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Shadow Report for India for the 93rd session of CEDAW on February 23rd to 27th 2026

The Provisions of CEDAW with respect to women's health are as follows -

Article 11.1.f : The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

Article 12.1 : States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

Article 12.2: Notwithstanding the provisions of paragraph I of this article, 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.

Apart from these there is a specific provision for better services across the board for rural women who tend to suffer more discrimination than urban women and especially so in the sphere of health.

Article 14.1: States Parties shall take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas.

While these provisions cover the obstetric problems faced by women in pregnancy and child birth they do not specifically mention the gynaecological problems that women face. The presumption seems to be that women are baby producing machines and the health of their reproductive system other than when they are pregnant with or delivering babies is not the concern of the States Parties. However, since reproduction is intimately connected with gynaecological health and is not just a matter or obstetric health by implication it can be said that the States Parties are to be held equally responsible for providing proper gynaecological health services to women so that their gynaecological health is also ensured. Unfortunately, in India this is not the case as most Government health facilities from the Primary Health Centres to the Tertiary Hospitals are grossly under staffed as far as gynaecologists are concerned and neither do they have adequate pathological testing facilities or medicines available. This is even more so in rural areas.

Reliable data are not available but informal estimates put the total number of practising gynaecologists at about 50000 in India of whom a paltry 2500 are in Government service. Thus, assuming conservatively that the population of economically poor women who are unable to access expensive private gynaecological care is around 250 million, the ratio of government gynaecologists to such women turns out to be a staggeringly low 1:100000 and even lower in rural areas. This means that

economically poor women aren't receiving free quality gynaecological care in India and this is a gross violation by the Governments in India, both the Federal and the State, of the provisions of CEDAW.

Right from the time in the late nineteenth century when for the first time in India women's health problems were addressed by the public health system, the concentration has been on the provision of maternal health services like safe delivery practices to the neglect of women's gynaecological problems. These latter arise from the burden of child delivery and care, overwork, a lack of menstrual hygiene and a lack of sexual rights and affect economically poor women more due to the double disadvantages of poverty and patriarchy. Thus, while ante-natal, delivery and post natal care have been provided to a certain extent, the problems of the reproductive tract and sexuality have been almost totally neglected by the Government Public Health System. Health policies are silent about the negative effects of gynaecological problems on the physical and mental health of women and their loss of economic capacity. Since there is a taboo on the discussion of these issues, women have to suffer their troubles in a deafening culture of silence surrounding women's gynaecological and sexual health problems. The biggest irony is that the menstrual cycle which is an integral part of the reproductive process is considered in the prevailing patriarchal system to be the cause of various negative things and has been given a dirty connotation in India. This affects the ability of women to maintain personal hygiene and results in their being afflicted by various diseases of the vaginal tract and uterus.

The NGO, Mahila Jagat Lihaaz Samiti (MAJLIS) (https://mahilajagatlihazsamiti.in), to this end, has initiated a programme of gynaecological health camps for women residing in slums in the city of Indore in Madhya Pradesh. The programme consists of a preliminary baseline survey to assess the felt needs of the women regarding their reproductive and gynaecological health and the various barriers they face to achieving a healthy status. While this survey is conducted, discussions are also held about these barriers to health and the offer is made from MAJLIS of holding a health camp which is to include clinical checkups by gynaecologists, laboratory tests and provision of medicine, all done free of cost to the women. After this a first health camp is held and then a follow up one fifteen days later. This whole process takes a month in one slum.

Even though all girls and women who are menstruating and those who have had menopause are provided diagnosis and treatment, for the purposes of research, only married women who are still in the menstrual age group are considered. The results of the intervention for the first 600 women to benefit from the programme are described here in brief. They show the devastating status of women's health in the slums in Indore city and the cost effective way in which a well designed programme can bring about substantial improvement in the situation if the public health system in India is better oriented to address this serious issue than it is at present.

The initial four tables below present a comparison between the National Family Health Survey V, 2019-21 (International Institute of Population Sciences, Mumbai, 2021) data for Indore district and that from the MAJLIS sample to situate the latter in the larger context of the district. Table 1 below provides a comparison of the demographic indicators that are common to both the surveys .

Table 1: Demographic Indicators (% of respondents)

Sl. No.	Indicators	NFHS V	MAJLIS
1.	Sex Ratio	987	976
2.	Women 15-49 years who are literate	80.3	55.4
3.	Women with 10+ years of schooling	47.7	6.8
4.	Women 20-24 married before 18 years	21.7	53.8

While the sex ratio is slightly worse in the MAJLIS sample than in the NFHS V sample, the literacy and education levels are significantly poorer for the MAJLIS sample and the proportion of women in the 20-24 year age group who have been married before reaching the legal age of 18 years is more than double and this affects the reproductive health of women adversely. Thus, overall the MAJLIS sample has a worse demographic profile than the NFHS V.

The Drinking water, Sanitation and Cooking Fuel situation is given in Table 2 below.

Table 2: Drinking water, Sanitation and Cookiing Fuel Indicators (% of respondents)

Sl. No.	Indicators	NFHS V	MAJLIS
1.	Good Drinking Water Source (Piped Treated Water Supply)	98.9	33.6
2.	Good Sanitation (Toilets)	90.0	67.2
3.	Clean Cooking Fuel (LPG or Electric)	86.9	53.2

The NFHS V sample has a significantly higher proportion of households with a Good Drinking water source, clean fuel and good sanitation and so in the case of these indicators also the MAJLIS sample overall has a worse situation than the NFHS V sample. Especially noteworthy is the very poor situation in the slums in Indore with regard to water supply which is a major cause of ill health.

The comparison of the indicators related to pregnancy and childbirth are given in Table 3 below.

Table 3: Pregnancy and Childbirth Indicators (% of respondents)

Sl. No.	Indicators	NFHS V	MAJLIS
1.	Contraceptive use among 15-49 years	35.5	16.7
2.	Mothers with full Antenatal Care	37.1	5.6
3.	Institutional births	96.5	44.7
4.	Total Fertility Rate (children per woman)	2	2.32
6.	Average Out of Pocket expense for delivery (₹)	1746	2400

The MAJLIS sample has much poorer values for all the indicators with the economic value of out of pocket delivery expense being particularly disadvantageous.

The comparison of the reproductive health indicators is given in Table 4 below.

Table 4: Reproductive Health Indicators (% of respondents)

Sl. No.	Indicators	NFHS IV	MAJLIS
1.	Women who are anaemic	55.9	76.4
2.	Women of 15-49 years who have undergone examination of cervix	29.1	4.1

Anaemia due to factors like overwork and malnutrition are the bane of women in India and there is an epidemic of Vitamin B12 deficiency which directly contributes to anaemia. The MAJLIS sample has an alarming proportion of 76.4 % women who are anaemic much more than the NFHS V sample. While many women suffer from gynaecological problems and especially erosion of the cervix, very few ever get themselves checked up by gynaecologists. The MAJLIS sample had only 4.1 % women who had had their cervix examined and these were all those who had had hysterectomies.

Thus, overall the women who have been chosen for the gynaecological health programme by MAJLIS are in a very disadvantageous situation as compared to the NFHS V survey results for the district of Indore, which latter themselves paint a very sorry picture of the status of women's health in the district. In fact the NFHS V data is very disturbing for the country as a whole. Therefore the implementation of the current programme by MAJLIS is eminently justified. Another important point is that the NFHS or other such surveys do not address the problem of gynaecological moribidity of women and their lack of access to diagnosis and treatment for this at all. In this respect this programme of MAJLIS is innovative and sheds light on the serious gynaecological problems that women face.

During the preliminary survey the women were asked whether they were suffering from any of twenty specific women's health problems that most commonly afflict women. 92.6 per cent of the women reported reproductive health problems with an average of three different complaints per woman, with some having as many as ten complaints. 96.3 percent of the women said that this was the first time they were revealing their gynaecological problems to anyone as they did not feel that they could speak about them either in private or in public due to a culture of silence.

Table 5 below gives the summary of the results with the proportion of women suffering from the most prevalent complaints as reported by the women themselves.

Table 5: Proportion of Women Complaining of Various Health Problems

Health Problem	Dizziness	Waist Pain	Vaginal Problems (Discharges, itching, swelling etc)	Urinary Tract Problems	Menstrual Problems
Proportion of Women with complaint (%)	64.9	71.6	44.7	20.9	49.9

Proportion of women who complained of dizziness is very high at 64.9 percent which correlates well with the proportion of women who were tested and found to be anaemic which is 76.4 percent. A very high proportion of 71.6 percent of women complained of waist pains which generally arise from a combination of anaemia, overwork and problems of the gynaecological tract. The proportion of women reporting vaginal problems which mostly arise from lack of menstrual hygiene was 44.7 percent which correlates well with the proportion of women who use cloth washed and dried in the shade during periods which is 59.5 percent. A very high proportion of 49.9 percent of the women reported having menstrual problems which too arise mostly from a combination of anaemia, overwork and lack of menstrual hygiene.

The summarised results of the clinical examination and laboratory tests are given in Table 6 below.

Table 6: Proportion of Women Diagnosed with Major Gynaecological Problems

Gynaecological Problems	Cervical Problems (erosion, cysts, hypertrophy etc)	Vaginal Problems (discharges, itching, eruptions etc)	Urinary Tract Problems	Menstrual Problems
Proportion of Women Affected (%)	67.6	49.1	5.5	11.5

A very high proportion of 67.6 percent of the women suffered from cervical problems like erosions and cysts and as much as 30 percent had serious problems requiring cauterisation and repeated medication. This is something that the women did not know about at all as they had never had their cervix examined by a gynaecologist. Many of these women also had vaginal problems and on the whole 49.1 percent of women were suffering from these. The proportion of women with urinary tract and menstrual problems was less than what they had reported in the survey because at the time of clinical examination they were not suffering from these problems which they do from time to time only.

Clinical diagnosis and laboratory testing of blood and urine samples are quite costly if done individually but since these were done in bulk, the costs came down by as much as 60 percent. Similarly medication for cervical and vaginal problems is quite costly if branded medicines are used. However, generic medicines were used in the camps and sourced at wholesale rates through bulk purchase and so the medicine costs were only about 15 percent of the retail value of branded drugs. All the women were cured of their problems over the month's time in which they were diagnosed and treated. Some required hospital procedures such as cauterisation. There was one woman who had stitches in her vagina which had not been removed after delivery a few years ago. She was repeatedly complaining of pain in her vagina but had never visited a gynaecologist afterwards. Some women had to be given intravenous iron drips as they were highly anaemic.

Clearly, the women had poor gynaecological health mainly due to inability to articulate their problems and get access to good reproductive and sexual health services and prevalence of malnutrition and overwork, which are all due to a combination of poverty and patriarchal oppression.

There is a high level of gender based violence with 33.1% of the women reporting having suffered the same. The survey also revealed that other indicators of women's disempowered status were equally bad -

1. The gender division of labour is highly skewed for this sample with 81.8 percent of women doing all domestic work.
2. The proportion of women who said that their men decided when to have sex and they had no say in the matter was very high at 90.4 percent.
3. The proportion of women who had some knowledge of governnment schemes favouring women was only 31.8 percent.
4. The proportion of women with knowledge of the Prevention of Domestic Violence Act was only 33.8 percent.

Meetings were held with the men also as without their cooperation, the women would fall back into ill health. In many cases the bacteria, fungi and viruses that cause vaginal infections in women are there in the penises of men also but do not affect them. Thus, it is necessary for the men also to take the medicines so that both are disinfected. These meetings with the men revealed that they too were unaware of the complexities of the reproductive tract problems of the women. In some cases the men were themselves suffering from infections of the penis but were too shy to go to a doctor for treatment. Thus, these meetings served the purpose of raising the awareness levels of the men.

Moreover, in most cases, the women do not have access to gynaecologists for their own problems even if they have the money due to lack of awareness. This programme of MAJLIS is consequently not only very essential but also a high impact one as it provides otherwise difficult to access treatment very cost effectively at an average expenditure of ₹ 1000 per woman.

Gynaecological health problems lead to both economic loss through inability to work and mental stress due to illness. An adverse gender division of labour, lack of sexual rights and domestic violence further queer the pitch for most women. Under the circumstances an effective programme of reproductive health and women's empowerment like the present one is bound to reap huge benefits in terms of economic and social progress for the society.

To this end, MAJLIS has now begun replicating this programme in other states in collaboration with other NGOs. As part of this a reproductive health survey and camp was conducted among the sexworkers residing in the Kalighat area of Kolkata in collaboration with the NGO Newlight and the funding agency Martinian '78. This has added a new dimension to this programme as sexworkers are a high risk category. As much as 25 percent of the women were suffering from sexually transmitted diseases and 26.5 percent of women had uterine malignancies which required further tests and treatment. This programme was replicated in the Chittorgarh district of Rajasthan and the Dewas district of Madhya Pradesh among Scheduled Tribe Women in rural areas with even worse status of gynaecological health being detected. The final innovative aspect of this programme is that it is crowd funded and is implemented by the community of women and so can be easily replicated.

NGOs, however, can only scratch the surface of this problem and can at the most develop prototypes of intervention modules and test them as MAJLIS has done. The question naturally arises as to why the Government of India, which can get the clinical diagnosis, laboratory tests, and medicines at even cheaper rates than an NGO like Majlis, isn't providing this important service to the women. Therefore, it is of utmost importance that the public health system in India should be better run to address and solve the serious gynaecological problems being faced by economically poor women in India in accordance with the spirit of CEDAW. To this end this shadow report has highlighted these problems and their solution and urges on the Committee of CEDAW to draw the attention of the Government of India to this so that the public health system does address and solve the gynaecological problems being faced by economically poor women.

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