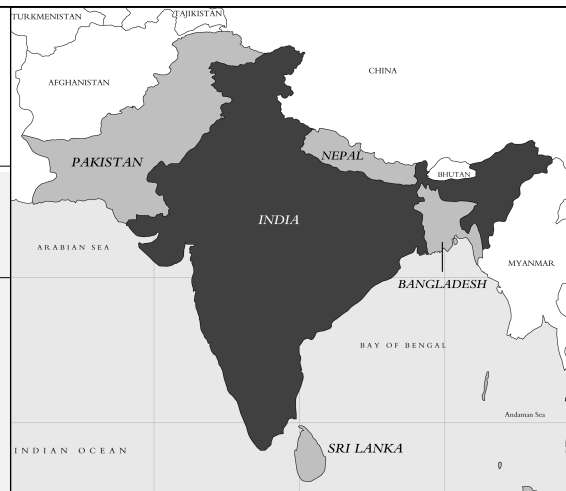


# 2. India



## Statistics

### GENERAL

#### Population

- Total population: 1,065,500,000.<sup>1</sup>
- Population by sex: 504,497,270 (female) and 536,646,720 (male).<sup>2</sup>
- Percentage of population aged 0–14: 33.1.<sup>3</sup>
- Percentage of population aged 15–24: 18.9.<sup>4</sup>
- Percentage of population in rural areas: 72.<sup>5</sup>

#### Economy

- Annual percentage growth of gross domestic product (GDP): 5.9.<sup>6</sup>
- Gross national income per capita: USD 480.<sup>7</sup>
- Government expenditure on health: 7.5% of GDP.<sup>8</sup>
- Government expenditure on education: 3.3% of GDP.<sup>9</sup>
- Population below the poverty line: 28.6% (below national poverty line); 34.7% (below USD 1 a day poverty line); 79.9% (below USD 2 a day poverty line).<sup>10</sup>

### WOMEN'S STATUS

- Life expectancy: 64.6 (female) and 63.2 (male).<sup>11</sup>
- Average age at marriage: 18.7 (female) and 23.4 (male).<sup>12</sup>
- Labor force participation: 43.5% (female) and 87.6% (male).<sup>13</sup>
- Percentage of employed women in agricultural labor force: 31.<sup>14</sup>
- Percentage of women among administrative and managerial workers: Information unavailable.<sup>15</sup>
- Literacy rate among population aged 15 and older: 45.4% (female) and 68.4% (male).<sup>16</sup>
- Percentage of female-headed households: 9.<sup>17</sup>
- Percentage of seats held by women in national government: 9.<sup>18</sup>

### CONTRACEPTION

- Total fertility rate: 3.01 lifetime births per woman.<sup>19</sup>
- Contraceptive prevalence rate among married women aged 15–49: 48% (any method) and 43% (modern methods).<sup>20</sup>
- Prevalence of sterilization among couples: 30.7% (total); 27.3% (female); 3.4% (male).<sup>21</sup>
- Sterilization as a percentage of overall contraceptive prevalence: 75.6.<sup>22</sup>

### MATERNAL HEALTH

- Lifetime risk of maternal death: 1 in 55 women.<sup>23</sup>
- Maternal mortality ratio per 100,000 live births: 540.<sup>24</sup>
- Percentage of pregnant women with anemia: 88.<sup>25</sup>
- Percentage of births monitored by trained attendants: 42.<sup>26</sup>

**ABORTION**

- Total number of abortions per year: 566,500.<sup>27</sup>
- Annual number of hospitalizations for abortion-related complications: Information unavailable.<sup>28</sup>
- Rate of abortion per 1,000 women aged 15–44: 2.7.<sup>29</sup>
- Breakdown by age of women obtaining abortions: 6.1% (under 20); 28.2% (between 20–24); 35.8% (between 25–29); 20.4% (between 30–34); 7.4% (between 35–39); 1.6% (40 or older).<sup>30</sup>
- Percentage of abortions that are obtained by married women: Information unavailable.<sup>31</sup>

**SEXUALLY TRANSMISSIBLE INFECTIONS (STIs)**

- Number of people living with sexually transmissible infections: Information unavailable.
- Number of people living with HIV/AIDS: 3,970,000.<sup>32</sup>
- Percentage of people aged 15–24 living with HIV/AIDS: 0.7 (female) and 0.3 (male).<sup>33</sup>
- Estimated number of deaths due to AIDS: Information unavailable.<sup>34</sup>

**CHILDREN AND ADOLESCENTS**

- Infant mortality rate per 1,000 live births: 64.<sup>35</sup>
- Under five mortality rate per 1,000 live births: 92 (female) and 79 (male).<sup>36</sup>
- Gross primary school enrollment ratio: 92 (female) and 111 (male).<sup>37</sup>
- Primary school completion rate: 65% (female) and 70% (male).<sup>38</sup>
- Number of births per 1,000 women aged 15–19: 45.<sup>39</sup>
- Contraceptive prevalence rates among married female adolescents: 4.7% (modern methods); 3.3% (traditional methods); 8.0% (any method).<sup>40</sup>
- Percentage of abortions that are obtained by women younger than 20: 6.1.<sup>41</sup>
- Number of children under the age of 15 living with HIV/AIDS: 170,000.<sup>42</sup>

## ENDNOTES

1. See UNITED NATIONS POPULATION FUND (UNFPA), THE STATE OF WORLD POPULATION 2003, at 75 (2003) [hereinafter STATE OF WORLD POPULATION 2003]. Estimates for 2003.
2. See United Nations Population Fund (UNFPA), UNFPA Country Profiles, available at <http://www.unfpa.org/profile/default.cfm> (last visited Aug. 12, 2003) [hereinafter UNFPA Country Profiles]. Estimates for 2001.
3. See THE WORLD BANK, WORLD DEVELOPMENT INDICATORS 2003, at 39 (2003) [hereinafter WORLD DEVELOPMENT INDICATORS 2003]. Estimates for 2001.
4. See UNFPA Country Profiles, *supra* note 2.
5. See STATE OF WORLD POPULATION 2003, *supra* note 1, at 75.
6. See WORLD DEVELOPMENT INDICATORS 2003, *supra* note 3, at 187.
7. See THE WORLD BANK, WORLD DEVELOPMENT INDICATORS 2003, DATA QUERY, available at <http://devdata.worldbank.org/data-query/> (last visited Feb. 24, 2004). The statistical figure was obtained through the Atlas method. Estimates for 2002.
8. See STATE OF WORLD POPULATION 2003, *supra* note 1, at 75.
9. See United Nations, Infonation, Government Education Expenditure, available at [http://www.un.org/Pubs/CyberSchoolBus/infonation/\\_e\\_infonation.htm](http://www.un.org/Pubs/CyberSchoolBus/infonation/_e_infonation.htm) (last visited Dec. 18, 2003). Estimates for 1990-99.
10. See WORLD DEVELOPMENT INDICATORS 2003, *supra* note 3, at 59. The statistical figures were based on 1999-2000.
11. See STATE OF WORLD POPULATION 2003, *supra* note 1, at 71. The government reports that from 1993 to 1997, life expectancy for women was 61.8 years, compared with 60.4 years for men. See Ministry of Finance, Government of India, Economic Survey 2000-2001, Family Welfare, available at <http://indiabudget.nic.in/es2001-02/welcome.html> (last visited Aug. 22, 2003).
12. See UNFPA Country Profiles, *supra* note 2.
13. See *id.*
14. See World Health Organization South-East Asia Region (WHOSEA), Women's Health in South-East Asia, Women's health and development indicators- India, at [http://w3.whosea.org/women/regtab\\_ind.htm](http://w3.whosea.org/women/regtab_ind.htm) (last visited Aug. 19, 2003).
15. While THE WORLD'S WOMEN 2000 provides statistics for other countries, the information for India is unavailable.
16. See UNFPA Country Profiles, *supra* note 2. The government reports that 46% of women were illiterate compared with 24% of men. See Ministry of Finance, Government of India, Economic Survey 2000-2001, available at <http://indiabudget.nic.in/es2001-02/welcome.html> (last visited Aug. 22, 2003).
17. See UNITED NATIONS, THE WORLD'S WOMEN 2000, at 48 (2000).
18. See SAVE THE CHILDREN, STATE OF WORLD'S MOTHERS 2003, at 40 (2003) [hereinafter STATE OF WORLD'S MOTHERS 2003]. Estimates for 1998. This indicator represents the percentage of seats in national legislatures or parliaments occupied by women.
19. See STATE OF WORLD POPULATION 2003, *supra* note 1, at 75. The government reports that the total fertility rate in 1998 was 3.2 lifetime births per woman. See Ministry of Finance, Government of India, Economic Survey 2000-2001, Family Welfare, available at <http://indiabudget.nic.in/es2001-02/welcome.html> (last visited Aug. 22, 2003).
20. See *id.*
21. See ENGENDERHEALTH, CONTRACEPTIVE STERILIZATION: GLOBAL ISSUES AND TRENDS, tbl. 2.2, at 47 (2002). Estimates for 1992-93.
22. See *id.*, tbl. 2.5, at 55.
23. See WHO ET AL., MATERNAL MORTALITY IN 1995: ESTIMATES DEVELOPED BY WHO, UNITED NATIONS CHILDREN'S FUND (UNICEF), UNFPA 44 (2001). Estimates for 1995.
24. See STATE OF WORLD POPULATION 2003, *supra* note 1, at 71.
25. See STATE OF WORLD'S MOTHERS 2003, *supra* note 18, at 40.
26. See STATE OF WORLD POPULATION 2003, *supra* note 1, at 75.
27. See Stanley K. Henshaw et al., *The Incidence of Abortion Worldwide*, 25 INT'L FAM. PLANNING PERSP. S30-S38 (Supp. 1999), available at <http://www.agi-usa.org/pubs/journals/25s3099.html> (last visited Aug. 19, 2003). Estimates for 1995-1996.
28. While the article, *The Incidence of Abortion Worldwide* in International Family Planning Perspectives, provides statistics for Bangladesh, the information for India is unavailable.
29. See United Nations, Population Division, Department of Economic and Social Affairs, United Nations World Abortion Policies 1999, U.N. Doc. ST/ESA/SER.A/178 (1999), available at <http://www.un.org/esa/population/publications/abt/abt.htm> (last visited Aug. 20, 2003). Estimates for 1995/1996.
30. See Akinrinola Bankole et al., *Characteristics of Women Who Obtain Induced Abortion: A Worldwide Review*, 25 INT'L FAM. PLANNING PERSP. 68-77 (1999) [hereinafter Akinrinola Bankole et al.], available at <http://www.agi-usa.org/pubs/journals/2506899.html> (last visited Aug. 21, 2003). The statistical figures were obtained through incomplete national statistics. Estimates for 1995-1996.
31. While the article, *Characteristics of Women Who Obtain Induced Abortion: A Worldwide Review* in International Family Planning Perspectives, provides statistics for Bangladesh, Nepal and Sri Lanka, the information for India is unavailable.
32. See UNAIDS & WORLD HEALTH ORGANIZATION (WHO), EPIDEMIOLOGICAL FACT SHEETS ON HIV/AIDS AND SEXUALLY TRANSMITTED INFECTIONS UPDATED 18 AUGUST 2003: INDIA 2 (2003), available at <http://www.who.int/GlobalAtlas/home.asp> (last visited Aug. 18, 2003) [hereinafter UNAIDS]. Estimates for 2001.
33. See STATE OF WORLD POPULATION 2003, *supra* note 1, at 75.
34. While the UNAIDS and WHO provide statistics for other countries, the information for India is unavailable in the report.
35. See STATE OF WORLD POPULATION 2003, *supra* note 1, at 71.
36. See UNFPA Country Profiles, *supra* note 2.
37. See STATE OF WORLD POPULATION 2003, *supra* note 1, at 71. The ratios indicate the number of students enrolled per 100 individuals in the appropriate age-group. The ratio may be more than 100 because the figures remain uncorrected for individuals who are older than the level-appropriate age due to late starts, interrupted schooling or grade repetition.
38. See *id.*
39. See *id.*
40. See Saroj Pachauri & K.G. Santhya, *Reproductive Choices for Asian Adolescents: A Focus on Contraceptive Behavior*, 28 INT'L FAM. PLANNING PERSP. 186-195 (2002), available at <http://www.agi-usa.org/pubs/journals/2818602t.html> (last visited Aug. 21, 2003). Estimates for 1998-1999.
41. See Akinrinola Bankole et al., *supra* note 30. The statistical figures were obtained through incomplete national statistics.
42. See UNAIDS, *supra* note 32, at 2.

India represents part of the former Indus Valley civilization, one of the first great civilizations of the world. India was also part of the former British Empire and remained a British colony for almost 250 years. In 1947, the country gained independence from the British and the Indian subcontinent was partitioned into present-day India and Pakistan, including modern-day Bangladesh.<sup>1</sup> Jawaharlal Nehru became prime minister of secular India and ruled from independence until his death in 1964.<sup>2</sup>

In 1966, Nehru's daughter, Indira Gandhi, took over as prime minister.<sup>3</sup> In the mid-1970s, she came under intense criticism for abusing her governing powers, and her 1971 election victory was invalidated in 1975. In response to demands for her resignation, Gandhi declared a state of emergency, ordered mass arrests of opposition figures and suspended many civil liberties.<sup>4</sup> Gandhi was harshly criticized for her new policies, including a compulsory birth control program.<sup>5</sup> She was defeated by Morarji Desai in the 1977 elections.<sup>6</sup> Gandhi returned to power in 1980, but was assassinated by her bodyguards four years later. Her son, Rajiv Gandhi, led the Congress Party to a sweeping victory and succeeded her as prime minister for the next four years. He was assassinated in 1991 during his campaign for re-election.<sup>7</sup> The party won a plurality in parliament in 1991, but lost at the polls in 1996. Since that time, no single party has held an absolute majority in India's parliament. In 1998, Atal Bihari Vajpayee of the Hindu nationalist Bharatiya Janata Party became prime minister.<sup>8</sup> He formed a coalition government that has held power ever since.

India has an estimated population of 1,027,015,247, approximately 48.3% of which is female.<sup>9</sup> Although the gender ratio varies by state, the 2001 national ratio was estimated at 933 females per 1000 males—a decline from 972 females per 1,000 males in 1901.<sup>10</sup>

India's official languages are Hindi and English, but the Constitution of India recognizes 15 official regional languages and more than 1,500 other languages and dialects.<sup>11</sup> The majority of India's population is Hindu (82.6%), but other religious groups include Muslims (11.3%), Christians (2.4%), Sikhs (2%), and Buddhists and Jains (1.19% together).<sup>12</sup> According to available census data, there are also 79,382 Parsis, or followers of the Zoroastrian faith, and 5,271 Jews living in India.<sup>13</sup>

India has been a state party to the United Nations since 1945.<sup>14</sup> It is also a member of the South Asian Association for Regional Cooperation (SAARC) and the Commonwealth of Nations, an organization of countries formerly part of the British Empire.<sup>15</sup>

## I. Setting the Stage: The Legal and Political Framework of India

Fundamental rights are rooted in a nation's legal and political framework, as established by its constitution. The principles and goals enshrined in a constitution, along with the processes it prescribes for advancing them, determine the extent to which these basic rights are enjoyed and protected. A constitution that upholds equality, liberty and social justice can provide a sound basis for the realization of women's human rights, including their reproductive rights. Likewise, a political system committed to democracy and the rule of law is critical to establishing an environment for advancing these rights. The following section outlines India's legal and political framework.

### A. THE STRUCTURE OF NATIONAL GOVERNMENT

The Constitution of India came into force in 1950.<sup>16</sup> The preamble establishes India as a "sovereign, socialist, secular democratic republic" that secures "justice, liberty, equality, and fraternity" to all its citizens.<sup>17</sup> With 380 (originally 395) articles and ten schedules, the Constitution of India is one of the world's longest and most detailed.<sup>18</sup> It is also one of the most frequently amended—between 1950 and 1991, the constitution had been amended more than 75 times.<sup>19</sup> The Union, as India's central government is known, is divided into three distinct but interrelated branches: executive, legislative and judicial.<sup>20</sup>

#### *Executive branch*

The president is the "Constitutional head of the Union."<sup>21</sup> He or she also serves as supreme commander of the armed forces.<sup>22</sup> The president has the power to appoint the prime minister, cabinet members, governors of states and union territories, and justices for both the Supreme Court and high courts throughout the country.<sup>23</sup> He or she may also summon and prorogue parliament, as well as dissolve the *Lok Sabha* (House of the People) and call for new elections.<sup>24</sup> The president also has the power to dismiss state and union territory governments.<sup>25</sup> Although the constitution vests an array of powers in the president, in practice the position is predominantly symbolic and ceremonial.<sup>26</sup>

The president is elected for a five-year term by an electoral college consisting of elected members of both houses of parliament and the legislative assemblies of the states.<sup>27</sup> Either house of parliament may charge the president with violating the constitution and may impeach him or her with a two-thirds vote.<sup>28</sup>

The prime minister is the most powerful figure in the gov-

ernment.<sup>29</sup> He or she is usually the leader of the majority party in the *Lok Sabha*.<sup>30</sup> The prime minister serves as head of the Council of Ministers, a body mandated by the constitution and composed of members of parliament who are collectively responsible to the *Lok Sabha*.<sup>31</sup> The president must act in accordance with the advice of the council.<sup>32</sup> The prime minister's duties include advising the president on the appointment of other ministers to the council, informing the president of all council decisions and presenting legislative proposals to the president.<sup>33</sup>

#### **Legislative branch**

Parliament consists of two houses, the *Rajya Sabha* (Council of States) and the *Lok Sabha*.<sup>34</sup> The *Rajya Sabha*, the upper house, may consist of no more than 250 members; the president nominates 12 members on the basis of their expertise in literature, science, art, or social service, and the remaining members are elected by the legislative assemblies of each state.<sup>35</sup> Each member serves for five years, with one-third of the membership retiring every two years.<sup>36</sup> The *Rajya Sabha* is not subject to dissolution.<sup>37</sup>

The *Lok Sabha* may consist of no more than 530 members directly elected from territorial constituencies in the states, and no more than 20 members to represent union territories.<sup>38</sup> The number of seats for each state is proportional to its population, and the allocation of seats is readjusted after each census.<sup>39</sup> Members serve for five years, after which point the entire house dissolves, unless the president dissolves it first.<sup>40</sup>

The "Women's Reservation Bill," introduced in 1996 as the 81<sup>st</sup> Amendment to the Constitution, is currently pending in parliament.<sup>41</sup> If passed, this bill would require one-third of seats in parliament and state legislatures to be reserved for women.<sup>42</sup>

Parliament's principal function is to legislate on matters within its constitutional jurisdiction.<sup>43</sup> Parliament alone has the authority to amend the constitution.<sup>44</sup> All parliamentary bills, with the exception of certain financial bills, may originate in either house.<sup>45</sup>

The constitution enumerates the separate and shared legislative powers of parliament and state legislatures in three separate lists: the Union List, the State List and the Concurrent List.<sup>46</sup> Parliament has exclusive legislative power over all items on the Union List, which include defense; foreign affairs; citizenship and naturalization; jurisdiction and powers of the Supreme Court; and jurisdiction and powers of all courts except the Supreme Court with respect to exclusively federal issues.<sup>47</sup> The constitution also grants parliament the exclusive power to legislate on matters not on the State or Concurrent Lists.<sup>48</sup>

Parliament and state legislatures share authority over matters on the Concurrent List, which include criminal law and procedure; marriage, divorce and all other personal law mat-

ters; economic and social planning; population control and family planning; social security and social insurance; employment; education; legal and medical professions; and prevention of the transmission of infectious or contagious diseases.<sup>49</sup> Laws passed by parliament with respect to matters on the Concurrent List supercede laws passed by state legislatures.<sup>50</sup>

Parliament generally has no power to legislate on items from the State List, including public health, hospitals and sanitation. However, two-thirds of the *Rajya Sabha* may vote to allow parliament to pass binding legislation on any state issue if "necessary or expedient in the national interest."<sup>51</sup> In addition, two or more states may ask parliament to legislate on an issue that is otherwise reserved for the state.<sup>52</sup> Other states may then choose to adopt the resulting legislation.<sup>53</sup>

In addition to its legislative powers, parliament has the authority to approve or remove members of the Council of Ministers, approve central government finances, authorize presidential orders for the removal of Supreme Court justices, and establish or eliminate states and union territories or change their boundaries and names.<sup>54</sup>

## **B. THE STRUCTURE OF LOCAL GOVERNMENTS**

India is a union of 28 states and seven union territories administered by the central government.<sup>55</sup> The structure and powers of state and union territory governments are prescribed by the constitution.

#### **Executive branch**

The constitution provides for a governor to head each state.<sup>56</sup> The president, in consultation with the prime minister, appoints governors to five-year terms.<sup>57</sup> Governors must act in accordance with the advice of the state Council of Ministers, which is headed by a chief minister and composed of members of the state legislature.<sup>58</sup> The governor appoints the chief minister, who is usually majority leader of the state legislature, and selects other ministers in consultation with the chief minister.<sup>59</sup>

India's seven union territories include the capital of Delhi, two groups of islands in the Bay of Bengal and the Arabian Sea, and cities and regions within states. The central government oversees the union territories through an administrator who is appointed by the president to act on his or her behalf.<sup>60</sup>

#### **Legislative branch**

The constitution requires each state to have a legislature that may consist of either one or two houses.<sup>61</sup> The number of seats in each state legislature is proportional to the population of territorial constituencies within the state.<sup>62</sup>

Not all union territories have a legislature, and parliament may directly legislate for union territories on issues that it may not normally legislate on for states.<sup>63</sup> Out of the seven union

territories, only two have elected legislative assemblies: Delhi and Pondicherry.<sup>64</sup> Though Delhi remains a union territory, the 69<sup>th</sup> Amendment to the Constitution, passed in 1991, empowered the national capital territory to directly elect members of its legislature and pass its own laws with respect to virtually every matter on the State or Concurrent List.<sup>65</sup>

The 73<sup>rd</sup> and 74<sup>th</sup> Amendments to the Constitution, which were passed in 1992, confer constitutional validity and status on urban and rural institutions of local governance.<sup>66</sup> The amendments direct states to establish *panchayats* (local governing bodies in rural areas) and *nagar palikas* (local governing bodies in urban areas), and to empower them to function as effective units of self-government.<sup>67</sup> The amendments provide for direct elections for all governing bodies and reserve one-third of the total number of seats in each body for women.<sup>68</sup> Seats are also reserved for the scheduled castes and scheduled tribes, one-third of which are reserved for women.<sup>69</sup> Women must also fill a proportion of the chairperson positions in each body.<sup>70</sup> The amendments also authorize states to empower *panchayats* and *nagar palikas* to develop and implement “economic development and social justice” plans for their communities with respect to a number of issues, including poverty alleviation and public health.<sup>71</sup> Issues specifically within the domain of *panchayats* include “family welfare” and women and children’s development.<sup>72</sup>

### C. THE JUDICIAL BRANCH

The constitution provides for a complex network of courts to administer national and state laws. The Supreme Court is the highest court in the judicial system and is the final arbiter of the constitution.<sup>73</sup> Its decisions are binding on all subordinate courts.<sup>74</sup> It has original and exclusive jurisdiction over suits between the central government and states or union territories and between different states and union territories, as well as appellate jurisdiction over all civil and criminal cases involving substantial constitutional issues.<sup>75</sup> It can also issue advisory rulings on issues referred to it by the president.<sup>76</sup> A unique component of the court’s jurisdiction is “public interest litigation,” or lawsuits involving issues that affect the interest of the general public.<sup>77</sup> Any individual or group of individuals may invoke such jurisdiction by filing a petition with the court or by writing a letter to the chief justice of India raising an issue of public importance.<sup>78</sup> Twenty-five associate judges and one chief justice serve on the Supreme Court.<sup>79</sup> The president appoints the chief justice and consults with him or her about the appointment of associate judges.<sup>80</sup> Parliament is not required to approve these appointments.<sup>81</sup> In general, justices may not be removed from office until mandatory retirement at age 65.<sup>82</sup> However, a parliamentary

majority may vote to remove a justice on grounds of “misbehaviour or incapacity.”<sup>83</sup>

Beneath the Supreme Court is a system of 18 high courts that serve one or more of India’s states and union territories.<sup>84</sup> The president appoints a chief justice and other judges to each high court in consultation with the chief justice of the Supreme Court and the relevant state governor.<sup>85</sup> State high court judges serve until mandatory retirement at age 62, but may be removed sooner in the same manner as Supreme Court judges.<sup>86</sup> Below high courts are district courts, which hear civil cases, and sessions courts, which hear criminal cases.<sup>87</sup> Each of these courts serves one *zilla* (district) within a state and is subordinate to its respective high court.<sup>88</sup> The judges for these courts are appointed by the relevant state governor in consultation with the state’s high court.<sup>89</sup>

A number of states have established district family courts pursuant to the 1984 Family Courts Act, which was passed in an effort to expedite the settlement of disputes relating to marriage and family affairs.<sup>90</sup> Family courts are headed by one or more judges and a preference is given to female appointees.<sup>91</sup>

A hierarchy of judicial officials exists below the district level.<sup>92</sup> Civil cases are filed in *munsif* (subdistrict) courts and lesser criminal cases are heard in subordinate magistrates’ courts, which are under the immediate supervisory authority of a district magistrate and the ultimate authority of the state’s high court.<sup>93</sup>

The constitution also authorizes parliament or the appropriate legislature to establish administrative or other special tribunals to resolve disputes involving the recruitment and service conditions of public servants; taxation; foreign trade; labor; certain land, property and tenancy issues; and other specified matters.<sup>94</sup>

In order to create greater access to India’s judicial system, the government began providing legal aid services in the 1970s and later appointed a committee to monitor and implement legal aid programs nationwide.<sup>95</sup> Pursuant to the 1987 Legal Services Authorities Act, statutory legal service institutions were established at the national, state and district levels for delivery of free legal aid to underprivileged groups, including women.<sup>96</sup> At the national level, the Supreme Court Legal Aid Committee provides an attorney and financial aid covering litigation costs to low-income individuals and other designated persons, including women and children, who wish to bring a claim before the court.<sup>97</sup>

#### **Customary forms of alternative dispute resolution**

*Lok adalats* (people’s courts) existed for many years as informal dispute resolution forums for low-income citizens.<sup>98</sup> The Legal Services Authorities Act, in addition to its other purposes, was enacted to give statutory backing to such institutions.<sup>99</sup>

A 2002 Amendment to the act provided for the establishment of permanent *lok adalats* with jurisdiction over cases involving public utilities services, including air; road and water transportation; telegraph or telephone services; power; water; sanitation; hospitals; and insurance.<sup>100</sup> Their jurisdiction is, however, limited to cases involving damages of up to Rupees 1,000,000 (approximately USD 22,000).<sup>101</sup> The permanent *lok adalats* are authorized to adjudicate pre-litigation disputes and issue binding awards in accordance with the “principles of natural justice, objectivity, fair play [and] equity.”<sup>102</sup> The objective of the amendment is to “decongest the existing courts.”<sup>103</sup>

#### **D. THE ROLE OF CIVIL SOCIETY AND NON-GOVERNMENTAL ORGANIZATIONS (NGOs)**

The government established the Central Social Welfare Board in 1953 to assist voluntary organizations and mobilize their efforts in developing social welfare services, especially for women and children.<sup>104</sup> The Board has networked with over 20,000 voluntary organizations across the country.<sup>105</sup>

There are more than 12,000 active NGOs throughout India that work in various fields, including credit schemes and income-generating activities for low-income women, as well as access to health care, education and literacy programs.<sup>106</sup> The Voluntary Health Association of India is a dominant presence in the non-profit health sector, comprising a network of 24 State Voluntary Health Associations and linking more than 4000 health-care institutions and grassroots-level community health programs across the country.<sup>107</sup>

#### **E. SOURCES OF LAW AND POLICY**

##### ***Domestic sources***

The main domestic sources of law are the constitution, central and state statutes, domestic jurisprudence, and personal and customary law.<sup>108</sup>

The constitution is the supreme law of the land. It is the source of the authority of all state institutions and creates the framework within which they discharge their duties.<sup>109</sup> It establishes a system of governance and makes detailed provisions regarding legally enforceable, fundamental rights of citizens and other persons.<sup>110</sup> It also issues broad directives to the state, called the Directive Principles of State Policy, that are not legally enforceable but help guide the different organs of state in discharging their functions.<sup>111</sup>

In 2000, the government founded the National Commission to Review the Working of the Constitution to evaluate the effectiveness of the constitution some 50 years after its adoption and to make any recommendations for change based on the modern needs of governance and socio-economic development.<sup>112</sup> The commission submitted its final

report in April 2002.<sup>113</sup> Its principal recommendations with regard to the constitution’s guarantee of fundamental rights included the following:

- extending the prohibition against discrimination to ethnic or social origin, political or other opinion, property, or birth;
- inserting a new article guaranteeing the right to respect for one’s private and family life, home and correspondence;
- inserting a new article requiring the state to establish a legal right to rural wage employment for a minimum of 80 days per year; and
- guaranteeing children the right to care and assistance in the fulfillment of basic needs and protection from all forms of neglect, harm and exploitation.<sup>114</sup>

The commission also recommended that population control through education and the furthering of a normative standard of the small family be added as a new Directive Principle of State Policy in the constitution.<sup>115</sup> It also recommended strengthening constitutional provisions relating to the “protection and promotion of the interests of Scheduled Castes and Scheduled Tribes, Backward classes, women, minorities and other weaker sections” by amendments and other measures.<sup>116</sup>

The 1860 Indian Penal Code, 1973 Code of Criminal Procedure, 1872 Indian Evidence Act, and 1908 Code of Civil Procedure are codified civil and criminal laws that apply to all citizens, regardless of religious or ethnic affiliation. The constitution directs the state to adopt a uniform civil code for all its citizens, but no such code has been enacted to date.<sup>117</sup>

Numerous national laws address civil rights-related issues such as labor, tax, insurance, and property. Acts that specifically address human rights include the 1993 Protection of Human Rights Act, the 1993 National Commission for Backward Classes Act, the 1992 National Commission for Minorities Act, and the 1995 Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act.

Other sources of primary law include statutes enacted by state and union territory legislatures. National laws always supercede state laws to the extent that they conflict: a trumped state law becomes “void unless it has received the assent of the President, and in such case, shall prevail in that state.”<sup>118</sup>

The Law Commission is a non-statutory body reconstituted by the government every three years to review all existing legislation and propose legal reforms in the interests of “maximising justice in society and promoting good governance under the rule of law.”<sup>119</sup> The National Commission for Women, established in 1992, and the National Human Rights Commission, established in 1993, are charged with reviewing and suggesting reforms to existing national laws

that involve issues of gender and human rights.<sup>120</sup>

Rules, regulations and by-laws developed by the central and state governments and local bodies of governance comprise a vast body of subordinate legislation.<sup>121</sup>

Case law from the Supreme Court and specialized tribunals comprise an important source of secondary law. Supreme Court decisions are binding on all courts and tribunals within India.<sup>122</sup> The judgments of a high court are binding on all subordinate courts and tribunals within its jurisdiction.<sup>123</sup> Such judgments are not binding on other high courts or their subordinate courts, though they do have persuasive value.<sup>124</sup>

The major religious communities in India—Hindus, Muslims, Christians, and Parsis—each have their own set of religious personal laws that generally govern issues involving family relations and private life, including marriage, divorce, maintenance, inheritance, adoption, and guardianship.<sup>125</sup> These laws are generally codified, with the exception of Muslim personal law, which is largely uncodified.<sup>126</sup> Buddhists, Jains and Sikhs constitute other major religious groups, but fall within the broad legal definition of “Hindu” and are thus governed by Hindu personal laws.<sup>127</sup> The central government has adopted “a policy of non-interference in the personal laws of any [religious] community unless the demand for change comes from within those communities.”<sup>128</sup> Hindu personal law has been reformed extensively to incorporate constitutional provisions.<sup>129</sup> With the exception of Parsi personal laws, the personal laws of other religious communities have been left virtually untouched.<sup>130</sup> Customary law governs matters of family and private life among tribal communities in India.<sup>131</sup> In some cases, customary law may trump codified personal laws.<sup>132</sup>

National and state policies are formulated within the broad framework of the constitution and its Directive Principles of State Policy, and are articulated and put into operation through successive five-year development plans. These plans are comprehensive policy documents that set forth the government’s main objectives in various areas of national development, including health, poverty alleviation, education, and population management. They include specific objectives and programmatic measures targeted toward marginalized groups, including women and children. The Tenth Five Year Plan, covering 2002–2007, is currently operative.<sup>133</sup>

#### **International sources**

The constitution enjoins the state to foster respect for international law and treaty obligations.<sup>134</sup> Courts are to interpret a statute according to international law principles to the extent possible. However, courts are bound to follow national laws whenever they conflict with international laws.<sup>135</sup> In the 1997 Supreme Court case *Vishakha v. State of Rajasthan*, the court opined that “[a]ny International Con-

vention not inconsistent with fundamental rights ... must be read into these [statute’s] provisions to enlarge the meaning and content thereof, to promote the object of constitutional guarantee.”<sup>136</sup>

India is state party to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (Children’s Rights Convention), the International Convention on the Elimination of All Forms of Racial Discrimination (Racial Discrimination Convention), the International Covenant on Civil and Political Rights (Civil and Political Rights Covenant) and the International Covenant on Economic, Social and Cultural Rights (Economic, Social and Cultural Rights Covenant).<sup>137</sup> India made a reservation to Article 29, paragraph 1 of CEDAW, which deals with the settling of disputes between states that interpret the convention differently.<sup>138</sup>

The government of India has also participated in several key international conferences and endorsed the development goals and human rights principles contained in the resulting consensus documents. International consensus documents the government has adopted include the 1993 Vienna Declaration and Programme of Action; 1994 International Conference on Population and Development (ICPD) Programme of Action; 1995 Beijing Declaration and Platform for Action; and 2000 United Nations Millennium Declaration.<sup>139</sup>

India has also ratified important regional conventions such as the SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution and the SAARC Convention on Regional Arrangements for the Promotion of Child Welfare in South Asia.<sup>140</sup>

## II. Examining Reproductive Health and Rights

In general, reproductive health issues are addressed through a variety of complementary, and sometimes contradictory, laws and policies. The manner in which these issues are addressed reflects a government’s commitment to advancing reproductive health. The following section presents key legal and policy provisions that together determine women’s reproductive rights and choices in India.

### **A. GENERAL HEALTH LAWS AND POLICIES**

The constitution enjoins the state to make the “improvement of public health” a primary responsibility.<sup>141</sup> The National Health Policy, adopted in 2002, and the Tenth Five Year Plan create the primary framework for the delivery of public



health services, and both aim to raise the health status of the population through ensuring equal access to primary health care for all citizens. The policy prescriptions of the National Health Policy are largely reflected in the Tenth Five Year Plan.<sup>142</sup>

The emphasis on primary health care in India's contemporary health and development policies is rooted in the thinking of the 1946 Bhore Commission Report, which declared that primary health care is a basic right of all individuals, regardless of their ability to pay for services or other socioeconomic factors.<sup>143</sup> The commission established primary health care as the foundation for the public health-care system in India and developed the blueprint for the delivery of primary health-care services in the public sector.<sup>144</sup> India further manifested its commitment to these principles in 1978 at the International Conference on Primary Health Care held in Alma-Ata, USSR, at which it pledged to attain the Alma Ata Declaration's goal of "Health for All" by the year 2000 by striving to ensure all individuals' equal access to primary health-care services.<sup>145</sup>

#### *Objectives*

The primary objective of the National Health Policy is to realize an "acceptable standard of good health" among the general population.<sup>146</sup> To achieve this goal, the policy points to the need to improve access to health services among all social groups and in all areas of the country.<sup>147</sup> It proposes to improve access by establishing new facilities in areas where they are lacking and improving and upgrading existing facilities.<sup>148</sup> The policy sets forth several time-bound objectives, which include the following:

- a reduction in maternal mortality and infant mortality rates to 100 in 100,000 and 30 in 1000, respectively, by 2010;
- zero level of growth of HIV/AIDS by 2007;
- a 50% reduction in mortality due to tuberculosis, malaria and other vector and waterborne diseases by 2010;
- an increase in the utilization of public health facilities from less than 20% to more than 75% by 2010.<sup>149</sup>

The policy also recognizes that women and other "underprivileged" groups disproportionately experience poor access to health services, and it aims to facilitate such groups' access to basic health-care services.<sup>150</sup> Under the policy, the central government is to give top funding priority to programs targeting women's health.<sup>151</sup>

Some of the broad objectives of the Tenth Five Year Plan

also address health issues. The plan recognizes that "economic growth cannot be the only objective of national planning ... over the years, development objectives are being defined not just in terms of increases in GDP or per capita income but more broadly in terms of enhancement of human well being."<sup>152</sup> In view of the importance of citizens' health to national development, the plan commits to providing services such as essential primary health care, emergency life saving services, and services under national programs for disease control and family welfare free of cost to all, and further commits to providing essential health-care services to people living below the poverty line.<sup>153</sup> The plan specifically recognizes the failings of the Ninth Five Year Plan with regard to quality of care objectives and commits to introducing "quality control concepts and tools ... into every aspect of health care in order to ensure that the population and the system benefit from

defined and institutionalized norms, accountability and responsibility."<sup>154</sup>

The plan also proposes to address deficiencies in the government's provision of health-care services to low-income populations in urban slums and remote rural and tribal areas.<sup>155</sup> Strategies and programs for the prevention, control and treatment of communicable diseases comprise continued areas of focus.<sup>156</sup>

#### *Infrastructure of health-care services*

##### *Government facilities*

Health is a shared responsibility of the central and state governments, although it is effectively a state responsibility in terms of execution of policies and services.<sup>157</sup> The Ministry of Health and Family Welfare is the main governmental body in charge of developing national health policies and broad-based public health initiatives and coordinating implementation efforts of states. The ministry's divisions include the Department of Health, the Department of Family Welfare and the Department of Indian Systems of Medicine and Homeopathy.<sup>158</sup>

India has a massive and largely underfunded public health infrastructure through which it primarily finances and delivers curative health-care services and implements centrally sponsored family welfare and disease control programs, including those relating to tuberculosis, HIV/AIDS, malaria, and leprosy.<sup>159</sup>

In urban areas, primary health-care services are delivered through a large network of health facilities, including postpartum centers, urban health posts and urban family welfare centers. There are 550 postpartum centers at the district level and 1,012 centers at the subdistrict level.<sup>160</sup> These facilities provide the following services:

#### **RELEVANT LAWS AND POLICIES**

- National Health Policy, 2002
- Tenth Five Year Plan, 2002-2007
- Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994

- essential obstetric care;
- early detection of complications arising from anemia, bleeding, toxemia, obstructed labor, and sepsis;
- emergency maternity services, including vacuum extraction, delivery by caesarian section, blood transfusion, and manual removal of placenta;
- all public health interventions for baby well-being;
- family planning services for permanent and spacing methods of contraception; and
- satellite outreach services for the population and referral services for subdistrict centers and primary health centers.<sup>161</sup> (See “Maternal Health” for information on government policies addressing maternal health.)

There are presently 871 urban health posts, which provide primary health care, family welfare and maternity services.<sup>162</sup> There are 1083 urban family welfare centers, which also provide family welfare services.<sup>163</sup>

In rural areas, a three-tiered infrastructure of subcenters, primary health centers and community health centers deliver primary health-care services to the rural population. The network of subcenters consists of 137,292 functioning facilities, which serve as the first contact point between the primary health-care system and the community.<sup>164</sup> Subcenters provide basic drugs for women and children’s minor ailments and essential health needs.<sup>165</sup> They are staffed by one male multipurpose worker and one female multipurpose worker/auxiliary midwife-nurse.<sup>166</sup> One female health assistant oversees the work of a group of six subcenters and provides technical guidance and supervision to auxiliary midwife-nurses.<sup>167</sup> More than 97,000 of functioning subcenters are funded by the Department of Family Welfare; the remaining facilities are funded by state governments.<sup>168</sup>

Primary health centers are established and funded by states and generally serve as the first contact point between the village community and a medical officer.<sup>169</sup> There are currently 22,807 functioning primary health centers.<sup>170</sup> These facilities provide “curative, preventive, promotive” health-care and family planning services.<sup>171</sup> Each is staffed by a medical officer and 14 paramedical and other workers, and serves as a referral unit for a group of six subcenters.<sup>172</sup>

Community health centers are similarly established and maintained by states and serve as a referral unit for a group of four primary health centers.<sup>173</sup> Community health centers also provide obstetric care and specialist consultations.<sup>174</sup> There are presently 3,027 functioning community health centers in India.<sup>175</sup> Each is staffed by four medical specialists—a surgeon, physician, gynecologist, and pediatrician—and 21 paramedical and other workers.<sup>176</sup>

A network of government hospitals also delivers primary,

secondary and more specialized health-care services to both the urban and rural population.<sup>177</sup> These include district, sub-district and rural hospitals.<sup>178</sup> The majority of hospitals are located in urban areas.<sup>179</sup>

#### *Privately run facilities*

The private health sector is composed largely of for-profit medically trained providers who operate their own clinics or work in facilities ranging from nursing homes with inpatient facilities that have generally fewer than 30 beds to large corporate hospitals.<sup>180</sup> There are approximately 67,000 private hospitals, accounting for 93% of all hospitals in India, a dramatic increase from an estimated 3,000 private hospitals in 1981.<sup>181</sup> Qualified and registered private doctors and institutions are not readily available in remote rural and tribal areas both because of a lack of social infrastructure and the inability of people to pay.

The private sector also includes a broad range of non-governmental actors. More than 7,000 voluntary agencies are involved in health-related activities, although their services are unevenly distributed among states and generally limited in scope.<sup>182</sup> In addition to providing health services independent of the government, some NGOs help implement government health programs sponsored by the Ministry of Health and Family Welfare.<sup>183</sup> The government also has given funding to some NGOs to establish health-care facilities in rural and marginalized urban areas in an effort to improve the quality and availability of their health services.<sup>184</sup>

#### *Financing and costs of health-care services*

##### *Government financing*

Since independence, successive five-year plans have provided the framework for policy and funding decisions related to the development of India’s health-care infrastructure. Aggregate expenditure for health is about 5.2% of GDP.<sup>185</sup> In contrast, public health investment is about 0.9% of GDP, which the National Health Policy aims to increase to 2.0% by 2010.<sup>186</sup> Spending on health is more often for curative than preventive care.<sup>187</sup> State spending on health accounts for 75%–90% of total public expenditure on health and is largely tied up in salary expenditures.<sup>188</sup>

The central and state governments equally share spending on most national health programs.<sup>189</sup> The central government fully funds national programs relating to disease control, including HIV/AIDS, and family planning.<sup>190</sup> Central government funds also support medical education, training for nurses, emergency relief measures, and pilot projects to develop disease control or other health-care strategies.<sup>191</sup> States are responsible for most spending on primary, secondary and tertiary health institutions.<sup>192</sup>

### *Private and international financing*

Health financing in India is predominantly private.<sup>193</sup> Private health spending accounts for more than 80% of total health spending, one of the highest proportions of private spending in the world.<sup>194</sup> Almost all such spending is out-of-pocket at the point of service.<sup>195</sup> The private sector accounts for most curative care services in the country, although quality and distribution of services varies widely across states.<sup>196</sup> The distribution of private services is heavily skewed toward the highest income groups.<sup>197</sup> Although low-income individuals rely on public services for most of their health-care needs, 79% of outpatient care for those below the poverty line is provided by the private sector.<sup>198</sup> However, this care is generally low quality and provided by untrained practitioners.<sup>199</sup>

Various international organizations and United Nations agencies provide significant technical and material assistance for many health and family welfare programs in India. The World Bank, European Commission, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), and other bilateral donors contribute funding to the Reproductive and Child Health Programme, the country's primary national program focused on reproductive health.<sup>200</sup> The World Bank contributed USD 248.3 million to the first phase of the program, which spanned 1997–2002, and an equal amount for the second phase.<sup>201</sup> The European Commission approved assistance of ECU 200 million while UNFPA provided USD 100 million for the program.<sup>202</sup>

From 2001–2002, the World Health Organization (WHO) contributed funding and technical assistance to the implementation of more than 33 projects.<sup>203</sup> Its funding amounted to approximately USD 13.7 million during this period.<sup>204</sup> Some important WHO activities in India include supplying essential medicines, drugs and kits to primary health centers; helping control the spread of communicable diseases; and providing and promoting health education to low-income individuals and adolescents.<sup>205</sup>

### *Costs*

The Tenth Five Year Plan articulates a “continued commitment” to providing essential primary health care, emergency life saving services, and services under government disease control and family welfare programs free of cost to all individuals.<sup>206</sup> However, user charges currently apply for some health-care services at public facilities, including public hospitals.<sup>207</sup> Hospitalization due to major illness is a cause of debt among all income groups.<sup>208</sup> Individuals receiving inpatient hospital treatment spend 58% of their total annual expenditures on health care.<sup>209</sup>

Less than 10% of the total population is covered by health insurance in the governmental and private sectors, and those

covered are primarily from upper-income groups, or government or industrial employees.<sup>210</sup>

Central government employees and their families living in the capital and 18 other major cities are entitled to health-care coverage through Central Government Health Schemes.<sup>211</sup> Covered services include: outpatient care in all systems of medicine; emergency services in the Allopathic system (Western, curative medical system); free supply of necessary drugs; home visits to patients with serious illnesses; family welfare services; treatment in specialized hospitals in both the public and private sector; and a 90% advance for necessary specialized hospital procedures.<sup>212</sup>

In 1948, the Employees' State Insurance Act introduced a national health insurance program for industrial employees.<sup>213</sup> The act provides for compulsory state insurance for sickness, pregnancy and employment-related injury in all but seasonal factories.<sup>214</sup> Under the act, employees and employers contribute to a fund held and administered by a corporation constituted under the act.<sup>215</sup>

In June 2000, the government launched a new group insurance scheme called Janashree Bima Yojana.<sup>216</sup> The program covers all families below the poverty line in urban and rural areas.<sup>217</sup> In urban areas, coverage extends to people slightly above the poverty line as well.<sup>218</sup> Families receive Rs 20,000 on natural death, Rs 50,000 on death or total permanent disability caused by accident, and Rs 25,000 on partial permanent disability due to an accident.<sup>219</sup>

The Health Ministers Discretionary Grant is a little known source of financial assistance distributed by health ministers to help low-income individuals defray the costs of hospitalization and medical treatment where free health services are unavailable.<sup>220</sup> Low-income individuals qualify for such funds, but there are otherwise no fixed guidelines for determining eligibility.<sup>221</sup> In 1999–2000, a total of Rs 4,489,000 in assistance was distributed to 270 patients.<sup>222</sup>

Public sector insurance companies are designing an insurance scheme called *Janraksha* targeted to needy populations.<sup>223</sup> The program would require subscribers to pay a premium of Rs 1 per day to entitle them to receive inpatient treatment costing up to Rs 30,000 per year at designated hospitals.<sup>224</sup> Covered services also would include outpatient treatment at a cost of up to Rs 2,000 per year at designated clinics such as those in public hospitals, medical colleges, private trust hospitals, and NGO-operated institutions.<sup>225</sup>

Life Insurance Corporation of India launched *Jeevan Bharati* in March 2003, an insurance plan exclusively for women aged 18–50, the benefits of which include coverage for critical illnesses such as cancers of the breast, ovary and fallopian tubes and for congenital defects of newborn babies.<sup>226</sup>

### ***Regulation of health-care providers***

India has established statutory regulatory councils to monitor the standards of medical education, promote medical training and research activities, and oversee the qualifications, registration, and professional conduct of doctors, dentists, nurses, pharmacists, and practitioners of non-traditional medical treatments such as Ayurveda, Siddha, Unani, yoga, and Naturopathy.

The Medical Council of India, established under the 1933 Indian Medical Council Act as repealed by the 1956 Indian Medical Council Act, oversees the licensing, educational standards, training, and research activities of doctors and maintains a register of all qualified medical practitioners in India.<sup>227</sup> The council is also empowered to establish ethical and professional standards for medical practitioners.<sup>228</sup> Violations of prescribed standards may result in the removal of a practitioner's name from a state medical register.<sup>229</sup>

Similarly, the Dental Council of India, the Indian Nursing Council and the Pharmacy Council of India are statutory bodies that regulate the professions they oversee.<sup>230</sup> The Central Council of Indian Medicine and the Central Council of Homeopathy regulate the educational and clinical programs of the Indian Systems of Medicine and Homoeopathy, which include Ayurveda, Siddha, Unani, yoga, and Naturopathy treatments.<sup>231</sup>

State Medical Councils have also been established with similar overall objectives.

The Indian Council of Medical Research is the primary governmental body that formulates, coordinates and promotes biomedical research.<sup>232</sup> The Union Health Minister presides over the council's governing body.<sup>233</sup> The council's research priorities, in line with those of the National Health Policy, include control and management of communicable diseases; fertility control; maternal and child health; and the development of alternative strategies for health-care delivery.<sup>234</sup> The council issued the Ethical Guidelines for Biomedical Research on Human Subjects in 2000. The guidelines provide for the establishment of institutional ethics committees to review all ethical aspects of proposed research protocols and monitor ethical compliance of approved projects.<sup>235</sup> (See "Regulation of Reproductive Technologies and Patients' Rights" sections for more information on the guidelines.)

### ***Regulation of reproductive health technologies***

#### *Assisted reproductive technologies*

There is currently no law that regulates assisted reproductive technologies despite the emergence of a considerable number of specialized hospitals and infertility clinics in India.

The Delhi Artificial Insemination (Human) Act, enacted by the Delhi Legislative Assembly in 1995, legalizes the donation of semen and ova.<sup>236</sup> The act calls for the registration of

all sperm banks that store, sell, donate, and supply semen. It also requires that all semen be tested for HIV infection and prohibits the segregation of sperm according to gender markers for the X or Y chromosome. It mandates the confidentiality of donors and recipients, and requires the written consent of both the woman who is receiving the sperm and her husband. Noncompliance with the act results in strict punishment.<sup>237</sup>

The Ethical Guidelines for Biomedical Research on Human Subjects also address ethical issues involved in assisted reproductive technologies.<sup>238</sup> The guidelines address issues such as informed consent, donor selection protocol, the legitimacy of a child born through assisted reproductive technologies, surrogacy, and the right of children born from such procedures and their adoptive parents to access relevant health information about a child's genetic parents.<sup>239</sup> The guidelines also mandate minimal screening of all relevant parties for sexually transmissible infections (STIs), HIV/AIDS and hepatitis.<sup>240</sup>

The Indian Council of Medical Research and the Draft National Academy of Medical Sciences have formulated the Draft National Guidelines for Accreditation, Supervision and Regulation of Assisted Reproductive Technology clinics in India, which were released for public debate in September 2002.<sup>241</sup> The guidelines address the issues of surrogacy and the rights of the child born through various assisted reproductive technologies.<sup>242</sup> They also express concern about the affordability and feasibility of related services.<sup>243</sup>

The guidelines include the following provisions:

- Assisted reproductive technology clinics must not be a party to any commercial element in donor programs or in gestational surrogacy;
- No assisted reproductive technology procedure shall be done without the spouse's consent;
- Sex selection at any stage—either before or after the fertilization or abortion of embryos of any particular sex—should not be permitted except to avoid the risk of transmission of a genetic abnormality linked to the biological parents or associated with pre-implantation genetic diagnosis;
- Use of sperm donated by a relative or a known friend of either the wife or the husband should not be permitted. It will be the responsibility of the assisted reproductive technology clinic to obtain sperm from appropriate banks;
- No relative or person known to the couple may act as a surrogate;
- Surrogacy by assisted conception should only be considered for patients who are physically or medically unable to carry a pregnancy to term;
- Sperm or egg donors may consent to have their

embryos stored for up to five years for use by another couple or for research purposes;

- The sale or transfer of human embryos or any part thereof, or of gametes in any form and in any way, to parties outside of the country must be prohibited;
- A child born through assisted reproductive technologies is presumed to be the legitimate child of a surrogate couple, born within wedlock and with all the attendant rights of parentage, support and inheritance;
- Although there is no legal bar on an unmarried or single woman receiving artificial insemination, it is universally recommended that this procedure be performed only on married women who have the written consent of their husbands;
- There is an urgent need to treat infertility like any other disease and to require the government, an employer or an insurance carrier to cover all attendant expenses for one child.<sup>244</sup>

#### *Sex determination techniques*

In response to the proliferation and misuse of prenatal diagnostic centers for the purpose of fetal sex determination, leading to female feticide, the national legislature enacted the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act in 1994, which has been amended twice, most recently in 2003.<sup>245</sup> The act prohibits the use of prenatal diagnostic tests for the purpose of determining fetal sex and the practice of “sex selection.”<sup>246</sup> Such tests may only be conducted at registered facilities and for limited purposes, including the detection of chromosomal abnormalities, genetic metabolic diseases, sex-linked genetic disorders, and congenital anomalies.

For a prenatal diagnostic test to be authorized, one or more of the following conditions must be present:

- the pregnant woman is above age 35;
- the pregnant woman has undergone two or more spontaneous abortions or fetal losses;
- the pregnant woman has been exposed to potentially teratogenic agents such as drugs, radiation, infection, or chemicals;
- the pregnant woman or her spouse has a family history of “mental retardation” or “physical deformities”; or
- any other condition specified by a supervisory board constituted under the act.<sup>248</sup>

Where authorized prenatal diagnostic tests are conducted, the act prohibits medical providers from disclosing the fetus’s sex to the pregnant woman or her relatives.<sup>249</sup> The advertisement of fetal sex determination services is also prohibited under the act.<sup>250</sup>

Contravention of the act’s provisions by those performing

or seeking prohibited services is punishable with imprisonment and a fine.<sup>251</sup> Medical practitioners also may have their licenses suspended for a first offense and revoked upon a second offense.<sup>252</sup> A woman who is “compelled” to undergo prenatal testing for the purpose of determining the sex of the fetus or to practice sex selection may not be punished under the act.<sup>253</sup> The act provides a rebuttable presumption that any pregnant woman who undergoes such a test was “compelled” by her husband or other relative.<sup>254</sup>

The act provides for the creation of supervisory boards at the central, state and union territory levels to monitor implementation of the act, advise the government on related policy matters and conduct awareness-raising activities about the practice of sex selection and female feticide.<sup>255</sup>

The 2002 Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations specifically prohibit medical practitioners from performing sex determination tests for the purpose of female feticide.<sup>256</sup> Violations of this provision constitute professional misconduct rendering the physician subject to criminal penalties and disciplinary action from the council.<sup>257</sup>

The Ethical Guidelines for Biomedical Research on Human Subjects address the issue of “prenatal diagnosis.” The guidelines state that “[prenatal diagnosis] should be performed only for reasons relevant to the health of the fetus or the mother. [It] should not be performed solely to select the sex of a child (in the absence of an X-linked disorder).”<sup>258</sup> They urge medical practitioners to “recognize the human and economic costs involved ... and limit its use to situations where there is a clear benefit.”<sup>259</sup>

In September 2003, the Supreme Court directed the central and state governments to enforce laws banning ultrasound scans for the purposes of determining the sex of the fetus.<sup>260</sup>

#### ***Patients’ rights***

There is no single national law that governs patients’ rights. Patients can seek remedial measures against doctors for medical negligence under the 1872 Indian Contract Act, Indian Penal Code, Law of Torts, the 1986 Consumer Protection Act, and the Indian Medical Council Act. Under the Indian Contract Act, a doctor is required to use “reasonable professional skill and care.”<sup>261</sup> A patient may sue under the act for breach of contract in civil court for his or her doctor’s failure to apply this level of skill and care.<sup>262</sup>

Under the Indian Penal Code, medical practitioners can be held criminally liable for causing the death of a patient by negligence.<sup>263</sup> Acts performed without criminal intent and in good faith to prevent other harm, or in good faith with the patient’s express or implied consent or without consent when obtaining consent is impossible, are protected.<sup>264</sup> A patient

may also seek damages for medical negligence under the Law of Torts.

Under the Consumer Protection Act, patients may seek compensation for suffering loss or injury due to their medical practitioner's negligence.<sup>265</sup> Although the act does not expressly protect harm caused by medical services, judgments under the act have held that paid, but not free, medical services are covered by the act.<sup>266</sup> Compensation has been granted in a number of medical negligence cases.<sup>267</sup> Courts have also articulated the duty of medical practitioners to act with a reasonable degree of skill, care and knowledge.<sup>268</sup>

A patient may also file a complaint with the appropriate State Medical Council for an act of professional misconduct by a medical provider.<sup>269</sup> The council would then conduct an inquiry.<sup>270</sup> The council may issue a warning, or suspend or terminate the provider's medical license, but is not empowered to award monetary damages to the patient.<sup>271</sup>

The Ethical Guidelines for Biomedical Research on Human Subjects set forth the duties and rights of medical researchers and human research subjects with respect to issues including informed consent, non-exploitation, privacy, confidentiality, professional competence, accountability, and transparency.<sup>272</sup>

In the 2000 Supreme Court case, *State of Haryana and Others v. Smt Santra*, the court held the state liable for a doctor's negligence in unsuccessfully performing a sterilization procedure after the patient became pregnant as a result of the failed procedure.<sup>273</sup> The court awarded the patient monetary damages.<sup>274</sup>

## **B. REPRODUCTIVE HEALTH LAWS AND POLICIES**

There is no comprehensive national health law or policy on reproductive health. However, several aspects of reproductive health are addressed in the Reproductive and Child Health Programme, a national program aimed at providing integrated health and family welfare services for women and children.<sup>275</sup> The Ministry of Health and Family Welfare reoriented and renamed its former Family Welfare Programme as the Reproductive and Child Health Programme in 1997 to improve the quality, distribution and accessibility of services and to meet the health-care needs of women and children more effectively.<sup>276</sup> The program's key components include the following:

- prevention and management of unwanted pregnancy;
- services to promote safe motherhood;
- services to promote child survival; and
- prevention and treatment of reproductive tract infections and STIs.<sup>277</sup>

The program marked an important shift in the govern-

ment's provision of reproductive health services "from a focus on achieving method-specific contraceptive targets to providing client-centered quality services."<sup>278</sup> It abolished demographic targets and provider incentives that were identified by the central government for contraceptive use, and replaced them with a decentralized participatory approach to planning and monitoring reproductive and child health services, involving *panchayats*, women and community groups.<sup>279</sup> Pursuant to this new approach, health plans are formulated at the primary health center and subcenter levels, not at the national or state level as they were under the Family Welfare Programme.<sup>280</sup> The decentralized participatory approach seeks to adapt the concepts for reproductive health and rights that emerged from the ICPD.<sup>281</sup>

### **Family Planning**

The Reproductive and Child Health Programme and National Population Policy, adopted in 2000, establish the framework for the government's delivery of family planning services.

A key objective of the Reproductive and Child Health Programme is to promote contraceptive use and provide a full range of contraceptive methods, including condoms, oral pills, IUDs, and male and female sterilization.<sup>282</sup>

The National Population Policy aims to address the unmet need for contraception in order to meet the medium-term objective of reducing the national fertility rate to replacement levels by 2010 and the long-term objective of stabilizing the population growth rate by 2045.<sup>283</sup> One of the 14 national socio-demographic goals identified in the policy is to achieve universal access to family planning information, counseling and services, including a wide range of contraceptives.<sup>284</sup>

### **Contraception**

Almost half of married women of reproductive age currently use modern contraceptive methods.<sup>285</sup> There are wide differences between states in the levels of unmet need, with the highest levels in Bihar and Uttar Pradesh.<sup>286</sup> Female sterilization is the most widely known and used method in all states although, again, there are substantial differences between states and districts.<sup>287</sup> Thirty-four percent of currently married women have undergone sterilization, 3% use condoms, 2% use the pill, 2% use IUDs, 2% rely on male sterilization, and 5% use traditional or other methods.<sup>288</sup> Prevalence rates for almost all methods are higher in urban than in rural areas, with condom use more than four times higher in urban than in rural areas.<sup>289</sup> Current contraceptive use peaks at 67% among women age 35–39.<sup>290</sup> The variation in contraceptive use by age is similar across urban and rural areas.<sup>291</sup>

### **Contraception: legal status**

There is no specific statute that exclusively governs or

controls the manufacture, advertisement, sale, or standards of contraceptives. Guidelines about contraception relate primarily to the approval of contraceptives as drugs. The key central statutes are the 1940 Drugs and Cosmetics Act and the 1945 Drugs and Cosmetics Rules.<sup>292</sup> Testing and trials of contraceptives are conducted by the Indian Council of Medical Research.<sup>293</sup>

Emergency contraception pills are available by prescription in family planning clinics, pharmacies and, more recently, in all urban government dispensaries and most rural primary health-care centers.<sup>294</sup> Dedicated Levonorgestral-only products were officially registered in India in January 2002.<sup>295</sup> In April 2003, the Federation of Obstetrics and Gynaecological Society of India established an emergency contraceptive hotline.<sup>296</sup>

In the 1998 Supreme Court case *All India Democratic Women Association v. Union of India*, petitioners challenged the use of the drug quinacrine as a method of female sterilization and contraception.<sup>297</sup> The court disposed of the petition based on the government's assurances that it intended to ban the use of the drug as a method of contraception.<sup>298</sup> A few months later, the government issued a notification banning the import, manufacture, sale, and distribution of quinacrine for use as a contraceptive, and established penalties for violators of the ban.<sup>299</sup>

At the direction of the Supreme Court, the Drugs Technical Advisory Board, a statutory body constituted under the Drugs and Cosmetics Act, issued a statement in 1995 recommending that Depo-Provera not be included in India's family planning programs.<sup>300</sup> In January 2002, the government abandoned its plan to offer injectables through the Reproductive and Child Health Programme.<sup>301</sup> Ministry of Health officials have stated that although injectables will not be offered through government programs, they may be made available in the private sector.<sup>302</sup>

#### *Regulation of information on contraception*

No specific statute regulates the dissemination of information regarding advertisement, promotion or packaging of contraceptives. Media and penal laws determine the legality of publicizing contraceptives. Previously, obscenity laws within the Indian Penal Code prohibited advertising a drug for the

prevention of conception.<sup>303</sup> These rules have since been liberalized to provide *prima facie* protection for "ideas having social importance ... unless obscenity is so gross ... that the interest of the public dictates the other way."<sup>304</sup>

#### *Sterilization*

Female sterilization is the most commonly used form of contraception in India.<sup>305</sup> About 29% of the approximately 74.22 million couples that use a government-approved family planning method are "protected" against conception by sterilization.<sup>306</sup> Female sterilization accounts for 95% of all reported sterilizations.<sup>307</sup> The median age for female sterilization is 25.7.<sup>308</sup> Acceptance of sterilization increased in all major states from 1997 to 1999, specifically, by 15.9% in Andhra Pradesh; 17.6% in Assam; 3.3% in Gujarat; 4.9% in Punjab; 2.2% in Rajasthan; 0.9% in Tamil Nadu; and 12.5% in Uttar Pradesh.<sup>309</sup>

#### *Sterilization: legal status*

No specific central statute regulates the provision of sterilization services. The Standards for Female and Male Sterilization issued by the Ministry of Health and Family Welfare set forth the eligibility criteria for sterilization.<sup>310</sup> Applicants for sterilization must be married.<sup>311</sup> Male applicants should "ideally" be below the age of 60, while female applicants must be between the ages of 22–45.<sup>312</sup> Couples must have at least one child above the age of one.<sup>313</sup> The standards also require that applicants be given counseling prior to undergoing the procedure; applicants should be informed about all available methods of family planning, the permanent nature of the procedure, the risk of complications, and the inability of sterilization to protect against reproductive tract infections, STIs or HIV/AIDS.<sup>314</sup> Applicants should be informed specifically of their

option to decide against sterilization without sacrificing their right to receive other reproductive health services.<sup>315</sup> All counseling should be provided in a language the client can understand.<sup>316</sup> Sterilization may only be performed with the applicant's informed written consent, which should be given free of "coercion" or "physical or mental stress."<sup>317</sup> In the case of pregnant women, the standards prohibit health providers from obtaining a woman's consent when she is "sedated or ... [experiencing] stress associated with some pregnancy-related events/problems."<sup>318</sup> A spouse's written consent is not

---

### RELEVANT LAWS AND POLICIES

- Reproductive and Child Health Programme
- National Population Policy, 2000
- Drugs and Cosmetics Act, 1940; and Drugs and Cosmetics Rules, 1945
- Standards for Female and Male Sterilization, 1999
- National Health Policy, 2002
- Tenth Five Year Plan, 2002-2007
- National Nutrition Policy, 1993
- Medical Termination of Pregnancy Act, 1971
- Indian Penal Code, 1860
- National AIDS Prevention and Control Policy, 2002
- National Blood Policy, 2002

required for sterilization.<sup>319</sup>

#### *Sterilization policies*

Although the Reproductive and Child Health Programme abolished centrally determined targets for method-specific contraceptives, including sterilization, certain government incentives for sterilization still exist. In order to further the goals of the National Population Policy, a government health insurance plan was proposed to provide insurance incentives to couples below the poverty line who are undergoing sterilization.<sup>320</sup> Such couples with no more than two children would be eligible for family health insurance, including hospitalization, of up to Rs 5000 and personal accident insurance for the spouse undergoing the sterilization procedure.<sup>321</sup> In certain states, such as Andhra Pradesh, low-income individuals who are sterilized after one or two children receive priority for anti-poverty benefits, including housing, land, wells, and loans.<sup>322</sup>

#### *Government delivery of family planning services*

In urban areas in India, a network of government hospitals and urban family welfare centers is primarily responsible for providing family planning methods and services. In rural areas, primary health centers and subcenters provide these services.<sup>323</sup>

The public health sector is the source of contraception for 76% of current users of modern methods.<sup>324</sup> Government facilities provide condoms, oral contraceptives and IUDs free of charge.<sup>325</sup> The government launched a Social Marketing Programme for condoms in 1968 and for oral contraceptives in 1987 through which condoms and oral pills are made available by marketing companies or NGOs at highly subsidized rates and through diverse outlets.<sup>326</sup>

Sterilization and IUD insertions are mostly performed in government hospitals and primary health centers.<sup>327</sup> On occasion, sterilization camps are organized in rural or urban areas throughout the country.<sup>328</sup> In 1987, a joint NGO-government program established Centres of Excellence in Medical Colleges in different parts of the country to provide training in government standards for male and female sterilization.<sup>329</sup> A UNFPA-funded non-scalpel vasectomy project is also being implemented by the Ministry of Health and Family Welfare. The project, which will train 1,500 medical personnel throughout the country to perform non-scalpel vasectomies, aims to promote male sterilization and male involvement in furthering family welfare.<sup>330</sup>

To encourage grassroots participation in the formulation of family planning services, the government allows medical personnel at the local and district levels to submit annual action plans and monthly activity reports to district family welfare officers who then inform state and national offi-

cial.<sup>331</sup> The government also instituted an Empowered Action Group in the Ministry of Health and Family Welfare to facilitate the planning of area-specific programs with the involvement of voluntary associations, community organizations and *Panchayat Raj* (local government) institutions.<sup>332</sup> Part of the group's mandate is to explore the possibility of socially marketing contraceptives in order to make them more accessible.<sup>333</sup>

By promoting a participatory approach to family planning services, the National Population Policy stresses the importance of *panchayat* institutions in furthering decentralized planning and program implementation in the context of the policy's goals of meeting unmet need and achieving population stabilization.<sup>334</sup> It urges panchayats to form representative committees to prepare "need-based, demand-driven, socio-demographic plans at the village level."<sup>335</sup>

#### *Family planning services provided by NGOs and the private sector*

Family planning services are provided by private hospitals and clinics as well as NGOs. Despite its provision of more than three-fourths of the country's curative health-care services, the private health sector provides less than one-third of all maternal and child health and family planning services.<sup>336</sup> Seventeen percent of modern contraceptive users rely on the private sector for their supply.<sup>337</sup> The major factors limiting the private sector's participation in family planning services include: the focus until now on curative services; the variable quality of services; and the inability of low-income people to pay for these services.<sup>338</sup> One of the aims of the Tenth Five Year Plan is to more closely involve the private sector in the provision of family planning services.<sup>339</sup>

About 1% of current users of modern contraceptive methods obtain their method from NGOs.<sup>340</sup> The Department of Family Welfare funds roughly 97 large NGOs and more than 800 smaller NGOs in ten states.<sup>341</sup> However, a large number of districts in states with high fertility and mortality rates have no NGO presence.<sup>342</sup> The National Population Policy aims to increase the role of NGOs and voluntary organizations in raising awareness about reproductive and child health interventions and improving community participation. To increase NGO participation, the Department of Family Welfare reached out to several well-established NGOs, such as the Family Planning Association of India and the Voluntary Health Association of India, to help select, train, assist, and monitor smaller NGOs working at the village level.<sup>343</sup>

#### **Maternal Health**

Recent government estimates of India's maternal mortality ratio range from 407 to 540 maternal deaths per 100,000 live births.<sup>344</sup> Maternal deaths account for an estimated 15% of all deaths of women of reproductive age.<sup>345</sup> Most mater-



nal deaths are caused by hemorrhage (29.7%), anemia (19%) and sepsis (16.1%).<sup>346</sup> Over half of all deliveries take place in private homes, while one-third take place in health facilities.<sup>347</sup> Forty-two percent of deliveries are attended by a health professional.<sup>348</sup> Older women as well as women from scheduled tribes, illiterate women and low-income women generally do not receive prenatal checkups.<sup>349</sup>

#### *Policies*

One of the primary goals of the National Health Policy and National Population Policy is to reduce the maternal mortality rate to less than 100 maternal deaths per 100,000 live births by 2010.<sup>350</sup> In support of this goal, the Tenth Five Year Plan gives emphasis to maternal health services including the following:

- essential obstetric care through early registration of pregnancy and screening of pregnant women to detect risk factors;
- identification and management of high-risk mothers;
- appropriate management of anemia and hypertension disorders; and
- referral care for at-risk mothers.<sup>351</sup>

Priority areas also include services for the prevention, detection and management of reproductive tract infections and STIs, and special efforts to promote institutional deliveries and safe home deliveries.<sup>352</sup> The government also commits to making special efforts to promote access to health care during pregnancy at primary health centers.<sup>353</sup>

On the occasion of International Women's Day on March 8, 2003, the Ministry of Health and Family Welfare initiated a program that compensates pregnant women for their travel costs to health centers.<sup>354</sup> The program additionally provides a sum of Rs 1000 for the birth of a daughter and Rs 500 for the birth of a son.<sup>355</sup>

Several initiatives undertaken in previous five-year plans and health policies have been incorporated into the government's current policies. The Universal Immunization Programme, launched in 1985, became part of the Reproductive and Child Health Programme in 1997. As a result of this initiative, the number of pregnant women who were vaccinated against tetanus toxoid more than doubled between the start of the program and 2001.<sup>356</sup> The interventions of the Child Survival and Safe Motherhood Programme, which was launched in 1992 in 72 districts and had expanded to 466 districts by the end of the Eighth Five Year Plan, also became part of the Reproductive and Child Health Programme.<sup>357</sup> During the Ninth Five Year Plan, a training program for *dais* (midwives) was initiated in 142 districts in 15 states.<sup>358</sup> Reproductive Child Health camps were also held to improve access in rural areas to primary-care services.<sup>359</sup>

The government also has launched a nationwide scheme of women's health groups called *Mahila Swasthya Sanghs* in villages. These groups provide a forum for discussing women's health concerns and issues.<sup>360</sup> Group participants also receive short-term training and counseling by local health-care workers as well as educational and informational materials.<sup>361</sup> More than 34,000 such groups have been formed in various states and union territories.<sup>362</sup>

#### *Nutrition*

Approximately one-third of newborn children are of low birth weight, indicating that many pregnant women suffer from nutritional deficiencies.<sup>363</sup>

The constitution's Directive Principles of State Policy enjoin the state "to regard raising the level of nutrition and standard of living of its people and the improvement of public health as among its primary duties."<sup>364</sup>

The 1993 National Nutrition Policy gives special priority to at-risk women, mothers and children.<sup>365</sup> During the Ninth Five Year Plan, several interventions were adopted as part of the policy, including the following:

- screening of all pregnant women and lactating mothers for chronic energy deficiency;
- identifying women who weigh less than 40 kg and providing them with adequate health care before, during and after pregnancy, as well as neonatal care, under the Reproductive and Child Health Programme; and
- ensuring that such women receive food supplementation through the Integrated Child Development Services scheme.<sup>366</sup>

The Integrated Child Development Services scheme, launched in 1975, is a major intervention in combating malnutrition and provides food supplementation to children below age six as well as to expectant and nursing mothers, with a special emphasis on the girl child.<sup>367</sup> It has grown to be the world's largest child development program, covering more than 17 million children and pregnant and lactating mothers.<sup>368</sup>

#### *Abortion*

There is no precise estimate of the total number of induced abortions in India because government data only account for abortions performed in government-approved facilities, which are a fraction of the total number of abortions that occur every year.<sup>369</sup> According to government data, an estimated 1.7% of pregnancies end in induced abortion, although there are wide interstate differences ranging from 0.3% in Bihar to 6% in Manipur.<sup>370</sup> The government also estimates that between 4 million and 6 million abortions are performed illegally and that unsafe abortion accounts for 9% of maternal deaths.<sup>371</sup> Non-governmental studies suggest

that an estimated 6.7 million abortions occur annually and that 4.5% to 16.9% of all maternal deaths result from unsafe abortion.<sup>372</sup>

*Abortion: legal status*

The 1971 Medical Termination of Pregnancy Act sets forth the grounds for legal abortion, which include the following:

- risk to the woman's life;
- grave injury to the woman's physical or mental health; and
- substantial risk of fetal impairment.<sup>373</sup>

In determining whether the continuation of a pregnancy would jeopardize a woman's health, the law permits consideration of socioeconomic factors affecting the woman's "actual or reasonable foreseeable environment."<sup>374</sup> Physical or mental injury to health may also be presumed when the pregnancy is the result of rape or contraceptive failure on the part of the man or woman.<sup>375</sup>

Abortions may only be performed by registered medical practitioners and in government hospitals or facilities approved for abortion by the government or district level committees.<sup>376</sup> For pregnancies of up to 12 weeks, an abortion is permitted upon the good faith opinion of one registered medical practitioner.<sup>377</sup> For pregnancies between 12 and 20 weeks, the opinions of two practitioners are required.<sup>378</sup> For pregnancies beyond 20 weeks, abortion is prohibited except when "immediately necessary to save the life of the pregnant woman."<sup>379</sup> Registered medical practitioners must adhere to an elaborate procedure for reporting abortions performed.<sup>380</sup>

The pregnant woman's consent, or that of a legal guardian where she is a minor or lacks mental capacity, is also required for legal abortion.<sup>381</sup> The consent of the woman's husband is not required. The central government has issued regulations to safeguard the confidentiality of a woman seeking legal abortion.<sup>382</sup>

The government approved the distribution of mifepristone and misoprostol, two drugs used in medical abortion, in March 2002.<sup>383</sup> Medical abortion is available in government-approved hospitals and at all registered abortion clinics.<sup>384</sup> Trials are underway to test the efficacy, dosage and safety of drugs for medical termination of pregnancy between 12 and 20 weeks.<sup>385</sup> Early pilot studies report that medical abortion may be especially beneficial in rural settings and suggest that nurses trained to insert intrauterine devices could also administer the drugs for medical abortion.<sup>386</sup>

The Medical Termination of Pregnancy Act imposes a fine of up to Rs 1,000 for willful contravention of its provisions.<sup>387</sup> Pursuant to amendments to the act in 2002, penalties for unauthorized clinics and unregistered practitioners perform-

ing abortions were increased.<sup>388</sup> The termination of a pregnancy by an unauthorized person or in an unauthorized facility is punishable with two to seven years imprisonment.<sup>389</sup> The owner of an unauthorized facility performing abortion is also subject to the same punishment.<sup>390</sup>

All other penalties are provided in the Indian Penal Code.<sup>391</sup> Any individual, including the pregnant woman herself, who causes a miscarriage for reasons other than to save the life of the mother, is punishable by up to seven years imprisonment and/or fines.<sup>392</sup> The severity of the punishment increases if the woman is at a late stage of pregnancy, which the penal code defines only as "quick with child."<sup>393</sup> The act of causing a miscarriage without the woman's consent is punishable by life imprisonment or a period of ten years and a fine.<sup>394</sup>

*Regulation of information on abortion*

A 2002 Supreme Court directive ordered state governments to enforce the ban on sex-selective abortion and punish clinics that advertise and promote sex-selective abortion.<sup>395</sup>

*Abortion policies*

The Tenth Five Year Plan identifies the improvement and expansion of, and women's access to, early and safe abortion services as continuing areas of government focus.<sup>396</sup> Government strategies for reducing abortion-related morbidity include meeting unmet needs for contraception to reduce the number of pregnancies; improving access to safe abortion services; and "ensuring that women do accept appropriate contraception at the time of [abortion] to prevent unwanted pregnancies requiring a repeat [abortion]."<sup>397</sup>

A major goal of the National Population Policy is the expansion of the availability of safe abortion services.<sup>398</sup> In accordance with this policy and the Reproductive and Child Health Programme, actions have been initiated to improve and expand abortion facilities and women's access to them, particularly in rural areas.<sup>399</sup> Specific strategies for improving women's access to safe abortion services include these:

- decentralizing the registration of abortion clinics from the state to the district level;
- simplifying the regulations for reporting of abortion;
- training physicians in the government, private and voluntary sector in abortion;
- providing manual vacuum aspiration syringes to recognized abortion centers where there is a trained physician but no vacuum aspiration machine;
- using manual vacuum aspiration for performing abortion in community health centers and primary health centers; and
- exploring the feasibility and safety of introducing non-surgical methods of abortion in medical college

hospitals and extending the service in a phased manner to district hospitals.<sup>400</sup>

The National Population Policy also calls for the provision of postabortion care, including services to manage complications and identify other health needs of postabortion patients, and refer them to appropriate services.<sup>401</sup> As part of postabortion care, physicians may also be trained to provide family planning counseling and services such as insertion of IUDs, sterilization, oral contraceptives, and condoms.<sup>402</sup>

*Government delivery of abortion services*

More than 8,500 hospitals and clinics are authorized to perform abortions.<sup>403</sup> The United Nations Special Rapporteur on Violence Against Women has reported that 1,800 of India's 20,000 primary health centers have certified abortion facilities.<sup>404</sup> Less developed but more populous states often have fewer abortion facilities than smaller and more developed states.<sup>405</sup> For example, Maharashtra, a more developed state, has over one-fifth of the country's registered abortion facilities.<sup>406</sup> The four large, less developed states of Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh contain 40% of the country's population but only 16.7% of its total registered facilities.<sup>407</sup>

Not all registered abortion facilities are fully functional or have ever provided abortion services. According to an analysis of abortion facilities in Gujarat, Maharashtra, Uttar Pradesh, and Tamil Nadu from 1995–1997, about one-fourth of the primary health centers in Maharashtra and Uttar Pradesh, one-third of those in Gujarat and one-half of those in Tamil Nadu were providing abortion services.<sup>408</sup> Up to half of surveyed primary health centers had never offered abortion services, even though they were approved as abortion facilities.<sup>409</sup> In contrast, the majority of community health centers, rural hospitals and subdistrict hospitals surveyed were equipped to provide abortion services.<sup>410</sup> According to national regulations, all community health centers, postpartum centers and other higher-level health facilities are expected to provide abortion services.<sup>411</sup> In each of the four states that were surveyed, the main reason abortion services were not offered was the lack of trained providers.<sup>412</sup> Some clinics cited lack of adequate equipment as the primary reason.<sup>413</sup>

To alleviate the shortage of trained providers in primary health centers, community health centers and subdistrict hospitals, the government is assisting states and union territories in hiring doctors trained in abortion techniques to pay weekly or bimonthly visits to these facilities to perform abortions and other reproductive health services.<sup>414</sup>

*Abortion services provided by NGOs and the private sector*

Several NGOs play an important role in providing safe abortion services in India. *Parivar Seva Sanstha*, one of the

country's largest NGOs working in the field of reproductive health, operates abortion care centers in urban areas throughout the country. The Family Planning Association of India provides counseling as well as abortion services at the district level.<sup>415</sup>

To support NGOs in providing abortion services, the government has proposed a plan to provide equipment and free training to authorized abortion facilities in the NGO sector.<sup>416</sup>

***Sexually Transmissible Infections (STIs) and HIV/AIDS***

There are approximately forty million new reported cases of STIs every year.<sup>417</sup> In rural areas, STI treatment facilities are not usually available.<sup>418</sup>

The incidence of HIV/AIDS has been on the rise for more than a decade and has reached alarming proportions in recent years. With nearly four million people infected with HIV, India has the world's second largest population of HIV-infected people.<sup>419</sup> At the end of 2001, there were 1.5 million women living with HIV/AIDS.<sup>420</sup> Studies indicate that a growing number of women attending prenatal clinics are testing HIV-positive.<sup>421</sup>

*Relevant laws*

There is no separate national legislation on STIs or HIV/AIDS. However, there are a number of legal provisions and court decisions that apply to persons living with STIs and HIV/AIDS. Under the Indian Penal Code, negligently or maliciously engaging in any act that one knows is likely to spread the infection of any disease dangerous to life is a crime punishable by imprisonment ranging from six months to two years and possibly a fine.<sup>422</sup> To date, this provision has been applied to STIs such as syphilis and gonorrhea, but it has not been applied to HIV/AIDS.<sup>423</sup>

Under most matrimonial laws, a spouse's infection with a communicable venereal disease is a ground for divorce.<sup>424</sup> To date, there are no reported cases where divorce has been sought on the basis of a spouse's infection with HIV/AIDS.<sup>425</sup>

As stated above, there are no national laws specific to HIV/AIDS. However, the state of Goa has introduced the 1985 Goa, Daman and Diu Public Health Act, as amended by the 1987 Goa Public Health Act, which contains provisions specific to persons affected by HIV/AIDS.<sup>426</sup> This act contains provisions for the isolation of persons found to be sero positive, under certain prescribed conditions.<sup>427</sup> Attempts have been made to introduce HIV/AIDS specific legislation in the legislative assemblies of two more states.<sup>428</sup>

Although there are no laws per se that prohibit discrimination against persons living with STIs or HIV/AIDS, some court decisions have upheld such persons' right to nondiscrimination, primarily in the health-care, employment and armed forces contexts.<sup>429</sup> In *MX v. ZY*, the Bombay High

Court held that the constitutional right to nondiscrimination requires that people living with HIV/AIDS not be refused treatment at public hospitals or terminated from their place of employment in the public sector on the basis of their HIV status.<sup>430</sup> In *Parmanand v. the Union of India*, the Supreme Court held that private health-care providers may not refuse to treat HIV-infected individuals in emergency situations.<sup>431</sup>

Other court decisions have undermined the rights of persons living with HIV/AIDS. In *Mr. X v. Hospital Z*, the Supreme Court ruled that health-care workers are liable under the Indian Penal Code for failing to disclose a patient's HIV status to his or her partner(s).<sup>432</sup> The original ruling also suspended the right of HIV-positive individuals to marry, though this right was later restored in an order issued by the court in December 2002.<sup>433</sup> However, HIV-positive individuals who know their status must still obtain informed consent from their prospective spouses prior to marriage.<sup>434</sup>

There are also several legal standards that address blood safety and transfusion services. In 1993, amendments to the Drugs and Cosmetics Act and accompanying rules required the screening of blood for five transmissible infections, including HIV/AIDS.<sup>435</sup> Blood banks must obtain a license from the relevant authority, and these licenses must be renewed at regular intervals.<sup>436</sup> A 1996 Supreme Court decision also generated key changes in the regulation of the country's blood supply. In *Common Cause v. Union of India and others*, the court set forth mandatory licensing of blood banks, a ban on professional blood donations and strict guidelines for holding blood donation camps.<sup>437</sup>

#### *Policies for the prevention and treatment of STIs and HIV/AIDS*

One year after the first HIV case was identified in 1986, the government formulated the National AIDS Control Program under the Ministry of Health and Family Welfare.<sup>438</sup> In 1992, the Ministry established the National AIDS Control Organization as the focal governmental body for the formulation and implementation of HIV/AIDS-related policies and programmatic initiatives.

In 2002, the government announced the National AIDS Prevention and Control Policy and National Blood Policy. The general objective of the National AIDS Prevention and Control Policy is to contain HIV/AIDS transmission and reduce the impact of the disease on infected persons and on the health and socioeconomic well-being of the general population.<sup>439</sup> One specific target is to achieve a zero growth rate of new HIV infections by 2007.<sup>440</sup> Other objectives include the following:

- creating a socioeconomic environment that helps prevent HIV/AIDS;
- providing care and support to people living with

HIV/AIDS and ensuring the protection and promotion of their human rights, including their rights to access the health-care system, education, employment, and privacy;

- mobilizing the support of NGOs and community-based organizations in initiatives for the prevention and alleviation of HIV/AIDS;
- decentralizing the National AIDS Control Program to the field level with adequate financial and administrative delegation of responsibilities;
- strengthening program management capabilities in state governments, municipal corporations, panchayat institutions, and leading NGOs participating in the National AIDS Control Program;
- integrating the National AIDS Control Program with other national programs such as Reproductive and Child Health, tuberculosis control, and the Integrated Child Development Scheme, and with the primary health-care system;
- preventing women, children and other socially marginalized groups from becoming vulnerable to HIV infection by improving their health education, legal status and economic prospects;
- providing adequate and equitable health care to HIV-infected individuals and drawing attention to the public health rationale for overcoming stigmatization, discrimination and seclusion in society;
- maintaining constant interaction with international and bilateral agencies for support and cooperation in the field of research in vaccines, drugs and emerging systems of health care;
- ensuring the availability of adequate and safe blood and blood products for the general population through promotion of voluntary blood donation; and
- promoting a better understanding of HIV/AIDS among young people, especially students, youth and other sexually active groups.<sup>441</sup>

The National AIDS Prevention and Control Policy also gives special priority to the prevention and control of STIs as a strategy for controlling the spread of HIV/AIDS.<sup>442</sup> The policy provides for the integration of services for treatment of STIs as well as reproductive tract infections at all levels of health care, including:

- strengthening STI clinics in all district hospitals, medical colleges and other facilities by providing technical support, equipment and drugs;
- undertaking a massive training program for all medical and paramedical workers involved in providing services for reproductive tract infections and STIs;

- ensuring that all STI clinics provide counseling services and good quality condoms for STI patients; and
- utilizing NGOs to provide such counseling services at STI clinics.<sup>443</sup>

The National Blood Policy aims to ensure accessibility and adequate supply of safe and quality blood and blood components collected from voluntary and non-remunerated blood donors.<sup>444</sup> The objectives of this policy include the following:

- making available adequate resources to develop and reorganize blood transfusion services in the entire country;
- making the latest technology available for operating blood transfusion services;
- launching extensive awareness programs for donor information, education, motivation, recruitment, and retention in order to ensure a safe blood supply;
- encouraging the appropriate clinical use of blood and blood products;
- encouraging research and development in the field of transfusion medicine and related technology; and
- taking adequate regulatory and legislative steps for the monitoring and evaluation of blood transfusion services and eliminating profiteering in blood banks.<sup>445</sup>

The Action Plan for Blood Safety was developed in 2003 to implement the objectives set forth in the National Blood Policy. The action plan provides for the following:

- accreditation of blood banks;
- disclosure of the status of all infections transmitted through blood transfusions;
- multiagency response through partnerships between government, private sector, the Red Cross Society of India, the Indian Council of Medical Research, Medical Council of India, NGOs, community-based organizations, and others;
- rational use of blood and blood products among clinicians; and
- external quality-control mechanisms for public sector blood banks.<sup>446</sup>

In an effort to expand the range of preventive methods available to women against HIV transmission, the government is considering introducing microbicides—creams or gels that can prevent transmission of STIs and HIV when applied at the mouth or female genitals—in its HIV/AIDS prevention programs.<sup>447</sup>

#### *Regulation of information on STIs and HIV/AIDS*

Restrictions on the right to freedom of expression and information on STIs and HIV/AIDS are traditionally covered by laws governing obscenity, censorship and the public interest.<sup>448</sup> The Indian Penal Code criminalizes the sale,

publication, distribution, and advertisement of “obscene” materials, but does not specifically define “obscene.”<sup>449</sup> The code does not prohibit materials if they are “for the public good.”<sup>450</sup> In May 2000, the authors of a controversial pamphlet entitled “AIDS and Us” were arrested under the 1980 National Security Act for circulating the pamphlet.<sup>451</sup>

### **C. POPULATION**

In 1952, India became the first country in the world to initiate a state-sponsored family planning program to slow population growth. From the early 1960s to the 1990s, India’s program was driven by government determined targets for contraceptive acceptance. After the ICPD, however, a major national policy shift occurred. In 1996, the government announced the “Target-Free Approach,” which eliminated nationally mandated targets for contraceptive acceptance while continuing to allow for locally determined targets. Under the new approach, planning would occur at the community level, where grassroots workers would set targets for their service areas after assessing the needs of clients.<sup>452</sup> The National Population Policy commits to continuing the “target-free” approach in the provision of family planning services, as well as decentralized planning and implementation of such services.

Despite the National Population Policy’s emphasis on client-based family planning services with locally determined needs, states are still authorized under the constitution to make their own laws with respect to population control and family planning, and they may implement population policies using various incentives and disincentives.<sup>453</sup> In a major 2003 ruling, the Supreme Court upheld a Haryana state law barring any person from becoming the *sarpanch* (head of a village *panchayat*) or *upsarpanch* (a *panchayat* leader below a *sarpanch*) if he or she had more than two children.<sup>454</sup>

#### ***Population policy***

##### *Objectives*

The National Population Policy commits to securing voluntary and informed choice and consent for anyone accessing reproductive health-care services. The policy also endorses the continuation of a “target free” approach to the administration of family planning services.<sup>455</sup>

The policy incorporates the following short-term, medium-term and long-term objectives:

- Short-term objective: to address the unmet needs for contraception, health-care infrastructure and health personnel, and to provide integrated service delivery for basic reproductive and child health care.
- Medium-term objective: to reduce the total fertility rate from 2.9 to replacement levels by 2010 through

vigorous implementation of inter-sectoral operational strategies.

- Long-term objective: to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development and environmental protection.<sup>456</sup>

By 2010, the National Population Policy seeks to achieve the following national socio-demographic goals:

- address the unmet needs for basic reproductive and child health services, supplies and infrastructure;
- make school education up to age 14 free and compulsory and reduce drop out rates at primary and secondary school levels to below 20% for both boys and girls;
- reduce the infant mortality rate to below 30 per 1,000 live births;
- reduce maternal mortality rate to below 100 per 100,000 live births;
- achieve universal immunization of children against all vaccine-preventable diseases;
- promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age;
- achieve 80% institutional deliveries and 100% deliveries by trained persons;
- achieve universal access to information, counseling and services for fertility regulation and contraception with a wide range of choices;
- achieve 100% registration of births, deaths, marriages, and pregnancies;
- contain the spread of AIDS and promote greater integration between the management of reproductive tract infections and STIs and the National AIDS Control Organization;
- prevent and control communicable diseases;
- integrate Indian Systems of Medicine in the provision of reproductive and child health services, and in reaching out to households;
- vigorously promote the small family norm to achieve replacement levels of the total fertility rate; and
- create a people-centered approach to all social programs relating to family welfare.<sup>457</sup>

The policy identifies several strategic themes to achieve the above goals, including these:

- decentralizing planning and program implementation;
- converging of service delivery at village levels;
- empowering women for improved health and nutrition;
- ensuring child health and survival;
- meeting unmet needs for family welfare services;
- improving access and quality of services to under-

served population groups, including urban slums, tribal communities, hill area populations, displaced and migrant populations, and adolescents;

- increasing participation of men in family planning;
- diversifying health-care providers;
- collaborating with and obtaining commitments from NGOs and the private sector;
- mainstreaming Indian systems of medicine and homeopathy;
- promoting contraceptive technology and research on reproductive and child health;
- providing care for the older population; and
- improving information, education and communication about family planning.<sup>458</sup>

In encouraging states to pursue these goals, the National Population Policy recommends that the 42nd Amendment to the Constitution, which has frozen the number of seats to the *Lok Sabha* and *Rajya Sabha* based on the 1971 census, be extended to 2026.<sup>459</sup> In this way, states that are making progress in their efforts toward population stabilization need not fear that the number of their representatives in the *Lok Sabha* will decrease. (See “Structure of National Government” for information on proportionality of representation in the *Lok Sabha*.)

#### *Implementing agencies*

The National Population Policy is formulated by the central government and implemented and managed at *panchayat* and municipality levels in coordination with the concerned state or union territory government.<sup>460</sup> The central and state or union territory governments, as well as international agencies, contribute to funding for implementation activities under the policy.<sup>461</sup>

In 2000, the prime minister established the National Commission on Population to oversee and review implementation of the population policy. The commission is headed by the prime minister and consists of 100 members, including the chief ministers of all states and union territories, the central minister of the Department of Family Welfare, personnel from other relevant ministries and departments, and reputed demographers, public health professionals and NGOs.

### III. Legal Status of Women

Women’s health and reproductive rights cannot be fully understood without taking into account the legal and social status of women. Laws relating to women’s legal status not only reflect societal attitudes that shape the landscape of reproductive rights, they directly impact women’s ability to

exercise these rights. Issues such as the respect and dignity a woman commands within marriage, her ability to own property and earn an independent income, her level of education, and her vulnerability to violence affect a woman's ability to make decisions about her reproductive health-care needs and to access the appropriate services.

The following section describes laws in India regulating those areas of women's lives that directly affect their health. The legal context of family life, women's access to education, and the laws and policies affecting their economic status can contribute to the promotion or the restriction of women's access to reproductive health care and their ability to make voluntary, informed decisions about such care. Laws regarding the age of first marriage can have a significant impact on young women's reproductive health. Furthermore, rape laws and other laws related to sexual assault or domestic violence present significant rights issues and also have direct consequences for women's health.

### **A. RIGHTS TO GENDER EQUALITY AND NONDISCRIMINATION**

The principle of gender equality is firmly established in the constitution. The constitution provides for equality before the law and equal protection of the law, and prohibition of discrimination against any citizen on the grounds of sex, religion, race, caste, or any other basis. It empowers the state to take affirmative action in favor of women.<sup>462</sup> These provisions can be redressed in both the country's high courts and the Supreme Court.<sup>463</sup> The constitution also prescribes several fundamental duties of citizens, among which is the duty to renounce practices derogatory to the dignity of women.<sup>464</sup>

Indian courts have widely held that to achieve true gender equality, it is essential that every person be given opportunities to facilitate personal choice and that no person be forced into a pre-determined role according to gender.<sup>465</sup>

#### ***Formal institutions and policies***

A number of national institutions and policies aim to advance gender equality. The Department of Women and Child Development is at the core of the national machinery for the advancement of women.<sup>466</sup> The department is under the charge of a cabinet minister, who is in turn accountable to parliament.<sup>467</sup> State-level departments also form part of this machinery.<sup>468</sup>

In 1990, the National Commission for Women Act was adopted, pursuant to which the National Commission for Women was established in January 1992.<sup>469</sup> The commission advises the government on all policy matters affecting women, oversees the working of constitutional safeguards for women, and reviews relevant laws and regulations, intervening whenever women's rights have been violated.<sup>470</sup> Several states have set up their own commissions that function as ombudsmen for women.<sup>471</sup> The National Commission for Women Act requires that central and state governments report annually to parliament on actions taken pursuant to the commission's recommendations and provide explanations if they fail to take actions.<sup>472</sup>

In addition to establishing the National Commission for Women, the Department of Women and Child Development established the Task Force on Women and Children in 2000 to review and make recommendations with regard to legislation relating to women.<sup>473</sup>

In 2001, the National Policy for the Empowerment of Women was adopted to eliminate all forms of discrimination against women, ensure gender justice and empower women both socially and economically.<sup>474</sup> The policy directs all central and state ministries to create time-bound action plans for translating the policy into a set of concrete actions. The plans

should include the following:

- goals to be achieved by 2010;
- identification and commitment of resources;
- assignment of responsibilities for implementation of goals;
- monitoring, reviewing and assessment mechanisms; and
- introduction of a gender perspective in the budgeting process.<sup>475</sup>

The Tenth Five Year Plan sets forth broad policy objectives to promote gender equality, including these:

- ensuring that women have equal access to health care, quality education at all levels, employment, and equal remuneration;
- strengthening legal systems aimed at the elimination of all forms of discrimination against women;
- mainstreaming a gender perspective in the development process;
- eliminating all forms of discrimination against women and the girl child; and
- providing equal access to participation and decision-making for women in social, political and economic realms.<sup>476</sup>

---

#### **RELEVANT LAWS AND POLICIES**

- National Policy for the Empowerment of Women, 2001
- Tenth Five Year Plan, 2002-2007

---

#### **UP AND COMING LEGISLATION**

- 81st Amendment to the Constitution, known as the "Women's Reservation Bill"

## B. CITIZENSHIP

The 1955 Citizenship Act provides for the acquisition and termination of Indian citizenship.<sup>477</sup> Under the act, women have equal rights with men to acquire and confer their citizenship.<sup>478</sup> The act also gives all Indian citizens of “full age and capacity” the right to voluntarily renounce their citizenship, although it stipulates that unmarried women are not considered to be of full age, thus precluding this group from exercising the right to freely renounce their citizenship.<sup>479</sup>

Certain states within the Indian union confer benefits to state residents. In October 2002, a landmark decision of the Jammu and Kashmir High Court held that women who marry non-state subjects and continue to reside in the state have the right to retain their status as permanent residents of the state, including their rights to work, education, inheritance, and employment.<sup>480</sup> Previously, women who married non-state residents lost their state residency, which resulted in the loss of their rights to obtain or continue in a government job, own land and property, pursue higher education, and contest or vote in municipal and state elections.<sup>481</sup> However, male Jammu and Kashmir residents have always retained their state residency rights even after marrying non-state subjects, who are automatically granted the state and class status of their husbands upon marriage.<sup>482</sup>

## C. RIGHTS WITHIN MARRIAGE

### Marriage laws

Family relations, including marriage, are generally governed by the personal laws of individual religious communities.<sup>483</sup> In addition to these laws, secular legislation applies to all citizens regardless of their religious affiliation. Among these secular laws is the 1954 Special Marriage Act, which allows people of different faiths to legally register their marriage.<sup>484</sup> A marriage celebrated under religious rites may also be registered under the act.<sup>485</sup> The 1929 Child Marriage Act establishes the legal minimum age for marriage as 21 for men and 18 for women and imposes penalties for any violation of its provisions.<sup>486</sup> The act does not, however, affect the validity of an underage marriage.<sup>487</sup> The 1961 Dowry Prohibition Act prohibits the giving, taking, abetting, or demanding of dowry.<sup>488</sup>

Personal laws generally supercede state laws. However, this is not the case in the union territories of Pondicherry, Goa, Daman, and Diu, and the state of Jammu and Kashmir, where distinct laws apply.<sup>489</sup>

#### *Laws governing Hindus*

The 1955 Hindu Marriage Act is a codification of Hindu personal law and is also applicable to Sikhs, Buddhists and Jains.<sup>490</sup> According to the act, marriage is a sacramental

union.<sup>491</sup> For most Hindu communities, the ritual of *saptapadi*—the taking of seven steps by the bridegroom and the bride jointly around the sacred fire—is necessary for a valid marriage.<sup>492</sup> Additional requirements for a valid Hindu marriage include these:

- at the time of marriage, neither party has a living spouse;
- at the time of marriage, neither party is (1) incapable of giving valid consent to the marriage; (2) unfit for marriage and procreation because of a mental disorder; or (3) suffering from insanity or epilepsy;
- the bridegroom has reached the age of 21 years and the bride 18 years;
- the parties are not within prohibited degrees of relationship; and
- the parties are not *sapindas* (close relatives) of each other.<sup>493</sup>

Despite the act’s prohibition of marriage between closely related individuals, customary practices may prevail if the custom of the relevant parties is contrary to this prohibition.<sup>494</sup>

#### *Laws governing Muslims*

Under Muslim personal law, which is largely uncodified, marriage is a contract.<sup>495</sup> Conditions for a valid Muslim marriage include these:

- a proposal of marriage by one party and acceptance by the other, called *nikah*; if the parties are minors, the proposal and acceptance must be secured by their guardians;
- among Sunnis, the presence of witnesses is necessary during *nikah*; among Shias, witnesses are not necessary during *nikah*;
- a *mahr*, or sum of money or other property, is given to the bride by the bridegroom at the time of marriage;
- the parties must not be closely related;
- the parties must be “mentally sound”;
- the bride and bridegroom must have attained the age of puberty, or 15 years of age.<sup>496</sup>

Muslim law allows a man to have up to four wives.<sup>497</sup>

#### *Laws governing Christians*

Christian marriage is governed by the 1872 Indian Christian Marriage Act.<sup>498</sup> There are three forms of marriage, including a religious marriage, a secular marriage and a marriage by certificate between Indian Christians.<sup>499</sup> The conditions for a valid marriage are as follows:

- the man should not be under age 21 and the woman should not be under age 18;
- neither party should have a living husband or wife;
- the parties must exchange vows in the presence of two witnesses and a person licensed under the act.<sup>500</sup>



### *Laws governing Parsis*

Marriage between Parsis is governed by the 1936 Parsi Marriage and Divorce Act.<sup>501</sup> The requirements for a valid marriage include the following:

- the parties must not be closely related;
- the marriage must be solemnized by a priest in the presence of two additional witnesses in a Parsi ceremony known as ashirvad;
- males must be at least 21 years of age and females must be at least 18;<sup>502</sup>
- neither party should have a husband or wife still living at the time of marriage.<sup>503</sup>

Additionally, all marriages must be registered where the marriage was solemnized.<sup>504</sup>

### *Divorce laws*

#### *Laws governing Hindus*

Under the Hindu Marriage Act, grounds for divorce include the following:

- adultery;
- cruelty to the other spouse;
- desertion for a continuous period of two years immediately preceding the petition;
- conversion to another religion;
- incurable unsoundness of mind;
- incurable leprosy;
- communicable venereal disease;
- renunciation by entering any religious order;
- not being heard of as alive for at least seven years.<sup>505</sup>

Additional bases for divorce under the act include:

- no resumption of cohabitation for at least one year after a decree for judicial separation;
- no restitution of conjugal rights for at least one year after a decree for restitution of conjugal rights;
- the husband has more than one living wife at the time of marriage;
- the husband is guilty of rape, sodomy or bestiality;
- the woman's marriage was solemnized (whether consummated or not) before she reached age 15, provided that she repudiates the marriage before reaching age 18;
- mutual consent, provided the parties have not been living together as husband and wife for at least one

year.<sup>506</sup>

The Indian Penal Code provides penalties for specific grounds of divorce, including bigamy, cruelty and adultery.<sup>507</sup>

### *Laws governing Muslims*

Under Muslim personal law, non-judicial divorce may occur in the following ways:

- by *talak* (at the husband's will);
- by *tafveez*, whereby the husband "delegates" his right of divorce to his wife in a marriage contract;

- by *khula*, whereby the wife gives or agrees to give consideration to her husband for her release from the marriage;

- by *mubara'at*, whereby the husband and wife mutually agree to divorce.<sup>508</sup>

A man may remarry immediately upon receiving a divorce.<sup>509</sup> If the marriage was consummated, a woman may not remarry before completion of *iddat*, which is a specified period of time (usually three months) that must pass after the date of divorce.<sup>510</sup>

The Supreme Court has ruled that a mere plea of *talak* taken in an unsubstantiated statement and submitted before a court cannot be accepted as adequate proof of *talak*.<sup>511</sup> Rather, the divorce must be for reasonable cause and preceded by an attempt at reconciliation between the husband and wife and a mediator representing each side.<sup>512</sup> Only if the attempt fails can

*talak* be effected.<sup>513</sup> Similarly, a city court in Delhi has ruled that divorce by *biddat* (pronouncement of *talak* three times) by mail "cannot be deemed a continuing practice in India."<sup>514</sup> Citing the aforementioned Supreme Court case and the Koran, the judge in the case stated that the Koran provides for pre-divorce conference between both sides with one mediator on behalf of the wife and one on behalf of the husband.<sup>515</sup>

Judicial divorce is also available at the suit of the wife under the 1939 Dissolution of Muslim Marriages Act.<sup>516</sup> Under the act, Muslim women may seek divorce on any of the following grounds:

- whereabouts have not been known for a period of four years;
- failure to provide maintenance for a period of two years;
- imprisonment for a period of seven or more years;
- failure to perform marital obligations for a period of

## RELEVANT LAWS AND POLICIES

- Special Marriage Act, 1954
- Child Marriage Restraint Act, 1929
- Dowry Prohibition Act, 1961
- Hindu Marriage Act, 1955
- Indian Christian Marriage Act, 1872
- Parsi Marriage and Divorce Act, 1936
- Dissolution of Muslim Marriages Act, 1939
- Indian Divorce Act, 1869
- Code of Criminal Procedure, 1973
- Marriage Laws (Amendment) Act, 2001
- Hindu Adoptions and Maintenance Act, 1956
- Muslim Women (Protection of Rights on Divorce) Act, 1986
- Guardians and Wards Act, 1890
- Hindu Minority and Guardianship Act, 1956

three years;

- impotency from the time of marriage;
- insanity for a period of two years;
- leprosy;
- virulent venereal disease;
- the woman's marriage was solemnized before she attained age 15 and she repudiates the marriage before she attains age 18, provided that the marriage has not been consummated;
- cruelty, including if the husband (1) habitually assaults her or makes her life miserable by cruelty of conduct not amounting to physical ill-treatment; (2) associates with women of "evil repute" or leads an "infamous" life; (3) attempts to force her to lead an "immoral" life; (4) disposes of her property or prevents her from exercising her legal rights over it; (5) obstructs her in the observance of her religious profession or practice; (6) has more than one wife and does not treat her equitably with the injunctions of Islam; or
- any other recognized ground for the dissolution of marriages under Muslim law.<sup>517</sup>

#### *Laws governing Christians*

Divorce among Christians is governed by the 1869 Indian Divorce Act.<sup>518</sup> Under the act, grounds for dissolution of marriage by either party include the following:

- adultery;
- conversion from Christianity to another faith;
- incurable unsoundness of mind for a continuous period of at least two years;
- incurable leprosy for at least two years;
- communicable venereal disease for at least two years;
- not being heard of as alive for at least seven years;
- willful refusal to consummate the marriage;
- failure to comply with a decree of restitution of conjugal rights for at least two years;
- desertion for at least two years;
- cruelty as to cause a reasonable apprehension of harm or injury from continued cohabitation.<sup>519</sup>

A woman may also seek divorce if her husband has been found guilty of rape, sodomy or bestiality.<sup>520</sup> Divorce may also be obtained by mutual consent.<sup>521</sup>

#### *Laws governing Parsis*

The Parsi Marriage and Divorce Act governs divorce among Parsis.<sup>522</sup> Under the act, divorce by either party to the marriage is permissible on the following grounds:

- the marriage has not been consummated within one year of its solemnization due to the willful refusal of the defendant to consummate it;
- unsoundness of mind from the time of marriage;

- incurable unsoundness of mind for a period of two or more years immediately preceding the filing of the lawsuit, or continuous or intermittent mental disorder of such nature and extent that the plaintiff cannot reasonably be expected to live with the defendant;
- the defendant was pregnant by someone other than the plaintiff at the time of marriage;
- adultery, "fornication," bigamy, rape, or an "unnatural offense";
- cruelty;
- grievous hurt;
- transmission of venereal disease by defendant to plaintiff;
- where the defendant is the husband, compelled the wife to submit herself to prostitution;
- imprisonment of seven or more years for an offense under the Indian Penal Code;
- desertion for at least two years;
- a court order awarding separate maintenance to the plaintiff against the defendant and the parties have not had marital intercourse for one or more years since such order;
- conversion to another religion;
- non-resumption of cohabitation or restitution of conjugal rights for a period of one or more years pursuant to a decree;
- mutual consent.<sup>523</sup>

Either party may attempt to nullify the marriage if consummation is impossible due to natural causes.<sup>524</sup> Either spouse may bring lawsuits to dissolve the marriage if the other spouse has been continually absent for a period of seven years and has not been heard of as alive within that time.<sup>525</sup>

#### **Judicial separation**

Judicial separation is explicitly recognized as a matrimonial remedy in all matrimonial laws except Muslim personal law.<sup>526</sup> Under all other personal laws, an individual can petition for judicial separation on any of the grounds available for divorce.<sup>527</sup> Once a decree of judicial separation is obtained the parties are legally permitted, although not required, to live separately. The law still regards the couple as husband and wife and forbids them from remarrying, although their conjugal duties are temporarily suspended.

#### *Laws governing Hindus*

Under the Hindu Marriage Act, either party to a marriage may bring a petition for judicial separation on any of the grounds specified in the act for divorce.<sup>528</sup> Once a decree for judicial separation has been obtained, the parties are no longer legally required to cohabit.<sup>529</sup> The court may rescind the decree upon the petition of either party.<sup>530</sup>

The Supreme Court of India has held that “husbands living in adultery during judicial separation can be denied divorce as their action constitute[s] ‘a continuing matrimonial offence’ under the Hindu Marriage Act.”<sup>531</sup>

*Laws governing Muslims*

Judicial separation is not recognized as a matrimonial remedy.<sup>532</sup>

*Laws governing Christians*

Under the Indian Divorce Act, judicial separation is available to either party on the following grounds:

- adultery;
- cruelty;
- desertion for at least two years.<sup>533</sup>

*Laws governing Parsis*

Under the Parsi Marriage and Divorce Act, judicial separation is available to either party on any of the grounds specified for divorce.<sup>534</sup>

**Maintenance and support laws**

Women of all religious communities in India are entitled to obtain financial or other support, known as maintenance, from their husbands upon dissolution of marriage.<sup>535</sup> Alternatively, women may seek maintenance under the Code of Criminal Procedure.<sup>536</sup>

Under the code, a man with sufficient means is required to provide maintenance to an ex-wife until she remarries, as well as to his legitimate or illegitimate children and his parents who are unable to maintain themselves.<sup>537</sup> A woman is not entitled to this support if she is living in adultery, has refused to live with her husband “without sufficient reason” or lives separately by mutual consent.<sup>538</sup> A party may apply to the court for an increase, decrease or cancellation in the amount of maintenance if new facts and circumstances arise.<sup>539</sup>

An April 2003 Supreme Court decision held that a man who marries a pregnant woman with knowledge of the pregnancy at the time of marriage may not avoid paying maintenance in the event of divorce by claiming the marriage was illegal or void because of the prior pregnancy.<sup>540</sup> The woman is entitled to maintenance in the event of divorce on that ground.<sup>541</sup>

The 2001 Marriage Laws (Amendment) Act amends certain provisions relating to maintenance in the Indian Divorce Act, Parsi Marriage and Divorce Act, Special Marriage Act, and Hindu Marriage Act.<sup>542</sup> The effect of the Amendment Act is generally to allow women to petition for payment of expenses of a proceeding for divorce or dissolution in addition to seeking maintenance and alimony.<sup>543</sup> Under the act, the court shall, as far as possible, deliver a disposition on petitions for expenses, alimony, maintenance, and education for minor children within 60 days of the peti-

tioner’s service on the respondent.<sup>544</sup>

*Laws governing Hindus*

Under the Hindu Marriage Act, a court may order either party, as the case may be, to pay maintenance and support for a term not exceeding the life of the payee.<sup>545</sup> In determining maintenance awards, the act instructs courts to consider the income, property and conduct of the parties and other circumstances of the case.<sup>546</sup> A party may request the court to vary, modify or rescind an award for maintenance for the following reasons:

- a change in circumstances of either party;
- remarriage of the party receiving maintenance;
- failure of the woman to remain chaste, if the party receiving maintenance is the woman; or
- adultery by the man, if the party receiving maintenance is the man.<sup>547</sup>

Under the 1956 Hindu Adoptions and Maintenance Act, a Hindu woman is entitled to live apart from her husband during marriage and collect maintenance if certain specified grounds are present or where judicial separation or divorce have been awarded.<sup>548</sup> A woman loses this right if she is unchaste or converts to another religion.<sup>549</sup> A Hindu widow is entitled to maintenance from her father-in-law under certain conditions.<sup>550</sup> In addition, the act provides that Hindus are bound during their lifetime to provide maintenance to their legitimate or illegitimate minor children and aged or infirm parents.<sup>551</sup> However, in the case of parents and unmarried daughters, this obligation exists insofar as the parent(s) or unmarried daughter(s) are unable to support themselves out of their own earnings or property.<sup>552</sup>

A recent Supreme Court decision held that a husband’s refusal to pay a monthly alimony during a separation period could “disentitle him from divorce.”<sup>553</sup>

*Laws governing Muslims*

Under the 1986 Muslim Women (Protection of Rights on Divorce) Act, a divorced woman is entitled to a “reasonable and fair” provision of maintenance within the period of *iddat* to be paid to her by her former husband.<sup>554</sup> If the woman gives birth before or after the divorce, she may also obtain maintenance for her children for a period of two years from their dates of birth.<sup>555</sup> A divorced woman is also entitled to an amount equal to the *mahr* agreed upon at the time of marriage.<sup>556</sup>

After the period of *iddat*, a court can order the divorced woman’s parents, children, relatives who would be entitled to inherit her property, or state *wakf* (charitable trust for religious purposes) board to pay maintenance to the woman, so long as she does not remarry.<sup>557</sup>

A divorced woman may also opt to seek maintenance under the Code of Criminal Procedure if both she and her

former husband file an affidavit or other written declaration in court agreeing to be governed by the code.<sup>558</sup>

#### *Laws governing Christians*

Under the Indian Divorce Act, a court may order a husband to pay maintenance to his wife for a term not exceeding her life upon confirmation of a decree of dissolution of marriage or judicial separation obtained by the wife.<sup>559</sup> In making the determination of the amount of maintenance, courts may consider the woman's financial circumstances, the man's ability to pay and the conduct of both parties.<sup>560</sup> A court may direct that maintenance be paid directly to the woman or a trustee on her behalf.<sup>561</sup>

#### *Laws governing Parsis*

Many provisions of the Parsi Marriage and Divorce Act relating to maintenance mirror the Hindu Marriage Act. Thus, a court may order either party, as the case may be, to pay maintenance and support for a term not exceeding the life of the payee.<sup>562</sup> In determining maintenance awards, the act instructs courts to consider the income, property and conduct of the parties and other circumstances of the case.<sup>563</sup> Either party may request the court to "vary, modify or rescind" an award for maintenance for the following reasons:

- a change in circumstances of either party;
- remarriage of the party receiving maintenance;
- failure of the woman to remain chaste, if the party receiving maintenance is the woman; or
- adultery by the man, if the party receiving maintenance is the man.<sup>564</sup>

A court may require that alimony be paid directly to the wife or a trustee on her behalf.<sup>565</sup>

#### ***Custody and adoption laws***

The personal laws of India's different religious communities apply to issues involving parental custody of minor children. Codified personal laws addressing custody are the 1956 Hindu Minority and Guardianship Act and the Parsi Marriage and Divorce Act. Personal laws do not generally address adoption, with the exception of the Hindu Adoption and Maintenance Act, which applies to Hindus, Buddhists, Jains, and Sikhs. Muslims, Christians and Parsis who wish to adopt may do so under the 1890 Guardians and Wards Act.<sup>566</sup>

Under the Guardians and Wards Act, fathers are considered the primary guardians of minor children and courts will not appoint another guardian unless the father is found to be unfit.<sup>567</sup> In the case of married minor girls, the girl's husband is considered her natural guardian and courts will similarly not appoint another guardian unless he is found to be unfit.<sup>568</sup> Where a court must appoint a guardian, it should be guided by several factors, including the circumstances, consistent with

the law to which the minor is subject, that appear to be in the welfare of the minor.<sup>569</sup> In determining what would be in the welfare of the minor, the court should consider the age, sex and religion of the minor; the "character and capacity" of the proposed guardian and his or her kinship to the minor; any wishes of a deceased parent; any existing or previous relations of the proposed guardian and the minor or his property; and the preference of the minor, if such minor is old enough to form an intelligent preference.<sup>570</sup>

#### *Laws governing Hindus*

Under the Hindu Minority and Guardianship Act, the natural guardians of a Hindu minor, defined as a person under age 18, are the following:

- in the case of a boy or an unmarried girl, the father and, after him, the mother;
- in the case of a child under age five, or an illegitimate son or illegitimate and unmarried daughter, the mother and, after her, the father;
- in the case of a married girl, the husband.<sup>571</sup>

A parent loses his or her rights to custody if he or she ceases to be a Hindu or renounces the world by becoming a hermit or an ascetic.<sup>572</sup>

The act directs courts to consider the welfare of the child to be of "paramount consideration" in deciding the question of guardianship.<sup>573</sup> Leading an immoral life or remarrying after divorce are grounds upon which the mother may lose her right to custody.<sup>574</sup>

Under the Hindu Adoptions and Maintenance Act, a Hindu woman may adopt if she is of sound mind and an unmarried adult or, if married, is widowed or divorced.<sup>575</sup> A married woman may only consent to an adoption petitioned by her husband; she may not be a joint petitioner with her husband in the process of adoption.<sup>576</sup> Any adult Hindu man who is of sound mind may adopt.<sup>577</sup> Married men need the consent of their wives in order to adopt.<sup>578</sup>

#### *Laws governing Muslims*

Different schools of Islam prescribe different laws for custodial rights. Under some schools, the mother has custodial rights until the children are seven years old.<sup>579</sup> Under other schools, she is entitled to custody until the children attain puberty.<sup>580</sup> A court could refuse custody to the mother if it finds that she is of bad character, is suffering from a mental illness or is otherwise unfit according to the "welfare of the child" standard.<sup>581</sup>

Muslim personal law does not recognize the concept of adoption as widely understood in most societies. Muslims who wish to adopt may seek "guardianship" under the Guardians and Wards Act.<sup>582</sup>

*Laws governing Christians*

Under Christian personal law, the mother is entitled to custody of her children until they are at least five years old.<sup>583</sup> The court may refuse custody to the mother if it finds her to be of very bad character, suffering from a mental illness, or otherwise unfit considering the “welfare of the child” standard.<sup>584</sup>

Christian personal law does not recognize the concept of adoption as widely understood in most societies. Christians who wish to adopt may seek “guardianship” under the Guardians and Wards Act.<sup>585</sup>

*Laws governing Parsis*

The Parsi Marriage and Divorce Act specifies that custody and related matters should be decided by courts.<sup>586</sup> Leading an immoral life or remarrying after divorce are grounds upon which a mother may lose her right to custody.<sup>587</sup>

Parsi personal law does not recognize the concept of adoption as widely understood in most societies. Parsis who wish to adopt may seek “guardianship” under the Guardians and Wards Act.<sup>588</sup>

**D. ECONOMIC AND SOCIAL RIGHTS***Property laws*

In general, all women have the right to acquire, hold and freely use their own property; to receive, keep or spend earnings; and to buy or sell property on par with men.<sup>589</sup> All women may also dispose of some or all of their property by will.<sup>590</sup> Inheritance rights, on the other hand, are governed by the personal laws of religious communities. The only law that accords substantive rights to the wife in the property of her husband during marriage is the 1867 Portuguese Civil Code, applicable generally to the residents of the state of Goa and the union territories of Daman and Diu.<sup>591</sup>

The Supreme Court of India has issued directives enjoining the government to implement the principles of equality articulated in the constitution, and ensure women’s right to property.<sup>592</sup>

*Laws governing Hindus*

Matters of intestate succession for Hindus are governed by the 1956 Hindu Succession Act.<sup>593</sup> Hindu males have a share in the family’s ancestral property by birth.<sup>594</sup> Women do not have a share in this property by birth, but do have rights to expenses for food, shelter, clothing, education, and marriage.<sup>595</sup> Personal property is equally divided among heirs.<sup>596</sup> Female heirs are entitled to a share from partition of a “dwelling house,” although they cannot themselves demand a partition—only male heirs have this right.<sup>597</sup> Partition con-

sists of separating and assigning the shares of a given property.<sup>598</sup> Female heirs, including widows, do have a right to residence (although not ownership) in the home, provided that in the case of daughters, they are unmarried, have been deserted by or have separated from their husbands, or are widows.<sup>599</sup>

In a 2003 Supreme Court case, the court ruled that where a Hindu woman inherits property from her mother or father, her husband and his heirs can no longer receive such property if the woman dies without a will or without children.<sup>600</sup> Rather, the property would revert to the heirs of the woman’s mother or father.<sup>601</sup> If the property is inherited from the woman’s husband or father-in-law, the property is divided among her husband’s heirs.<sup>602</sup>

*Laws governing Muslims*

In general, Muslim personal law dictates that a male inherits double the share of a female.<sup>603</sup> A widow is entitled to one-eighth of her husband’s property when there are children and one-fourth when there are none.<sup>604</sup> If the wife has not been paid her *mahr* upon her husband’s death, the amount must be satisfied out of her husband’s property.<sup>605</sup> Similarly, her heirs are entitled to any unpaid *mahr* if it is still unpaid upon her death.<sup>606</sup>

A wife has the right to residence in the matrimonial home during marriage, but relinquishes that right upon divorce. She does not have a right to ownership of the matrimonial home.<sup>607</sup>

*Laws governing Christians*

The 1925 Indian Succession Act governs intestate distribution of property for Christians.<sup>608</sup> A Christian widower or widow is entitled to one-third of his or her deceased spouse’s property.<sup>609</sup> All children, including married and single daughters, receive equal shares in the remaining property.<sup>610</sup>

*Laws governing Parsis*

The Indian Succession Act governs intestate distribution of property for Parsis as well as Christians.<sup>611</sup> A Parsi widower or widow and his or her children are entitled to equal shares of his or her deceased spouse’s property.<sup>612</sup>

*Rights to agricultural land*

Each state has its own laws governing succession to agricultural land. Under the 1954 Delhi Land Reforms Act, the order of succession to a deceased male’s property is the “male lineal descendant in the male line of the descent.”<sup>613</sup> An interest inherited by a female heir, including a widow, mother or unmarried sister, ceases upon her death or remarriage.<sup>614</sup> There is no means for a daughter to inherit.<sup>615</sup>

**RELEVANT LAWS AND POLICIES**

- Hindu Succession Act, 1956
- Indian Succession Act, 1925

### **Women's exclusive property**

In order to help empower women economically and improve their property rights, the Delhi government has proposed a new property tax scheme that would impose a lower house tax on residential properties issued to women.<sup>616</sup>

#### *Laws governing Hindus*

Hindu women have exclusive rights to all property and gifts given to or acquired by them during their lifetime, known as a woman's *stridhan*.<sup>617</sup> Women are the sole owners of such *stridhan* and may dispose of it as they wish.<sup>618</sup>

#### *Laws governing Muslims*

A woman's *mahr* is her exclusive property to use and dispose of as she wishes.<sup>619</sup>

#### *Laws governing Christians*

Under Christian personal law, any gifts given to a woman by her family at the time of marriage, as well as any money or other property earned or acquired by her, are her personal property, which she may dispose of as she wishes.<sup>620</sup>

#### *Laws governing Parsis*

Parsi women do not have special or exclusive rights to any separate category of property.<sup>621</sup>

### **Labor and employment**

Some 8.3% of women are engaged in regular salaried employment, compared with 18% of men.<sup>622</sup> In rural areas, women's workforce participation is 86.5%, compared with 75.3% for men.<sup>623</sup> Of women working in rural areas, 87% are employed in agriculture as laborers and cultivators.<sup>624</sup> Among women working in urban areas, about 80% are employed in unorganized sectors such as household industries, petty trades and services, and building construction.<sup>625</sup> Women constitute only 17.6% of total organized sector employment.<sup>626</sup> The majority of women in this sector are employed in community, personal and social services.<sup>627</sup>

The constitution guarantees the right to equality of opportunity for all citizens in matters relating to public employment or appointment to public office.<sup>628</sup> In addition, the constitution's Directive Principles of State Policy enjoin the state to ensure equal rights to adequate means of livelihood; equal pay for equal work; just and humane conditions of work and women's right to maternity relief; the health and strength of workers; and that no citizen is "forced by economic necessity to enter avocations unsuited to their age or

strength."<sup>629</sup> The principles also direct the state "to promote cottage industries on an individual or co-operative basis in rural areas."<sup>630</sup>

The 1976 Equal Remuneration Act provides a statutory right to equal pay for equal or similar work.<sup>631</sup> The act applies to all employment establishments, regardless of their

size or the nature of their work.<sup>632</sup> In addition to the equal pay provision, the act prohibits sex discrimination in recruitment, promotions, training, or employment conditions and forbids employers from lowering the wages of any worker in an attempt to achieve compliance with the act.<sup>633</sup> In order to monitor compliance with the act, state governments must submit annual reports to the central government detailing their efforts at compliance and progress.<sup>634</sup> To strengthen compliance with the act, voluntary organizations have been authorized to file complaints for violation of the act.<sup>635</sup> In addition, courts of judicial magistrates "can *suo moto* take cognizance of an offence punishable under the act."<sup>636</sup>

There are a number of labor laws

that provide benefits to pregnant women and mothers. Under the 1961 Maternity Benefits Act, women working in factories, mines, plantations, circuses, shops, and other establishments in which ten or more people are employed are entitled to 12 weeks of paid maternity leave, six weeks of paid leave in cases of miscarriage or abortion and two weeks of paid leave for sterilization.<sup>637</sup> The act prohibits women from working during the six-week period following delivery, miscarriage or abortion and employers from knowingly employing a woman during this period.<sup>638</sup> Employers are also prohibited from requiring work of an arduous nature or that may cause miscarriage or negatively impact health from a woman within ten weeks of delivery.<sup>639</sup> Additional benefits under the act include a one-month paid leave for illness arising out of pregnancy, delivery, premature birth, or miscarriage; two nursing breaks of prescribed duration in addition to regular rest intervals until the child attains 15 months of age, without a deduction of wages; and a medical bonus of Rs 250 to a woman who has not been able to obtain free pre- or postnatal care.<sup>640</sup> The benefits of the act accrue after an employee has worked for a period of 80 days in the 12 months immediately preceding the date of her delivery.<sup>641</sup>

---

### **RELEVANT LAWS AND POLICIES**

- Equal Remuneration Act, 1976
  - Maternity Benefits Act, 1961
  - Factories Act, 1948
  - Employees' State Insurance Act, 1948
  - Central Civil Service (Leave) Rules, 1972
  - Plantations Labour Act, 1951
  - Mines Act, 1952
  - Beedi and Cigar Workers (Conditions of Employment) Act, 1966
  - Employees' Provident Fund and Miscellaneous Provisions Act, 1952
  - Payment of Gratuity Act, 1972
- 

### **UP AND COMING LEGISLATION**

- Sexual Harassment of Women at their Work Place (Prevention) Bill, 2003

The 1948 Factories Act and 1948 Employees' State Insurance Act also include provisions for maternity benefits.<sup>642</sup> The Factories Act, which covers any factory with ten or more employees, provides for up to 12 weeks paid maternity leave.<sup>643</sup> The Employees' State Insurance Act, which is similar in scope but does not include seasonal factories, authorizes the central government to prescribe the wage rates and duration of maternity leave.<sup>644</sup> Both this act and the Maternity Benefits Acts prohibit the dismissal, discharge, reduction in salary, or other punishment of an employee during the period in which an employee is in receipt of maternity benefits or absent from work as a result of illness arising out of pregnancy or confinement.<sup>645</sup>

Under the 1972 Central Civil Service (Leave) Rules, female employees of the central government are entitled to 135 days paid maternity leave.<sup>646</sup> Maternity leave is also allowed in cases of legal abortion.<sup>647</sup>

Schemes have also been introduced at the central, state and local levels to provide maternity benefits to the large number of women who are self-employed or working in the unorganized sector.<sup>648</sup>

Laws including the Factories Act, the 1951 Plantations Labour Act, the 1952 Mines Act, and the 1966 Beedi and Cigar Workers (Condition of Employment) Act enjoin employers to make provisions for nurseries or crèches if a certain number of women are employed in their establishments.<sup>649</sup> The government has also established the National Crèche Fund to expand the network of government crèches with the help of NGOs for low-income women in the unorganized sector.<sup>650</sup> Such services are offered mostly in urban and semi-urban areas.<sup>651</sup>

Women are restricted in the nature of work they may perform by a number of labor laws. The Factories Act prohibits women from cleaning, lubricating or adjusting heavy machinery and performing other specified types of work.<sup>652</sup> The act also sets limits on the amount of weight women are allowed to lift, carry or move.<sup>653</sup> The Mines Act prohibits women from working in underground mines.<sup>654</sup> The Mines Act, Plantation Labour Act, and Beedi and Cigar Workers (Condition of Employment) Act prohibit women's employment between 7 p.m. and 6 a.m., with some exceptions.<sup>655</sup> A similar restriction on the Factories Act was lifted by amendment in May 2003.<sup>656</sup> In a number of cases, Indian courts have struck down restrictions on the employment of married women or requirements that unmarried women resign upon marriage.<sup>657</sup> Specifically, courts have held that any law that

forbids or restricts the employment of married women violates the constitution's prohibition of discrimination on the basis of sex.<sup>658</sup>

Various labor laws, including the 1952 Employees' Provident Fund and Miscellaneous Provisions Act and 1972 Payment of Gratuity Act, include social security provisions for female and male workers.<sup>659</sup> These schemes provide for a lump sum to a worker upon his or her retirement after a prescribed length of employment or to his or her family in the case of work-related death.<sup>660</sup> These provisions apply, however, only to workers in the formal sector.<sup>661</sup> There is no legislation regarding social security for workers in the informal sector.<sup>662</sup>

#### *Access to credit*

The government has taken a number of steps to improve women's access to credit, both through mainstream financial institutions and, with the involvement of NGOs, alternative systems of credit.

Measures to improve women's access to mainstream credit have included quotas of 30%–40% in all major credit and subsidy programs targeted toward families below the

poverty line for women, providing low interest rates on loans, and eliminating requirements of collateral on loans.<sup>663</sup> In a pilot project with the National Institute of Bank Management in Pune, the government has also made efforts to sensitize bankers on gender issues relating to access to credit.<sup>664</sup>

Alternative systems of credit have been developed whereby, generally, NGOs serve as intermediary organizations that channel loans from informal credit institutions to individual female borrowers or collectives of female borrowers at the grassroots level.<sup>665</sup> These systems are more "women-friendly" and less formal and have lower transaction costs.<sup>666</sup> There are also generally no collateral or consent regulations for women seeking microcredit.<sup>667</sup> Significant central government initiatives include the *Rashtriya Mahila Kosh* (National Credit Fund for Women) and the Self-Help Group Scheme of the National Bank for Agriculture and Rural Development.<sup>668</sup> In delivering micro-finance services to low-income women, the National Credit Fund channels low-interest loans to borrowers through intermediate micro-finance organizations, the vast majority of which include NGOs.<sup>669</sup> The fund also makes loans to borrowers directly at the grassroots level, where borrowers include thrift, credit or self-help groups.<sup>670</sup>

#### *Education*

Statistics from 2001 indicate that 54.21% of females are lit-

---

### **RELEVANT LAWS AND POLICIES**

- **National Policy on Education, revised 1992**
- **86th Amendment to the Constitution**

erate compared with 75.90% of males, although wide variations exist throughout the country.<sup>671</sup>

The constitution's Directive Principles of State Policy enjoin the state to make education free and compulsory for all children up to the age of 14, although this goal has not yet been fully realized in India.<sup>672</sup> The Supreme Court affirmed this principle in 1993 in *J.P. Unnikrishnan v. State of Andhra Pradesh*, holding that the right to education is fundamental and flows from the right to life, and that all children up to age 14 should be entitled to free education.<sup>673</sup> The 86<sup>th</sup> Amendment to the Constitution, enacted in 2002, was a partial response to the constitutional directive, making free and compulsory education a fundamental right for children between the ages of six and 14.<sup>674</sup> The amendment enjoins the state to "endeavor" to provide early childhood care and education for all children until they complete age six.<sup>675</sup> The amendment also places the responsibility on the parent or ward of the child to provide educational opportunities to the child.<sup>676</sup> The constitution also guarantees that "[n]o citizen shall be denied admission into any [state-supported] educational institution" solely on the basis of religion, race, caste, or language.<sup>677</sup>

The National Policy on Education, announced in 1986 and revised in 1992, expressly refers to education as a form of women's empowerment and advocates the goal of "education for women's equality."<sup>678</sup> Priority areas identified in the policy include incorporation of gender perspectives into school curricula and educational training materials, and gender sensitization of teachers.<sup>679</sup> The National Council for Educational Research and Training and the National Institute for Educational Planning and Administration are the main governmental agencies charged with implementation of these objectives.<sup>680</sup> In the field of higher education, the University Grants Commission assists 22 universities in operating centers for women's studies to help engender university curricula, research and community development activities.<sup>681</sup>

The government has initiated a number of programs to decrease illiteracy rates and offer functional skills to socially marginalized groups.<sup>682</sup> One major women's development program is *Mahila Samakhyā*, which was launched in 1989 to translate the goals of the National Policy on Education into "a concrete programme for education and empowerment of women in rural areas, particularly women in socially and economically marginalized groups."<sup>683</sup> As of 2002, the program had been implemented in more than 9,000 villages in 60 districts across ten states.<sup>684</sup> The National Literacy Mission, launched in 1988, aims to offer functional literacy to individuals left out of the formal education system. One specific target is to attain a sustainable threshold level of 75% literacy by 2005.<sup>685</sup> Non-Formal Education programs have

been developed with a similar purpose.<sup>686</sup> The Ministry of Labor has also implemented a number of vocational training programs for women. Programs have been established in the National Vocational Training Institute and Indian Technical Institutes.<sup>687</sup> Vocational Rehabilitation Centers have also been established to rehabilitate women with disabilities through vocational training.<sup>688</sup>

## E. RIGHT TO PHYSICAL INTEGRITY

### *Rape*

The Indian Penal Code defines rape as an act that occurs when a man has sexual intercourse with a woman without her consent or with her consent in particular circumstances.<sup>689</sup> Sexual intercourse is defined as an act of penetration.<sup>690</sup> A man is subject to punishment for rape even when the woman has consented to sexual intercourse when her consent was obtained in the following ways:

- under threat of harm or death to herself or another;
- by fraud;
- when the woman believes that the man is her lawful husband; or
- under circumstances where the woman cannot understand the nature and consequences of her consent due to unsoundness of mind, intoxication, or a "stupefying or unwholesome substance."<sup>691</sup>

Statutory rape is defined to occur when a man has sex with a woman, with or without her consent, when she is under the age of 16.<sup>692</sup> Marital rape is not recognized nor penalized unless either the wife is under the age of 15 or if she is living separately from her husband "under a decree of separation or under any custom or usage without her consent."<sup>693</sup>

Rape laws were made more stringent following amendments in 1983 to rape provisions in the Indian Penal Code, Code of Criminal Procedure and Indian Evidence Act.<sup>694</sup> Under the Indian Penal Code, for example, the burden of proof for rebutting a charge of sexual assault now falls upon the accused.<sup>695</sup> However, the accused is permitted to use the victim's sexual history to impeach the credibility of the witness by alleging that she is of "generally immoral character."<sup>696</sup>

Punishment for non-marital rape ranges from seven years to life imprisonment and may include a fine.<sup>697</sup> Marital rape during a separation, as well as of a wife aged 12–15, is punishable by up to two years of imprisonment and fines.<sup>698</sup> Penalties increase in gang rape, custodial rape, rape where the perpetrator knows the woman is pregnant, or rape where the victim is under 12 years of age.<sup>699</sup> Although the Supreme Court has held in a number of cases that the victim must be compensated, the court is entitled to impose a lesser prison sentence than that specified by law.<sup>700</sup>



In *Delhi Domestic Working Women's Forum v. Union of India*, the Supreme Court laid down some broad parameters for assisting rape victims, including the following:

- the police have a duty to inform the victim of her right to representation;
- a legal representative must be provided to the victim;
- the anonymity of the victim must be maintained;
- regardless of whether the accused is convicted, the Criminal Injuries Compensation Board must award compensation to the victim; and
- upon conviction of the accused, the court must direct him to compensate the victim.<sup>701</sup>

The Ministry of Law and Justice has drafted the 2003 Sexual Offenses (Special Courts) Bill for speedy disposal of cases relating to rape and other sexual offenses in special courts.<sup>702</sup> The proposed law seeks to establish special courts in all districts at the sessions court level and a larger number of such courts in cities and state capitals where the incidence of crime is high.<sup>703</sup> In conjunction with the bill, provisions of the Indian Evidence Act and Code of Criminal Procedure will also be amended.<sup>704</sup>

There have also been local efforts to improve the handling of rape cases. Special police cells have been established to provide professional and support services to women and children victims of violence.<sup>705</sup> The cells work with police departments and women's and social service groups to provide these services.<sup>706</sup> In 2003, the Delhi police department implemented several steps to provide more sensitive treatment toward women victims of crime. Female officers are now assigned to investigate rape cases, law enforcement officials associated with the Delhi Rape Crisis Intervention Center must attend sensitivity training programs, and rape victims may register complaints over the telephone as opposed to making them in person. The changes were implemented after NGOs working with the center complained that investigating officers were impolite and intimidating toward rape victims.<sup>707</sup>

### ***Incest***

There is no specific legislation that prohibits and criminalizes incest. However, incest is addressed under sections of the Indian Penal Code relating to rape and general laws relating to neglect and abuse of children.<sup>708</sup> The personal laws of various religious communities governing marriage specifi-

cally prohibit marriage between closely related individuals. (See "Marriage Laws" for more information.)

### ***Domestic violence***

There is no single law on domestic violence, although a proposal for a national bill—the Protection from Domestic Violence Bill—was introduced in 2002 to eliminate all forms of domestic violence against women and the girl child.<sup>709</sup> In the absence of a national domestic violence law, criminal and civil remedies are available against an abusive husband or his relatives under the Indian Penal Code for the crimes of cruelty, hurt, grievous hurt, assault, confinement, abetment of suicide, and murder.<sup>710</sup> Penal code provisions dealing with causing miscarriage may also provide legal redress for women who experience violence during preg-

nancy.<sup>711</sup> Women may also obtain civil redress under personal laws that grant divorce or judicial separation on the basis of cruelty.<sup>712</sup> Under the Indian Evidence Act, there is a presumption that a woman who was subjected to cruelty by her husband or his relatives and who commits suicide within seven years from the date of her marriage was "abetted" by her husband or his relatives.<sup>713</sup> The act also provides for an inquiry by an executive magistrate and mandates post-mortem in all cases where a woman has committed suicide or died in

circumstances raising a "reasonable suspicion" of foul play within seven years of her marriage.<sup>714</sup>

The death of a woman caused by her husband or any of his relatives in connection with a demand for dowry is a crime. Such deaths are punished under the Dowry Prohibition Act, the India Penal Code and the Indian Evidence Act. The Dowry Prohibition Act punishes the giving, taking or abetting of dowry with a minimum of five years imprisonment and fines.<sup>715</sup> The Indian Penal Code renders any agreement for the giving and taking of dowry void and unenforceable and criminalizes dowry deaths within the first seven years of marriage.<sup>716</sup> Under the Indian Evidence Act, a person is presumed guilty of causing a dowry death if it is shown that such person subjected the victim to cruelty or harassment in connection with any demand for dowry prior to the victim's death.<sup>717</sup> In addition to a police investigation, the court must hold an inquest or inquiry investigating the cause of death whenever a dowry death is suspected.<sup>718</sup>

---

### **RELEVANT LAWS AND POLICIES**

- Indian Penal Code, 1860
- Code of Criminal Procedure, 1973
- Indian Evidence Act, 1872
- Dowry Prohibition Act, 1961
- Immoral Traffic (Prevention) Act, 1956

---

### **UP AND COMING LEGISLATION**

- Sexual Offenses (Special Courts) Bill, 2003
- Protection from Domestic Violence Bill, 2002

### **Sexual harassment**

There is no single legislation specifically addressing sexual harassment, although the 2003 Sexual Harassment of Women at their Work Place (Prevention) Bill is currently pending before parliament.<sup>719</sup>

In the landmark 1997 Supreme Court case *Vishaka vs. State of Rajasthan*, the court ruled that sexual harassment is a violation of the constitution.<sup>720</sup> Specifically, the decision held that sexual harassment is a violation of the constitutional right to practice any profession, trade or business, since the right to work is contingent upon a safe working environment, and the right to life with dignity.<sup>721</sup> The court defined sexual harassment as “unwelcome sexually determined behaviour (whether directly or by implication),” including the following:

- physical contact and advances;
- a demand or request for sexual favors;
- sexually colored remarks;
- showing pornography; and
- any other unwelcome physical, verbal and nonverbal conduct of a sexual nature.<sup>722</sup>

Subsequent to the judgement, both public and private employers have a duty to include a prohibition of sexual harassment in their service rules as a specific act of misconduct and establish a permanent committee to deal with complaints and recommend suitable disciplinary action to be taken by the employer.<sup>723</sup>

In accordance with the *Vishaka* ruling, the National Commission of Women formulated the Code of Conduct for Work Place.<sup>724</sup> Duties of employers include providing for effective complaint procedures and remedies.<sup>725</sup>

Courts have continued to issue important rulings upholding women’s right to be free from sexual harassment. In the 1999 Supreme Court case *Apparel Export Promotion Council v. A.K. Chopra*, the court upheld the decision of a disciplinary committee to remove a person from service for sexual harassment of a woman at the workplace.<sup>726</sup>

### **Commercial Sex Work**

The 1956 Immoral Traffic (Prevention) Act defines “prostitution” as “the sexual exploitation or abuse of persons for commercial purposes.”<sup>727</sup> The act does not directly criminalize all commercial sex work, although it does criminalize a number of related activities.<sup>728</sup> Prostitution in or near a public place and seduction or soliciting for the purposes of prostitution, for example, are criminal offenses.<sup>729</sup> The act covers children (persons under age 16); minors (persons under age 18); and majors (persons age 18 or older), whether male or female.<sup>730</sup> A 2003 decision of the Allahabad High Court directed the state government to economically empower women working as prostitutes in cities by providing them

with technical training programs.<sup>731</sup>

### **Sex-Trafficking**

The constitution expressly prohibits the traffic in human beings for certain forms of forced labour.<sup>732</sup> The Indian Penal Code also contains provisions related to trafficking of persons and other offenses. It imposes criminal penalties for kidnapping or abduction for various purposes, buying or selling a person for slavery, buying or selling a minor for prostitution, procuring a minor girl, and rape.<sup>733</sup>

The main legislative tool for combating trafficking in persons is the Immoral Traffic (Prevention) Act. The act does not define “trafficking” or establish criminal penalties for “trafficking” as such. The activities that are criminalized under the act include keeping a brothel or allowing premises to be used as a brothel; living on the earnings of prostitution; procuring a person for prostitution, with or without consent; soliciting for prostitution; and seducing a person for prostitution while in custody.<sup>734</sup> To “procure, induce or take a person” for prostitution is punishable with a three-year minimum prison sentence and a fine.<sup>735</sup> The penalties for these offenses vary from three months to ten years plus a fine, with stiffer penalties—up to 14 years imprisonment or even life, but not fewer than seven years—for offenses that involve a child under the age of 16 or offenses that were committed against the will of any person.<sup>736</sup> The penalties for solicitation vary depending on the gender of the solicitor: for a woman, up to six months for the first offense and up to one year for subsequent offenses; for a man, seven days to three months.<sup>737</sup> In addition, in the case of a female offender, in lieu of a prison sentence, the court may place the woman in a corrective institution for two to five years, or until there is a determination that there is a “reasonable probability that the offender will lead a useful and industrious life.”<sup>738</sup> The state is obligated to provide for such corrective institutions.<sup>739</sup>

The act contains a number of law enforcement measures. Police officers may carry out a search of any premises under the act without a warrant.<sup>740</sup> The police are also empowered to rescue persons found in brothels.<sup>741</sup> Additionally, the act provides for the appointment of trafficking police officers to investigate crimes with interstate ramifications and calls for special police officers assigned to specific areas to enforce the act.<sup>742</sup> State governments are authorized to establish an unofficial advisory body consisting of up to five leading social workers from the area, including women, to advise the special police officers on implementation of the act.<sup>743</sup>

Although the Immoral Traffic (Prevention) Act and other national laws apply in all states of India, their enforcement is primarily left to the state governments, and the states may enact their own laws.<sup>744</sup> For example, the state of Maharashtra enacted its own Organized Crime Act, which could be used to

prosecute more organized forms of trafficking.<sup>745</sup> The Immoral Traffic (Prevention) Act specifically authorizes the central or state governments to establish special courts for the speedy disposal of cases and implementing rules to carry out its purposes.<sup>746</sup>

In response to the suggestion of various studies that existing laws tend to penalize the prostitute or sex worker more severely than the perpetrator, the government requested the National Law School of India University in Bangalore to thoroughly review the body of law dealing with sex-trafficking and make recommendations for legal reform.<sup>747</sup> The law school's final report is under consideration by the government in consultation with the National Commission for Women.<sup>748</sup>

## IV. Focusing on the Rights of a Special Group: Adolescents

The reproductive rights of adolescents, particularly the girl child, are often neglected. Adolescents face many age-specific disadvantages that are not addressed through formal laws and policies. The ability of adolescents to access the health system, their rights within the family, their level of education, and their vulnerability to sexual violence together determine the state of their reproductive health and their overall well-being. The following section presents some of the factors that shape adolescents' reproductive lives in India.

### A. REPRODUCTIVE HEALTH

India has more than 10 million pregnant adolescents and adolescent mothers, and one in six girls begin childbearing between the ages of 13 and 19.<sup>750</sup> Some 56% of adolescent girls are anemic, and 7.4% of married girls aged 15–19 use contraception.<sup>751</sup> Among mothers under the age of 20, 68.7% receive prenatal care from a health worker and 41.6% give birth with the assistance of a skilled birth attendant.<sup>752</sup> Unsafe abortions account for half of the maternal deaths among girls aged 15–19.<sup>753</sup> Of married women aged 15–24, only 37.2% have heard of HIV/AIDS.<sup>754</sup> Women and girls also lack knowledge about prenatal care and lactation for the health of the mother and child, and lack access to pre- and postnatal services.<sup>755</sup>

There are no specific government health policies or programs specifically targeting adolescents' reproductive health. However, the Tenth Five Year Plan and the National Population Policy include provisions that address

certain aspects of adolescents' reproductive health.<sup>756</sup>

The government increasingly has acknowledged that the health needs of adolescents are significant and should be addressed in future programs. The Tenth Five Year Plan specifically recognizes that the process of empowering women necessitates a "life-cycle approach" and that "every stage of [women's] lives counts as a priority in the planning process."<sup>757</sup> One of the plan's main objectives is to eliminate discrimination and all forms of violence against women and the girl child, recognizing that increasing violence against these groups and persistent discrimination against the girl child are critical areas of concern requiring government attention.<sup>758</sup> Specifically, the plan calls for "urgent interventions to protect the girl child," who continues to be a "victim of various types of discrimination, both within and outside the family."<sup>759</sup>

The National Population Policy acknowledges that the needs of adolescents have not been specifically addressed in previous policies. It calls for programs to encourage delayed marriage and childbearing and to educate adolescents about the risks of unprotected sex.<sup>760</sup> It highlights the needs of adolescents in rural areas, where early marriage and pregnancy are widespread, and calls for information, counseling, education on population, accessible and affordable contraceptive services, food supplements and nutritional services, and enforcement of the Child Marriage Restraint Act to address the special needs of this group.<sup>761</sup>

The action plan to implement the National Population Policy calls for the development of a health-care package for adolescents.<sup>762</sup> It also encourages community education outreach to adolescents about the availability of safe abortion services and the dangers of unsafe abortion.<sup>763</sup> It enjoins states to ensure adolescents' access to information, counseling and affordable services, including reproductive health services, and to strengthen primary health centers and subcenters to include counseling services for adolescents and newlyweds, specifically on proper birth spacing.<sup>764</sup>

The Department of Women and Child Development drafted a National Policy and Charter for Children in 2001, which is still under review. The draft policy calls upon the state to "take measures to ensure that all children enjoy the highest attainable standard of health."<sup>765</sup> It specifically recognizes the right to protection of the girl child, and requires the state and communities to take the following actions:

- ensure that offenses committed against the girl child, including child marriage, forcing girls into prostitution and trafficking are speedily abolished;
- undertake measures, including social, educational and legal, to ensure that there is greater respect for the girl

child in the family and society; and

- take serious measures to ensure that the practice of child marriage is speedily abolished.<sup>766</sup>

Additionally, the draft policy calls upon the state and community to undertake special programs to improve the health and nutritional status of children.<sup>767</sup>

NGO providers of reproductive health services and information include the Bharat Scouts and Guides' Healthy Adolescent Project in India, Parivar Seva Sanstha and Marie Stopes International's partner in India, Population Health Services. The Family Planning Association of India has a program that provides counseling for young newlyweds and engaged couples as well as free family planning services to married couples.<sup>768</sup>

## B. MARRIAGE

On average, the age at first marriage for women aged 20–49 is 16.7, with a two-year difference between urban and rural women.<sup>769</sup> In urban areas, 18% of females aged 15–19 have been married, compared with 3% of men in the same age group.<sup>770</sup> In rural areas, comparable statistics are 40% of women and 8% of men.<sup>771</sup> According to national household surveys, only 38.6% of married women aged 15–19 are involved in decisions about their own health care and 86% need permission just to go to the market.<sup>772</sup>

The Child Marriage Restraint Act requires that the bridegroom be at least 21 years old and the bride at least 18.<sup>773</sup> Under the act, a man over the age of 21 marrying a child is punishable by imprisonment of up to three months and a fine, but a man between ages 18–21 is subject to a punishment of up to 15 days and a fine of up to Rs 1,000.<sup>774</sup> To further discourage child marriages, the act also punishes any parent or guardian of a minor who promotes or permits a child marriage to be solemnized, or who negligently fails to prevent it from being solemnized, with up to three months imprisonment and a fine.<sup>775</sup> Although the law invites penal action for child marriages, the act does not render such marriages void.

The Special Marriage Act and 1969 Foreign Marriage Act have similar age requirements as the Child Marriage Restraint Act.<sup>776</sup>

Despite the law, in practice the minimum age of marriage varies among communities and is governed by each community's respective personal laws. (See "Rights within Marriage" for more information on laws relating to marriage.)

### *Laws governing Hindus*

Marriage among adolescent Hindus is governed by the Hindu Marriage Act, which requires that the bridegroom be at least 21 years of age and the bride at least 18 at the time of mar-

riage.<sup>777</sup> (See "Marriage Laws governing Hindus" section for more information.)

### *Laws governing Muslims*

Each of the various schools of Islam has its own personal law that governs the legal age for marriage. Generally, one marriage is allowed for those who have reached puberty, which is presumed to occur at 15 years of age.<sup>778</sup> (See "Marriage Laws governing Muslims" for more information.)

### *Laws governing Christians*

Under the Indian Christian Marriage Act, the legal minimum age for marriage is 21 years for males and 18 years for females.<sup>779</sup> Minors may be married with the consent of the minor's father or guardian.<sup>780</sup> The act voids any marriage solemnized in contravention of its provisions and penalizes the person solemnizing the marriage of a minor in contravention of the act.<sup>781</sup> (See "Marriage Laws governing Christians" for more information.)

### *Laws governing Parsis*

The Parsi Marriage and Divorce Act stipulates that a marriage shall not be valid unless the male has completed 21 years of age and the female 18 years of age.<sup>782</sup> (See "Marriage Laws governing Parsis" for more information.)

## C. EDUCATION

The gross enrollment ratio for girls at the primary school level is close to 85%, compared with 100% for boys.<sup>783</sup> Only one-third of girls who enter primary school ultimately complete their schooling.<sup>784</sup> Some 38% of girls aged 15–19 are enrolled at the secondary school level, compared with 59% of boys in the same age group.<sup>785</sup> Forty million children have never entered schools.<sup>786</sup>

The constitution's Directive Principles of State Policy enjoin the state to provide free and compulsory education for all children up to the age of 14.<sup>787</sup> The 86<sup>th</sup> Amendment to the constitution makes free and compulsory education a fundamental right for children between the ages of 6–14.<sup>788</sup> The amendment encourages but does not mandate the state to provide early childhood care and education for children below the age of six.<sup>789</sup> The amendment also charges the parent or ward of the child with the responsibility to provide educational opportunities to the child.<sup>790</sup>

With respect to primary level education, the National Policy on Education calls for universal access and enrollment, universal retention of children up to the age of 14 and improvements in the quality of education.<sup>791</sup> The policy's objectives for secondary education include increasing the enrollment of girls and children of the scheduled castes and

## UP AND COMING LEGISLATION

- National Policy and Chart for Children, 2001

tribes, particularly in science, commerce and vocational fields.<sup>792</sup> The policy's 1992 Programme of Action makes recommendations for centrally sponsored special education development programs for girls belonging to scheduled castes of very low literacy; non-formal and distance education programs for children of scheduled castes who cannot attend formal school; scholarships and the provision of uniforms, textbooks, stationary and mid-day meals for children of scheduled castes and tribes and other "backward" sections; and special incentives to low-income families among scheduled castes and tribes to send their children, particularly girls, to school.<sup>793</sup>

The draft National Policy and Charter for Children recognizes the right to free elementary education for all children and calls upon the state to provide access to education at the secondary level.<sup>794</sup> It further recognizes the right of adolescents to education and the development of skills.<sup>795</sup> It specifically requires the state "to take appropriate measures to ensure that the education is sensitive to the rights of the girl child."<sup>796</sup>

Several government initiatives have been launched to promote access to education at the secondary level, including the provision of free secondary education to girls in some states, scholarship programs for members of vulnerable groups, including girls of scheduled castes and tribes, and assistance to voluntary organizations to strengthen boarding and hostel facilities for female students at the secondary and higher levels.<sup>797</sup>

The *Sarva Shiksha Abhiyan*, launched in 2000, is an educational program specially targeted toward "un-reached women and the girl child."<sup>798</sup> The program aims to provide quality elementary education to all children in the 6–14 age group by 2010 as well as bridge all gender and social gaps at the primary level by 2007.<sup>799</sup> The Tenth Five Year Plan commits to making full efforts to ensure that the program achieves its objectives within its established time limits.

The Non-Formal Education system operates coeducational and all-girls centers to meet the needs of students unable to attend formal schooling.<sup>800</sup> As a special initiative for girls, the government has increased the number of non-formal centers that are run exclusively for girls to approximately 100,000 out of 270,000.<sup>801</sup>

Adolescent girls in India have extremely limited knowledge of sexuality, reproduction and menstruation.<sup>802</sup> The Nutrition Foundation of India estimates that the average age of menarche is 13.4, yet 50% of both urban and rural girls aged 12–15 have no understanding of this basic biological process.<sup>803</sup>

India recently included sex education in its National Curriculum, with segments on HIV/AIDS awareness, adolescent education and life skills.<sup>804</sup> The central government and states run separate HIV/AIDS awareness programs in secondary schools, although these programs have not yet been fully implemented and states vary in the topics they will cover.<sup>805</sup> Some significant programs have been implemented by NGOs. One example is the Bharat Scouts and Guides' Healthy Adolescent Project, which provides training in physiological aspects of reproductive health and promotes discussions of gender relations, confidence and relationships.<sup>806</sup> Another NGO program offers counseling and free services to engaged and recently married couples.<sup>807</sup>

#### **D. SEXUAL OFFENSES AGAINST MINORS**

Certain sexual offenses against minors are governed by the Indian Penal Code and by the Immoral Traffic (Prevention) Act. The Indian Penal Code levies a punishment of imprisonment and fines for the kidnapping of a minor, procuring of a minor girl for illicit intercourse, buying or selling a minor for the purposes of prostitution, and rape.<sup>808</sup> A man commits statutory rape upon having intercourse with any female under the age of 16 and may be punished with a prison term of seven years to life.<sup>809</sup> If the girl is under 12, the minimum prison term is ten years.<sup>810</sup>

Under the Immoral Traffic (Prevention) Act, anyone who procures, induces or takes a youth between the ages of 16–18 for the sake of prostitution is punishable with seven to fourteen years imprisonment, and seven years to life if it involves a youth under age 16.<sup>811</sup> Additionally, any person with custody, charge or care of, or authority over a minor, and who aids, abets or causes the minor to be seduced into prostitution, is punishable with seven to ten years imprisonment.<sup>812</sup>

According to the draft National Policy and Charter for Children, all children have a right to protection from all forms of abuse, exploitation and violence, including sexual and physical abuse and trafficking.<sup>813</sup> The draft policy calls for states to ensure that children are not exploited for illegal activities, especially prostitution and pornography, and that children who are victimized receive immediate care and protection.<sup>814</sup> The draft policy also urges states and communities to abolish violence against the girl child, including child marriage, forced prostitution and trafficking.<sup>815</sup>

## ENDNOTES

1. See TIME ALMANAC 2000: MILLENNIUM COLLECTOR'S EDITION 233 (1999) [hereinafter TIME ALMANAC 2000]. The British crown officially took over the administration of the Indian colony following the Sepoy Mutiny in 1857–58. Partition unleashed unprecedented anguish, bloodshed and death as an estimated 17 million Hindu and Muslim refugees fled to either India or Pakistan, creating the largest migration in human history. The two fledgling countries also engaged in a variety of disagreements, including control over Kashmir. Unresolved disputes and antagonistic relations have led to constant and continued conflict, escalating into war in 1947 and 1971.
2. See *id.*
3. See *id.*
4. See *id.* The Allahabad High Court disqualified Ms. Gandhi's election on the grounds of electoral misconduct involving the use of official machinery. It was found that the landslide victory she had achieved had been fixed and that she had received illegal aid from civil servants.
5. See *id.*
6. See *id.*
7. See *id.*
8. See *id.* at 234.
9. See Census of India: 2001, Provisional Population Totals: India, <http://www.censusindia.net/results/resultsmain.html> (last visited Nov. 11, 2003) [hereinafter Census of India 2001].
10. See *id.* The ratio of females per 1,000 males is 1,070 in Himachal Pradesh; 1,068 in Kerala; 1,019 in Goa; 1,000 in Tamil Nadu; 824 in Delhi; 880 in Rajasthan; and 888 in Haryana. See also Consideration of Reports Submitted by States Parties under Article 18 of Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Initial reports of States parties, India, CEDAW Committee, 22nd Sess., ¶ 21, U.N. Doc. CEDAW/C/IND/1 (1999) [hereinafter CEDAW Committee, States parties initial reports, India].
11. INDIA CONST., 8th sched., available at <http://parliamentofindia.nic.in/const/const.html> (last visited Sept. 22, 2003). See also TIME ALMANAC 2000, *supra* note 1, at 754.
12. See TIME ALMANAC 2000, *supra* note 1, at 232.
13. See Federal Research Division, Library of Congress, Country Studies: India, ch. 3, Other Minority Religions: Zoroastrianism (James Heitzman and Robert L. Worden, eds. 1995), <http://lcweb2.loc.gov/frd/cs/intoc.html> (last visited Dec. 16, 2003) [hereinafter Library of Congress country studies, India]. These totals are from the 1991 Indian census.
14. See United Nations, List of Member States, <http://www.un.org/Overview/unmember.html> (last visited Sept. 22, 2003).
15. See DEPARTMENT OF STATE OF THE UNITED STATES OF AMERICA, COUNTRIES AND REGIONS, INDIA, available at <http://www.state.gov/r/pa/bgn/index.cfm?docid=3454> (last visited Sept. 22, 2003); see also COMMONWEALTH SECRETARIAT, COMMONWEALTH COUNTRIES, at <http://www.thecommonwealth.org/dynamic/Country.asp> (last visited Sept. 22, 2003).
16. See D.K. AGARWAL, INTERNATIONAL ENCYCLOPEDIA OF LAWS: CONSTITUTIONAL LAW, vol. 3, ¶ 12, at 33 (1993) [hereinafter INTERNATIONAL ENCYCLOPEDIA OF LAWS].
17. INDIA CONST., pmbl.
18. See INTERNATIONAL ENCYCLOPEDIA OF LAWS, *supra* note 16, ¶ 30, at 45.
19. See *id.* ¶ 39, at 48.
20. See INDIA CONST., pt.V; see also INTERNATIONAL ENCYCLOPEDIA OF LAWS, *supra* note 16, at 34.
21. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 11.
22. See Library of Congress country studies, India, *supra* note 13, ch. 8, The Structure of Government: The Executive (last visited Sept. 22, 2003).
23. See *id.*
24. See *id.*
25. See *id.*
26. See *id.*
27. INDIA CONST., arts. 54(a)–(b), 56(1). An eligible candidate for the office of the presidency must be a citizen of India, at least 35 years of age and qualified for election as a member of the Lok Sabha (House of the People). *Id.* art. 58. A candidate may not hold any national, state or local government office for profit. *Id.* art. 59.
28. *Id.* art. 61(1), (4).
29. See Library of Congress country studies, India, *supra* note 13, ch. 8, The Structure of Government: The Executive (last visited Sept. 22, 2003).
30. See INTERNATIONAL ENCYCLOPEDIA OF LAWS, *supra* note 16, at 74.
31. INDIA CONST., arts. 74(1), 75(3).
32. *Id.* art. 74(1).
33. *Id.* arts. 75(1), 78(a)–(c).
34. *Id.* art. 79.
35. *Id.* art. 80(1), (3)–(4).
36. *Id.* art. 83(1)–(2). Eligible candidates for membership in the Rajya Sabha must be citizens of India and at least 30 years of age, and must possess other qualifications as prescribed by law. *Id.* art. 84(a)–(c).
37. *Id.* art. 83(1).
38. *Id.* art. 81(1)(a)–(b). Eligible candidates for membership in the Lok Sabha must be citizens of India and at least 25 years of age, and must possess other qualifications as prescribed by law. *Id.* art. 84.
39. *Id.* arts. 81(2)(a)–(b), 82.
40. *Id.* art. 83(2).
41. The Constitution (84th Amendment) Bill (1998) (India), <http://www.altindia.net/gender/readings/84AMENDMENT.html> (last visited Dec. 16, 2003). See *Talks on for passing Women's Bill*, THE HINDU (Apr. 25, 2003); see CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 109.
42. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 109; see also *Chaos over Indian Women's Bill*, BBC NEWS (May 6, 2003), available at [http://news.bbc.co.uk/2/hi/south\\_asia/3002979.stm](http://news.bbc.co.uk/2/hi/south_asia/3002979.stm) (last visited Sept. 22, 2003).
43. See Library of Congress country studies, India, *supra* note 13, ch. 8, The Structure of Government: The Executive (last visited Dec. 3, 2003).
44. See INTERNATIONAL ENCYCLOPEDIA OF LAWS, *supra* note 16, at 35.
45. Money bills can only originate in the Lok Sabha. If they are passed in the Lok Sabha, they move to the Rajya Sabha for recommendation. The Rajya Sabha has 14 days to make recommendations, but the bill passes regardless of whether the Lok Sabha incorporates the recommendations. INDIA CONST., arts. 107(1), 109(1)–(2), 110, 117.
46. *Id.* 7th sched.
47. *Id.* 7th sched., List I.
48. *Id.* art. 248.
49. *Id.* 7th sched., List III.
50. See Library of Congress country studies, India, *supra* note 13, ch. 8, The Structure of Government: The Executive (last visited Dec. 3, 2003).
51. INDIA CONST., art. 249(1).
52. *Id.* art. 252.
53. *Id.*
54. *Id.* art. 3. See Library of Congress country studies, India, *supra* note 13, ch. 8, The Structure of Government: The Judiciary (last visited Dec. 3, 2003).
55. Ministry of Home Affairs, Government of India, at <http://mha.nic.in/stat.htm> and <http://mha.nic.in/unio.htm> (last visited Dec. 3, 2003). See also Embassy of India, Washington, DC, at <http://www.indianembassy.org/dydemo/indiaprofile/profile.htm> (last visited Dec. 3, 2003).
56. INDIA CONST., art. 153. Eligible candidates for governor must citizens of India and at least 35 years of age, and must not be a member of either the national or state legislature. *Id.* arts. 157–158.
57. *Id.* arts. 155, 156(3).
58. *Id.* art. 163(1).
59. *Id.* art. 164.
60. *Id.* art. 239.
61. *Id.* art. 168(1)(a)–(b). A state legislature consisting of only one house is called a legislative assembly. A bicameral state legislature consists of a legislative council and a legislative assembly. *Id.* art. 168(2). Members of the legislative council serve five-year terms, with one-third of the membership retiring every two years. They must be at least 30 years of age and citizens of India. Members of the legislative assembly also serve five-year terms, and must be at least 25 years of age and citizens of India. *Id.* arts. 172–173.
62. *Id.* art. 170(2).
63. See Library of Congress country studies, India, *supra* note 13, ch. 8, The Structure of Government: State Governments and Territories (last visited Sept. 23, 2003); see also Chandigarh City Government, at <http://chandigarh.nic.in/frctg.htm> (last visited Dec. 5, 2003).
64. George Mathew, Decentralized Governance through Panchayati Raj: A Presentation, Forum on Intergovernmental Relations and Improved Services Delivery in Pakistan, Bhurban, Murree, June 27–29, 2003, available at <http://lnweb18.worldbank.org/sar/sa.nsf/0/d485d3126299ec6545256d52001cf1b8?OpenDocument> (last visited Dec. 16, 2003).
65. INDIA CONST., amend., 69.
66. *Id.* amend., 73–74.
67. *Id.*
68. *Id.* amend., 73, art. 243c(2), d(3), r(2), t(3).
69. *Id.* art. 243d(1)–(2), t(1)–(2).
70. *Id.* art. 243d(4), t(4).
71. *Id.* art. 243(g), (w). See also CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 35.
72. INDIA CONST., 11th sched.
73. See INTERNATIONAL ENCYCLOPEDIA OF LAWS, *supra* note 16, at 35.
74. INDIA CONST., art. 141.
75. See Library of Congress country studies, India, *supra* note 13, ch. 8, The Structure of Government: The Judiciary (last visited Sept. 23, 2003).
76. See *id.*
77. See Supreme Court of India, Jurisdiction of the Supreme Court, [http://supremecourtindia.nic.in/new\\_s/juris.htm](http://supremecourtindia.nic.in/new_s/juris.htm) (last visited Dec. 4, 2003).
78. See *id.*
79. INDIA CONST., art. 124(1).
80. *Id.* art. 124(2).
81. See Library of Congress country studies, India, *supra* note 13, ch. 8, The Structure of Government: The Judiciary (last visited Sept. 23, 2003).
82. INDIA CONST., art. 124(2). Judges serving on the Supreme Court must be citizens of

- India and must have served as judge on a high court for at least five years, as an advocate of the high court for ten years, or as a distinguished jurist in the opinion of the president. *Id.* art. 124(3).
83. *Id.* art. 124(4).
84. See Indian Courts, Ministry of Law and Justice, Government of India, [http://indiancourts.nic.in/indian\\_jud.htm](http://indiancourts.nic.in/indian_jud.htm) (last visited Sept. 23, 2003); see Library of Congress country studies, India, *supra* note 13, ch. 8, The Structure of Government: High Courts (last visited Sept. 23, 2003).
85. INDIA CONST., art. 217. High court judges must be citizens of India and must have worked as a judicial officer or an advocate for ten years.
86. *Id.* art. 217(1).
87. See Library of Congress country studies, India, *supra* note 13, ch. 8, The Structure of Government: Lower Courts (last visited Nov. 11, 2003).
88. *See id.*
89. See INTERNATIONAL ENCYCLOPEDIA OF LAWS, *supra* note 16, pt. 2, ch. 5, §3.
90. The Family Court Act, No. 66 (1984) (India). *See also* CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 366.
91. Family Court Act § 4(1), (4)(b).
92. See Library of Congress country studies, India, *supra* note 13, ch. 8, The Structure of Government: Lower Courts (last visited Oct. 14, 2003).
93. *See id.*
94. INDIA CONST., art. 323(a)–(b).
95. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 99; *see also* Legal Services Authorities Act, No. 39, Introduction (1987) (India) (Am. 1994, 1996, 2002).
96. *See id.*
97. See Supreme Court of India, Jurisdiction of the Supreme Court, at [http://supremecourtindia.nic.in/new\\_s/juris.htm](http://supremecourtindia.nic.in/new_s/juris.htm) (last visited Dec. 4, 2003).
98. Legal Services Authorities Act, No. 39 (1987) (India).
99. *See id.*; *see also* Indian Courts, Ministry of Law and Justice, Government of India, at [http://indiancourts.nic.in/indian\\_jud.htm](http://indiancourts.nic.in/indian_jud.htm) (last visited Sept. 23, 2003).
100. Legal Services Authorities (Amendment) Act, No. 37, § 4 (2002) (India).
101. *Id.* § 4(22)(C).
102. *Id.* § 4(22)(C)–(E).
103. See Press Release, Ministry of Law, Justice and Company Affairs, Government of India, President's Assent to Three More Bills (June 18, 2002), <http://www.pib.nic.in/archieve/lreng/lyr2002/rjun2002/18062002/r180620022.htm> 1 (last visited Oct. 14, 2002).
104. See Consideration of Reports Submitted by States Parties Under Article 44 of the Convention on the Rights of the Child, Initial reports of States parties due in 1995, Addendum, India, CRC Committee, 22nd Sess., ¶ 10, U.N. Doc. CRC/C/28/Add.10 (1997).
105. See Central Social Welfare Board, at <http://www.cswb.org/board.htm> (last visited Nov. 11, 2003).
106. See CENTRE FOR SOCIAL AND TECHNOLOGICAL CHANGE, REPRODUCTIVE AND SEXUAL HEALTH RIGHTS IN INDIA, ch. 3, § 3.4.5 (2000) [hereinafter REPRODUCTIVE AND SEXUAL HEALTH RIGHTS IN INDIA].
107. See Voluntary Health Association of India, at <http://www.vhai.org/> (last visited Dec. 4, 2003).
108. See CHUN-CHI YOUNG, MODERN LEGAL SYSTEMS CYCLOPEDIA, THE LEGAL SYSTEM OF THE REPUBLIC OF INDIA (Kenneth Robert Redden & Linda L. Schlueter eds., 2001), vol. 9, § 1.5(A), at 9.80.29 [hereinafter MODERN LEGAL SYSTEMS CYCLOPEDIA].
109. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 11.
110. See INDIA CONST., pt. III. Fundamental rights guaranteed by the Constitution include the rights to equality before the law; nondiscrimination on grounds of religion, caste, sex, or place of birth; freedom of speech and peaceful assembly; and freedom of religion. *Id.* art. 14–15, 19, 25. The constitution also abolishes untouchability. *Id.* art. 17.
111. *See id.* pt. IV.
112. See Department of Legal Affairs, Ministry of Law and Justice, Government of India, at <http://lawmin.nic.in/Legal.htm> (last visited Sept. 23, 2003).
113. National Commission to Review the Working of the Constitution, Department of Legal Affairs, Ministry of Law and Justice, Government of India, at <http://ncrc.nic.in> (last visited Oct. 14, 2003).
114. NATIONAL COMMISSION TO REVIEW THE WORKING OF THE CONSTITUTION, MINISTRY OF LAW AND JUSTICE, GOVERNMENT OF INDIA, REPORT OF THE NATIONAL COMMISSION TO REVIEW THE WORKING OF THE CONSTITUTION, vol. 1, ch. 11, recommendation nos. 2, 8–9, 16, <http://lawmin.nic.in/ncrcw/finalreport/v1ch11.htm> (last visited Oct. 14, 2003).
115. *Id.* recommendation no. 24.
116. *Id.* recommendation no. 239.
117. INDIA CONST., pt. IV, art. 44. *See* REPRODUCTIVE AND SEXUAL HEALTH RIGHTS IN INDIA, *supra* note 106, ch. 3, § 3.3.2.
118. Supreme Court of India, at [http://supremecourtindia.nic.in/new\\_s/constitution.htm](http://supremecourtindia.nic.in/new_s/constitution.htm) (last visited Sept. 22, 2003).
119. Law Commission of India, Ministry of Law and Justice, Government of India, at <http://lawcommissionofindia.nic.in/> (last visited Sept. 23, 2003).
120. See National Commission for Women, at [http://www.ncw-india.org/about\\_ncw/brief\\_history.php](http://www.ncw-india.org/about_ncw/brief_history.php) (last visited Oct. 14, 2003); *see also* National Human Rights Commission, at <http://nhrc.nic.in/> (last visited Oct. 14, 2003).
121. See Supreme Court of India, at [http://supremecourtindia.nic.in/new\\_s/constitution.htm](http://supremecourtindia.nic.in/new_s/constitution.htm) (last visited Sept. 23, 2003).
122. *See id.*
123. See Indian Courts, Ministry of Law and Justice, Government of India, at [http://indiancourts.nic.in/indian\\_jud.htm](http://indiancourts.nic.in/indian_jud.htm) (last visited Dec. 4, 2003).
124. See V. Ramakrishnan, *Guide to Indian Laws* (2001), available at <http://www.llrx.com/features/indian.htm> (last visited Dec. 4, 2003).
125. See MODERN LEGAL SYSTEMS CYCLOPEDIA, *supra* note 108, at 9.80.30. In the union territory of Goa, however, there is one family code applicable to all citizens irrespective of religion. The code is based largely on Portuguese family law. *See* Memorandum from Jaya Sagade to the Center for Reproductive Rights (Sept. 1, 2003) (on file with the Center for Reproductive Rights).
126. *See* Memorandum from Jaya Sagade, *supra* note 125. The Muslim Personal Law (Shariat) Application Act of 1937 states that “in all questions (save questions relating to agricultural land) regarding intestate succession, special property of females ... marriage, dissolution of marriage ... maintenance, dower, guardianship, gifts, trust and trust properties, and *walafs* ... the rule of decision in cases where the parties are Muslims shall be the Muslim Personal Law (*shariat*).” Muslim Personal Law (Shariat) Application Act, No. 26, § 2 (1937) (India).
127. See REPRODUCTIVE AND SEXUAL HEALTH RIGHTS IN INDIA, *supra* note 106, ch. 3, § 3.3.2.
128. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 363.
129. *See id.*
130. *See id.*
131. *See* Memorandum from Jaya Sagade, *supra* note 125.
132. For example, the 1955 Hindu Marriage Act prohibits marriages between certain closely related individuals. Hindu Marriage Act, No. 25, § 5(iv)–(v), 11 (1955) (India). However, if there is a custom prevalent in both families contrary to such provision, then custom prevails over the statutory prohibition. *See* Memorandum from Jaya Sagade, *supra* note 125.
133. See NATIONAL DEVELOPMENT COUNCIL, PLANNING COMMISSION, TENTH FIVE YEAR PLAN (2002–2007), available at <http://planningcommission.nic.in/plans/plan-rel/fiveyr/10th/default.htm> (last visited Sept. 23, 2003) [hereinafter TENTH FIVE YEAR PLAN].
134. INDIA CONST., art. 51.
135. *See* Memorandum from Jaya Sagade, *supra* note 125.
136. *Vishaka v. State of Rajasthan*, 1997 SOL 177 (India), [www.supremecourtindia.nic.in/cases/2447.html](http://www.supremecourtindia.nic.in/cases/2447.html). The Supreme Court quoted relevant articles of CEDAW in developing guidelines regarding sexual harassment of women in the workplace.
137. See CEDAW, adopted Dec. 18, 1979, U.N. GAOR, 34th Sess. Supp. No. 46, U.N. Doc. A/34/46, at 193 (1979) (*entered into force* Sept. 3, 1981) (*ratified by India* Aug. 8, 1993); Convention on the Rights of the Child, adopted Nov. 20, 1989, G.A. Res. 44/25, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49, at 166 (1989) (*entered into force* Sept. 2, 1990) (*ratified by India* Jan. 11, 1993); International Convention on the Elimination of All Forms of Racial Discrimination, adopted Dec. 21, 1965, 660 U.N.T.S. 195 (*entered into force* Jan. 4, 1969) (*ratified by India* Jan. 4, 1969); International Covenant on Civil and Political Rights, adopted Dec. 16, 1966, 999 U.N.T.S. 3 (*entered into force* Mar. 23, 1976) (*ratified with reservations by India* July 10, 1979); International Covenant on Economic, Social, and Cultural Rights, adopted Dec. 16, 1966, 993 U.N.T.S. 3, (*entered into force* Jan. 3, 1976) (*ratified by India* July 10, 1979).
138. See CEDAW, Reservations made by India, <http://www.unhcr.ch/tbs/doc.nsf/StatusofReservations?OpenFrameSet> (last visited Sept. 23, 2003).
139. *Vienna Declaration and Programme of Action, World Conference on Human Rights*, Vienna, Austria, June 14–25, 1993, U.N. Doc. A/CONF.157/23 (1993); *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5–13, 1994, U.N. Doc. A/CONF.171/13/Rev.1 (1995); *Beijing Declaration and the Platform for Action, Fourth World Conference on Women*, Beijing, China, Sept. 4–15, 1995, U.N. Doc. A/CONF.177/20 (1995); *Millennium Declaration, Millennium Assembly*, New York, United States, Sept. 6–8, 2000, U.N. GAOR, 55th Sess., U.N. Doc. A/Res/55/2 (2000).
140. *India keen on combating trafficking in women and children*, THE HINDU (June 9, 2003); South Asian Association for Regional Cooperation (SAARC), SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution (2002), available at <http://www.saarc-sec.org/publication/conv-trafficking.pdf> (last visited Oct. 14, 2003); *India ratifies SAARC convention on child welfare*, SOUTH ASIA MONITOR (Aug. 6, 2003), available at <http://southasiamonitor.org/events/2003/june/05child.html> (last visited Dec. 4, 2003); South Asian Association for Regional Cooperation (SAARC), SAARC Convention on Regional Arrangements for the Promotion of Child Welfare in South Asia, available at <http://www.saarc-sec.org/> (last visited Dec. 4, 2003).
141. INDIA CONST., art. 47.
142. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2, ¶ 2.8.216.
143. See WORLD BANK, INDIA—RAISING THE SIGHTS: BETTER HEALTH SYSTEMS FOR INDIA'S POOR 25 (2001) [hereinafter INDIA—RAISING THE SIGHTS], available at [http://lnweb18.worldbank.org/sar/sa.nsf/Attachments/rprt/\\$File/INhlth.pdf](http://lnweb18.worldbank.org/sar/sa.nsf/Attachments/rprt/$File/INhlth.pdf) (last visited Sept. 29, 2003).
144. *See id.*
145. See MINISTRY OF HEALTH AND FAMILY WELFARE, 1998–1999 Annual Report, pt. II, ch. 7, § 7.1.3 (1999); *see also* World Health Organization (WHO), South-East Asia Regional Office (SEARO), 50 Years of WHO in South-East Asia, Highlights 1948–1998, 1978–1987: The Fourth Decade, available at <http://w3.whosea.org/aboutsearo/> (last visited Nov. 6, 2003).
146. DEPARTMENT OF HEALTH, MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT

- OF INDIA, NATIONAL HEALTH POLICY 2002, ¶ 3.1 (2002) [hereinafter NATIONAL HEALTH POLICY].
147. *Id.*
148. *Id.*
149. *Id.* box IV.
150. *Id.* ¶ 4.20.1.
151. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2.11, ¶ 2.11.8.
152. *Id.* vol. I, ch. 1, ¶ 1.22.
153. *Id.* vol. II, ch. 2.8, ¶ 2.8.7.
154. *Id.* vol. II, ch. 2.8, ¶ 2.8.62.
155. *Id.* vol. II, ch. 2.8, ¶ 2.8.64.
156. *Id.* vol. II, ch. 2.8, ¶ 2.8.82.
157. See INDIA—RAISING THE SIGHTS, *supra* note 143, at 17.
158. See Ministry of Health and Family Welfare, at <http://mohfw.nic.in/> (last visited Sept. 29, 2003).
159. See INDIA—RAISING THE SIGHTS, *supra* note 143, ¶ 1.4, 1.7.
160. MINISTRY OF HEALTH AND FAMILY WELFARE, 2001–2002 ANNUAL REPORT, pt. II, ch. 3, ¶ 3.2.1 (2002). [hereinafter MINISTRY OF HEALTH ANNUAL REPORT 2001–2002].
161. *Id.*
162. *Id.* pt. II, ch. 3, ¶ 3.2.4.
163. *Id.* pt. II, ch. 3, ¶ 3.2.8.
164. *Id.* pt. II, ch. 3, ¶ 3.3.2.
165. *Id.*
166. *Id.*
167. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 331.
168. MINISTRY OF HEALTH ANNUAL REPORT 2001–2002, *supra* note 160, pt. II, ch. 3, ¶ 3.3.2.
169. *Id.* pt. II, ch. 3, ¶ 3.3.3.
170. *Id.*
171. *Id.*
172. *Id.*
173. *Id.* pt. II, ch. 3, ¶ 3.3.4.
174. *Id.*
175. *Id.*
176. *Id.*
177. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ¶ 2.8.12, chart I.
178. *Id.* vol. II, ch. 2, chart I.
179. *Id.* vol. II, ch. 2, ¶ 2.8.26.
180. See INDIA—RAISING THE SIGHTS, *supra* note 143, ¶ 1.16.
181. See *id.* pt. 1, ¶ 1.18, at 21.
182. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2, ¶ 2.8.53.
183. *Id.*
184. MINISTRY OF HEALTH AND FAMILY WELFARE, 1999–2000 ANNUAL REPORT, pt. II, ch. 2, § 2.2 (2000) [hereinafter MINISTRY OF HEALTH ANNUAL REPORT 1999–2000].
185. NATIONAL HEALTH POLICY, *supra* note 146, ¶ 2.1.1.
186. *Id.* ¶ 3.1, box IV.
187. See INDIA—RAISING THE SIGHTS, *supra* note 143, ¶ 5, at 2.
188. See *id.* ¶ 6, at 2.
189. See VOLUNTARY HEALTH ASSOCIATION OF INDIA (VHAI) AND WHO, NATIONAL PROFILE ON WOMEN, HEALTH AND DEVELOPMENT: COUNTRY PROFILE—INDIA 57 (Sarala Gopalan and Mira Shiva, eds., 2000) [hereinafter VHAI & WHO, NATIONAL PROFILE ON WOMEN].
190. See *id.*
191. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2.8, ¶ 2.8.211.
192. *Id.* vol. II, ch. 2.8, ¶ 2.8.209.
193. See INDIA—RAISING THE SIGHTS, *supra* note 143, ¶ 1.17.
194. See *id.* ¶ 8, at 3.
195. See *id.* pt. 1, ¶ 9, at 3.
196. See *id.* ¶ 12, at 3.
197. See *id.*
198. See *id.*
199. See *id.*
200. MINISTRY OF HEALTH AND FAMILY WELFARE, 2000–2001 ANNUAL REPORT, pt. II, ch. 4, ¶ 4.1.4 (2001) [hereinafter MINISTRY OF HEALTH ANNUAL REPORT 2000–2001].
201. *Id.* pt. II, ch. 4, ¶ 4.1.5.
202. *Id.*
203. MINISTRY OF HEALTH ANNUAL REPORT 2001–2002, *supra* note 160, pt. I, ch. 9, ¶ 9.2.3.
204. *Id.*
205. *Id.*
206. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2.8, ¶ 2.8.7.
207. *Id.* vol. II, ch. 2, ¶ 2.8.192–2.8.193, fig. 2.8.33.
208. *Id.* vol. II, ch. 2, fig. 2.8.37.
209. See INDIA—RAISING THE SIGHTS, *supra* note 143, ¶ 10, at 3.
210. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2.8, fig. 2.8.37.
211. MINISTRY OF HEALTH ANNUAL REPORT 1999–2000, *supra* note 184, pt. I, ch. 3, § 3.2. See also MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA, A COMPILATION OF THE CENTRAL GOVERNMENT HEALTH SCHEME: ORDERS AND INSTRUCTIONS (1976).
212. MINISTRY OF HEALTH ANNUAL REPORT 1999–2000, *supra* note 184, pt. I, ch. 3, § 3.2.6. See also MINISTRY OF HEALTH AND FAMILY PLANNING, GOVERNMENT OF INDIA, A COMPILATION OF THE CENTRAL GOVERNMENT HEALTH SCHEME: ORDERS AND INSTRUCTIONS (1976).
213. See Employee's State Insurance Act, No. 34 (1948) (India).
214. See *id.*
215. *Id.* §§ 3, 26, 28, 39–40.
216. See Economic Editors Conference 2000, Oct. 16–18, 2000, at <http://pib.nic.in/archive/eec2000/finance/finance3.html#7> (last visited Sept. 30, 2003).
217. See *id.*
218. See *id.*
219. See *id.*
220. MINISTRY OF HEALTH ANNUAL REPORT 2000–2001, *supra* note 200, pt. I, ch. 2, ¶ 2.4.1.
221. See Memorandum from Jaya Sagade, *supra* note 125.
222. MINISTRY OF HEALTH ANNUAL REPORT 2000–2001, *supra* note 200, pt. I, ch. 2, ¶ 2.4.1.
223. See Shri Yashwant Sinha, Minister of Finance, Budget 2002–2003, pt. A, § 68 (Feb. 28, 2002), at <http://indiabudget.nic.in/> (last visited Sept. 30, 2003).
224. See *id.*
225. See *id.*
226. See LIC Launches Policy for Women, THE HINDU (Mar. 9, 2003), available at <http://www.thehindu.com/thehindu/2003/03/09/stories/2003030900931500.htm> (last visited Sept. 30, 2003).
227. See Indian Medical Council Act, No. 102 (1956) (India).
228. *Id.* § 20A(1). See also INDIAN MEDICAL COUNCIL (PROFESSIONAL CONDUCT, ETIQUETTE AND ETHICS) REGULATIONS (2002) [hereinafter INDIAN MEDICAL COUNCIL PROFESSIONAL CONDUCT REGULATIONS].
229. Indian Medical Council Act, No. 102, § 24(1) (1956) (India).
230. See Dentists Act, No. 16 (1948) (India); [Indian] Nursing Council Act, No. 48 (1947); Pharmacy Act, No. 8 (1948) (India). The Indian Nursing Council regulates and maintains uniform standards of education and training for nurses, midwives, auxiliary nurse/midwives and health visitors.
231. See Indian Medicine Central Council Act, No. 48 (1970) (India); see Homoeopathy Central Council Act, No. 59 (1973); see MINISTRY OF HEALTH ANNUAL REPORT 2000–2001, *supra* note 200, pt. III, ch. 2, ¶ 2.2.1. The philosophy of Ayurveda and the allopathic system of medicine have had a major impact on India's approach to health care and the pattern of development of India's health infrastructure. There are a large number of private practitioners in various systems such as Ayurveda, Allopathy, Unani, Sidhi, Homeopathy, Yoga, and Naturopathy. These practitioners enjoy high local acceptance and respect and consequently exert considerable influence on health beliefs and practices. See *id.* pt. III, ch. 3, ¶ 3.1.1.
232. See Indian Council of Medical Research, at <http://icmr.nic.in/abouticmr.htm> (last visited Oct. 15, 2003).
233. See *id.*
234. See *id.*
235. See INDIAN COUNCIL ON MEDICAL RESEARCH, ETHICAL GUIDELINES FOR BIOMEDICAL RESEARCH ON HUMAN SUBJECTS (2000), <http://www.icmr.nic.in/ethical.pdf> (last visited Oct. 15, 2003) [hereinafter INDIAN COUNCIL ON MEDICAL RESEARCH ETHICAL GUIDELINES].
236. See REGIONAL OFFICE FOR SOUTH-EAST ASIA, WHO, HEALTH ETHICS IN SIX SEAR COUNTRIES, HEALTH ETHICS IN ASIA, vol. 1, at 35 (Nimal Kasturiratchi, et al. eds.), available at <http://www.hf.uib.no/i/Filosofisk/seahen/vol1rev3.pdf> (last visited Oct. 1, 2003).
237. See *id.*
238. INDIAN COUNCIL ON MEDICAL RESEARCH ETHICAL GUIDELINES, *supra* note 235, at 64–68.
239. *Id.*
240. *Id.*
241. See INDIAN COUNCIL OF MEDICAL RESEARCH AND NATIONAL ACADEMY OF MEDICAL SCIENCES, DRAFT NATIONAL GUIDELINES FOR ACCREDITATION, SUPERVISION AND REGULATION OF ART CLINICS IN INDIA (2002), <http://icmr.nic.in/art/chap3.PDF> (last visited Oct. 14, 2003) [hereinafter INDIAN COUNCIL OF MEDICAL RESEARCH DRAFT ASSISTED REPRODUCTIVE TECHNOLOGIES GUIDELINES]; see TC Anand Kumar, *Proposed legislation for assisted reproduction technology clinics in India*, 5 REPRODUCTIVE BIOMEDICINE ONLINE 3.351, (Oct. 1, 2002), <http://www.sisab.net/docs/guidelines.pdf> (last visited Oct. 1, 2003).
242. INDIAN COUNCIL OF MEDICAL RESEARCH DRAFT ASSISTED REPRODUCTIVE TECHNOLOGIES GUIDELINES, *supra* note 241, § 3.10, 3.12.
243. TC Anand Kumar, *supra* note 241.
244. See INDIAN COUNCIL OF MEDICAL RESEARCH DRAFT ASSISTED REPRODUCTIVE TECHNOLOGIES GUIDELINES, *supra* note 241.
245. Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act, No. 57 (1994) (India) (amended 2001, 2003). In West Bengal, the male to female ratio is 970 females for every 1000 males, which some medical officials believe is evidence of “rampant” female foeticide. See Jhimli Mkerjee Pandey, *Parents press doctors to reveal foetus sex*, ASIA INTELLIGENCE WIRE VIA NEWSEDGE CORPORATION, Mar. 12, 2002 (quoting the former president of the Bengal Chapter of the Federation of Obstetrics and Gynaecological Societies of India, Alakendu Chatterjee, who referred to the 2001 census data). In the Haryana state in north India, the male to female ratio is even more exaggerated at 861 females to 1000 males. In neighboring Punjab, the ratio is 874 females to



- 1,000 males. See Sanjay Kumar, *India Cracks Down on Abortion of Female Fetuses*, REUTERS HEALTH, Jan. 31, 2002.
246. See Pre-conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, pmbi.
247. *Id.* §§ 3, 4(1)–(2).
248. *Id.* § 4(3), amended by Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Act 2002, No. 14, § 7 (2003).
249. *Id.* § 5(2), amended by No. 14, § 8 (2003).
250. *Id.* § 3A–B, amended by No. 14, § 18 (2003).
251. *Id.* § 23(1), (3), amended by No. 14, § 19 (2003).
252. *Id.* § 23(2), amended by No. 14, § 19 (2003).
253. *Id.* § 23(4), amended by No. 14, § 19 (2003).
254. *Id.* § 24, amended by No. 14, § 20 (2003).
255. *Id.* §§ 7–16A, amended by No. 14 (2003).
256. INDIAN MEDICAL COUNCIL PROFESSIONAL CONDUCT REGULATIONS, *supra* note 228, § 7.6.
257. *Id.*
258. INDIAN COUNCIL ON MEDICAL RESEARCH ETHICAL GUIDELINES, *supra* note 235, at 48.
259. *Id.*
260. See *Ban on Prenatal Scans Ordered Enforced*, N.Y. TIMES (Sept. 11, 2003), <http://www.nytimes.com/2003/09/11/international/asia/11BRIE4.html> (last visited Oct. 1, 2003).
261. See R.C. Goyal, *Dilemma of Doctors and Patients*, at 13 (on file with the Center for Reproductive Rights).
262. Indian Contract Act, No. 9 § 73 (1872) (India). See R.C. Goyal, *supra* note 261.
263. INDIA PEN. CODE, No. 45, § 304(A).
264. INDIA PEN. CODE, No. 45, §§ 81, 88, 92.
265. See The Consumer Protection Act, No. 68 (1986) (India); see R.C. Goyal, *supra* note 261, at 15–16.
266. The Consumer Protection Act, ch. I, § 2, Definitions. See R.C. Goyal, *supra* note 261, at 15.
267. See Poonam Verma v. Ashwin Patel and Others (1996) 4 S.C.C. 332.
268. See Indian Medical Association v. V.P. Shantha and Others (1995) 6 S.C.C. 651; Achutrao Haribhau Khodwa and Others v. State of Maharashtra and Others (1996) 2 S.C.C. 634.
269. See INDIAN MEDICAL COUNCIL PROFESSIONAL CONDUCT REGULATIONS, *supra* note 228, § 8.2.
270. See *id.*
271. See *id.*; see Memorandum from Jaya Sagade, *supra* note 125. According to some sources, patients do not make use of the Indian Medical Act because of the perception that complaints are not taken seriously by the council. See R.C. Goyal, *supra* note 261.
272. INDIAN COUNCIL ON MEDICAL RESEARCH ETHICAL GUIDELINES, *supra* note 235.
273. State of Haryana v. Smt Santra, (2000) SOL 268.
274. *Id.*
275. See TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2.10, ¶ 2.10.32.
276. See DEPARTMENT OF FAMILY WELFARE, MINISTRY OF HEALTH AND FAMILY WELFARE, REPRODUCTIVE AND CHILD HEALTH PROGRAMME, Introductory letter [hereinafter REPRODUCTIVE AND CHILD HEALTH PROGRAMME BOOKLET].
277. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ¶ 2.10.32.
278. Press Release, Population Council, Implementing a Reproductive Health Agenda in India: An Assessment of the New Policy (June 12, 1999) (on file with the Center for Reproductive Rights).
279. See REPRODUCTIVE AND CHILD HEALTH PROGRAMME BOOKLET, *supra* note 276, at 9–12.
280. See *id.*, Introductory letter.
281. Ministry of Health and Family Welfare, Reproductive and Child Health Programme, at <http://health.nic.in/reproheal.htm> (last visited Dec. 16, 2003).
282. See REPRODUCTIVE AND CHILD HEALTH PROGRAMME BOOKLET, *supra* note 276, at 5.
283. DEPARTMENT OF FAMILY WELFARE, MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA, NATIONAL POPULATION POLICY 2000 ¶ 7 (2000) [hereinafter NATIONAL POPULATION POLICY].
284. See *id.* box 2.
285. INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES (IIPS) AND ORC MACRO, NATIONAL FAMILY HEALTH SURVEY (NFHS–2), 1998–1999: INDIA, tbl. 5.4, at 132 (2000), available at <http://www.nfhsindia.org/india2.html> (last visited Sept. 29, 2003) [hereinafter INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS–2) 1998–1999]. The rate for current use is 48.2% for any method and 42.8% for modern methods.
286. TENTH FIVE YEAR PLAN, *supra* note 133, ¶ 2.10.49, fig. 2.10.13.
287. *Id.* ¶ 2.10.51.
288. INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS–2) 1998–1999, *supra* note 285, fig. 5.1, at 129.
289. *Id.* at 133.
290. *Id.*
291. See *id.*
292. Drugs and Cosmetics Act, No. 23 (1940) (India); Drugs and Cosmetics Rules (1945) (India) (amended 2001). See Central Drugs Standard Control Organization, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, at <http://cdsco.nic.in/> (last visited Oct. 2, 2003).
293. See Indian Council of Medical Research, Ministry of Health and Family Welfare, at <http://icmr.nic.in/abouticmr.htm> (last visited Oct. 2, 2003).
294. See International Consortium for Emergency Contraception (ICEC), ECPs Status and Activity by Country, at <http://www.cccinfo.org/files/ecstatusavailability.pdf> (last visited Oct. 2, 2003); see Statesman News Service, *Pills and boons for Indian women*, THE STATESMAN (Sept. 8, 2003), <http://www.thestatesman.net/page.arcview.php?clid=2&cid=50509&date=2003-09-08&currss=1> (last visited Oct. 2, 2003).
295. See International Consortium for Emergency Contraception (ICEC), ECPs Status and Activity by Country, at <http://www.cccinfo.org/files/ecstatusavailability.pdf> (last visited Oct. 2, 2003).
296. See *Emergency contraceptive help's just a phone call away*, THE TIMES OF INDIA (May 24, 2003), <http://timesofindia.indiatimes.com/cms.dll/html/uncomp/articleshow?msid=47320241> (last visited Oct. 2, 2003).
297. A.I. Democratic Women Association and Others v. Union of India and Another, (1998) 5 S.C.C. 214 (India).
298. See *id.*
299. See *Use of quinacrine as contraceptive banned*, THE HINDU 10 (Aug. 18, 1998), [www.hsph.harvard.edu/Organizations/healthnet/SAsia/repro/bolquinacrine3.html](http://www.hsph.harvard.edu/Organizations/healthnet/SAsia/repro/bolquinacrine3.html) (last visited Dec. 15, 2003).
300. See SAMA–RESOURCE GROUP FOR WOMEN AND HEALTH, UNVEILED REALITIES: A STUDY ON WOMEN'S EXPERIENCES WITH DEPO-PROVERA, AN INJECTABLE CONTRACEPTIVE 5 (2003).
301. See *id.* at 6.
302. See *id.* (quoting THE HINDU, Jan. 4, 2002).
303. INDIA PEN. CODE, No. 45, §§ 292–293.
304. Ranjit D. Udeshi v. The State of Maharashtra (1965) A.I.R. 1965 S.C. 881 (India).
305. MINISTRY OF HEALTH ANNUAL REPORT 2000–2001, *supra* note 200, pt. II 181.
306. *Id.* pt. II, ¶ 9.5.9.
307. INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS–2) 1998–1999, *supra* note 285, at 146.
308. *Id.* at 147.
309. MINISTRY OF HEALTH ANNUAL REPORT 2000–2001, *supra* note 200, pt. II, ¶ 9.1.4(a). Note that all of the major states, except Orissa (–11.2%) and Rajasthan (–1.9%), have shown increased use from 1998 to 2000.
310. DIVISION OF RESEARCH STUDIES AND STANDARDS, MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA, STANDARDS FOR FEMALE AND MALE STERILISATION (1999).
311. See *id.* § 1.1.1.
312. *Id.* § 1.1.2–1.1.3.
313. See *id.* § 1.1.4.
314. See *id.* § 1.2.
315. See *id.* § 1.2.7.
316. See *id.* § 1.2.3.
317. *Id.* § 1.3.1.
318. See *id.* § 1.3.2.
319. See *id.* § 1.3.
320. See MINISTRY OF HEALTH ANNUAL REPORT 2000–2001, *supra* note 200, pt. II ¶ 2.1.6(iv).
321. See *id.*
322. See Celia W. Dugger, *Relying on Hard and Soft Sells, India Pushes Sterilization*, N.Y. TIMES, June 22, 2001, at A1.
323. See INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS–2) 1998–1999, *supra* note 285, at 147.
324. *Id.* at 149.
325. See Family Welfare Programme, Department of Family Welfare, Ministry of Health and Family Welfare, Government of India, at <http://health.nic.in/fsfvp.htm> (last visited Oct. 2, 2003).
326. See MINISTRY OF HEALTH ANNUAL REPORT 2000–2001, *supra* note 200, pt. II ¶ 9.1.7.1. The extent of the subsidy ranges from 70% to 80%. Health officials have reported that selling condoms through “social marketing” techniques is more effective than giving them away since up to 75% of free condoms are “wasted.” See *Social Marketing Fosters Condom Use in India*, KAISER DAILY REPRODUCTIVE HEALTH REPORT (Dec. 14, 2000), [http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?DR\\_ID=1677](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=1677). As part of a new scheme by the Indian State Innovative Family Planning Service Agency, over 270 postal workers were trained to function as “family planning propagators” and were paid an additional USD 1 per month to deliver condoms in the Uttar Pradesh districts of Agra and Firozabad. See Population Connection, Legislative Update: November 7, 2000, India: Postal Workers to Deliver Contraception (2000), [http://www.populationconnection.org/Action\\_Alerts/alert60.html](http://www.populationconnection.org/Action_Alerts/alert60.html) (last visited Dec. 15, 2003).
327. See INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS–2) 1998–1999, *supra* note 285, at 149.
328. See *id.*
329. See MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA, MAJOR SCHEMES AND PROGRAMMES 153 (2000), available at <http://mohfw.nic.in/MSP-1.pdf> (last visited Oct. 2, 2003).
330. *Id.* at 154.
331. See Family Welfare Programme, Department of Family Welfare, Ministry of Health

- and Family Welfare, Government of India, at <http://health.nic.in/fsfwp.htm> (last visited Oct. 2, 2003).
332. *Id.*
333. *See id.*
334. *See* NATIONAL POPULATION POLICY, *supra* note 283, ¶ 11.
335. *See id.*
336. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ¶ 2.10.119.
337. *See* INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS-2) 1998-1999, *supra* note 285, at 149.
338. *See* TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ¶ 2.10.119.
339. *See id.* vol. II, ¶ 2.10.90.
340. INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS-2) 1998-1999, *supra* note 285, at 149.
341. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ¶ 2.10.122.
342. *See id.*
343. *See id.* vol. II, ¶ 2.10.121.
344. INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS-2) 1998-1999, *supra* note 285, § 6.3, at 196.
345. CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 221.
346. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2.11, tbl. 2.11.8.
347. INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS-2) 1998-1999, *supra* note 285, at 294.
348. *Id.* at 297.
349. *See id.* at 284.
350. NATIONAL HEALTH POLICY, *supra* note 146, box IV; NATIONAL POPULATION POLICY, *supra* note 283, box 2, at 2. *See also* TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2.8, at 143.
351. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ¶ 2.11.70.
352. *See id.*
353. *See id.* vol. II, ¶ 2.11.71.
354. *See* Posting of Center for Women's Development Studies Library, [cwdslib@alpha.nic.in](mailto:cwdslib@alpha.nic.in), to [bol@cwdsbol.net](mailto:bol@cwdsbol.net) (Dec. 13, 2002) (copy on file with the Center for Reproductive Rights).
355. *Id.*
356. Forty percent of pregnant women were vaccinated in 1985-1986 and 83.4% were covered by 2000-2001. *See* TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ¶ 2.11.9.
357. *Id.* vol. II, ¶ 3.8.61.
358. NATIONAL DEVELOPMENT COUNCIL, PLANNING COMMISSION, NINTH FIVE YEAR PLAN (1997-2002), vol. II, ¶ 3.5.66; MINISTRY OF HEALTH ANNUAL REPORT 2000-2001, *supra* note 200, pt. II, ¶ 5.9.2.
359. *See* MINISTRY OF HEALTH ANNUAL REPORT 2000-2001, *supra* note 200, pt. II, ¶ 5.10.1.
360. *See* CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 275.
361. *See id.* ¶ 333.
362. *See id.*
363. INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS-2) 1998-1999, *supra* note 285, at 291.
364. INDIA CONST., art. 47.
365. *See* TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ¶ 2.11.10.
366. *Id.*
367. *See id.*; *see* CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 273.
368. CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 273.
369. *See* M.E. Khan et al., *Abortion in India: An Overview*, SOCIAL CHANGE, Sept.-Dec. 1996, at 208-225, available at [http://www.hsph.harvard.edu/grhf-asia/suchana/0510/khan\\_etc.html](http://www.hsph.harvard.edu/grhf-asia/suchana/0510/khan_etc.html) (last visited Oct. 3, 2003).
370. INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS-2) 1998-1999, *supra* note 285, tbl. 4.7, at 92. The survey acknowledges the likelihood of underreporting of non-live births. *See id.* at 96.
371. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ¶ 2.10.56.
372. Heidi Bart Johnston, *Induced Abortion Practice in India: A Review of Literature* 4-5 (2002) (Abortion Assessment Project-India, Working Paper Series), [www.cehat.org/app1/app1.html](http://www.cehat.org/app1/app1.html) (last visited Dec. 17, 2003).
373. Medical Termination of Pregnancy Act, No. 34, § 3(2)(a)(i)-(ii) (1971) (India).
374. *Id.* § 3(3). Such factors may include socioeconomic factors such as a woman's age, marital status and the number of her living children. *See* Anika Rahman et al., *A Global Review of Laws on Induced Abortion, 1985-1997*, 24 INT'L FAM. PLANNING PERSP. 56-64 (1998).
375. *See* Medical Termination of Pregnancy Act, § 3(2), Explanation 1 (1971) (India).
376. *See* Medical Termination of Pregnancy (Amendment) Act, No. 64, ¶ 4(b) (2002) (India). As of December 2002, the government had not yet set an enforcement date for the amendment. *See* Press Release, Ministry of Law and Justice, Six More Bills Get President's Assent (Dec. 27, 2002), available at <http://pib.nic.in/archieve/Ireleng/lyr2002/rdec2002/27122002/r271220022.html> (last visited Oct. 3, 2003). The 1975 Medical Termination of Pregnancy Regulations elaborate upon the qualifications of registered medical practitioners and facilities providing abortion services. *See* The Medical Termination of Pregnancy Regulations, 1975 § 3 (1975) (India).
377. Medical Termination of Pregnancy Act, § 3(2)(a) (1971)(India).
378. *Id.* § 3(2)(b).
379. *Id.* § 5(1). In such circumstances, the restrictions on the number of doctors' opinions and on the location of abortion procedure may be waived. *See id.*
380. *See* Medical Termination of Pregnancy Regulations, 1975, § 3-7 (1975) (India).
381. Medical Termination of Pregnancy Act, § 3(4)(a)-(b) (1971) (India).
382. *See* Medical Termination of Pregnancy Regulations, § 4 (1975)(India).
383. *See* Ministry of Health and Family Welfare, Central Drugs Standard Control Organization, List of Drugs Approved 1999-2002, at <http://www.drugscontrol.org/news/news1.htm> (last visited Dec. 15, 2003).
384. *See* Statesman News Service, *Pills and boons for Indian women*, THE STATESMAN, Sept. 8, 2003, available at <http://www.thestatesman.net/page.arcview.php?clid=2&cid=50509&date=2003-09-08&ursess=1> (last visited Oct. 2, 2003).
385. *See* Gargi Parsai, *Plan to launch abortion pill in Family Welfare Programme*, THE HINDU, Mar. 6, 2003, at <http://www.thehindu.com/2003/03/06/stories/2003030607811200.htm> (last visited Oct. 3, 2003).
386. *See* Bela Ganatra and Heidi Bart Johnston, *Reducing Abortion-Related Mortality in South Asia: A Review of Constraints and a Road Map for Change*, 57 J. AM MED. WOMEN'S ASS'N 162 (2002).
387. Medical Termination of Pregnancy Act, No. 34 § 7(3) (1971) (India).
388. Medical Termination of Pregnancy (Amendment) Act, No. 64 § 5(3) (2002) (India).
389. Medical Termination of Pregnancy (Amendment) Bill, No. 64 § 5(2)-(3) (2002) (India).
390. *Id.* § 5(a)(4).
391. Prior to the Medical Termination of Pregnancy Act, the Indian Penal Code criminalized all abortions other than those performed to save the life of the mother. INDIA PEN. CODE, No. 45, §§ 312-316 (India).
392. INDIA PEN. CODE, No. 45, § 312.
393. *Id.*
394. *Id.* § 313.
395. *See* Posting of Center for Women's Development Studies Library, [cwdslib@alpha.nic.in](mailto:cwdslib@alpha.nic.in), to [bol@cwdsbol.net](mailto:bol@cwdsbol.net) (Dec. 13, 2002) (copy on file with the Center for Reproductive Rights).
396. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ¶ 2.11.71.
397. *Id.* vol. II, ¶ 2.10.59.
398. *See* NATIONAL POPULATION POLICY, *supra* note 283, § 13.
399. *See* MINISTRY OF HEALTH ANNUAL REPORT 2001-2002, *supra* note 160, vol. II, ¶ 5.8.3.
400. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ¶ 2.10.59.
401. *See* NATIONAL POPULATION POLICY, *supra* note 283, app. 1, ¶ 13.
402. *See id.*
403. M.E. KHAN ET AL., AVAILABILITY AND ACCESS TO ABORTION SERVICES IN INDIA: MYTH AND REALITIES 3 (2001), available at [http://www.iussp.org/Brazil2001/s20/S21\\_P10\\_Barge.pdf](http://www.iussp.org/Brazil2001/s20/S21_P10_Barge.pdf) (last visited Oct. 3, 2003).
404. CENTER FOR REPRODUCTIVE RIGHTS, REPRODUCTIVE RIGHTS 2000: MOVING FORWARD 28 (2000) (citing Radhika Coomaraswamy, Report of the Special Rapporteur on Violence against Women, Its causes and consequences, Addendum: Policies and Practices that impact Women's Reproductive Rights and Contribute to, Cause or Constitute Violence against Women ¶ 50, U.N. Doc. E/CN.4/1999/68/Add.4 (1999)).
405. Maharashtra has 1,808 approved abortion facilities, constituting 21.2% of all registered abortion facilities. *See* M.E. Khan et al., *supra* note 403, at 6.
406. *Id.*
407. *Id.*
408. *Id.* at 7.
409. *Id.*
410. *See id.*
411. *See id.*
412. *See id.* at 8.
413. *See id.*
414. *See* MINISTRY OF HEALTH ANNUAL REPORT 2000-2001, *supra* note 200, vol. II, ¶ 5.6.3.
415. *See* Family Planning Association of India, available at <http://www.fpaindia.com/fpa-activity.htm> (Dec. 15, 2003).
416. *See* MINISTRY OF HEALTH ANNUAL REPORT 2000-2001, *supra* note 200, vol. II, ¶ 5.6.4.
417. NATIONAL AIDS CONTROL ORGANIZATION, MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA, COUNTRY SCENARIO 1997-1998 35 (1998) [hereinafter NATIONAL AIDS CONTROL ORGANIZATION COUNTRY SCENARIO 1997-1998].
418. *Id.*
419. *Id.* at 2; The Joint United Nations Programme on HIV/AIDS (UNAIDS), Country information: India, at <http://www.unaids.org/en/geographical+area/by+country/india.asp> (last visited Oct. 3, 2003); *see* India Announces New National Policy to Control Disease, UN Wire, Apr. 3, 2002, available at [http://www.unwire.org/UNWire/20020403/25266\\_story.asp](http://www.unwire.org/UNWire/20020403/25266_story.asp) (last visited Dec. 16, 2003).
420. UNAIDS & WHO, Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections: India 2002 Update, [http://www.who.int/emc-hiv/fact\\_sheets/pdfs/india\\_en.pdf](http://www.who.int/emc-hiv/fact_sheets/pdfs/india_en.pdf) (last visited Dec. 17, 2003) (2002).
421. NATIONAL AIDS CONTROL ORGANIZATION COUNTRY SCENARIO 1997-1998, *supra* note 417, at 2.
422. INDIA PEN. CODE, No. 45, §§ 269-270.

423. See Memorandum from Jaya Sagade, *supra* note 125; see LAWYERS COLLECTIVE, LEGISLATING AN EPIDEMIC: HIV/AIDS IN INDIA 267 (2003).
424. Special Marriage Act, No. 43, § 27 (1954) (India); Hindu Marriage Act, No. 25, § 13 (1955) (India); Parsi Marriage and Divorce Act, No. 3, § 32 (1936) (India).
425. See Memorandum from Jaya Sagade, *supra* note 125.
426. See Communication with Leena Prasad, Lawyer's Collective, *India country report draft* (June 16, 2001) (on file with the Center for Reproductive Rights).
427. See *id.*
428. See *id.*
429. See LAWYERS COLLECTIVE, LEGISLATING AN EPIDEMIC: HIV/AIDS IN INDIA 14 (2003); see also Indo-Asian News Service, *Free drugs for HIV positive, Laws against discrimination*, YAHOO! INDIA NEWS (Nov. 30, 2003), available at <http://in.news.yahoo.com/031130/43/29z3e.html> (noting that the Indian government is planning to introduce legislation addressing discrimination against persons living with HIV/AIDS).
430. *MX v. ZY*, A.I.R. 1997 Bombay 406 (India). See INDIA CONST., art 14, 21.
431. *Parmanand Katara v. Union of India*, (1989) 4 S.C.C. 286 (India).
432. INDIA PEN. CODE, No. 45, § 269–270; *Mr. X v. Hospital Z*, (1998) 8 S.C.C. 296 (India). The court states that it requires this disclosure to protect the right to life of partners of HIV-positive individuals.
433. *Mr. X v. Hospital Z*, (2002) SOL 657 (India).
434. *Id.*
435. NATIONAL AIDS CONTROL ORGANIZATION, MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA, AN ACTION PLAN FOR BLOOD SAFETY 5 (2003), available at <http://www.naco.nic.in/nacp/action.pdf> (last visited Oct. 7, 2003) [hereinafter NATIONAL AIDS CONTROL ORGANIZATION BLOOD SAFETY ACTION PLAN].
436. See *id.*
437. *Common Cause v. Union of India*, (1996) 1 S.C.C. 753 (India).
438. National AIDS Control Organization, Ministry of Health and Family Welfare, Government of India, at <http://naco.nic.in/nacp/nacobkg.htm> (last visited Oct. 7, 2003).
439. See NATIONAL AIDS CONTROL ORGANIZATION, MINISTRY OF HEALTH AND FAMILY WELFARE, NATIONAL AIDS PREVENTION AND CONTROL POLICY § 3 [hereinafter NATIONAL AIDS POLICY].
440. *Id.*
441. *Id.*
442. See *id.* ¶ 5.4.1.
443. *Id.*
444. See NATIONAL AIDS CONTROL ORGANIZATION BLOOD SAFETY ACTION PLAN, *supra* note 435, at 15.
445. NATIONAL AIDS CONTROL ORGANIZATION, MINISTRY OF HEALTH AND FAMILY WELFARE, NATIONAL BLOOD POLICY.
446. NATIONAL AIDS CONTROL ORGANIZATION BLOOD SAFETY ACTION PLAN, *supra* note 435, at 5.
447. See *Microbicides to be introduced for AIDS prevention*, THE TIMES OF INDIA (Sept. 28, 2003), available at <http://timesofindia.indiatimes.com/cms.dll/xml/uncomp/articleshow?msid=205971> (last visited Dec. 15, 2003).
448. See Lawyers Collective, HIV/AIDS Unit, Abstracts of Papers, available at <http://www.lawyerscollective.org/lc-hiv-aids/Abstracts/Media.htm> (last visited Oct. 15, 2003).
449. INDIA PEN. CODE, No. 45, § 292–294 (India). See also Lawyers Collective, HIV/AIDS Unit, Abstracts of Papers.
450. INDIA PEN. CODE, No. 45, § 292.
451. Lawyers Collective, HIV/AIDS Unit, Abstracts of Papers, *supra* note 448.
452. See Population Reference Bureau, Population Bulletin, vol. 56, No. 1, box 6, India: From Family Planning Targets to Reproductive Health (Mar. 2001), available at [http://www.prb.org/Template.cfm?Section=Population\\_Bulletin1&template=/ContentManagement/ContentDisplay.cfm&ContentID=5878#evolution](http://www.prb.org/Template.cfm?Section=Population_Bulletin1&template=/ContentManagement/ContentDisplay.cfm&ContentID=5878#evolution) (last visited Dec. 16, 2003).
453. INDIA CONST., 7th sched.
454. See *Javed and Others v. State of Haryana and Others*, (2003) SOL 411 (India).
455. NATIONAL POPULATION POLICY, *supra* note 283, ¶ 6.
456. *Id.* ¶ 7.
457. *Id.* box 2.
458. *Id.* ¶¶ 4–11.
459. *Id.* ¶ 37.
460. See *id.* ¶ 39.
461. See NATIONAL POPULATION POLICY, *supra* note 283, ¶ 44; MINISTRY OF HEALTH ANNUAL REPORT 2000–2001, *supra* note 200, vol. II, ¶ 4.2.
462. INDIA CONST., arts 14–15, 15(3), 16.
463. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 83.
464. INDIA CONST., art. 51A(e).
465. See *W.A. Baid v. Union of India*, 1976 A.I.R. (Del.) 302 (India); *A.N. Rajamma v. State of Kerala*, 1983 LB 1388 (India); *Brij Bala v. State of H.P.* (1984) 2 SLR 408 (India); CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 180.
466. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 33.
467. See *id.*
468. See *id.*
469. See National Commission for Women, at <http://www.nationalcommissionforwomen.org/> (last visited Oct. 7, 2003).
470. See *id.*
471. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 91.
472. See *id.* ¶ 15.
473. See TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, at 222.
474. See *id.*
475. DEPARTMENT OF WOMEN AND CHILD DEVELOPMENT, MINISTRY OF HUMAN RESOURCE DEVELOPMENT, GOVERNMENT OF INDIA, NATIONAL POLICY FOR THE EMPOWERMENT OF WOMEN ¶ 10.1 (2001), available at <http://www.wcd.nic.in/empwomen.htm> (last visited Oct 7, 2003).
476. TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ¶ 2.11.57.
477. Citizenship Act, No. 57 (1955) (India) (amended 1986, 1992).
478. *Id.* §§ 3–6, 8–9. See also CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 143.
479. Citizenship Act, § 8. See also CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 143.
480. See *HC on J&K women's right to property, service*, THE TRIBUNE (Oct. 9, 2002), <http://www.tribuneindia.com/2002/20021009/j&k.htm#6> (last visited Oct. 7, 2003).
481. See *Kashmiri women: Citizens at last*, INDIATOGETHER.ORG (Dec. 2002), <http://indiatogether.org/women/articles/kashciti.htm> (last visited Nov. 10, 2003).
482. See *id.*
483. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 363.
484. Special Marriage Act, No. 43, Statement of Object and Reasons (1954) (India). Also, under the Indian Christian Marriage Act, a Christian and a non-Christian may marry. See Indian Christian Marriage Act, No. 15, art. 4 (1872) (India).
485. Special Marriage Act, No. 43, § 15 (1954) (India).
486. Child Marriage Restraint Act, No. 19, § 2(a) (1929) (India) (amended 1978).
487. See Usha Tandon, *Population Law: An Instrument for Population Stabilization* 129 (2003).
488. Dowry Prohibition Act, No. 28 (1961) (India) (*Am.* 1984, 1986).
489. See Memorandum from Lawyers Collective to the Center for Reproductive Rights (on file with the Center for Reproductive Rights).
490. Hindu Marriage Act, No. 25, § 2(2) (1955) (India). The scheduled tribes of India, irrespective of their religion, are governed by their uncodified customary laws and not by Hindu laws.
491. *Id.* Introduction.
492. Where a Hindu marriage is being performed according to religious ceremonies, certain rituals, which vary according to the customs of community, are necessary to make the marriage valid, but for most Hindu communities “saptapadi” is necessary. See *id.* art. 7.
493. See *id.* § 5. Two parties are said to be *sapindas* of each other if one is a lineal ascendant of the other within the limits of *sapinda* relationship, or if they have a common lineal ascendant who is within the limits of *sapinda* relationship with reference to each of them. See *id.* art. 3(f)(i)–(ii).
494. *Id.* § 5.
495. See M. HIDAYATULLAH and ARSHAD HIDAYATULLAH, MULLA'S PRINCIPLES OF MAHOMEDAN LAW § 250 (19th ed. N. M. Tripathi Private Ltd. 2003).
496. MULTIPLE ACTION RESEARCH GROUP FOR THE DEPARTMENT OF WOMEN AND CHILD DEVELOPMENT, MINISTRY OF HUMAN RESOURCE DEVELOPMENT, GOVERNMENT OF INDIA, No. 6, OUR LAWS: MUSLIM MARRIAGE LAW/RIGHT TO PROPERTY 1–7 (1992).
497. Hidayatullah and Hidayatullah, *supra* note 495, § 255.
498. Indian Christian Marriage Act, No. 15 (1872) (India).
499. See OUR LAWS: MUSLIM MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 496, at 1–3.
500. Indian Christian Marriage Act, No. 15, § 60 (1872) (India).
501. Parsi Marriage and Divorce Act, No. 3 (1936) (India).
502. *Id.* § 3, amended by Parsi Marriage and Divorce (Amendment) Act, No. 5, § 2 (1988) (India).
503. *Id.* § 4.
504. *Id.* § 6.
505. Hindu Marriage Act, No. 25, § 13(1) (1955) (India).
506. *Id.* § 13(1A), 13(2), 13B.
507. Bigamy is punishable with imprisonment of up to seven years. INDIA PEN. CODE, No. 45, art. 494. A husband or his relative is subject to imprisonment of up to three years and fines for cruelty to the husband's wife. *Id.* art. 498A. An adulterer is subject to imprisonment of up to five years and fines. Note that the definition of “adultery” in this section applies only to male offenders; women cannot be guilty of adultery. See *id.* art. 497.
508. Hidayatullah and Hidayatullah, *supra* note 495, §§ 307–308, 314, 319.
509. See *id.* § 336(1).
510. Muslim Women (Protection of Rights on Divorce) Act, No. 25, § 2(b) (1986) (India).
511. See *Shamim Ara v. State of U.P. and Anr.*, 2002 SOL 514 (India).
512. See *id.*
513. See *id.*
514. Meenal Dubey, *Talaq by post not admissible: Court*, HINDUSTAN TIMES (Mar. 8, 2003), <http://www.hindustantimes.com/news/printedition/080303/detCIT01.shtml> (last visited May 5, 2003).
515. See *id.*
516. Dissolution of Muslim Marriages Act, No. 8 (1939) (India); Hidayatullah and Hidayatullah, *supra* note 495, § 323.

517. Dissolution of Muslim Marriages Act, No. 8, art. 2 (1939) (India).  
 518. Indian Divorce Act, No. 4 (1869) (India) (*amended* 2001).  
 519. *Id.* § 10, *amended* by Indian Divorce (Amendment) Act, No. 51, § 5 (2001) (India).  
 520. *See id.* § 10(2), *amended* by Indian Divorce (Amendment) Act, No. 51, § 5 (2001) (India).  
 521. *See id.* § 10(A), *amended* by Indian Divorce (Amendment) Act, No. 51, § 6 (2001) (India).  
 522. Parsi Marriage and Divorce Act, No. 3 (1936) (India) (*amended* 1988).  
 523. *Id.* § 32, 32A–32B, *amended* by Parsi Marriage and Divorce (Amendment) Act, No. 5, § 9 (1988) (India).  
 524. *See id.* § 30.  
 525. *See id.* § 31.  
 526. *See* Memorandum from Jaya Sagade, *supra* note 125.  
 527. Hindu Marriage Act, No. 25, § 10 (1955) (India); Indian Divorce Act, No. 4, § 22 (1869) (India); Parsi Marriage and Divorce Act, No. 3, § 34 (1936) (India).  
 528. Hindu Marriage Act, § 10(1)(1955) (India).  
 529. *Id.* § 10(2).  
 530. *Id.*  
 531. Memorandum from Lawyers Collective to the Center for Reproductive Rights (on file with the Center for Reproductive Rights).  
 532. *See* Memorandum from Jaya Sagade, *supra* note 125; *see relatedly* Hidayatullah and Hidayatullah, *supra* note 495, § 281(3).  
 533. Indian Divorce Act, No. 4, § 10 (1869) (India).  
 534. Parsi Marriage and Divorce Act, No. 3, art. 34 (1936) (India).  
 535. *See* CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 379.  
 536. *See id.*  
 537. Code of Criminal Procedure, No. 2, § 125(1)(b)–(d) (1973) (India).  
 538. *Id.* § 125(5).  
 539. Code of Criminal Procedure (Amendment) Act, No. 50, § 3 (2001) (India).  
 540. *See* Amina v. Hassn Koya, 2003 SOL 239 (India).  
 541. *See id.*  
 542. Marriage Laws (Amendment) Act, No. 49 (2001) (India).  
 543. *Id.* §§ 2, 4, 6, 8.  
 544. *Id.* §§ 2–9.  
 545. Hindu Marriage Act, No. 25, § 25 (1955) (India).  
 546. *Id.* § 25.  
 547. *Id.* § 25(2)–(3).  
 548. Hindu Adoptions and Maintenance Act, No. 78, § 18(1)–(2) (1956) (India); Hindu Marriage Act, No. 25, § 25 (1955) (India).  
 549. Hindu Adoptions and Maintenance Act, No. 78, § 18(3) (1956) (India).  
 550. *Id.* § 19.  
 551. *Id.* § 20.  
 552. *Id.* § 20(3).  
 553. Hirachand Srinivas Managanonkar v. Sunanda, 2001 SOL 188 (India).  
 554. Muslim Women (Protection of Rights on Divorce) Act, No. 25, ¶ 3(1)(a) (1986) (India). If the woman is pregnant, *iddat* may be extended to the time of delivery of the child. OUR LAWS: MUSLIM MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 496, at 16.  
 555. Muslim Women (Protection of Rights on Divorce) Act, No. 25, ¶ 3(1)(b) (1986) (India).  
 556. *Id.* ¶ 3(1)(c).  
 557. *See* OUR LAWS: MUSLIM MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 496, at 17. Under Muslim law, a *wakf* is a dedication by a Muslim of property or money for pious or charitable purposes. There are a number of *wakf* acts under which state governments have appointed state *wakf* boards to act as corporate bodies, holding the money and property dedicated to the *wakf* for maintenance of Muslim women divorcees, among other purposes. *See* LAWYERS COLLECTIVE, LAW OF DOMESTIC VIOLENCE: A USER'S MANUAL FOR WOMEN (Indira Jaising ed., 2001); *see* Muslim Women (Protection of Rights on Divorce) Act, No. 25, § 4 (1986) (India).  
 558. *See* OUR LAWS: MUSLIM MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 496, at 17 (1992); Muslim Women (Protection of Rights on Divorce) Act, No. 25, § 5 (1986) (India).  
 559. Indian Divorce Act, No. 4, ¶ 37 (1869) (India).  
 560. *Id.* ¶ 37.  
 561. *Id.* ¶ 38.  
 562. Parsi Marriage and Divorce Act, No. 3, § 40(1) (1936) (India).  
 563. *Id.*.  
 564. *Id.* § 40(2)–(3).  
 565. *See id.* § 41.  
 566. Hindu Adoption and Maintenance Act, No. 78 (1956) (India); Guardians and Wards Act, No. 8 (1890) (India).  
 567. Guardians and Wards Act, No. 8, § 19 (1890) (India).  
 568. *Id.*  
 569. *Id.* § 17(1).  
 570. *Id.* § 17(2)–(3), (5).  
 571. Hindu Minority and Guardianship Act, No. 32, § 6(a)–(c) (1956) (India).  
 572. *Id.* § 6.  
 573. *Id.* § 6 (Comments).  
 574. *See* Memorandum from Jaya Sagade, *supra* note 125.  
 575. Hindu Adoptions and Maintenance Act, No. 78, § 8 (1956) (India).  
 576. *Id.* §§ 7, 11(v).  
 577. *Id.* § 7.  
 578. *See id.*  
 579. *See* OUR LAWS: MUSLIM MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 496, at 19.  
 580. *See id.* Under the *Hanafi* school of Muslim jurisprudence, the mother is deemed the natural guardian of her son until he is seven years old. Under *Hanbali* and *Shafi* law, a son may choose to live with either parent after the age of seven. Among *Shias*, the mother has custody of her son until he is weaned. Under *Maliki* law, a son stays with his mother until he reaches puberty. In the case of female children, the mother retains custody of her daughter until she attains the age of puberty under *Hanafi* law. Under *Ithana Ashari* law, daughters remain with their mothers until the age of seven. In other sects, mothers have custody of their daughters until they marry. *See* LAW OF DOMESTIC VIOLENCE: A USER'S MANUAL FOR WOMEN, *supra* note 557, at 78.  
 581. *See* OUR LAWS: MUSLIM MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 496, at 20.  
 582. Guardian and Wards Act, No. 8, §§ 6–19 (1890) (India); Hidayatullah and Hidayatullah, *supra* note 495, § 349.  
 583. *See* OUR LAWS: MUSLIM MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 496, at 16.  
 584. *See id.* 16–17.  
 585. Guardian and Wards Act, No. 8, §§ 6–19 (1890) (India).  
 586. Parsi Marriage and Divorce Act, No. 3, art. 49–50 (1936) (India).  
 587. *See* Memorandum from Jaya Sagade, *supra* note 125.  
 588. Guardian and Wards Act, No. 8, §§ 6–19 (1890) (India).  
 589. *See* MULTIPLE ACTION RESEARCH GROUP FOR THE DEPARTMENT OF WOMEN AND CHILD DEVELOPMENT, MINISTRY OF HUMAN RESOURCE DEVELOPMENT, GOVERNMENT OF INDIA, No. 5, OUR LAWS: HINDU MARRIAGE LAW/RIGHT TO PROPERTY 27; OUR LAWS: MUSLIM MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 496, at 21; MULTIPLE ACTION RESEARCH GROUP FOR THE DEPARTMENT OF WOMEN AND CHILD DEVELOPMENT, MINISTRY OF HUMAN RESOURCE DEVELOPMENT, GOVERNMENT OF INDIA, No. 7, OUR LAWS: CHRISTIAN MARRIAGE LAW/RIGHT TO PROPERTY 19(1992).  
 590. OUR LAWS: MUSLIM MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 496, at 30–31; OUR LAWS: CHRISTIAN MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 589, at 21; OUR LAWS: HINDU MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 589, at 38.  
 591. *See* CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 395.  
 592. *See id.* ¶ 81.  
 593. Hindu Succession Act, No. 30 (1956) (India).  
 594. *See* OUR LAWS: HINDU MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 589, at 30.  
 595. *See id.* at 30–31.  
 596. Hindu Succession Act, No. 30, §§ 10–11, sched. (1956) (India).  
 597. *Id.* art. 23. *See also* OUR LAWS: HINDU MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 589, at 34–36.  
 598. *See* SATYAJEET A. DESAI, MULLA HINDU LAW § 347 (vol. 1) (18th ed. 2001).  
 599. Hindu Succession Act, No. 30, art. 23 (1956) (India). *See also* OUR LAWS: HINDU MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 589, at 36.  
 600. V. Dandapani Chettiar v. Balasubramanian Chettiar, 2003 SOL Case NO. 440 (India 2003), [www.supremecourtsonline.com/cases/7926.html](http://www.supremecourtsonline.com/cases/7926.html).  
 601. *Id.*  
 602. *Id.*  
 603. *See* OUR LAWS: MUSLIM MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 496, at 22.  
 604. *See id.* at 24. Note that the property and share are determined according to the relationship of the heir to the deceased and the number of heirs. *See id.* at 22–24.  
 605. *See id.* at 26–28. The widow or divorcee has a right of retention, and, as such, is entitled to take possession of her husband's property until her *mahr* is paid. Although she cannot gift or sell the property, she may satisfy the *mahr* owed to her out of profits from the property. She may also file a lawsuit to recover her *mahr*. *See id.* at 28.  
 606. *See id.* at 27.  
 607. *See* Memorandum from Jaya Sagade, *supra* note 125.  
 608. Indian Succession Act, No. 39, art. 29 (1925) (India).  
 609. *Id.* art. 32, 33(a), 35 (1925) (India). In cases where there is no lineal descendant, but the descendant has other kin, a widow is entitled to one-half of her deceased husband's property, with the remaining property divided among his surviving kin. If there are no other survivors, the widow inherits all of the property. *Id.* art. 33(c).  
 610. *See* OUR LAWS: CHRISTIAN MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 589, at 23.  
 611. Indian Succession Act, No. 39, pt. V, ch. III (1925) (India).  
 612. *Id.* art. 51(a).  
 613. Delhi Land Reforms Act, No. 8, art. 50 (1954) (India).  
 614. *Id.* art. 51.  
 615. *Id.* art. 50.  
 616. *See* Lower tax on houses in women's name, Tribune of India, National Capital Region, Mar. 9, 2003, <http://www.tribuneindia.com/2003/20030309/ncr1.htm#5> (last visited Oct. 9, 2003).  
 617. *See* OUR LAWS: HINDU MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 589, at 37.  
 618. *See id.*  
 619. *See* Memorandum from Jaya Sagade, *supra* note 125.  
 620. *See* OUR LAWS: CHRISTIAN MARRIAGE LAW/RIGHT TO PROPERTY, *supra* note 589, at 25–27.  
 621. *See* Memorandum from Jaya Sagade, *supra* note 125.  
 622. *See* CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 195.  
 623. *See id.*  
 624. *See id.* ¶ 197.  
 625. *See id.*

626. See MINISTRY OF LABOUR, GOVERNMENT OF INDIA, 2001–2002 ANNUAL REPORT, § 11.2, <http://labour.nic.in/annrep/files2k1/lab11.pdf> (last visited Dec. 15, 2003).
627. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 197.
628. INDIA CONST., arts 14–16.
629. *Id.* arts. 39(a), (d)–(e), 42.
630. *Id.* art. 43.
631. The Equal Remuneration Act defines “same work or work of a similar nature” as, “work in respect of which the skill, effort and responsibility required are the same, when performed under similar working conditions, by a man or a woman and the difference, if any, between the skill, effort and responsibility required of a man and those required of a woman are not of practical importance in relation to the terms and conditions of employment.” Equal Remuneration Act, No. 25, § 2(h) (1976) (India).
632. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 183.
633. Equal Remuneration Act, No. 25, pmb1, § 4(2) (1976) (India).
634. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 188.
635. *See id.*
636. *See id.*
637. Maternity Benefit Act, No. 53, §§ 2, 5, 5(3), 9, 9A (1961) (India), <http://www.indialawinfo.com/bareacts/maternity.html> (last visited Dec. 15, 2003).
638. *Id.* § 4(1)–(2).
639. *See id.* § 4(4).
640. *Id.* §§ 8, 10–11, 13.
641. *Id.* § 5(2).
642. Employees’ State Insurance Act, No. 34, § 50 (1948) (India); Factories Act, No. 63, § 79(1)(b) (1948) (India).
643. Factories Act, No. 63, §§ 2(m), 79(1)(b) (1948) (India).
644. Employees’ State Insurance Act, No. 34, §§ 1, 50 (1948) (India).
645. *Id.* § 73. “Confinement” is defined under § 2(3) as “labour resulting in the issue of a living child, or labour after twenty-six weeks of pregnancy resulting in the issue of a child whether dead or alive” and “miscarriage” is defined under § 2(14B) as “expulsion of the contents of a pregnant uterus at any period prior to or during the twenty-sixth week of pregnancy, but does not include any mis-carriage, the causing of which is punishable under the Indian Penal Code.” *Id.* §§ 12–13. Note that § 13 prohibits the deduction of wages on account of the reduction of hard work.
646. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 285; Office Memorandum Recommendation of Fifth Central Pay Commission relating to grant of Commuted Leave/ Leave on Medical Certificate to Gazetted and Non-Gazetted Governemnt (sic) Servants No. 13018/1/97-Estt. (L), from B. Gangar, Under Secretary to the Govt. of India, Ministry of Personnel, Government of India, (Oct. 7, 1997), <http://persmin.nic.in/estt/leave2.htm> (last visited Oct. 9, 2003).
647. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 287.
648. *See id.* ¶ 209.
649. Factories Act, No. 63, § 48 (1948) (India); Plantations Labour Act, No. 69, § 12 (1951) (India); Mines Act, No. 35, § 58 (Comments) (1952) (India); Beedi and Cigar Workers (Conditions of Employment) Act, No. 32, § 14(1966) (India).
650. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 213, 289.
651. *See id.* ¶ 213.
652. Factories Act, No. 63, §§ 22, 27, 34 (1948) (India).
653. *Id.* § 27.
654. Mines Act, No. 35, § 46 (1952) (India).
655. *Id.*; Plantations Labour Act, No. 69, § 25 (1951) (India); Beedi and Cigar Workers (Conditions of Employment) Act, No. 32, § 25 (1966) (India).
656. See Press Release, Press Information Bureau, Ministry of Labour and Empowerment, Government of India, Women Workers in Night Shifts (Apr. 7, 2003), <http://pib.nic.in/archieve/irelang/lyr2003/rapr2003/07042003/r0704200312.html> (last visited Dec. 15, 2003).
657. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 203.
658. *See id.* Relevant cases discussed include Bombay Labour Union v. International Franchises Pvt. Ltd., AIR 1966 SC 1942; Muthumma v. Union of India, AIR 1979 SC 1868; Air India v. Nergeesh Mirza, AIR 1981 SC 1829.
659. *See id.* ¶ 189.
660. Employees Provident Fund and Miscellaneous Provisions, No. 19, § 6A (1952) (India); Payment of Gratuity Act, No. 39, § 4 (1972) (India).
661. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 338.
662. *See id.*
663. *See id.* ¶¶ 292, 294. The Integrated Rural Development Program was launched in 1978 and extended to all development blocks in the country by 1981. It was conceived as one of the main governmental antipoverty initiatives. Credit from banking institutions and subsidies from the government were loaned to families below the poverty line for self-employment and income generation. *See id.* ¶ 306.
664. *See id.* ¶ 293.
665. *See id.* ¶ 294.
666. *See id.*
667. See Memorandum from Jaya Sagade, *supra* note 125.
668. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 294.
669. See RASHTRIYA MAHILA KOSHI (RMK), COMPENDIUM OF RMK SCHEMES 7 [hereinafter COMPENDIUM OF RMK SCHEMES]. Intermediate microfinance organizations include NGOs, women’s cooperative societies, women development corporations, and state urban development authorities. However, NGOs have been the primary conduits for RMK credit funds to beneficiaries. *See id.* at 7.
670. Self-help groups should be based on affinity; small in size; voluntary, cohesive and stable; democratic; and possess decision-making abilities. *See id.* at 23.
671. See Census of India 2001, *supra* note 9; see CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 28.
672. INDIA CONST., art. 45. In particular, the state shall promote the educational interests of the scheduled castes and tribes. *Id.* art. 46. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 150–155.
673. Unni Krishnan, J.P. and Ors. v. State of Andhra Pradesh and Ors., 1 S.C.C. 645 (India 1993).
674. INDIA CONST., amend. 86, available at <http://indiacode.nic.in/coiweb/amend/amend86.htm> (last visited Oct. 15, 2003).
675. *Id.*
676. *Id.*
677. INDIA CONST., art 29(2).
678. See VHAI & WHO, NATIONAL PROFILE ON WOMEN, *supra* note 189, at 114–115. The policy provides, “women become empowered through collective reflection and decision-making. The parameters of empowerment are building a positive self image and self confidence; developing [the] ability to think critically; building . . . group cohesion and fostering decision-making; ensuring equal participation in the process of bringing about social change; [and] providing the wherewithal for economic independence.” *Supra* at 115.
679. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 175.
680. *See id.* ¶¶ 117, 175.
681. *See id.* ¶ 176.
682. See VHAI & WHO, NATIONAL PROFILE ON WOMEN, *supra* note 189, at 113.
683. See TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2.11, ¶ 2.11.14.
684. *See id.*
685. *See id.* vol. II, ch. 2.11, ¶ 2.11.13.
686. See VHAI & WHO, NATIONAL PROFILE ON WOMEN, *supra* note 189, at 113.
687. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 173.
688. *See id.*
689. INDIA PEN. CODE, No. 45, § 375. According to § 114A of the Indian Evidence Act, in a prosecution for rape brought under Indian Penal Code §§ 376(2)(a)–(e) or (g), there is a presumption that a woman did not consent where sexual intercourse is proved and the woman states that she did not consent.
690. *Id.*
691. *Id.*
692. *Id.*
693. *Id.* § 375 (Exception), 376–A.
694. See REPRODUCTIVE AND SEXUAL HEALTH RIGHTS IN INDIA, *supra* note 106, ch. 3, § 3.3.1(b).
695. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 94.
696. Indian Evidence Act, No. 1, § 155(4) (1872) (India).
697. INDIA PEN. CODE, No. 45, § 376(1).
698. *Id.* § 376(1), 376–A.
699. *Id.* § 376(2)(a)–(g).
700. See Jarnail Singh v. State of Punjab, (1998) 8 S.C.C. 629, a case of statutory rape of a 15-year-old girl by a 17-year-old boy where the girl was a consenting party. The court decreased the sentence of the accused but directed him to pay Rs 12,000 as compensation to the girl. *See also* cases involving rape by public functionaries, such as the decision in Chairman, Railway Board v. Chandrima Das, (2000) 2 S.C.C. 465. In P.A. Narayanan v Union of India and Others, (1998) 3 S.C.C. 67, a case of rape, robbery and murder on a moving train, the court held that the railway must pay compensation to the husband of the deceased for failing to take care. *See also* INDIA PEN. CODE, No. 45, § 376(1)–(2).
701. Delhi Domestic Working Women’s Forum v. UOI, (1995) 1 S.C.C. 14.
702. See Posting of CWDS Library, [cwdslib@alpha.nic.in](mailto:cwdslib@alpha.nic.in), to [bol@cwdsbol.net](mailto:bol@cwdsbol.net) (May 2, 2003) (on file with the Center for Reproductive Rights).
703. *See id.*
704. *See id.*
705. See REPRODUCTIVE AND SEXUAL HEALTH RIGHTS IN INDIA, *supra* note 106, ch. 3, § 3.4.2.
706. *See id.*
707. Posting of CWDS Library, [cwdslib@alpha.nic.in](mailto:cwdslib@alpha.nic.in), to [bol@cwdsbol.net](mailto:bol@cwdsbol.net) (Jan. 21, 2003) (on file with the Center for Reproductive Rights).
708. INDIA PEN. CODE, No. 45, §§ 375–376; Children Act, No. LX, § 41 (1960) (India); Juvenile Justice Act, No. 53, § 41 (1986). Note that India is a signatory to the Convention on the Rights of the Child, adopted Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, U.N. Doc. A/44/49 (1989), reprinted in 28 I.L.M. 1448 (entered into force Sept. 2, 1990), which provides under article 34 that the state shall undertake to protect the child from all forms of sexual exploitation and sexual abuse.
709. See TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2.11, at 222. As of April 2003, the bill was shown on the Ministry of Law and Justice, Government of India website as “pending on conclusion of Winter Session, 2002.”
710. INDIA PEN. CODE, No. 45, §§ 300, 319–320, 351, 498–A.
711. *See id.* §§ 313–316.
712. All personal laws (except for Christian law) and secular statutes allow cruelty as grounds for divorce.
713. Indian Evidence Act, No. 1, § 113A (1872) (India).

714. CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 370.
715. Dowry Prohibition Act, No. 28, §3 (1961) (India). The penalty for demanding dowry is a prison term of between 6 months and 2 years and up to Rs 10,000 in fines. *Id.* § 4. The burden of proof is on the accused to show that he or she did not give, take, or demand dowry. *Id.* § 8.
716. INDIA PEN. CODE, No. 45, § 304-B. The provision provides, “[w]here the death of a woman is caused by any burns or bodily injury or occurs otherwise than under normal circumstances within seven years of her marriage and it is shown that soon before her death she was subjected to cruelty or harassment by her husband or any relative of her husband for, or in connection with, any demand for dowry, such death shall be called ‘dowry death,’ and such husband or relative shall be deemed to have caused her death.” The prison term for dowry death is between seven years and life.
717. Indian Evidence Act, No. 1, § 113-B (1872).
718. See Code of Criminal Procedure, No. 2, §176 (1973) (India).
719. Prevention of Sexual Harassment of Women Employees at their Work Places, *Rajya Sabha*, pvt. bill, (1994), available at [http://www.ncw-india.org/publications/sexual\\_harassment/shpbill1.htm](http://www.ncw-india.org/publications/sexual_harassment/shpbill1.htm) (last visited Oct. 15, 2003).
720. Vishaka and others v. State of Rajasthan, 1997 SOL Case No. 177 (India). Prior to this judgement, since sexual harassment was not recognized as a systemic form of violence that interfered with the constitutionally guaranteed right to work, women sought relief through penal, labour and tort laws. For example, women could initiate lawsuits on the basis of laws dealing with obscenity, or criminal force or assault with the object of outraging the modesty of a woman; wrongful dismissal; and the causing of emotional trauma.
721. *Id.* See also VHAI & WHO, NATIONAL PROFILE ON WOMEN, *supra* note 189, at 126.
722. Vishaka and others v. State of Rajasthan, (1997) 1997 SOL Case No. 177 (India).
723. See VHAI & WHO, NATIONAL PROFILE ON WOMEN, *supra* note 189, at 126.
724. See *id.* at 223.
725. National Commission for Women, Code of Conduct for Work Place, ¶¶ 5–6, 11, available at [http://www.nationalcommissionforwomen.org/publications/code\\_of\\_conduct/index.htm](http://www.nationalcommissionforwomen.org/publications/code_of_conduct/index.htm) (last visited Oct. 15, 2003).
726. Apparel Export Promotion Council v. A.K. Chopra (1999) 1 S.C.C. 759.
727. Immoral Traffic (Prevention) Act, No. 104, § 2(f) (1956) (India).
728. See ASIAN DEVELOPMENT BANK, COMBATING TRAFFICKING OF WOMEN AND CHILDREN IN SOUTH ASIA 99 (Apr. 2003), [http://www.adb.org/Documents/Books/Combating\\_Trafficking/default.asp](http://www.adb.org/Documents/Books/Combating_Trafficking/default.asp) (last visited Oct. 10, 2003).
729. See Immoral Traffic (Prevention) Act, No. 104, §§ 7–8 (1956) (India).
730. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 127–128.
731. Posting of CWDS Library, [cwdslib@alpha.nic.in](mailto:cwdslib@alpha.nic.in), to [cwdsbol.net](http://cwdsbol.net) (Jan. 20, 2003) (on file with the Center for Reproductive Rights).
732. INDIA CONST., art. 23.
733. INDIA PEN. CODE, No. 45, §§367–370, 372–373, 366A–B, 375–376.
734. Immoral Traffic (Prevention) Act, No. 104, §§ 7–8 (1956) (India).
735. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 128.
736. See *id.*
737. Immoral Traffic (Prevention) Act, No. 104, §8 (Commentary) (1956) (India).
738. See Immoral Traffic (Prevention) Act, No. 104, §§ 10A (1956) (India).
739. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 129.
740. See *id.*
741. See *id.*
742. See *id.* ¶ 130.
743. See *id.*
744. See COMBATING TRAFFICKING OF WOMEN AND CHILDREN IN SOUTH ASIA, *supra* note 728, at 103.
745. See *id.*
746. Immoral Traffic (Prevention) Act, No. 104, §§ 22A, 22AA, 23 (1956) (India).
747. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 136.
748. See *id.*
749. See NATIONAL POPULATION POLICY, *supra* note 283, ¶ 26.
750. See CENTRE FOR DEVELOPMENT AND POPULATION ACTIVITIES (CEDPA), ADOLESCENT GIRLS IN INDIA CHOOSE A BETTER FUTURE: AN IMPACT ASSESSMENT, (2001).
751. See *id.* (citing INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS–2) 1998–1999, *supra* note 285).
752. See *id.* 7.
753. See *id.* n.3.
754. See *id.* n.4.
755. See ADOLESCENT GIRLS IN INDIA CHOOSE A BETTER FUTURE: AN IMPACT ASSESSMENT, *supra* note 750, at 7.
756. According to the National Population Policy, “the needs of adolescents, including protection from unwanted pregnancies and sexually transmitted diseases (STD), have not been specifically addressed in the past.” See NATIONAL POPULATION POLICY, *supra* note 283, at 8.
757. See TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2.11, ¶ 2.11.2.
758. See *id.* vol. II, ch. 2.11, ¶ 2.11.57.
759. See *id.* vol. II, ch. 2.11, ¶ 2.11.66.
760. See NATIONAL POPULATION POLICY, *supra* note 283, ¶ 26.
761. See *id.*
762. DEPARTMENT OF FAMILY WELFARE, MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA, NATIONAL POPULATION POLICY 2000, ACTION PLAN, app. 1, § iii, ¶ 12.
763. *Id.* app. 1, § iii, ¶ 13.
764. *Id.* app. 1, § iv(c), ¶ 1.
765. Department of Women and Child Development, Government of India, Draft National Policy and Charter for Children, 2001, ¶ 2.a, <http://wed.nic.in/charterchild.htm> (last visited Oct. 13, 2003) [hereinafter Draft National Children’s Policy and Charter].
766. *Id.* ¶ 11 a–c.
767. *Id.* §§ 2–3.
768. See MARGARET E. GREENE, ET AL., IN THIS GENERATION: SEXUAL & REPRODUCTIVE HEALTH POLICIES FOR A YOUTHFUL WORLD 22 (2002).
769. ADOLESCENT GIRLS IN INDIA CHOOSE A BETTER FUTURE: AN IMPACT ASSESSMENT, *supra* note 750, at 7.
770. See INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS–2) 1998–1999, *supra* note 285, at 20.
771. See *id.*
772. See *id.* at 67.
773. Child Marriage Restraint Act, No. 19, §2(a) (1929) (India).
774. *Id.* §§3–4.
775. *Id.* § 6. Note that the act expressly provides that “...no woman shall be punishable with imprisonment.”
776. Special Marriage Act, No. 43, § 4(c) (1954) (India); Foreign Marriage Act, No. 33, § 4(c) (1969) (India).
777. Hindu Marriage Act, No. 25, art. 5.3 (1955) (India).
778. See Hidayatullah and Hidayatullah, *supra* note 495, §25t.
779. Indian Christian Marriage Act, No. 15, art. 60 (1872) (India).
780. *Id.* arts. 19, 44.
781. *Id.* arts. 4, 70–72.
782. Parsi Marriage and Divorce Act, No. 3, art. 3(1)(c) (1936) (India).
783. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 29.
784. See *id.*
785. See ADOLESCENT GIRLS IN INDIA CHOOSE A BETTER FUTURE: AN IMPACT ASSESSMENT, *supra* note 750, at 6.
786. See TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2.11, ¶ 2.11.138.
787. INDIA CONST., art. 45.
788. *Id.* amend. 86.
789. *Id.*
790. *Id.*
791. Revised National Policy on Education (1992), in R. C. SHARMA, NATIONAL POLICY ON EDUCATION & PROGRAMME OF IMPLEMENTATION 274 (2002).
792. *Id.* at 276–277.
793. *Id.* at 299–354.
794. Draft National Children’s Policy and Charter, *supra* note 765, ¶ 7(a)–(b).
795. *Id.* ¶ 12.
796. *Id.* ¶ 7(e).
797. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 167.
798. See TENTH FIVE YEAR PLAN, *supra* note 133, vol. II, ch. 2.11, ¶ 2.11.73.
799. See *id.* vol. II, ch. 2.11, ¶ 2.11.117.
800. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 162.
801. See *id.*
802. See ADOLESCENT GIRLS IN INDIA CHOOSE A BETTER FUTURE: AN IMPACT ASSESSMENT, *supra* note 750, at 7.
803. See *id.*
804. See Greene, et. al., *supra* note 768, at 20.
805. For example, Tamil Nadu is the only state that has advanced sexual health education programs. Maharashtra actually banned AIDS education in public schools, despite having the worst epidemic of any state. See Greene, et. al, *supra* note 768, at 20 (citing S. DUBE, SEX, LIES AND AIDS 99 (2000)).
806. See *id.* at 22.
807. See *id.*
808. INDIA PEN. CODE, No. 45, §§ 359–366A, 372–373, 375–376.
809. See *id.* §§ 375–376.
810. See *id.* § 376(2)(f).
811. Immoral Traffic (Prevention) Act, No. 104, §§ 5(1)(i)–(ii) (1956) (India). See also §2(cb), (aa) regarding the definition of a minor and a child.
812. See CEDAW Committee, States parties initial reports, India, *supra* note 10, ¶ 129.
813. Draft National Children’s Policy and Charter, *supra* note 765, §9(a).
814. *Id.* § 10(a).
815. *Id.* § 11(a).