



October 1, 2013

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

Re: Supplementary information on India, scheduled for review by the Committee on the Elimination of Discrimination against Women during its Pre-Sessional Working Group

Dear Committee Members:

This letter intends to supplement the fourth periodic report of the Government of India (India's Fourth Report),¹ scheduled for review by this Committee during its Pre-Sessional Working Group. The Center for Reproductive Rights (the Center) and the Human Rights Law Network (HRLN) hope to further the work of the Committee on the Elimination of All Forms of Discrimination against Women (the Committee) by reporting information concerning reproductive rights in India protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). In this letter, the Center also respectfully proposes questions to pose to India during the Pre-Session.

In prior concluding observations issued in 2000 and 2007, the Committee urged India to develop a comprehensive plan and concrete mechanisms at the state-level to stop gender-based violence,² reform laws regarding rape and sexual violence,³ protect girls from child marriage,⁴ and prioritize decreasing maternal mortality.⁵ As this letter will discuss, India has failed to effectively address these issues. While India should be commended for enacting key programs and policies aimed to improve maternal healthcare,⁶ implementation has been insufficient. The World Health Organization (WHO) estimates that **56,000 women and girls in India died from maternal causes in 2010.**⁷ Despite the Committee's request for detailed information on trends and programs to improve women's health and decrease maternal mortality,⁸ India's Fourth Report provides limited information on these issues and has remained silent on barriers to safe abortion services and access to contraception.⁹ In addition, India maintains declarations and a reservation to the Articles 5(a), 16(1), and 16(2) of CEDAW that prevent India from fully protecting Indian women from violations of their rights.¹⁰

I. RIGHT TO REPRODUCTIVE HEALTH SERVICES & INFORMATION (ARTS. 10(h), 12, 14, 16)

India continues to have the **highest number of maternal deaths in the world**¹¹ due to poor quality of maternal health care, the prevalence of unsafe abortions, and barriers to accessing contraception. The rights and standards recognized by CEDAW and the Committee support recognition of the right to survive pregnancy and childbirth as a fundamental human right.¹² General Recommendation 24 requires states to "implement a comprehensive national strategy"

to protect women's right to health.¹³ India's failure to guarantee reproductive health services violates articles 10(h),¹⁴ and 16(e),¹⁵ which require states to ensure that women have access to the reproductive health information and services they need, including access to safe abortion and contraception.

a. Maternal Mortality and Morbidity

The Committee has consistently affirmed that states must ensure women's rights to survive pregnancy and childbirth,¹⁶ and that a "lack of appropriate maternal health services has a differential impact on the right to life of women."¹⁷ While India should be commended for strong decisions from its high courts that recognize a right to survive pregnancy,¹⁸ in practice the right remains unfulfilled for many women due to lack of implementation and India alone accounts for 20% of the world's maternal deaths.¹⁹ Government studies show that the maternal mortality ratio (MMR) in India declined from 254 in 2006 to 212 in 2009.²⁰ However, the WHO estimated that in 2010, **India's MMR could have been as high as 310.**²¹ Further, significant disparities exist among states in India: for example, a 2012 government study estimates the MMR in the state of Assam could be as high as 417.²² Under any estimate, **India has acknowledged it is not on track to meet its Millennium Development Goal of reducing its MMR to 109 per 100,000 live births by 2015.**²³

Poor Quality of Maternal Health Care. The Committee has emphasized the importance of skilled birth attendants in ensuring safe pregnancy and childbirth.²⁴ In India, less than 50% of women deliver with the support of a skilled attendant.²⁵ International standards established by the WHO recommend four antenatal care (ANC) visits²⁶ and the Indian government itself commits to providing these visits under the National Rural Health Mission (NRHM),²⁷ a government program with a significant maternal health component. However, according to the NFHS-3, published in 2007, only 50% of women were able to access all four antenatal care (ANC) visits.²⁸ Less than 48% of women received any postnatal care (PNC) within two days of delivery,²⁹ even though half of all maternal deaths take place postpartum.³⁰ Although Government policies incentivize pregnant women to seek institutional care,³¹ women have been turned away without receiving services, have been left waiting for long periods of time, and have been discharged too soon after labor.³² Often, institutions are not fully staffed or do not offer services for evening births,³³ do not have workable toilets or basic sanitation facilities,³⁴ and lack even the most basic drugs and equipment.³⁵

Failure to Effectively Implement Maternal Health Policies. Under CEDAW Article 12 and General Recommendation 24, states are obligated to utilize the "maximum extent of their available resources" to ensure women's access to health services.³⁶ India has designated significant resources to ensuring women's access to health services as noted in its periodic report; however, the Indian Comptroller and Auditor General (CAG) audit reported that **national funds allocated to states under maternal health-related programs remained unutilized** and the **national government ultimately demanded that the funds be returned.**³⁷ The Ministry of Health and Family Welfare has reported that corruption at all levels is a major problem, hindering effective implementation of these maternal health policies.³⁸ As a result of ineffective utilization of maternal health-related funds, women in high-risk states like Bihar and Assam are prevented from realizing the full benefits: in Bihar, only 5.8% of women received the recommended ANC and only 15.9% received PNC within two days of delivery.³⁹ The situation is

similar in Assam, with only 9.6% of women receiving the recommended ANC and only 13.9% receiving PNC within two days of delivery.⁴⁰

Lack of Accountability for Poor Quality of Pregnancy-Related Care. In a 2010 landmark decision in the consolidated cases of *Laxmi Mandal v. Deen Dayal Harinagar Hospital* and *Jaitun v. Maternal Home, MCD, Jangpura and Others*, the Delhi High Court ruled that the right to life includes reproductive rights and the right to survive childbirth.⁴¹ In 2012, the Madhya Pradesh High Court followed suit in the case of and *Sandesh Bansal v. Union of India and Others*, and ruled that the state has an obligation to ensure that every woman survives pregnancy and child birth.⁴² Each legally binding court order outlined specific steps for each state government including changing in government entitlement programs, improving service provision, ensuring hygiene at facilities, and taking steps to ensure staffing at public health facilities. Despite these strong decisions, India's central government has not taken steps to hold states accountable for non-implementation of schemes or failure to adhere to Court orders.

b. Unsafe Abortion

The Committee has repeatedly expressed concern where unsafe abortions persist.⁴³ The Committee noted in *L.C. v. Peru* that when a state has legalized abortion, it “must establish an appropriate legal framework that allows women to exercise their right to it under conditions that guarantee the necessary legal security, both for those who have recourse to abortion and for the health professionals who must perform it.”⁴⁴ Abortion is legal on broad grounds in India under the Medical Termination of Pregnancy (MTP) Act.⁴⁵ However, **significant obstacles to obtaining safe and legal abortion in India still exist**, including: prohibitive costs, shortage of trained providers and adequate equipment, lack of confidentiality and informal demands for spousal consent, poor access to facilities, and lack of knowledge about the legal status among women, lawyers, and medical professionals concerning abortion and where to access safe services.⁴⁶ 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.**⁴⁷

The Committee has specifically urged the government to prioritize ensuring access to safe abortion to decrease maternal mortality.⁴⁸ Despite the Committee's recommendations to ensure access to safe abortion, India has not provided any information about access to abortion in its report.⁴⁹ A leading Indian NGO's review of the NRHM reports that these programs still fail to disseminate information on safe abortion, and in some cases, women are not provided accurate information on safe abortion services.⁵⁰

Lack of Access to Facilities and Poor Quality of Care. General Recommendation 19 requires states to “ensure that women are not forced to seek unsafe medical procedures such as illegal abortion because of lack of appropriate services in regard to fertility control.”⁵¹ Under the MTP Act, all abortions must be performed in a government-operated hospital or a government-approved hospital.⁵² There are few accredited facilities as required under the MTP Act and access remains limited.⁵³ Of the few abortion facilities that are government-accredited, many lack running water, toilets, clean operating tables, a regular power supply, and privacy for clients; there is also a shortage of medical equipment, analgesics, and antihemorrhagic medications.⁵⁴ Poor conditions and few facilities leave women, especially in rural areas, no

option but to resort to unsafe abortion. According to media reports an Indian woman dies every two hours because an abortion goes wrong.⁵⁵

Restrictions on Medical Abortion. The Committee has noted that states discriminate against women when they refuse to legally provide for the performance of reproductive health services, including abortion.⁵⁶ Restrictions on certain types of abortions often have the effect of reducing access to safe abortion services.⁵⁷ In India, mifepristone and misoprostol, medicines used in performing medical abortion, are licensed for use and consensus protocols and guidelines for appropriate use of mifepristone–misoprostol for medical abortion in early pregnancy were developed in 2004 by a national consortium consisting of national and international experts.⁵⁸

However, a recent study by Ipas India has found that government authorities in the state of Maharashtra have intensified efforts to enforce regulations on medical abortion pills, including by requiring onerous documentation where medical abortion pills are dispensed and issuing threats to drug stores against distribution of these pills.⁵⁹ As a result of the crackdown, drug stores have stopped stocking medical abortion pills altogether, and a “black market” has emerged.⁶⁰ Local media have reported women paying up to five times the normal retail price to get the pills, even with a prescription.⁶¹

The government’s particular focus on dispensation of medical abortion pills is rooted in a misguided attempt to address India’s unbalanced sex ratio by restricting access to abortion.⁶² The barriers experienced by women in Maharashtra reflect the harmful impact caused by the stigma of sex- selective abortions on women’s access to safe abortion services in India. In this case, the government has focused on a form of abortion that is intended to be utilized before 12 weeks of pregnancy,⁶³ despite the fact that sex determination typically occurs after 16 weeks of pregnancy.⁶⁴ The government’s actions constitute discrimination by treating abortion, a medical service that only women need, distinctly from other health care services needed by men and women alike through excessive scrutiny and regulation. 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.”⁶⁵ 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.”⁶⁶

Broad restrictions on abortions past 20 weeks. Under the MTP Act, abortion past twenty weeks is only permitted where the life of the pregnant woman is in danger.⁶⁷ In practice, this has led to women seeking abortions past 20 weeks for other reasons, including risks to their physical or mental health and severe fetal impairments undermining the viability of a pregnancy, being denied abortions by medical practitioners and courts.⁶⁸ India’s own National Commission on Women (NCW) has expressed concern that poorer women specifically face barriers under the 20 week limitation, because they are more likely to only receive an ultrasound and find out about health risks later in pregnancy.⁶⁹ Citing comparative legal trends, the NCW has urged India to extend the 20 week limit to 24 weeks to protect women’s rights.⁷⁰

c. Barriers to Accessing the Full Range of Modern Contraceptives

The Committee has recognized that lack of access to contraceptives contributes to maternal mortality by denying women the ability to prevent unwanted pregnancies and by exposing them to the risk of pregnancy complications as well as unsafe abortion complications.⁷¹ General Recommendation 21 requires governments to ensure adequate access to contraceptives, including emergency contraception,⁷² and information about contraceptives⁷³ to ensure women's rights to "decide freely and responsibly on the number and spacing" of children.⁷⁴ Though India does not address access to contraception in its most recent report to the Committee,⁷⁵ India has committed both through its own National Population Policy (NPP) and MDG 5.B to ensure universal access to contraception.⁷⁶ 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,"⁷⁷ and sets a target of "universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices" by 2010,⁷⁸ which India has failed to realize. **The government's progress in reducing unmet need for family planning has stagnated, decreasing by only 3% from 1999-2006.**⁷⁹ There are also significant disparities among states. Government data indicates the unmet need in Andhra Pradesh is 5%, compared to 35% in Meghalaya.⁸⁰

Coercive and Unsafe Sterilization. The Committee has noted that "States parties should not permit forms of coercion, such as non-consensual sterilization ... that violate women's rights to informed consent and dignity."⁸¹ The Special Rapporteur on Violence Against Women has stated "[f]orced sterilization is a method of medical control of a woman's fertility without the consent of a woman. Essentially involving the battery of a woman—violating her physical integrity and security—forced sterilization constitutes violence against women."⁸²

Supreme Court rulings in cases concerning coercive and unsafe sterilization in India⁸³ have mandated extensive guidelines for sterilizations, with an emphasis on counseling and informed consent.⁸⁴ Yet, implementation of these guidelines has been insufficient, and there have been several media reports of sterilization abuses throughout the country. A report in *The Hindu*, a leading national daily newspaper, on a sterilization camp conducted in January 2012 in a remote village in Bihar exposed how government-set population targets, financial incentives, and lack of oversight have led rules that require informed consent, as well as guidelines on national sterilization and public health intended to ensure quality of care, to be ignored.⁸⁵ According to the report, 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. The report states that these women were all sterilized in a matter of a few hours. In response to the media investigation of the camp, the Principal Secretary of Health in Bihar presented a report that fails to acknowledge any of the alleged violations, indicating the lack of political will by state officials to investigate the abuses and ongoing impunity for human rights violations resulting from coerced and unsafe sterilizations.⁸⁶ Similar reports have been published by the media in other states, even alleging denial of food rations for refusal to be sterilized.⁸⁷

It is evident from these reports that full compliance with the Supreme Court's rulings has not yet been achieved and violations of women's reproductive rights are continuing. **These violations**

are compounded by state-level family planning programs that promote a “one child norm” and set targets for sterilization, insertion of intrauterine devices, and adoption of contraceptive pills.⁸⁸ The government of India has also failed to take any steps to address such population policies and programs introduced by state governments that include sterilization targets and are inherently coercive and inconsistent with national policy goals and commitments to free and informed consent in contraceptive decision-making.

Limited Access to and Information about Emergency Contraception. This Committee has urged states to make emergency contraception available to women as part of the full range of contraceptive methods referenced under CEDAW Article 12.⁸⁹ Despite the fact that emergency contraceptives are permitted in India, only 30.9% of women have heard of emergency contraceptives; among rural women, awareness is only 23.8%.⁹⁰ Further, less than 1% of women have ever used emergency contraceptives.⁹¹ A 2008 study found that although 67% of practitioners offered victims of sexual violence emergency contraceptives, only 25% of these clinics had emergency contraceptives in stock at the time.⁹²

II. RIGHT TO NONDISCRIMINATION (ARTS. 1, 2, 5, 12, 14, 16)

Under CEDAW, the obligation to elimination discrimination against women is recognized as immediate. CEDAW Article 2 affirms that States parties shall “agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women.”⁹³ 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. Marriage-Related Discrimination

Child Marriage. The marriage of a young girl sets in motion a continuum of reproductive rights violations that impact her future and well-being, including sexual violence, marital rape, and early and frequent pregnancy resulting in a higher risk of maternal mortality and morbidity. Under CEDAW Article 16, women have the same right as men to freely choose a spouse and “to enter into marriage only with their free and full consent.”⁹⁴ CEDAW Article 16(2) prohibits child marriage and affirms that such marriages should be completely void and have no legal effect.⁹⁵ The Committee has explicitly called on states parties to introduce and enforce national legislation establishing the minimum age of marriage at 18 for both boys and girls, regardless of any religious custom or law.⁹⁶

India continues to account for the highest number of child marriages in the world,⁹⁷ despite legal and policy commitments to eliminate the practice. India pledged to eliminate child marriage by 2010 in its 2005 National Plan of Action for the Girl Child and adopted the Prohibition of Child Marriage Act (PCMA) in 2006, which establishes penalties for the marriage of girls below 18 and boys below 21 and renders such marriages voidable.⁹⁸ India’s most recent national health and demographic survey found that **46% of all marriages in India are child marriages.**⁹⁹ Recent government state-level studies indicate that child marriage continues to persist on a staggering scale, with **some states reporting as many as 60% of girls having been married by age 18.**¹⁰⁰

CEDAW and this Committee has stated that States parties must regard child marriages as completely void under the law, establish an equal age of marriage for girls and boys, and ensure that religiously-based laws do not lead to inconsistent regulation of child marriage, including conflicting minimum ages of marriage.¹⁰¹ India's PCMA violates all three of these standards. First, the PCMA provides a different definition of "child" based on gender: for males, the age of marriage is 21; for females, 18.¹⁰² The legal disparity reflects social practice in India; the median age of marriage for girls in India is more than 6 years younger than for boys.¹⁰³ **Only 9.5% of boys ages 20-24 were married as children, compared to 47% of girls ages 20-24.**¹⁰⁴ 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."¹⁰⁵

Second, the PCMA makes marriages voidable, not void, which violates recommendations put forth by both Committee and India's own National Commission for Women and Law Commission.¹⁰⁶ Under the PCMA, either spouse who was a child when the marriage occurred has the option to void the marriage; however, this can only be done until two years after attaining majority,¹⁰⁷ which may be while married girls are experiencing their first pregnancies or have small children. Voiding a marriage requires judicial authorization, which can be a barrier for girls who may lack the autonomy to access and pay for legal services. The legal obstacles posed by the PCMA's recognition of child marriage as void rather than voidable are further complicated by the persistence of multiple religiously-based personal laws (e.g., Muslim Personal Law, Hindu Marriage Act, Christian Marriage Act, Parsi Marriage and Divorce Act) in India. Passage of the PCMA did 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.¹⁰⁸ While a few state-level High Court decisions have held that the PCMA supersedes certain personal laws, the Supreme Court has not rendered a decision on the issue.¹⁰⁹ The Committee has specifically expressed concern to State parties where plural legal systems allow for discrimination against women and where "under-age marriage[s] of girls...are legitimized under different religious laws governing personal status."¹¹⁰

Despite the PCMA, India continues to allow child marriage to persist with impunity. In 2007, this Committee has specifically called on India to take "take comprehensive, effective and stringent measures aimed at deterrence of those engaged in child marriages, the elimination of such practices and the protection of the human rights of the girl child."¹¹¹ However, **prosecution for promotion or solemnization of child marriages remains very low. Further, Child Marriage Protection Officers, who are tasked under the PCMA to prevent child marriage, have only been appointed in about half of the states in India.**¹¹²

Marital Rape. General Recommendation 19 requires that "[s]tates parties should ensure that laws against family violence and abuse, rape, sexual assault and other gender-based violence give adequate protection to all women, and respect their integrity and dignity."¹¹³ This Committee has specifically expressed concern where States parties have failed to criminalize marital rape and has called for States parties to exercise due diligence in addressing all forms of gender-based violence.¹¹⁴

Incidences of sexual violence, such as marital rape, remain high in India: for example, one study shows that over half (59%) of women in Bihar experienced physical or sexual violence in marriage.¹¹⁵ In 12 other states, more than one third of women experience physical or sexual violence in their marriages.¹¹⁶ Child marriage specifically exposes girls in India to sexual violence. A publication cosponsored by the government describes child marriage as “open[ing] the door to an endless and vicious cycle of domestic violence and abuse.”¹¹⁷ Recent studies have affirmed that married girls in India are particularly vulnerable to sexual abuse.¹¹⁸ Despite these statistics, **rape within marriage is not criminalized in the Indian Penal Code (IPC) unless it involves a girl below the age of 15.**¹¹⁹ Legislation passed in 2012 concerning sexual abuse of children raised the age for statutory rape to 18 and removed the marriage exception through this age;¹²⁰ however, the Criminal Procedure Code (Amendment) Ordinance, passed in March 2013,¹²¹ **retrogressively reaffirms the IPC standard and does not recognize rape within marriage once a girl is above 15.**¹²² The Committee has consistently urged India to address the high incidence of violence against women in the country,¹²³ and specifically criticized India’s failure to criminalize marital rape and child sexual abuse.¹²⁴

b. Discrimination in Fulfillment of the Right to Reproductive Health Services for Rural and Poor Women & Adolescent Girls

The Committee has recognized that the intersection of gender with race, ethnic or religious identity, disability, age, class, or caste may result in women experiencing multiple and compounded forms of discrimination.¹²⁵ The Committee has emphasized that societal factors can lead to different outcomes in health status among women, and has called for special attention to be given by states to the needs of those women in vulnerable groups, such as young girls¹²⁶ and rural women.¹²⁷ As such, the Committee has urged states to initiate specific measures to eliminate these multiple forms of discrimination.¹²⁸

Rural and Poor Women. Inequitable access to contraceptive services for rural women violates Article 14 of CEDAW, which specifies that states must take special steps to provide rural women with access to adequate health care and family planning services.¹²⁹ Despite this obligation, low-income and rural women fare worst in both access to and quality of care in India.¹³⁰ **Some of the gravest disparities in access to maternal care occur on the urban and rural divide:** in urban areas 75% of pregnant women report having had at least three prenatal visits, while in rural areas that number is only 44%.¹³¹ Further, deliveries are much more likely to be assisted by a skilled birth attendant in urban areas than in rural areas: 62% of women in urban areas were assisted by a skilled birth attendant, compared to 26% of women living in rural areas.¹³² As a result of the disparities in care, the MMR is higher than the national MMR in states such as Assam (390) and Uttar Pradesh (359).¹³³

Adolescents. Early pregnancy, which is linked with early marriage, significantly jeopardizes the lives and health of adolescent girls.¹³⁴ Pregnancy is particularly dangerous for adolescent girls in India, due to the fact that they are less likely to receive proper ANC and are more likely to have pregnancies timed frequently and too closely together.¹³⁵ Only 40% of adolescent births were delivered in a health facility.¹³⁶ Further, government studies show that more than half of adolescent girls aged 15-19 did not even have one ANC visit in the first trimester of pregnancy.¹³⁷ The numbers indicate that despite the increased risk of early pregnancy and

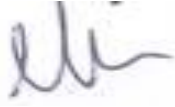
childbirth, a significant percentage of pregnant adolescent girls are receiving far less than the internationally-recommended four antenatal visits and are delivering without skilled birth attendance.

III. Suggested Questions to be Posed to the State Party

The Center and HRLN respectfully request that this Committee pose the following questions to the delegation representing the government of India during its Pre-Sessional Working Group.

1. What steps have been taken by the State party to improve maternal health for rural, adolescent, and poor women since the last periodic review and what are some of the positive results of those steps? What is the State party specifically doing to address leading causes of maternal death and morbidity such as early marriage and unsafe abortion?
2. What steps are being taken by the State party to ensure implementation of decisions finding violations of women's right to survive pregnancy and child birth and their reproductive rights, including specifically the cases of *Laxmi Mandal v. Deen Dayal Harinagar Hospital*, *Jaitun v. Maternal Home*, *MCD*, *Jangpura and Others*, and *Sandesh Bansal v. Union of India*?
3. What steps have been taken by the State party since the last periodic review to establish universal access to a full range of contraceptives, including emergency contraception, in order to reduce the unmet need for contraceptives and risk of unplanned pregnancies, especially among adolescents, rural women, and poor women?
4. What measures have been taken by the State party since the last periodic review to ensure women's access to safe abortion services? What steps has the state party taken to ensure that attempts to balance the sex ratio do not result in barriers to safe abortion services?
5. What specific steps are being taken to effectively prevent child marriage as envisioned by the PCMA, including by ensuring the appointment of CMPOs and the prosecution of perpetrators of child marriage?
6. What specific measures has the state party taken to ensure access to effective legal remedies for victims of child marriage in accordance with the law and to assess the need for additional measures aimed at removing barriers that young girls face in seeking legal remedies?
7. What steps has the state party taken to clarify the minimum legal age of marriage and status of child marriage and to ensure uniformity in the legal regulation of child marriage?
8. What steps are being taken to recognize marital rape as a crime?

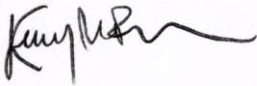
Sincerely,



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¹ Government of India, *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women: Combined 4th and 5th periodic reports of States parties: India*, U.N. Doc. CEDAW/C/IND/4-5 (2012) [hereinafter India Government Report (2012)].

² Committee on the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: India*, paras. 68-71, U.N. Doc. A/55/38 (2000); *see also India*, para. 20, U.N. Doc. CEDAW/C/IND/CO/3 (2007).

³ CEDAW Committee, *Concluding Observations: India*, paras. 69, U.N. Doc. A/55/38 (2000); *India*, paras. 22-23, U.N. Doc. CEDAW/C/IND/CO/3 (2007).

⁴ CEDAW Committee, *Concluding Observations: India*, para. 62, U.N. Doc. A/55/38 (2000); *India*, paras. 56-57, U.N. Doc. CEDAW/C/IND/CO/3 (2007).

⁵ CEDAW Committee, *Concluding Observations: India*, para. 78, U.N. Doc. A/55/38 (2000); *India*, paras. 40-41, U.N. Doc. CEDAW/C/IND/CO/3 (2007).

⁶ *See, e.g.*, the NATIONAL RURAL HEALTH MISSION (NRHM), NATIONAL RURAL HEALTH MISSION, MISSION DOCUMENT 2005-2012, available at http://www.nird.org.in/brgf/doc/Rural%20HealthMission_Document.pdf; NATIONAL INSTITUTE OF HEALTH AND FAMILY WELFARE, *Reproductive and Child Health Program*, available at <http://www.nihfw.org/NDC/DocumentationServices/NationalHealthProgramme/REPRODUCTIVEANDCHILDHEALTH.html>; GOVERNMENT OF INDIA, MINISTRY OF HEALTH AND FAMILY WELFARE, MATERNAL HEALTH DIVISION, JANANI SURAKSHA YOJANA FEATURES & FREQUENTLY ASKED QUESTIONS (2006) available at <http://jknrh.com/PDF/JSR.pdf>.

⁷ WHO, UNICEF, UNFPA AND THE WORLD BANK, TRENDS IN MATERNAL MORTALITY: 1990 to 2010 1 (2012) [hereinafter TRENDS IN MATERNAL MORTALITY (2012)].

⁸ CEDAW Committee, *Concluding Observations: India*, para. 41, U.N. Doc. CEDAW/C/IND/CO/3 (2007).

⁹ India Government Report (2012), *supra* note 1.

¹⁰ India has made a declaration regarding article 5(a) and 16(1) of the Convention, claiming that it agrees to these provisions to the extent that they do not interfere with India's "policy of non-interference in the personal affairs of any Community without its initiative and consent." India's second declaration involves article 16(2) of the Convention and states while India "fully supports the principle" of marriage registration, "it is not practical in a vast country like India with its variety of customs, religions and level of literacy." India's reservation regarding article 29 declares that it does not consider itself bound to the jurisdiction of the International Court of Justice in the event of a dispute between itself and another state. *Declarations, Reservations and Objections to CEDAW*, UNITED NATIONS (U.N.) DIVISION FOR THE ADVANCEMENT OF WOMEN, DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, available at <http://www.un.org/womenwatch/daw/cedaw/reservations-country.htm>.

¹¹ In 2010, India accounted for the highest number of maternal deaths (56,000); Nigeria accounted for the second highest number (40,000). TRENDS IN MATERNAL MORTALITY (2012), *supra* note 7, at 1.

¹² See, e.g., 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*, at 361, 363, paras. 17, 27, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*]; see also CEDAW Committee, *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38 (1999); *Dominican Republic*, para. 337, U.N. Doc. A/53/38 (1998).

¹³ CEDAW Committee, *General Recommendation No. 24*, *supra* note 12, paras. 17, 27. Women's right to health is guaranteed under CEDAW Article 12. Convention on the Elimination of All Forms of Discrimination against Women, adopted Dec. 18, 1979, art. 12, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (entered into force Sept. 3, 1981) [hereinafter CEDAW].

¹⁴ CEDAW, *supra* note 13, art. 10(h).

¹⁵ *Id.*, art. 16(e) (ensuring "[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").

¹⁶ See, e.g., CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 12, paras. 17, 27; see also CEDAW Committee, *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38 (1999); see also *Alyne da Silva Pimentel Teixeira v. Brazil*, CEDAW Committee, Commc'n No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (2011); *L.C. v. Peru*, CEDAW Committee, Commc'n No. 22/2009, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

¹⁷ *Alyne da Silva Pimentel Teixeira v. Brazil*, CEDAW Committee, Commc'n No. 17/2008, para. 7.6, U.N. Doc. CEDAW/C/49/D/17/2008 (2011) (noting that a "lack of appropriate maternal health services has a differential impact on the right to life of women").

¹⁸ Justice S. Muralidhar issued landmark rulings in both cases holding that the denial of maternal healthcare is a violation of fundamental constitutional and human rights. See, e.g., Consolidated Decision, *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others*, W.P. (C) No. 8853/2008 & *Jaitun v. Maternal Home MCD, Jangpura & Others*, W.P. (C) Nos. 8853/2008 & 10700/2009 Delhi High Court (2010) (India). In addition to the individual remedies in these cases, the Court issued a series of orders aimed at strengthening maternal healthcare provisions generally, including improving implementation of various government schemes and policies, such as ensuring the following: portability of benefits, benefits regardless of number of children or age, and ensuring families who experience maternal death are entitled to INR 10,000. See *Court of its own Motion v. U.O.I.*, W.P. (C) 5913/2010 (2011) (India) at p. 6-7, (affirming the government's obligation to protect the fundamental right to life of pregnant women), available at <http://lobis.nic.in/dhc/DMA/judgement/12-01-2011/DMA12012011CW59132010.pdf>.

¹⁹ Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health (SRRH), *Rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt—Addendum—Mission to India*, para. 94, U.N. Doc. A/HRC/14/20/Add.2 (April 15, 2010).

²⁰ GOVERNMENT OF INDIA, OFFICE OF THE REGISTRAR GENERAL. SAMPLE REGISTRATION SYSTEM, SPECIAL BULLETIN ON MATERNAL MORTALITY IN INDIA 2007-09, para. 3 (2011), available at http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/Final-MMR%20Bulletin-2007-09_070711.pdf. The survey's MMR data reflects the total number of women aged 15-49 years who die due to maternal causes per 100,000 live births.

²¹ TRENDS IN MATERNAL MORTALITY (2012), *supra* note 7, at 33.

²² GOVERNMENT OF INDIA, OFFICE OF THE REGISTRAR GENERAL. SAMPLE REGISTRATION SYSTEM, ANNUAL HEALTH SURVEY BULLETIN 2011-12: ASSAM, tbl. 10 (2012), available at http://www.censusindia.gov.in/vital_statistics/AHSBulletins/files2012/Assam_Bulletin%202011-12.pdf.

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- ²³ GOVERNMENT OF INDIA, CENTRAL STATISTICAL ORGANIZATION, MILLENNIUM DEVELOPMENT GOALS: INDIA COUNTRY REPORT 2011 66 *available at* http://www.undp.org/content/dam/undp/library/MDG/english/MDG%20Country%20Reports/India/MDG_India_2011.pdf.
- ²⁴ *See, e.g.*, CEDAW Committee, *Concluding Observations: Bolivia*, para. 43, U.N. Doc. CEDAW/C/BOL/CO/4 (2008); *Burkina Faso*, para. 39, U.N. Doc. CEDAW/C/BFA/CO/6 (2010); *Kenya*, para. 37, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); *Tunisia*, para. 50, U.N. Doc. CEDAW/C/TUN/CO/6 (2010); *Turkey*, para. 38, U.N. Doc. CEDAW/C/TUR/4-5 (2005); *The Gambia*, para. 34, U.N. Doc. CEDAW/C/GMB/1-3 (2005); *Democratic Republic of the Congo*, para. 175, U.N. Doc. A/58/38 (2003); *Ecuadorial Guinea*, para. 205, U.N. Doc. A/59/38 (2004).
- ²⁵ GOVERNMENT OF INDIA, MINISTRY OF HEALTH AND FAMILY WELFARE, NATIONAL FAMILY HEALTH SURVEY (NFHS-3) 2005-06, INDIA, VOLUME I, tbl. 8.18 at 215 (2007), *available at* <http://hetv.org/india/nfhs/index.html> [hereinafter GOVERNMENT OF INDIA, NFHS-3].
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- ²⁷ CENTRE FOR HEALTH AND SOCIAL JUSTICE, REVIEWING TWO YEARS OF NRHM, OCTOBER 2007: CITIZENS REPORT 41 (2007), *available at* <http://www.chsj.org/uploads/1/0/2/1/10215849/citizenreport-2007.pdf> [hereinafter CENTRE FOR HEALTH AND SOCIAL JUSTICE, REVIEWING TWO YEARS OF NRHM: CITIZENS REPORT].
- ²⁸ GOVERNMENT OF INDIA, NFHS-3, *supra* note 25, tbl. 8.4 at 196.
- ²⁹ GOVERNMENT OF INDIA, MINISTRY OF HEALTH AND FAMILY WELFARE, NATIONAL FAMILY HEALTH SURVEY (NFHS-3) 2005-06, INDIA, NATIONAL FACT SHEET, 3, *available at* <http://hetv.org/india/nfhs/nfhs3/NFHS-3-IN.pdf>.
- ³⁰ *See* UNITED NATIONS POPULATION FUND (UNFPA) –INDIA, CONCURRENT ASSESSMENT OF JANANI SURAKSHA YOJANA (JSY) IN SELECTED STATES: BIHAR, MADHYA PRADESH, ORISSA, RAJASTHAN, UTTAR PRADESH 5 (2009), *available at* <http://india.unfpa.org/?publications=1938>.
- ³¹ GOVERNMENT OF INDIA, NFHS-3, *supra* note 25.
- ³² GUTTMACHER INSTITUTE, BARRIERS TO SAFE MOTHERHOOD IN INDIA 22 (2009), *available at* <http://www.guttmacher.org/pubs/2009/07/29/Safe-Motherhood-India.pdf>.
- ³³ CENTRE FOR HEALTH AND SOCIAL JUSTICE, REVIEWING TWO YEARS OF NRHM: CITIZENS REPORT, *supra* note 27, at 25.
- ³⁴ *Id.* at 64.
- ³⁵ *Id.* at 81.
- ³⁶ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 12, para. 17.
- ³⁷ COMPTROLLER AND AUDITOR GENERAL OF INDIA (CAG), REPORT NO. 8 – PERFORMANCE AUDIT OF NATIONAL RURAL HEALTH MISSION (NRHM) – MINISTRY OF HEALTH & FAMILY WELFARE (MOHFW) 43-44 (2009), *available at* http://www.cag.gov.in/html/reports/civil/2009_8_PA/chap_5.pdf.
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- ³⁹ GOVERNMENT OF INDIA, NFHS-3, *supra* note 25, tbl. 8.22 at 220.
- ⁴⁰ *Id.*, tbl. 8.22 at 220.
- ⁴¹ Consolidated Decision, *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others*, W.P. (C) No. 8853/2008 & *Jaitun v. Maternal Home MCD, Jangpura & Others*, W.P. (C) Nos. 8853/2008 & 10700/2009 Delhi High Court (2010) (India).
- ⁴² *Sandesh Bansal v. Union of India & Others*, W.P. (C) No. 9061 of 2008 (2012).
- ⁴³ *See, e.g.*, CEDAW Committee, *Concluding Observations: Oman*, para. 41, U.N. Doc. CEDAW/C/OMN/CO/1 (2011); *Paraguay*, para. 31, U.N. Doc. CEDAW/C/PRY/CO/6 (2011).
- ⁴⁴ *L.C. v. Peru*, CEDAW Committee, Comm’n No. 22/2009, para. 8.17, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).
- ⁴⁵ The Medical Termination of Pregnancy Act, No. 34 of 1971, INDIA CODE (1971).
- ⁴⁶ CENTRE FOR HEALTH AND SOCIAL JUSTICE, REVIEWING TWO YEARS OF NRHM: CITIZENS REPORT, *supra* note 27, at 111; WHO, UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF THE INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2008 7-8 (6th ed. 2011).
- ⁴⁷ Duggal R, Ramachandran V, *The abortion assessment project - India: key findings and recommendations*, REPRODUCTIVE HEALTH MATTERS 12, 122-129 (2004).
- ⁴⁸ CEDAW Committee: *Concluding Observations: India*, paras. 40-41, U.N. Doc. CEDAW/C/IND/CO/3 (2007).

⁴⁹ See India Government Report (2012), *supra* note 1.

⁵⁰ See, e.g., CENTRE FOR HEALTH AND SOCIAL JUSTICE, REVIEWING TWO YEARS OF NRHM: CITIZENS REPORT, *supra* note 27, at 111.

⁵¹ 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 335, para. 24(m), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 19*].

⁵² The Medical Termination of Pregnancy Act, No. 34 of 1971, art. 4(a-b), INDIA CODE (1971).

⁵³ Sharad D. Iyengar & K. Iyengar, *Elective Abortion As a Primary Health Service in Rural India: Experience with Manual Vacuum Aspiration*, REPRODUCTIVE HEALTH MATTERS 54, 61 (2002) (“A questionnaire on MTP registration sent out by the Federation of Obstetric and Gynecological Societies of India (FOGSI) found that 13% of 118 centres were registered after delays of one to seven years, 44% were mired in the certification process, while 12% were not even aware of the need for registration.”).

⁵⁴ GUTTMACHER INSTITUTE, ABORTION WORLDWIDE: A DECADE OF UNEVEN PROGRESS, 24 (2009), available at <http://www.guttmacher.org/pubs/Abortion-Worldwide.pdf> (citing Santhya, K.G. and Verma, S, *Induced abortion: the current scenario in India* 1-14, REGIONAL HEALTH FORUM 8(2) (2004).

⁵⁵ *Unsafe Abortions Killing Thousands in India*, BBC NEWS, April 17, 2013, <http://www.bbc.co.uk/news/world-asia-india-22119447> (last accessed Sept. 30th, 2013).

⁵⁶ L.C. v. Peru, CEDAW Committee, Comm’n No. 22/2009, para. 8.11, U.N. Doc. CEDAW/C/50/D/22/2009 (2011); see also CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 12, para. 11.

⁵⁷ The CEDAW Committee has noted that illegal and unsafe abortions are prevalent in countries that have restrictive abortion laws. See CEDAW Committee, *Concluding Observations: Chile*, para 19, U.N. Doc. CEDAW/C/CHI/CO/4 (2006).

⁵⁸ Bela Ganatra et al., *Availability of Medical Abortion Pills and the Role of Chemists: A Study from Bihar and Jharkhand, India*, REPRODUCTIVE HEALTH MATTERS 65 (2005).

⁵⁹ 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*].

⁶⁰ IPAS INDIA, *DISAPPEARING MEDICAL ABORTION DRUGS: FACTS AND REASONS 2* (2013) [hereinafter IPAS INDIA, *DISAPPEARING MEDICAL ABORTION DRUGS*]; *Id.*

⁶¹ Pratibha Masand, *Hard Labour for Abortion Pills*, *supra* note 59.

⁶² IPAS INDIA, *DISAPPEARING MEDICAL ABORTION DRUGS*, *supra* note 60, at 2.

⁶³ (WHO), *SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS*, 4 (2nd ed. 2012) [hereinafter *SAFE ABORTION* (2012)].

⁶⁴ United Nations Population Fund (UNFPA), *GUIDANCE NOTE ON PRENATAL SEX SELECTION*, 3 (2010).

⁶⁵ OHCHR, UNFPA, UNICEF, UN WOMEN AND WHO, *PREVENTING GENDER-BIASED SEX SELECTION: AN INTERAGENCY STATEMENT 4* (2011).

⁶⁶ OHCHR, UNFPA, UNICEF, UN WOMEN AND WHO, *PREVENTING GENDER-BIASED SEX SELECTION: AN INTERAGENCY STATEMENT 4* (2011).

⁶⁷ The Medical Termination of Pregnancy Act, No. 34 of 1971, INDIA CODE (1971).

⁶⁸ NATIONAL WOMEN’S COMMISSION OF INDIA (NCW INDIA), *Review of Medical Termination of Pregnancy Act*, available at <http://ncw.nic.in/Comments/DraftNoteMTPAct1971.pdf>. 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 Sept. 30, 2013).

⁶⁹ NATIONAL WOMEN’S COMMISSION OF INDIA (NCW INDIA), *Review of Medical Termination of Pregnancy Act*, available at <http://ncw.nic.in/Comments/DraftNoteMTPAct1971.pdf>.; 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 Sept. 30, 2013).

⁷⁰ *Id.*

⁷¹ CEDAW Committee, *Concluding Observations: Pakistan*, para. 41, U.N. Doc. CEDAW/C/PAK/CO/3 (2007).

⁷² 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*, at 344, paras. 1, 22, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 21*].

- ⁷³ CEDAW Committee, *Concluding Observations: Costa Rica*, para. 32, U.N. Doc. CEDAW/CO/CRI/CO/5-6 (2011); *Djibouti*, para. 30, U.N. Doc. CEDAW/C/DJI/CO/1-3 (2011); *Lithuania*, para. 25, U.N. Doc. CEDAW/C/LTU/CO/4 (2008); *Nepal*, paras. 32(c), 32(g), U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).
- ⁷⁴ CEDAW, *supra* note 13, art. 16.1.
- ⁷⁵ See India Government Report (2012), *supra* note 1.
- ⁷⁶ MDGs, *Goal 5: Improve Maternal Health*, U.N. DEV. PROGRAMME, <http://www.undp.org/mdg/goal5.shtml>; Nat'l Comm'n on Population, Gov't of India, Nat'l Population Policy 2000, Objectives.
- ⁷⁷ Nat'l Comm'n on Population, Gov't of India, Nat'l Population Policy 2000, Introduction, ¶ 6.
- ⁷⁸ *Id.*, Objectives, box 2.
- ⁷⁹ GOVERNMENT OF INDIA, NFHS-3, *supra* note 25, at 160.
- ⁸⁰ *Id.*
- ⁸¹ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 12, para. 22.
- ⁸² Special Rapporteur on Violence against Women, Its Causes and Consequences, *Rep. of the Special Rapporteur on violence against women, its causes and consequences, Radhika Coomaraswamy, in accordance with Commission on Human Rights resolution 1997/44 —Addendum—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 (Jan. 21, 1999) [hereinafter SRVAW, *Policies and Practices that Impact Women's Reproductive Rights* (1999)].
- ⁸³ Ramakant Rai & Another. v. Union of India, W.P (C) No. 209/2003 (2003).
- ⁸⁴ See MINISTRY OF HEALTH & FAMILY WELFARE, MANUAL FOR FAMILY PLANNING INSURANCE SCHEME 3-4 (2009), available at <http://mohfw.nic.in/index1.php?lang=1&level=1&sublinkid=1206&lid=1050> (discussing the Supreme Court orders to government for ensuring the enforcement of sterilization guidelines).
- ⁸⁵ Shoumohit Banerjee, *Barrack-room surgery in Bihar's backwaters*, THE HINDU, Jan. 23, 2012 <http://www.thehindu.com/todays-paper/tp-opinion/article2824008.ece> (last accessed Sept. 30, 2013).
- ⁸⁶ *Id.*
- ⁸⁷ Milind Ghatwai, *No sterilization, no ration: MP Sarpanch's new order*, THE INDIAN EXPRESS, March 8, 2012 <http://www.indianexpress.com/news/no-sterilisation-no-ration-mp-sarpanchs-new-order/921445/> (last accessed Sept. 30th, 2013).
- ⁸⁸ 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).
- ⁸⁹ CEDAW, *supra* note 13, art. 12; CEDAW Committee, *Concluding Observations: Mexico*, para. 33, U.N. Doc. CEDAW/C/MEX/CO/6 (2006).
- ⁹⁰ GOVERNMENT OF INDIA, MINISTRY OF HEALTH AND FAMILY WELFARE, 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.
- ⁹¹ *Id.* at 244.
- ⁹² INTERNATIONAL CONSORTIUM ON EMERGENCY CONTRACEPTION, *Counting what counts: Tracking Access to Emergency Contraception 1-2* (2013) available at <http://www.cecinfo.org/custom-content/uploads/2013/05/ICEC-India-5-22-13.pdf>
- ⁹³ CEDAW, *supra* note 13, art. 2.
- ⁹⁴ *Id.*, art. 16(1).
- ⁹⁵ *Id.*, art. 16(1).
- ⁹⁶ CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 72, para. 36.
- ⁹⁷ Press Release, World Health Organization (WHO), Child Marriages: 39,000 every day (Mar. 7, 2013), available at http://www.who.int/mediacentre/news/releases/2013/child_marriage_20130307/en/.
- ⁹⁸ GOVERNMENT OF INDIA, MINISTRY OF HUMAN RESOURCE DEVELOPMENT, DEPARTMENT OF WOMEN AND CHILD DEVELOPMENT, NATIONAL PLAN OF ACTION FOR CHILDREN 2005, 18 (2005); Prohibition of Child Marriage Act, No. 6 of 2007, arts. 2(a), 3. INDIA CODE (2007) [hereinafter Prohibition of Child Marriage Act].
- ⁹⁹ GOVERNMENT OF INDIA, NFHS-3, *supra* note 25, at 166.
- ¹⁰⁰ United Nations Population Fund (UNFPA), MARRYING TOO YOUNG: END CHILD MARRIAGE 29 (2012).
- ¹⁰¹ CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 72, para. 36; CEDAW Committee, *Concluding Observations: Burundi*, para. 12, U.N. Doc CEDAW/C/BDI/CO/4 (2008).

¹⁰² Prohibition of Child Marriage Act of 2006, No. 6 of 2007, art. 2(a), INDIA CODE (2006), [hereinafter PCMA].

¹⁰³ GOVERNMENT OF INDIA, NFHS-3, *supra* note 25, at 165.

¹⁰⁴ *Id.* at 163.

¹⁰⁵ CEDAW Committee, *Gen. Recommendation No. 21*, *supra* note 72, para. 38.

¹⁰⁶ NCW (INDIA), *Reviews of Laws and Legislative Measures Affecting Women by National Commission for Women: No. 31. The Child Marriage Restraint Act, 1929 (19 of 1929)* available at <http://ncw.nic.in/frmReportLaws31.aspx>

¹⁰⁷ PCMA, *supra* note 102, sec. 3.

¹⁰⁸ Prohibition of Child Marriage Act, *supra* note 17, arts. 2(a), 3; The Hindu Marriage Act, No. 25 of 1955, INDIA CODE (1978) (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. (CrI.) 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.

¹⁰⁹ *T. Sivakumar v. The Inspector Of Police*, H.C.P. No. 907 of 2011, Madras H.C. (India) (2011); *Court On Its Own Motion (Lajja Devi) v. State*, W.P. (CrI.) No. 338/2008, Delhi H.C. (India) (2012).

¹¹⁰ 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).

¹¹¹ CEDAW Committee: *Concluding Observations: India*, para. 57, U.N. Doc. CEDAW/C/IND/CO/3 (2007).

¹¹² UNITED NATIONS CHILDREN’S FUND (UNICEF), UNICEF INFORMATION SHEET: CHILD MARRIAGE 3 (2011) (referencing a 2011 e-mail exchange with the Ministry of Women and Child Development from December 14, 2011).

¹¹³ CEDAW Committee, *Gen. Recommendation No. 19*, *supra* note 51, para 24(b).

¹¹⁴ CEDAW Committee, *Concluding Observations: Pakistan*, para. 21, U.N. Doc. CEDAW/C/Pak/CO/4 (2013).

¹¹⁵ GOVERNMENT OF INDIA, NFHS-3, *supra* note 25, tbl. 15.14 at 519.

¹¹⁶ Those states are: Rajasthan at 46.3%, Madhya Pradesh at 45.7%, Tripura at 44.1%, Manipur at 43.8%, Uttar Pradesh at 42.4%, Tamil Nadu at 41.9%, West Bengal at 40.3%, Assam at 39.5%, Arunachal Pradesh 38.8%, Orissa 38.4%, Jharkhand at 36.9%, and Andhra Pradesh at 35.2%. *Id.*

¹¹⁷ GOVERNMENT OF INDIA, MINISTRY OF WOMEN AND CHILD DEVELOPMENT, HAQ: CENTRE FOR CHILD RIGHTS, UNICEF, HANDBOOK ON THE PROHIBITION OF MARRIAGE ACT, 2006, 6 (2009).

¹¹⁸ Anita Raj et al., *Association between adolescent marriage and marital violence among young adult women in India*, INT’L JOURNAL OF GYNECOLOGY AND OBSTETRICS 38 (2010).

¹¹⁹ The Criminal Law (Amendment) Ordinance, art. 8, No. 13 of 2013, INDIA CODE (2013).

¹²⁰ The Protection of Children From Sexual Offences Act art. 2(d), No. 32 of 2012, INDIA CODE (2012).

¹²¹ The Criminal Law (Amendment) Ordinance, No. 13 of 2013, INDIA CODE (2013).

¹²² *Id.*, art. 8.

¹²³ CEDAW Committee, *Concluding Observations: India*, para. 52, U.N. Doc. A/55/38 (2000).

¹²⁴ CEDAW Committee: *Concluding Observations: India*, para. 22, U.N. Doc. CEDAW/C/IND/CO/3 (2007).

¹²⁵ 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*, at 367, para. 12, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 25*].

¹²⁶ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 12, para. 6.

¹²⁷ *Id.*, para. 28.

¹²⁸ CEDAW Committee, *Gen. Recommendation No. 25*, *supra* note 125, para. 12.

¹²⁹ CEDAW, *supra* note 13, art. 14(1), 14(2)(b). (“Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning”).

¹³⁰ See Nirmala Murthy and Alka Barua, *Non-Medical Determinants of Maternal Death in India*, J. OF HEALTH MGMT. 47, 59-60 (2004).

¹³¹ GOVERNMENT OF INDIA, NFHS-3, *supra* note 25, at 196.

¹³² *Id.* at 214.

¹³³ GOVERNMENT OF INDIA, OFFICE OF THE REGISTRAR GENERAL. SAMPLE REGISTRATION SYSTEM, SPECIAL BULLETIN ON MATERNAL MORTALITY IN INDIA 2007-09, tbl. 1 (2011), *available at* http://www.censusindia.gov.in/vital_statistics/SRS_Bulletins/Final-MMR%20Bulletin-2007-09_070711.pdf.

¹³⁴ UNICEF, THE SITUATION OF CHILDREN IN INDIA: A PROFILE 9 (2011).

¹³⁵ See Anita Raj, *When the mother is a child: the impact of child marriages on the health and human rights of girls*, ARCH. DIS. CHILD 931, tbl. 2 at 932 (2010) (showing that, compared to women married at 18 or 19, girls married before age 14 are more than twice as likely to go through a pregnancy without receiving any prenatal care and to give birth to multiple children with less than two years’ spacing between them).

¹³⁶ GOVERNMENT OF INDIA, MINISTRY OF HEALTH AND FAMILY WELFARE, INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES, A PROFILE OF YOUTH IN INDIA: NATIONAL FAMILY HEALTH SURVEY (NFHS-3), INDIA, 2005-06, viii, (2009).

¹³⁷ *Id.*, tbl. 6.1 at 72.