



June 19, 2014

CEDAW Secretariat
Office of the High Commissioner for Human Rights (OHCHR)
Palais Wilson
52, rue des Paquis
CH-1201 Geneva - Switzerland

Re: Supplementary Information on India, scheduled for review by the Committee on the Elimination of Discrimination against Women during its 58th Session (July 2014)

Honorable Committee Members,

The Center for Reproductive Rights (the Center), an international non-governmental organization with offices in Nepal, Colombia, Kenya, Switzerland, and the United States, and the Human Rights Law Network (HRLN), with offices throughout India, respectfully submit this letter to assist the Committee on the Elimination of Discrimination against Women (the Committee) in its review of India's compliance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)¹ during its 58th Session in July 2014. The Center and HRLN welcome the Committee's inclusion of questions relating to maternal mortality, unsafe abortion, access to reproductive health services and child marriage in its list of issues for India's periodic report. This letter provides updates to a pre-session letter submitted by the Center and HRLN (Annex I), highlighting information relevant to questions raised by the Committee in the list of issues and the government of India's official responses.

I. Reproductive Autonomy and the Rights to Substantive Equality and Nondiscrimination

As the hallmark international convention on women's rights, CEDAW provides significant protections for a range of women's human rights, including their reproductive rights and their rights to equality and nondiscrimination. Recognizing the inextricable link between women's reproductive rights and their other human rights, the Committee has made clear that reproductive autonomy is essential to ensuring that women can equally exercise their human rights.² The Committee has noted that "the Convention requires that women be given an equal start and that they be empowered by an enabling environment to achieve equality of results" and that "[t]he position of women will not be improved as long as the underlying causes of discrimination against women, and of their inequality, are not effectively addressed."³ Furthermore, the Committee has affirmed that to fulfill women's human rights, states must use all appropriate means to promote substantive equality, including by adopting temporary special measures.⁴ To attain substantive equality for women, it is critical that India fulfill women's reproductive rights and guarantee their ability to exercise reproductive autonomy – that is, to make independent and informed decisions about their lives and their bodies without undue influence or coercion, including concerning the right to determine the number and spacing of their children.

As recognized by the Committee, the burden of childrearing disproportionately falls on women, which affects their rights to education and employment, as well as their physical and mental health.⁵ The Committee recognizes that this burden is one of the most significant factors inhibiting women's ability to

participate in public life⁶ and that reduced domestic burdens enable women to engage more fully in activities outside the home.⁷ The Committee has also noted that women's ability to voluntarily control their fertility improves their own and their families' health, development, and well-being.⁸ The Committee has criticized and called for the criminalization of discriminatory harmful practices, such as child marriage and marital rape, which undermine women's and girls' capacity to exercise reproductive autonomy.⁹

Notably, the Committee has expressed concern about India's failure to ensure substantive inequality for women and noted that, "while de jure equality for women has been realized in many spheres, there remain many impediments to the realization of de facto equality."¹⁰ The Committee has recommended that India must "take proactive steps to remove structural barriers to women's equality."¹¹

II. Maternal Mortality and Morbidity (Articles 10(h), 12, 16)

CEDAW contains specific protections for the right to maternal health care, and recognizes the right to safe and healthy pregnancy as a component of the right to health without discrimination, stating that "States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."¹² The CEDAW Committee has expressed concern over high maternal mortality in states parties,¹³ framing the issue as a violation of the rights to health¹⁴ and nondiscrimination.¹⁵ Under CEDAW, states are not only required to reduce maternal mortality but also ensure that health services meet the distinct needs of women and are inclusive of marginalized and vulnerable sectors of society.¹⁶

The CEDAW Committee has previously urged India to "prioritize decreasing maternal mortality rates by establishing adequate obstetric delivery services and ensuring women access to health services, including safe abortion and gender-sensitive comprehensive contraceptive services."¹⁷ The Committee has also recommended that India provide detailed information about the impact, and trends over time, of programs to decrease maternal mortality.¹⁸ As our pre-session letter notes, despite these recommendations, poor quality of maternal health care and lack of accountability for poor quality pregnancy-related care continue to contribute to maternal mortality and morbidity in India.¹⁹ A related concern is the lack of official data in India on different types of maternal morbidities, which in other parts of the region with similar health infrastructure and indicators commonly include fistula and uterine prolapse.

The Center and HRLN welcome the Committee's inclusion of questions pertaining to women's reproductive health issues, including those related to the high maternal mortality ratio (MMR), in the list of issues.²⁰ India's response to the Committee's query about urban health care reveals that the government is ready to launch a National Urban Health Mission (NUHM) to focus on primary health care needs of the urban poor, including women and girls, in order to reduce the overall MMR.²¹ The Ministry of Health & Family Welfare formally launched the nationwide scheme in January 2014, beginning in select cities such as Bangalore; coverage is proposed to expand to 779 urban areas by March 2015.²² Although this appears to be a promising scheme, India's response does not discuss what concrete measures are actually being taken to expand the NUHM, and provides no specific information on the coverage for sexual and reproductive health services and the potential impact on maternal mortality and morbidity.

As included in Annex VIII of India's reply to the list of issues, government studies indicate that the MMR in India declined from 212 maternal deaths per 100,000 live births in 2007-2009 to 178 in 2010-2012.²³ However, the World Health Organization estimates that in 2013, India's MMR may have been as high as 300.²⁴ As noted in the pre-session letter, significant disparities in MMR exist among states in India: for example, a 2013 government study estimates the MMR in the state of Assam could be as high as 328, whereas the MMR in the state of Andhra Pradesh was 110.²⁵ There are also disparities between the

different reports released by the government - for instance the 2012-2013 Annual Health Survey reports that the MMR in Assam could be as high as 333.²⁶ India has also acknowledged it is not on track to meet its Millennium Development Goal (MDG) of reducing its MMR to 109 per 100,000 live births by 2015.²⁷

While the government has pilot tested policies that are relevant to maternal health and nutrition, such as the Indira Gandhi Matrivita Sahyog Yojana (IGMSY), launched in 2011 and designed to provide cash incentives to women who are pregnant or lactating to partially compensate them for wages that are lost during childbirth and childcare,²⁸ there are concerns regarding the scheme's terms and implementation. The IGMSY policy does not extend to women under age 19 or to those who have had more than two children.²⁹ These excluded populations are particularly vulnerable, as early age at pregnancy and frequent or poorly spaced pregnancies give rise to higher risks of maternal mortality.³⁰ Further, the IGMSY is a pilot program and the government has failed to state whether and when this program will be introduced nation-wide.

Age limitations in government policies aimed at preventing maternal mortality are discriminatory to the extent that they penalize a particularly vulnerable sub-group of women, adolescent girls, on the ground of pregnancy. Pregnancy is particularly dangerous for adolescent girls in India, due to the inherent risks associated with pregnancy and childbearing during adolescence and the fact that they are less likely to receive proper antenatal care,³¹ to be aware of the legal status of abortion or where to obtain a safe abortion,³² and are more likely to have pregnancies timed too closely together and too frequently.³³ The Indian government has in the past acknowledged the risks of pregnancy for adolescent girls, and removed restrictions in previous maternal health policies that limited maternal health benefits to pregnant girls below the age of 19.³⁴ The IGMSY's reintroduction of age-based restrictions constitutes a regressive measure in violation of CEDAW.³⁵ Age-based restrictions are also present in state-level policies, including in the state of Odisha's Mamata policy, which is intended to improve maternal health through partial wage compensation for pregnant and nursing mothers.³⁶ These schemes violate the government's obligations under CEDAW to eliminate discriminatory laws and policies and to ensure all women's access to appropriate maternity care during pregnancy and confinement.

III. Unsafe Abortion (Articles 10(h), 12, 14, 16)

In its statement on the Beyond 2014 ICPD review, which focuses on women's reproductive rights, the Committee noted that safe abortion is part of the right to sexual and reproductive health.³⁷ The Committee has previously urged the government of India to prioritize access to safe abortion to decrease maternal mortality.³⁸ In its list of issues, the Committee requested information on measures in place to reduce the number of unsafe abortions performed, given that such abortions contribute to India's high maternal mortality rate.³⁹

The continued prevalence of unsafe abortion in India undermines women's exercise of reproductive autonomy and substantive equality. As women only ever become pregnant, ensuring access to such services as safe abortion is essential to ensuring that women can equally exercise their human rights.⁴⁰ As noted in the pre-session letter, abortion is legal on broad grounds in India under the Medical Termination of Pregnancy Act (MTP Act).⁴¹ However, significant obstacles to obtaining safe and legal abortion in India still exist, including: prohibitive costs; shortage of trained providers; inadequate equipment; lack of confidentiality and informal demands for spousal consent; lack of knowledge about the legal status of abortion among women, lawyers, and medical professionals; and women's poor access to safe services.⁴² As a result, one study has found that of the 6.4 million abortions performed in India annually, 3.6 million, or 56%, were unsafe.⁴³ These barriers to safe abortion have been documented in major studies of which the government is aware but has failed to take effective steps to address.⁴⁴

Restrictions on medical abortion. As noted in our pre-session letter, restrictions on medical abortion have curtailed women’s access to safe abortion services, despite the MTP Act. A recent study by Ipas India has documented barriers in access to medical abortion even where women have a prescription from their providers. The medicines used in medical abortion, mifepristone and misoprostol, have been classified as Schedule H drugs by the Food and Drugs Administration’s rules,⁴⁵ a category of drugs that is highly regulated.⁴⁶ As such, a prescription is required to obtain the pills and the chemist must keep detailed personal records of clients.⁴⁷ For women seeking abortion services, the requirement that they disclose personal information to avail of these medicines deters their access to medical abortion pills, and violates their rights under sections 5(3) and 6 of the MTP Regulations 2003,⁴⁸ which were intended to protect the confidentiality and privacy of women who undergo abortions. Pharmacists also report that such reporting requirements expose them to greater risk of harassment by authorities, leading them to refuse to stock such medication.⁴⁹ For example, government authorities in the state of Maharashtra have intensified efforts to regulate the availability of medical abortion pills, including by requiring onerous documentation when medical abortion pills are dispensed by pharmacists and issuing threats to drug stores against distribution of these pills.⁵⁰ As a result of the crackdown, a “black market” for medical abortion medication has emerged.⁵¹ Local media have reported women paying up to five times the normal retail price to get pills, even with a prescription.⁵² The CEDAW Committee has urged states to make every effort to increase women’s access to confidential medical care by trained personnel, including reproductive health care.⁵³

Lack of harmonization of national laws and regulations also threatens the right to confidentiality of adolescent girls under 18 who seek abortion. Under the Protection of Children from Sexual Offences Act of 2012 (PCSO Act of 2012) and the Criminal Law (Amendment) Act 2013, sex below the age of 18 years is criminalized and pregnancy is presumed to be a result of rape - thus the Acts make it mandatory for hospitals or local bodies to report cases involving pregnant minors to the police.⁵⁴ These provisions are inconsistent with the CEDAW Committee’s call for all reproductive health services to be “consistent with the human rights of women, including the rights to privacy, autonomy [and] confidentiality.”⁵⁵

Sex-selective abortion. Attempts to address the unbalanced sex ratio in India have led to serious risks to women’s access to safe abortion services and undermined women’s autonomy by making abortions harder to obtain. In India, the government has specifically criminalized sex determination, but has not criminalized sex selective abortion.⁵⁶ However, in practice, studies have repeatedly found that despite this distinction, the focus of government officials on sex selective abortion has led to significant stigma of all abortions, forcing many women to seek unsafe, illegal abortions that endanger their survival and well-being.⁵⁷ The government’s actions constitute discrimination by treating abortion, a medical service that only women need, distinctly from other health care services through excessive scrutiny.

A 2011 UN Interagency statement on sex-selection has affirmed that women’s rights are violated where they must resort to unsafe abortion or are forced to carry an unwanted pregnancy to term, and governments should ensure that “campaigns against sex selection do not jeopardize knowledge of – or access to – safe abortion services.”⁵⁸ The statement emphasizes that “[s]ex selection in favour of boys is a symptom of pervasive social, cultural, political and economic injustices against women, and a manifest violation of women’s human rights. Such injustices must be addressed and resolved without exposing women and children to the risk of death or serious injury through denying them access to needed services – and thus further violating their rights.”⁵⁹ To successfully counter son preference as expressed through sex selection, the government must work to meet their obligations to put in place a comprehensive approach to overcoming traditional views and stereotypes that devalue girls, in accordance with articles 2 (f) and 5 (a) of CEDAW.⁶⁰

Broad restrictions on abortions past 20 weeks. As noted in our pre-session letter, under the MTP Act, abortion past twenty weeks is only permitted where a pregnant woman's life is in danger.⁶¹ This has unfortunately led to denial of abortions to women seeking abortions in the second and third trimesters for other reasons, including risks to their physical or mental health and severe fetal impairments undermining the viability of a pregnancy.⁶² India's National Commission on Women (NCW) has expressed concern that women face barriers under the 20-week limitation, because it is possible nowadays to learn in detail of health risks and fetal impairments later in pregnancy, due to developments in medical diagnostic technology.⁶³ Citing comparative legal trends, the NCW has urged India to extend the 20-week limit to 24 weeks to protect women's rights.⁶⁴

Unskilled providers. While the government indicated that it has taken steps under the National Rural Health Mission to reduce the number of unsafe abortions in the country, in practice women continue to report that the majority of abortions are performed by unskilled providers. In India, about three unsafe abortions take place for every two safe procedures due to the relative preponderance of unskilled abortion providers.⁶⁵ In the state of Madhya Pradesh, for example, only 3% of primary health centers and 19% of community health centers provided induced abortion services.⁶⁶ The state government of Madhya Pradesh has expressed concern regarding unsafe abortion practices and has co-published a study documenting post-abortion complications in 2009,⁶⁷ yet the trend continues. Along with abortion stigma and lack of knowledge about safe services, the paucity of trained providers often leads women to seek care from unskilled providers who may be more easily accessible or the only option available in a community. In Chhattisgarh, for instance, only 35.2% of abortions in rural areas were performed by skilled providers.⁶⁸

Spousal consent. Studies have shown that insistence on spousal consent by abortion providers in India often prevents women from accessing safe abortion services.⁶⁹ Although the MTP Act and the Ministry of Health and Family Welfare's guidelines for medical termination of pregnancy state that third party consent is not required unless the woman is a minor or "mentally challenged," a survey in Rajasthan found that 80% of women had been asked for spousal consent by their provider.⁷⁰ Similarly, in Maharashtra, a 2008 study reported that "In case of adult women, husband's consent is a mandatory requirement in most of the facilities but in some facilities, any other adult's consent is accepted."⁷¹ According to the study, service providers believed it was essential to obtain consent from the husband in order to safeguard the doctor and the hospital.⁷² The Committee has previously expressed concern about spousal consent requirements as infringing on women's autonomy and as a violation of women's rights.⁷³

IV. Barriers to Accessing the Full Range of Modern Contraceptives and Contraceptive Services (Articles 10(h), 12, 14, 16)

The Committee's General Recommendation 21 requires governments to ensure adequate access to contraceptives, including emergency contraception,⁷⁴ and information about contraceptives⁷⁵ to ensure women's rights to "decide freely and responsibly on the number and spacing" of their children.⁷⁶ Furthermore, the Committee's General Recommendation 24 requires governments to report on health conditions and conditions hazardous to health that affect women differently from men, and to report on their understanding of how health care policies address the health rights of women and their unique conditions.⁷⁷

The Committee, in its list of issues, asked India to provide information about the impact of health care programs in providing women and girls with access to adequate and affordable health-care services, including sexual and reproductive health care.⁷⁸ Despite this request, lack of access to a full range of modern contraceptives, which compromises the reproductive health of women in India by exposing them to the risk of unplanned pregnancies, was not addressed in India's reply to the list of issues. As discussed in the pre-session letter, India has committed both through its own National Population Policy (NPP) and MDG 5.B to ensure universal access to contraception.⁷⁹ The NPP "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,”⁸⁰ and sets a target of “universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices” by 2010,⁸¹ which India has failed to realize. In fact, contraceptive use is on the decline – for instance, as of 2013, 48.1% of married women in India are using a modern contraceptive method,⁸² down from an estimated 56% in 2006.⁸³

In order to guarantee women’s reproductive autonomy and health and rights to substantive equality and nondiscrimination, it is critical that India ensures practical access to a full range of contraceptives for women across all sectors of society. The CEDAW Committee has affirmed that all health services, including those related to reproductive health, must be consistent with women’s rights to autonomy⁸⁴ and that the right to autonomy requires access to comprehensive health information and services.⁸⁵

Coercive and Unsafe Sterilization. In India, contraceptive policies tend to be driven by population-based targets, resulting in coercive family planning policies that violate women’s rights. The Committee has affirmed that that “States parties should not permit forms of coercion, such as non-consensual sterilization... that violate women’s rights to informed consent and dignity.”⁸⁶ The Special Rapporteur on Violence Against Women has also described coercive sterilization as “a method of medical control of a woman’s fertility without the consent of a woman,” which essentially becomes “the battery of a woman—violating her physical integrity and security—forced sterilization constitutes violence against women.”⁸⁷ As discussed in our pre-session letter, in India, Supreme Court rulings aimed at addressing coercive sterilization have been insufficiently implemented, and there have been a number of media reports of coercive sterilization in the country.⁸⁸ These violations of women’s reproductive rights and bodily autonomy continue to be compounded by state-level family planning programs that promote a “one child norm” and set targets for sterilization, insertion of intrauterine devices, and use of contraceptive pills.⁸⁹ In its replies to the list of issues and questions for its upcoming review, India did not mention or discuss any steps taken to eliminate coercive and unsafe sterilization in the country.⁹⁰

Limited Access to and Information about Emergency Contraception. The Committee has urged states to make emergency contraception available to women as part of the full range of contraceptive methods referenced under CEDAW Article 12.⁹¹ Yet in India, only 30.9% of women have heard of emergency contraceptives, and among rural women (ever-married), awareness is only 23.8%.⁹² Further, less than 1% of women have ever used emergency contraceptives.⁹³ The lack of emergency contraceptives is particularly problematic in India, where sexual violence is very common—recent records suggest a sexual assault occurs every 22 minutes.⁹⁴ The Committee has specifically called on states to ensure that women and girls who suffer sexual violence have access to emergency contraception.⁹⁵

V. Right to Nondiscrimination (Arts. 1, 2, 5, 12, 14, 16)

Under CEDAW Article 2, the obligation to eliminate discrimination against women is recognized as immediate, whereby states parties shall “agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women.”⁹⁶ Despite this, India has continued to allow significant barriers to women’s and girls’ equal enjoyment of their human rights to persist, including child marriage, marital rape, and neglect of the health needs of vulnerable subgroups of women.

a. Child Marriage (Arts. 2, 5, 16)

The Committee has explicitly called on India to “take comprehensive, effective and stringent measures” to deter the performance of child marriages, the elimination of such practices, and the protection of the human rights of the girl child.⁹⁷ In the list of issues, the Committee has raised questions concerning barriers to implementation and steps taken to ensure effective implementation of the Prohibition of Child

Marriage Act (PCMA), in various states of India⁹⁸ and requested data on whether registration of marriage is mandatory for all religious groups.⁹⁹ The Committee has also requested information on the provisions and enforcement of the Hindu Succession (Amendment) Act (2005) and the Personal Laws (Amendment) Act (2010).¹⁰⁰ Since the time of our pre-session submission, the Center has published a report entitled *Child Marriage in South Asia: Stop the Impunity* (Annex II), which discusses legal barriers to the elimination of child marriage in the region, including India, and presents the human rights standards violated as a result of this practice.

In India's reply to the list of issues, the government has noted the passage of the PCMA eight years ago, but failed to discuss the gaps and weaknesses in the law that have continued to undermine legal accountability for child marriage and the elimination of the practice.¹⁰¹ These barriers, which violate standards established in CEDAW and by the Committee, have been discussed in depth in the pre-session letter.¹⁰² For example, CEDAW Article 16 establishes that all child marriages should be legally void; despite this, child marriages are voidable rather than void under the PCMA.¹⁰³ Similarly, the CEDAW Committee has recognized that states parties must establish an equal age of marriage for girls and boys.¹⁰⁴ However, the PCMA provides a different definition of "child" based on sex: for males, the age of marriage is 21; and for females, 18.¹⁰⁵ Once performed, marriages even under these ages are legally recognized, but the PCMA penalizes parents, guardians, religious officials, and others for involvement in such marriages.¹⁰⁶ This Committee has affirmed that a lower minimum age of marriage for girls promotes discriminatory stereotypes and "assume[s] incorrectly that women have a different rate of intellectual development from men, or that their stage of physical and intellectual development at marriage is immaterial."¹⁰⁷ In India's reply to the list of issues, the state party provides no evidence that it is addressing the patriarchal attitudes that underlie child marriage¹⁰⁸ or reforming provisions of the PCMA that reflect stereotypical assumptions about women and girls.

Similarly, India's reply to the list of issues also fails to acknowledge its continued tolerance of discriminatory provisions within religion-based personal laws which blatantly undermine the PCMA. In 2007, the Committee called on the government to "review and reform personal laws... to ensure de jure gender equality and compliance with the Convention."¹⁰⁹ The PCMA does not clarify whether it supersedes personal laws, which has led to ambiguity concerning whether the minimum ages of marriage and the status of child marriages as voidable should be universally applied, or if the ages of marriage and legal statuses of child marriage established under personal laws should prevail.¹¹⁰ News reports indicate that in the absence of clear prohibitions on child marriage under personal laws, local governments, including in the state of Kerala, have passed circulars permitting registration of marriage of Muslim girls under the age of 18 as permitted under Muslim personal law.¹¹¹ This lack of clarity permits weaker standards on child marriage: for instance, under the Hindu Marriage Act, marriages below the age of 18 are only voidable if a girl was married before the age of 15; thus a girl married after the age of 15 without her consent will be considered to be in a valid marriage.¹¹²

In its General Recommendation 29, the Committee established that to comply with human rights law, states parties must address inequality stemming from personal laws: "Personal laws should embody the fundamental principle of equality between women and men, and should be fully harmonized with the provisions of the Convention so as to eliminate all discrimination against women in all matters relating to marriage and family relations."¹¹³ The Committee has clearly recognized that states parties "must address patriarchal traditions and attitudes and open family law and policy to the same scrutiny with regard to discrimination against women that is given to the 'public' aspects of individual and community life."¹¹⁴ The Committee has specifically expressed concern to state parties where multiple legal systems, including religiously based laws, allow for discrimination against women and where "under-age marriage[s] of girls...are legitimized under different religious laws governing personal status."¹¹⁵

Ensuring birth and marriage registration has been recognized as crucial to the enforcement of laws prohibiting child marriage.¹¹⁶ As a result of poor birth and marriage registration systems in India, girls face significant barriers to establishing their age at the time of marriage and in substantiating that their marriage was a child marriage in violation of the law. The Committee has requested information on whether registration of marriage is mandatory for all,¹¹⁷ and has previously recommended that India take proactive measures to work with states and union territories to effectively implement legislation to require compulsory registration of all marriages.¹¹⁸ As India's response notes, the Registration of Births and Deaths (Amendment) Bill 2012, seeking to amend the Registration of Births and Deaths Act 1969, is still pending for consideration in the Lower House of Parliament (Lok Sabha).¹¹⁹ As discussed in the pre-session letter, attempts to ensure compulsory birth and marriage registration in India have historically failed, even where required by legislation or ordered by the Supreme Court of India.¹²⁰

Expert panels and commissions convened by the government have repeatedly recognized the need for reform on laws related to marriage that are consistent with the standards required under CEDAW. The Justice Verma Committee's (Verma Committee) recommendations regarding child marriage, including weak birth and marriage registration systems,¹²¹ have not been followed; similarly, the government has not discussed any steps to implement recommendations by India's NCW concerning law reform on child marriage. These recommendations include enforcement of a uniform minimum age of marriage that supersedes conflicting personal laws and penalties for every person present at a child marriage.¹²² While the government discussed some of the Verma Committee's recommendations in its reply to the list of issues, they failed to note important recommendations that were not adopted in the Criminal Law (Amendment) Act; these omissions represent missed opportunities for crucial law reform in India.

Enforcement of the PCMA is also undermined by continuing impunity for child marriage. The Committee has asked the government to explain how it ensures effective implementation of the PCMA.¹²³ While the government's replies note that circulars have been issued to state governments delegating enforcement of the PCMA, it publically conceded in a 2013 report that "on ground, implementation of PCMA[] 2006 has not been as effective as expected."¹²⁴ Prosecution for promotion or solemnization of child marriages remains very low. For instance, although 55.7% of marriages in Jharkhand are child marriages,¹²⁵ the National Crime Records Bureau records not a single incidence of prosecution of child marriage in this state in 2012.¹²⁶ Even when child marriages are reported, only a few cases are fully prosecuted: the Bureau found that one of highest percentages of cases pending disposal was under the PCMA (90.6%, or 1,669 out of 1,843 cases).¹²⁷ Further, Child Marriage Prevention Officers, who are tasked under the PCMA to prevent child marriage, have only been appointed in approximately half of the states in India.¹²⁸

India's failure to prioritize the elimination of child marriage is also reflected in its recent refusal to co-sponsor major international resolutions condemning the practice. In September 2013, the Human Rights Council adopted the first-ever procedural resolution, endorsed by well over 100 member states, recognizing child marriage as a human rights violation.¹²⁹ India failed to co-sponsor this resolution, as well as a subsequent U.N. General Assembly resolution calling for the elimination of child marriage to be included in the follow-up framework to the MDGs.¹³⁰

b. Marital Rape (Arts. 1, 2, 10, 16)

The Committee has recognized that marital rape constitutes a form of gender-based discrimination and violates CEDAW.¹³¹ The Committee has specifically asked the government to describe concrete steps it has taken to implement the Verma Committee's recommendations to criminalize marital rape.¹³² In India's reply to the list of issues, the government failed to discuss any measures that it has taken to criminalize marital rape. While the government notes that its definition of rape has been made more

comprehensive through certain amendments to section 375 of the Indian Penal Code, marital rape is still not included in the Code.¹³³ The Protection of Women from Domestic Violence Act (PWDA) also fails to criminalize marital rape.¹³⁴ In addition, though the government cites punishments for public servants who fail to record information on incidents of rape reported to local authorities, it gives no information on whether and how this is enforced. Protection for married adolescents has also been undermined by recent legislative change. The PCSO Act of 2012 defines sex with a minor below 18 years as a crime and has eliminated the marriage exception.¹³⁵ However, the Criminal Law (Amendment) Act passed in March 2013 does not recognize rape in marriage once a girl is above 16 years of age.¹³⁶ This constitutes legal recognition of child marriage under the Criminal Law (Amendment) Act and permits sexual crimes against adolescents in the form of marital rape.

VI. Suggested Concluding Observations for the State Party

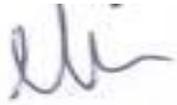
Reflecting the information and concerns presented in our pre-session letter and this submission, the Center and HRLN respectfully request that this Committee consider incorporating the following recommendations in its Concluding Observations to the government of India.

1. Prioritize reducing maternal mortality and morbidity in India, including specifically amongst rural, adolescent, and poor women, by improving access to maternal health services at all levels of government as required under government schemes, collecting accurate data on the incidence and nature of maternal deaths and morbidities, ensuring accountability for maternal deaths and legal remedies to women and their families where denials of maternal health care occur and removal of restrictions in government policies and schemes that exclude pregnant adolescent girls and women with more than two children from maternal health benefits (Art. 12).
2. Address and eliminate barriers to implementation of the Medical Termination of Pregnancy Act that leave women at risk of unsafe abortions, including by ensuring that providers and health centers are licensed and equipped to perform safe abortions, removing restrictions on medical abortion, amending policies and regulations that jeopardize women's confidentiality when accessing reproductive health services, and introducing programs to reduce abortion stigma (Art. 12).
3. Ensure that women are able to exercise their reproductive autonomy, which is essential for achievement of substantive equality, by providing women with access to the full range of modern contraceptives—including emergency contraceptives—and the information and means to make informed decisions about their use. Recognizing that targets or incentives prioritizing specific contraceptive methods or a population control agenda often lead to violations of women's rights to determine the number and spacing of their children, eliminate the use of population control driven targets in contraceptive policies, and ensure that such policies respect women's rights to make voluntary decisions about contraception (Art. 16).
4. Recognizing that child marriage perpetuates discriminatory stereotypes about women and girls and triggers a continuum of harm that interferes with women's and girls' equal enjoyment of their human rights, including by exposing them to significant risk of early and unplanned pregnancies, maternal mortality and morbidity, and sexual violence, take immediate steps to:
 - a. Ensure the enforcement of the Prohibition of Child Marriage Act, including by appointing Child Marriage Prohibition Officers, ensuring prosecution of perpetrators of child marriage, and addressing legal and social barriers that prevent victims of child marriage from being able to seek legal remedies for harms suffered as a result of this practice;

- b. Ensure access to reproductive health services, including counseling, for marriage girls in recognition of their increased vulnerability to early pregnancy and unsafe sex; and
 - c. Clarify that the Prohibition of Child Marriage Act supersedes all religion-based laws with regards to age of marriage (Arts. 5, 12, 16).
5. Take all appropriate legislative, administrative, social, and educational measures to protect women and girls from physical and sexual violence both within and outside of marriage, including by recognizing marital rape as a crime and eliminating the exception recognized in Section 375 of the Indian Penal Code that lowers the age under which sex with a girl is criminalized when it occurs within marriage (Arts. 2, 16).

We hope that this information is useful to the Committee as it prepares to review the Indian government's compliance with the provisions of the Convention. If you have any questions or would like further information, please do not hesitate to contact us know.

Sincerely,



Colin Gonsalves
 Founder-Director
 Human Rights Law Network



Melissa Upreti
 Regional Director for Asia
 Center for Reproductive Rights



Kerry McBroom
 Director, Reproductive Rights Unit
 Human Rights Law Network



Payal Shah
 Senior Legal Adviser for Asia
 Center for Reproductive Rights

This letter was prepared with research and drafting assistance by the Cornell International Human Rights Clinic.

¹ Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, U.N. Doc. A/34/46 (1979), 1249 U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].

² Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, paras. 11-12, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].

³ CEDAW Committee, *General Recommendation No. 25: Article 4, Paragraph 1 of the Convention (Temporary special Measures)*, (30th Sess., 2004), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, paras. 8 & 10, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008).

⁴ CEDAW Committee, *General Recommendation No. 28: The Core Obligations of States Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, (47th Sess., 2010), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 20, U.N. Doc. CEDAW/C/GC/28 (2010).

⁵ CEDAW Committee, *General Recommendation No. 21: Equality in marriage and family relations*, (13th Sess., 1994), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty*

Bodies, para. 21, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 21*].

⁶ CEDAW Committee, *General Recommendation No. 23: Women in political and public life* (16th Sess., 1997), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, para. 10, U.N. Doc. A/52/38 (1997).

⁷ *Id.* para. 11.

⁸ CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 5, para. 23.

⁹ CEDAW Committee, *Concluding Observations: Guyana*, para. 39, U.N. Doc. CEDAW/C/GUY/CO/7-8 (2012).

¹⁰ CEDAW Committee, *Concluding Observations: India*, para. 12., U.N. Doc. CEDAW/C/IND/CO/3 (2007).

¹¹ *Id.* para. 13.

¹² CEDAW, *supra* note 1, art. 12(2).

¹³ *See, e.g.*, Report of the CEDAW Committee, UNGA 59th Sess., Supp. No. 38, para. 380, U.N. Doc. A/59/38 (2004); CEDAW Committee, *Concluding Observations: Paraguay*, para. 30, U.N. Doc. CEDAW/C/PRY/CO/6 (2011).

¹⁴ *Alyne da Silva Pimentel Teixeira v. Brazil*, CEDAW Committee, Commc'n No. 17/2008, para. 7.5, U.N. Doc. CEDAW/C/49/D/17/2008 (2011).

¹⁵ *Id.* para. 7.6.

¹⁶ *Id.* paras. 7.6-7.7.

¹⁷ CEDAW Committee, *Concluding Observations: India*, para. 41, U.N. Doc. CEDAW/C/IND/CO/3 (2007).

¹⁸ *Id.*

¹⁹ CENTER FOR REPRODUCTIVE RIGHTS [CRR] AND HUMAN RIGHTS LAW NETWORK [HRLN], *Supplementary information on India, scheduled for review by the Committee on the Elimination of Discrimination against Women during its Pre-Sessional Working Group 2-3* (Oct. 1 2013) [hereinafter CRR AND HRLN, *Annex I*].

²⁰ CEDAW Committee, *List of issues and questions in relation to the combined fourth and fifth periodic reports of India**, para. 15, U.N. Doc. CEDAW/C/IND/Q/4-5 (2013).

²¹ GOVERNMENT OF INDIA (GOVT. OF INDIA), *List of issues and questions in relation to the combined fourth and fifth periodic reports of India: Replies of India*, para. 15, U.N. Doc. CEDAW/C/IND/Q/4-5/Add.1 (2014).

²² PRESS TRUST OF INDIA, *National Urban Health Mission launched*, January 20, 2014, last accessed June 4, 2013.

²³ OFFICE OF THE REGISTRAR GENERAL (INDIA), *Special Bulletin on Maternal Mortality in India 2010-12*, para. 3 (2013) available at http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_Bulletin-2010-12.pdf.

²⁴ WORLD HEALTH ORGANIZATION (WHO) ET AL., *TRENDS IN MATERNAL MORTALITY: 1990-2013* 32 (2014).

²⁵ *Id.* at 3.

²⁶ OFFICE OF THE REGISTRAR GENERAL & CENSUS COMMISSIONER, GOVT. OF INDIA, *ANNUAL HEALTH SURVEY BULLETIN 2012-13: ASSAM 16* (2013) available at

http://www.censusindia.gov.in/vital_statistics/AHSBulletins/AHS_Bulletin_2012_13/Assam/Assam_Bulletin.pdf.

²⁷ CENTRAL STATISTICAL ORGANIZATION, GOVT. OF INDIA, *MILLENNIUM DEVELOPMENT GOALS: INDIA COUNTRY REPORT 2011* 66 (2012) available at

http://www.undp.org/content/dam/undp/library/MDG/english/MDG%20Country%20Reports/India/MDG_India_2011.pdf.

²⁸ MINISTRY OF WOMEN AND CHILD DEVELOPMENT, GOVT. OF INDIA, *IGSY – A Conditional Maternity Benefit Scheme: Implementation Guidelines for State Governments, Ministry of Women and Child Development* (2011) available at <http://wcd.nic.in/schemes/sabla/IGMSYImpGuidelinesApr11.pdf>.

²⁹ *See Id.* at 3 (“[A] cash incentive of 4000 (rupees) will be provided directly to women 19 years and above for the first two live births subject to the woman fulfilling specific conditions relating to maternal child health and nutrition.”).

³⁰ *See WHO, Maternal Mortality: Factsheet No. 348* (2014) available at <http://www.who.int/mediacentre/factsheets/fs348/en/>.

³¹ Anita Raj, *When the Mother is a Child: The Impact of Child Marriage on the Health and Human Rights of Girls* 95 ARCH. DIS. CHILD 931, 932 (2010) [hereinafter Anita Raj, *When the Mother is a Child*].

³² GUTTMACHER INSTITUTE, *ABORTION WORLDWIDE: A DECADE OF UNEVEN PROGRESS* 40 (2009).

³³ Anita Raj, *When the Mother is a Child*, *supra* note 31, at 95.

³⁴ MINISTRY OF HEALTH AND WELFARE, GOVT. OF INDIA, *Removal of conditionalities associated with parity and minimum age of mother for institutional deliveries in High Performing States and for home deliveries in all the States/UTs under Janani Suraksha Yojana-Approval of Mission Steering Group (MSG) -in continuation of letter*

dated 8.5.2013 regarding 1 (2013), available at

http://www.2cnpop.net/uploads/1/0/2/1/10215849/goi_on_removal_of_2cn_in_jsy.pdf.

³⁵ *Id.* at 2.

³⁶ WOMEN AND CHILD DEVELOPMENT DEPARTMENT, GOVERNMENT OF ODISHA, *Mamata*, available at <http://wcdodisha.gov.in/node/46>.

³⁷ CEDAW Committee, *Statement of the Committee on the Elimination of Discrimination against Women on sexual and reproductive health and rights: Beyond 2014 ICPD review 2* (2014) [hereinafter CEDAW Committee, *Statement of the Committee on sexual and reproductive health and rights*].

³⁸ CEDAW Committee, *Concluding Observations: India*, paras. 40-41, U.N. Doc. CEDAW/C/IND/CO/3 (2007).

³⁹ CEDAW Committee, *List of issues and questions in relation to the combined fourth and fifth periodic reports of India**, para. 15, U.N. Doc. CEDAW/C/IND/Q/4-5 (2013).

⁴⁰ See CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 2, paras. 11-12(a).

⁴¹ The Medical Termination of Pregnancy Act, No. 34 of 1971, INDIA CODE (1971).

⁴² CENTRE FOR HEALTH AND SOCIAL JUSTICE, REVIEWING TWO YEARS OF NRHM: OCTOBER 2007 111 (2007); WHO, UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF THE INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2008 7-8 (2011).

⁴³ Duggal R, Ramachandran V, *The abortion assessment project - India: key findings and recommendations*, REPRODUCTIVE HEALTH MATTERS 12, 122-129 (2004).

⁴⁴ *Id.* at 7. The 2007 National Stakeholders Consultation on the National Rural Health Mission was attended by a number of government representatives from the Ministry of Health and Family Welfare, including Dr Syeeda Hameed, Member, Planning Commission; Mr G.C. Chaturvedi, Mission Director, NRHM; Mr Amarjeet Sinha, Joint Secretary, MoHFW; Dr N. K. Sethi, Senior Advisor Health at Planning Commission, and Dr Tarun Seem, Director, NRHM, from the Government of India.

⁴⁵ Bela Ganatra et al., *Availability of Medical Abortion Pills and the Role of Chemists: A Study from Bihar and Jharkhand, India*, REPRODUCTIVE HEALTH MATTERS 13(26)65-74 65 (2005). In addition, the Drug Controller of India registration for mifepristone requires product packaging to mention that it be used under the supervision of a gynecologist.

⁴⁶ Schedule H drugs must be labeled with a warning, stating that it can only be sold by retail on the prescription of a Registered Medical Practitioner only. See DEPARTMENT OF HEALTH, GOVT. OF INDIA, DRUGS AND COSMETICS RULES 1945 (AS CORRECTED UP TO THE 30TH NOVEMBER, 2004) 146 (1945).

⁴⁷ Anuradha Mascarenhas, *Illegal sale of abortion pills: Notices to 54 city chemists*, THE INDIAN EXPRESS, July 4, 2012, last accessed June 5, 2014.

⁴⁸ MINISTRY OF HEALTH AND FAMILY WELFARE, GOVT. OF INDIA, *Medical Termination of Pregnancy Regulations 2003* 3 (2003).

⁴⁹ Pratibha Masand, *Hard Labour for Abortion Pills as Strict Rules Spook Chemists*, TIMES OF INDIA, April 14, 2013, <http://timesofindia.indiatimes.com/city/mumbai/Hard-labour-for-abortion-pills-as-strict-rules-spook-chemists/articleshow/19534922.cms> [hereinafter Pratibha Masand, *Hard Labour for Abortion Pills*].

⁵⁰ *Id.*

⁵¹ *Id.*; IPAS INDIA, DISAPPEARING MEDICAL ABORTION DRUGS: FACTS AND REASONS 2 (2013).

⁵² Pratibha Masand, *Hard Labour for Abortion Pills*, *supra* note 49.

⁵³ CEDAW Committee, *Concluding Observations: Bhutan*, para. 20, UN Doc. CEDAW/C/BTN/CO/7 (2009).

⁵⁴ Ishita Chaudary, Founder & Executive Director, YP Foundation, Uniting for Safe Abortion, IPAS Side Event for CDP 47 (Apr. 11 2014) available at <http://www.resurj.org/wp-content/uploads/2014/04/IPAS-Side-Event-CPD-2014-Ishita-Speech.pdf>. See also Aarti Dhar, *Ambiguity in abortion and other laws puts doctors in a fix*, THE HINDU, October 20, 2013, <http://www.thehindu.com/news/national/ambiguity-in-abortion-other-laws-puts-doctors-in-a-fix/article5161297.ece>.

⁵⁵ CEDAW Committee, *Statement of the Committee on sexual and reproductive health and rights*, *supra* note 37, at 2.

⁵⁶ Mallika Kaur Sarkaria, LESSONS FROM PUNJAB'S "MISSING GIRLS": TOWARD A GLOBAL FEMINIST PERSPECTIVE ON "CHOICE" IN ABORTION 920-921 CALIFORNIA LAW REVIEW (2009).

⁵⁷ Bela Ganatra, *Maintaining Access to Safe Abortion and Reducing Sex Ratio Imbalances in Asia*, REPRODUCTIVE HEALTH MATTERS (16)(31) 90-98 (2008); Sugandha Nagpal, *Sex-selective Abortion in India: Exploring Institutional Dynamics and Responses*, MCGILL SOCIOLOGICAL REVIEW (3) 18-35 (2013); Mallika Kaur Sarkaria, *Lessons from*

Punjab's "Missing Girls": Toward a Global Feminist Perspective on "Choice" in Abortion, CALIFORNIA LAW REVIEW (97) 905-942.

⁵⁸ OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS et al., PREVENTING GENDER-BIASED SEX SELECTION: AN INTERAGENCY STATEMENT 4 (2011).

⁵⁹ *Id.*

⁶⁰ CEDAW Committee, *Concluding Observations: China*, paras 17-18, U.N. Doc. CEDAW/C/CHN/CO/6 (2006). The Committee expressed concern regarding the practice of sex-selective abortion and called for the state party to implement a comprehensive strategy to overcome traditional stereotypes regarding men's and women's roles in society, which underlie the practice.

⁶¹ The Medical Termination of Pregnancy Act, No. 34 of 1971, art. 3(2)(b), INDIA CODE (1971).

⁶² NATIONAL COMMISSION FOR WOMEN OF INDIA (NCW INDIA), *Review of Medical Termination of Pregnancy Act 3 available at* <http://ncw.nic.in/Comments/DraftNoteMTPAct1971.pdf> [hereinafter NCW INDIA, *Review of the Medical Termination of Pregnancy Act*]; THE TIMES OF INDIA, *Allow abortion up to 24 weeks, national women's panel says*, Feb. 3, 2013, http://articles.timesofindia.indiatimes.com/2013-02-03/india/36720450_1_ncw-member-niketa-mehta-mtp-act (last accessed June 5, 2014) [hereinafter THE TIMES OF INDIA, *Allow abortion up to 24 weeks*].

⁶³ NCW INDIA, *Review of the Medical Termination of Pregnancy Act*, *supra* note 62; THE TIMES OF INDIA, *Allow abortion up to 24 weeks*, *supra* note 62. *See also* Santosh Andhale, *Gynaec's laud proposal to extend abortion limit*, DNA INDIA, Feb. 3, 2013, <http://www.dnaindia.com/mumbai/report-gynaec-s-laund-proposal-to-extend-abortion-limit-1795603> (last accessed June 5, 2014) [hereinafter Santosh Andhale, *Gynaec's laud proposal to extend abortion limit*]. "The National Commission of Women (NCW) recommendation's to the Union health ministry to extend the time till abortion is allowed to 24 weeks has been welcomed by city gynaecologists. They said 20-22 weeks of pregnancy is the appropriate period during which, through sonography, the foetal anomalies test can give detailed information, particularly about heart-related problems."

⁶⁴ NCW INDIA, *Review of the Medical Termination of Pregnancy Act*, *supra* note 62, at 2; THE TIMES OF INDIA, *Allow abortion up to 24 weeks*, *supra* note 62, at 2-3; Santosh Andhale, *Gynaec's laud proposal to extend abortion limit*, *supra* note 63.

⁶⁵ Susan A. Cohen, *Facts and Consequences: Legality, Incidence and Safety of Abortion Worldwide*, GUTTMACHER POLICY REVIEW (12)(4) (2009).

⁶⁶ INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES, INDIA: FACILITY SURVEY (UNDER REPRODUCTIVE AND CHILD HEALTH PROJECT) PHASE-II, 2003 (2005) *available at* http://www.rchips.org/pdf/rch2/National_Facility_Report_RCH-II.pdf.

⁶⁷ IPAS INDIA, *EXPLORING THE PATHWAYS OF UNSAFE ABORTION: A PROSPECTIVE STUDY OF ABORTION CLIENTS IN SELECTED HOSPITALS OF MADHYA PRADESH* (2009).

⁶⁸ OFFICE OF THE REGISTRAR GENERAL & CENSUS COMMISSIONER, GOVT. OF INDIA, *ANNUAL HEALTH SURVEY 2010-11: FACT SHEET 44* (2012) *available at* http://www.censusindia.gov.in/vital_statistics/AHSBulletins/AHS_Baseline_Factsheets/Chhattisgarh.pdf.

⁶⁹ *See* Manisha Gupte et al., *Women's perspectives on the quality of general and reproductive health care: evidence from rural Maharashtra* 7 *IMPROVING QUALITY OF CARE IN INDIA'S FAMILY WELFARE PROGRAMME: THE CHALLENGE AHEAD* (199).

⁷⁰ POPULATION COUNCIL, *Understanding induced abortion: findings from a programme of research in Rajasthan, India 3* (2004) *available at* <http://www.popcouncil.org/uploads/pdfs/popsyn/PopulationSynthesis4.pdf>.

⁷¹ TK Sundari Rvanidran and Renu Khanna, *Many a slip between the cup and the lip: Universal access to safe abortion services in India 8* (XXXX) *available at* <http://www.commonhealth.in/report-pdf/3a.%20monograph.%20MANY%20A%20SLIP%20BETWEEN%20THE%20CUP%20AND%20THE%20LIP%202012.pdf> *citing* Chaudhuri L and Kadam K., *SITUATION ANALYSIS OF MTP AND PCPNDT FACILITIES IN MAHARASHTRA: A REPORT* (2010) (Unpublished report).

⁷² *Id.*

⁷³ *See* CEDAW Committee, *Concluding Observations, Indonesia*, para. 42, U.N. Doc. CEDAW/C/IDN/CO/6-7 (2012).

⁷⁴ CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 5, paras. 22-23.

⁷⁵ *Id.* para. 23.

⁷⁶ *Id.* art. 16(1)(e).

⁷⁷ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 2, paras. 10, 12.

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- ⁷⁸ CEDAW Committee, *List of issues and questions in relation to the combined fourth and fifth periodic reports of India**, para. 15, U.N. Doc. CEDAW/C/IND/Q/4-5 (2013).
- ⁷⁹ GOVT. OF INDIA, NATIONAL POPULATION POLICY 2000, objective 1 (2000) [hereinafter GOVT. OF INDIA, NATIONAL POPULATION POLICY (2000)]; UNITED NATIONS DEVELOPMENT PROGRAM, *MDGs, Goal 5: Improve Maternal Health* (2013), available at http://www.undp.org/content/undp/en/home/mdgoverview/mdg_goals/mdg5/.
- ⁸⁰ GOVT. OF INDIA, NATIONAL POPULATION POLICY (2000), *supra* note 79, introduction, para. 6.
- ⁸¹ *Id.* box 2.
- ⁸² UNITED NATIONS DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS POPULATION DIVISION, *World Contraceptive Patterns 2013 1* (2013) available at: <http://www.un.org/en/development/desa/population/publications/pdf/family/worldContraceptivePatternsWallChart2013.pdf>.
- ⁸³ Ranjan Kumar Prusty, *Contraceptive Use and Unmet Need for Family Planning among Tribal Women in India and Selected Hilly States* 8 (2013) available at <http://paa2013.princeton.edu/papers/130391>.
- ⁸⁴ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 2, para. 31(e).
- ⁸⁵ CEDAW Committee, *Statement of the Committee on sexual and reproductive health and rights*, *supra* note 37, at 1-2.
- ⁸⁶ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 2, para. 22.
- ⁸⁷ See SRVAW Radhika Coomaraswamy, *Policies and practices that impact women's reproductive rights and contribute to, cause or constitute violence against women*, para. 51, U.N. Doc. E/CN.4/1999/68/Add.4 (1999).
- ⁸⁸ CRR AND HRLN, *Annex I*, *supra* note 19, at 5.
- ⁸⁹ See, e.g., JINDAL GLOBAL LAW SCHOOL, VOICES FROM THE FIELD: BARRIERS TO CONTRACEPTIVE INFORMATION AND SERVICES IN THE STATE OF HARYANA 23 (2013) (summarizing the Haryana State Commission on Population's promotion of a one child norm and the Haryana Family Welfare Program's targets for specific contraceptive methods in Haryana). Sterilization is incentivized in a number of other Indian states; for instance, in Madhya Pradesh sterilization was encouraged by increased access to gun licenses. <http://archive.indianexpress.com/news/in-mp-meet-sterilisation-target-or-be-punished/735517/>. Several districts in Rajasthan announced 'lucky draws' for couples who sought out sterilization: <http://timesofindia.indiatimes.com/city/jaipur/Alwar-set-to-launch-Nano-scheme-for-sterilization/articleshow/10639915.cms?referral=PM>, and Andhra Pradesh, Karnataka, Madhya Pradesh, Punjab, and Himachal Pradesh state governments had programs in which couples had to produce sterilization certificates to be eligible for benefits (including monetary payments), http://www.unfpa.org/gender/docs/sexselection/UNFPA_Publication-39772.pdf. It is also reported that more than 50 lower caste and illiterate women from a poor village in Bihar, including some adolescents, were gathered together by a government licensed NGO to undergo female sterilizations, motivated by a state objective to sterilize one percent of Bihar's population.
- ⁹⁰ See generally, GOVT. OF INDIA, *List of issues and questions in relation to the combined fourth and fifth periodic reports of India: Replies of India*, U.N. Doc. CEDAW/C/IND/Q/4-5/Add.1 (2014).
- ⁹¹ CEDAW, *supra* note 1, art. 12; CEDAW Committee, *Concluding Observations: Mexico*, para. 33, U.N. Doc. CEDAW/C/MEX/CO/6 (2006).
- ⁹² MINISTRY OF HEALTH AND FAMILY WELFARE, GOVT. OF INDIA, DISTRICT LEVEL HOUSEHOLD AND FACILITY SURVEY 2007-2008 (DLHS-3) 108 (2010) available at http://www.rchiips.org/pdf/INDIA_REPORT_DLHS-3.pdf 108.
- ⁹³ See MINISTRY OF HEALTH AND FAMILY WELFARE, GOVT. OF INDIA, MANUAL FOR FAMILY PLANNING INSURANCE SCHEME 3-4 (2009) available at <http://mohfw.nic.in/showfile.php?lid=2402> (discussing the Supreme Court orders to government for ensuring the enforcement of sterilization guidelines).
- ⁹⁴ Mishra, *A rape every 22 mins: What makes us so complacent?*, FIRST POST, http://www.firstpost.com/india/a-rape-every-22-mins-what-makes-us-so-complacent-489080.html?utm_source=ref_article (last accessed 18 June 2014).
- ⁹⁵ CEDAW Committee, *Concluding Observations: Egypt*, para. 40, U.N. Doc. CEDAW/C/EGY/CO/7 (2010).
- ⁹⁶ CEDAW, *supra* note 1, art. 2.
- ⁹⁷ CEDAW Committee, *Concluding Observations: India*, para. 57, U.N. Doc. CEDAW/C/IND/CO/3 (2007).
- ⁹⁸ CEDAW Committee, *List of issues and questions in relation to the combined fourth and fifth periodic reports of India**, para. 21, U.N. Doc. CEDAW/C/IND/Q/4-5 (2013).
- ⁹⁹ *Id.*
- ¹⁰⁰ *Id.*

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- ¹⁰¹ See GOVT. OF INDIA, *List of issues and questions in relation to the combined fourth and fifth periodic reports of India: Replies of India*, para. 21, U.N. Doc. CEDAW/C/IND/Q/4-5/Add.1 (2014).
- ¹⁰² CRR AND HRLN, *Annex I, supra* note 19, at 6.
- ¹⁰³ The Prohibition of Child Marriage Act, 2006, No. 6 of 2007, art. 2(a) (2007) (India) [hereinafter PCMA (India)]; CEDAW, *supra* note 1, art. 16.
- ¹⁰⁴ CEDAW Committee, *Gen. Recommendation No. 21, supra* note 5, para. 36; *Concluding Observations: Burundi*, para. 12, U.N. Doc CEDAW/C/BDI/CO/4 (2008).
- ¹⁰⁵ PCMA (India), *supra* note 103, art. 2(a).
- ¹⁰⁶ *Id.*
- ¹⁰⁷ CEDAW Committee, *Gen. Recommendation No. 21, supra* note 5, para. 38.
- ¹⁰⁸ CEDAW Committee, *List of issues and questions in relation to the combined fourth and fifth periodic reports of India**, para. 21, U.N. Doc. CEDAW/C/IND/Q/4-5 (2013).
- ¹⁰⁹ CEDAW Committee, *Concluding Observations: India*, para. 11, U.N. Doc. CEDAW/C/IND/CO/3 (2007).
- ¹¹⁰ PCMA (India), *supra* note 103, art. 2(a), 3; The Hindu Marriage Act, No. 25 of 1955 (India) [hereinafter Hindu Marriage Act (India)] (providing the minimum age for marriage for girls is 18 and for boys, 21); The Muslim Personal Law (Shariat) Application Act, No. 26 of 1937, INDIA CODE (1937) (though not codified, the personal law gives Muslims the authority to determine when marriage is acceptable; common practice indicates that this is typically understood to be the age of puberty); The Parsi Marriage and Divorce Act, No. 3 of 1936, INDIA CODE (1993); The Indian Christian Marriage Act, No. 15 of 1872, INDIA CODE (1993). The lack of clarity concerning the PCMA and personal laws is evidenced by several high court cases seeking to answer this specific question. T. Sivakumar v. The Inspector Of Police, H.C.P. No. 907/2011, Madras H.C. (2011); Court On Its Own Motion (Lajja Devi) v. State, W.P. (Crl.) No. 338/2008, Delhi H.C. (2012). For example, under the PCMA, marriages of girls below 18 and boys below 21 are voidable at the request of either party who was a minor at the time that the marriage occurred within 2 years of attaining majority. However, child marriages are not void or voidable under the Hindu Marriage Act. Rather, a girl may leave a child marriage through a divorce, which can be granted if the girl was married before 15 and she repudiates the marriage after 15 and before 18. Hindu Marriage Act, *supra* note 32, art. 13(2)(iv). The Muslim personal laws are also distinct from the PCMA and the Hindu Marriage Act. Under Muslim personal laws, a girl who was married as a child can “avoid” the marriage if she repudiates it within 3 years of turning 15 years of age so long as the marriage has not been consummated. Further, a marriage involving a party who has reached puberty requires the consent of that party; without consent, such marriages are void under the law. These legal standards are conflicting, and lead to confusion about the minimum age of marriage, status of child marriages, and rights of girls who are seeking to dissolve a child marriage.
- ¹¹¹ THE TELEGRAPH, *Child Marriage Row in Kerala*, http://www.telegraphindia.com/1130624/jsp/nation/story_17041236.jsp#.U2qRM4Xo4hU (last accessed May 28, 2014).
- ¹¹² Hindu Marriage Act (India), *supra* note 110, arts. 11, 13(2)(iv).
- ¹¹³ CEDAW Committee, *General recommendation No. 28 on the core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, para. 15, U.N. Doc. CEDAW/C/GC/28.
- ¹¹⁴ *Id.* para 18.
- ¹¹⁵ CEDAW Committee, *Concluding Observations: Israel*, para. 48, U.N. Doc. CEDAW/C/ISR/CO/5 (2011); *Pakistan*, para. 37, U.N. Doc. CEDAW/C/Pak/CO/4 (2013).
- ¹¹⁶ See e.g. CEDAW Committee, *Concluding Observations: Peru*, U.N. Doc. CEDAW/C/PER/CO/6 (2007); *Bolivia*, U.N. Doc. CEDAW/C/BOL/CO/4 (2008); *Indonesia*, U.N. Doc. CEDAW/C/IDN/CO/5 (2007).
- ¹¹⁷ CEDAW Committee, *List of issues and questions in relation to the combined fourth and fifth periodic reports of India**, para. 21, U.N. Doc. CEDAW/C/IND/Q/4-5 (2013).
- ¹¹⁸ CEDAW Committee, *Concluding Observations: India*, para. 59, U.N. Doc. CEDAW/C/IND/CO/3 (2007).
- ¹¹⁹ GOVT. OF INDIA, *List of issues and questions in relation to the combined fourth and fifth periodic reports of India: Replies of India*, para. 21, U.N. Doc. CEDAW/C/IND/Q/4-5/Add.1 (2014).
- ¹²⁰ There are some states that have compulsory marriage registration, but readily available information is unclear regarding widespread adherence. A few of the state laws that have made marriage registration compulsory are: Bombay Registration of Marriages Act, 1953, Replacement Series No. LXV (1954) (amended 1977); Karnataka Marriages Registration and Miscellaneous Provisions Act, No. 2 of 1984 (1976); Himachal Pradesh Registration of Marriage Act, 1997; Compulsory Registration of Marriage Act, 2002, Andhra Pradesh. India’s Periodic notes that

“[a]s of now, registration of marriage is compulsory under the Christian Marriage Act, 1872, the Parsi Marriage and Divorce Act, 1936, and the Special Marriage Act, 1954, and optional under the Hindu Marriage Act, 1955.”

MINISTRY OF WOMEN & CHILD DEVELOPMENT, GOVT. OF INDIA, INDIA: THIRD AND FOURTH COMBINED PERIODIC REPORT ON THE CONVENTION ON THE RIGHTS OF THE CHILD 35 (2011). However, these laws require registration with different officials, such as the religious institution in which one marries. *See* MINISTRY OF HEALTH & FAMILY WELFARE, GOVT. OF INDIA, NATIONAL FAMILY HEALTH SURVEY (NFHS-3) 2005-2006 45 (2007).

¹²¹ DNA INDIA, *Justice JS Verma Committee's Recommendations: Complete List* (Jan. 23, 2013), available at: http://www.dnaindia.com/india/report-justice-js-verma-committees-recommendations-complete-list-1792005_

¹²² *Smt. Seema v. Ashwani Kumar*, 2 S.C.C. 578 (2006) (India); NCW, *Review of Laws and Legislative Measures Affecting Women by National Commission for Women, No. 10. The Child Marriage Restraint Act, 1929*, available at <http://ncw.nic.in/frmReportLaws10.aspx>.

¹²³ GOVT. OF INDIA, *List of issues and questions in relation to the combined fourth and fifth periodic reports of India: Replies of India*, para. 21, U.N. Doc. CEDAW/C/IND/Q/4-5/Add.1 (2014).

¹²⁴ Government of India Ministry of Women and Child Development, *Annual Report 2012-13*, 74, available at: http://wcd.nic.in/publication/AR201213_english.pdf.

¹²⁵ Government of India Ministry of Health and Family Welfare, *District Level Household and Facility Survey 2007-08 (DLHS-3): Fact Sheet: Jharkhand*, 3, available at: <http://www.rchiips.org/pdf/rch3/state/Jharkhand.pdf>.

¹²⁶ National Crime Records Bureau Ministry of Home Affairs, *Crime in India 2012: Statistics*, 409, available at <http://ncrb.nic.in/CD-CII2012/Statistics2012.pdf>.

¹²⁷ National Crime Records Bureau Ministry of Home Affairs, *Crime in India 2012: Compendium*, 150, available at <http://ncrb.nic.in/CD-CII2012/Compendium2012.pdf>.

¹²⁸ UNITED NATIONS CHILDREN'S FUND (UNICEF), *UNICEF Information Sheet: Child Marriage* 3 (2011).

¹²⁹ Human Rights Council Res. 23/25, Accelerating efforts to eliminate all forms of violence against women: preventing and responding to rape and other forms of sexual violence, preamble, U.N. Doc. A/HRC/23/L.28-1 (June 25, 2013); Res. 22/32, Rights of the child: the right of the child to the enjoyment of the highest attainable standard of health, paras. 22-23, U.N. Doc. A/HRC/RES/22/32 (Apr. 17, 2013); Res. 19/37, Rep. of the Human Rights Council, 19th Sess., U.N. Doc. A/HRC/19/2, at 104, para. 17(b) (May 24, 2013); the Universal Period Review is a state-driven review of the human rights records of all U.N. Member States. *Universal Periodic Review*, OFFICE OF THE HIGH COMMISSIONER OF HUMAN RIGHTS (OHCHR), <http://www.ohchr.org/EN/HRBodies/UPR/Pages/UPRMain.aspx> (last accessed Aug. 5, 2013). *See, e.g.*, Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Afghanistan*, paras. 95.36, 95.39, U.N. Doc. A/HRC/12/9 (2009); *Bangladesh*, para. 94.15, U.N. Doc. A/HRC/11/18 (2009); *India*, para. 138.41, U.N. Doc. A/HRC/21/10 (2012); *Pakistan*, para. 122.102, U.N. Doc. A/HRC/22/12 (2012); *Sri Lanka*, para. 49, U.N. Doc. A/HRC/8/46 (2008).

¹³⁰ Human Rights Council, *24/... Strengthening efforts to prevent and eliminate child, early and forced marriage: challenges, achievements, best practices and implementation gaps*, U.N. Doc. A/HRC/24/L.34/Rev.1 (2013).

¹³¹ CEDAW Committee, *General Recommendation No. 19: Violence against women*, (11th Sess., 1992), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 331, para. 6, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008). “The definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Gender-based violence may breach specific provisions of the Convention, regardless of whether those provisions expressly mention violence.”

¹³² *See* GOVT. OF INDIA, *List of issues and questions in relation to the combined fourth and fifth periodic reports of India: Replies of India*, para. 9, U.N. Doc. CEDAW/C/IND/Q/4-5/Add.1 (2014).

¹³³ INDIA PENAL CODE, secs. 375-376.

¹³⁴ The Protection of Women from Domestic Violence Act, No. 23 of 2005 (2005) (India).

¹³⁵ The Protection of Children from Sexual Offences Act art. 2(d), No. 32 of 2012, (2012) (India).

¹³⁶ The Criminal Law (Amendment) Act art. 8, No. 13 of 2013 (2013) (India).