**, 31/07/01, U.N. Doc. A/56/38, Part II, ¶¶ 314–315; **Norway**, 31/05/95, U.N. Doc. A/50/38, ¶ 494; **Philippines**, 12/08/97, U.N. Doc. A/52/38/Rev.1, ¶¶ 292, 299; **Republic of Moldova**, 27/06/00, U.N. Doc. A/55/38, ¶¶ 103–104; **Romania**, 23/06/00, U.N. Doc. A/55/38, ¶¶ 300, 308–309; **Singapore**, 31/07/01, U.N. Doc. A/56/38, Part II, ¶¶ 90–91; **Slovakia**, 30/06/98, U.N. Doc. A/53/38, ¶¶ 81–82; **Sweden**, 31/07/01, U.N. Doc. A/56/38, Part II, ¶¶ 354–355; **Thailand**, 02/02/99, U.N. Doc. A/54/38, ¶¶ 236–238; **United Republic of Tanzania**, 06/07/98, A/53/38, ¶ 240; **Uzbekistan**, 31/07/01, U.N. Doc. A/56/38, Part II, ¶¶ 178–179; **Vietnam**, 31/07/01, U.N. Doc. A/56/38, Part II, ¶¶ 260–261.
- 143 See Radhika Coomaraswamy, *Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences*, Human Rights Commission, 56th Sess., Agenda Item 12(a), ¶ 13, U.N. Doc.E/CN.4/2000/68 (2000).
- 144 *Concluding Observations of CEDAW: India*, *supra* note 27, at para. 76.
- 145 *Id.* at para. 77.
- 146 UNFPA STATE OF THE WORLD POPULATION REPORT, *supra* note 68, at 45.
- 147 *Id.*
- 148 *Id.* at 46.
- 149 *Id.* at 45.
- 150 India Report, *supra* note 10, at 46.
- 151 WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 102.
- 152 *Id.*
- 153 *Id.*
- 154 India Report, *supra* note 10, at 46.
- 155 *Id.*
- 156 *Id.*
- 157 *Id.* at 48.

¹⁵⁸ WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 103.

¹⁵⁹ *Concluding Observations of CEDAW: India*, *supra* note 27, at 84.

¹⁶⁰ *Id.*

¹⁶¹ WOMEN OF THE WORLD SOUTH ASIA, *supra* note 13, at 20.,

¹⁶² *Id.*

¹⁶³ India Report, *supra* note 10, at 47.

¹⁶⁴ *Id.* at 48.

¹⁶⁵ *Smt. Seema v. Ashwani Kumar*, T.P. Civ. No. 291 of 2005 (Supreme Court of India, Feb. 14, 2006).