CENTER FOR REPRODUCTIVE RIGHTS

The Committee on the Rights of the Child

Re: Supplementary information on India scheduled for review by the Committee on the Rights of the Child during its 35th Session

Dear Committee Members:

This letter is intended to supplement the periodic report submitted by India, which is scheduled to be reviewed by the Committee on the Rights of the Child during its 35th Session. The Center for Reproductive Rights, an independent non-governmental organization, hopes to further the work of the Committee by providing independent information concerning the rights protected in the Convention on the Rights of the Child (Children's Rights Convention). This letter highlights several areas of concern related to the status of the reproductive health and rights of girls and adolescents in India, with a focus on discriminatory or inadequate laws and policies.

Because reproductive rights are fundamental to adolescents' health and equality, states parties' commitment to ensuring them should receive serious attention. Furthermore, adolescent reproductive health and rights receive broad protection under the Children's Rights Convention. Article 24 of the Children's Rights Convention recognizes girls' and adolescents' right "to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health." It also requires states parties to take appropriate measures to develop "family planning and education services." Yet, despite these protections, the reproductive rights of girls and adolescents in India continue to be neglected and, at times, blatantly violated.

We hope to bring to the Committee's attention the following issues of concern, which directly affect the reproductive health and rights of girls and adolescents in India:

I. The Right to Reproductive Health Services (Article 24 of the Children's Rights Convention)

The Committee has regularly expressed concern in its Concluding Observations where adolescents have limited access to reproductive health services and has asked states parties to increase women's and adolescents' access to such services.[1] It has frequently drawn attention to high rates of maternal mortality affecting adolescents,[2] highlighting

the need to address unsafe or illegal abortion[3] and teenagers' lack of access to reproductive health services.[4] It has further recommended measures to improve women's access to pregnancy-related health care services,[5] emphasizing the importance of appropriately trained personnel attending births.[6] In its General Comment on Adolescent Health and Development, the Committee urges governments "to develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, [and] adequate and comprehensive obstetric care and counselling."[7]

Adolescents[8] make up one-fifth of India's total population,[9] but pervasive misconceptions about adolescent sexuality have led law and policy makers to largely ignore adolescents' specific health needs. As a consequence, adolescents are vulnerable to a host of health problems, sexual violence and abuse. Laws, policies and programs that cater specifically to adolescents' reproductive health needs are necessary to ensure and advance the fundamental rights to life, health, self-determination and equality of this vulnerable group. Effective implementation of governmental policy measures is essential to improving adolescents' health and social status, which, at present, are matters of very serious concern.

In India, there are still no comprehensive government policies or programs that target adolescents' reproductive health.[10] However, the Tenth Five Year Plan (Tenth Plan), the 2000 National Population Policy (2000 NPP) and the Reproductive Child and Health Program together prescribe governmental interventions that address certain adolescent reproductive health issues. The Tenth Plan recognizes that the process of empowering women demands a life-cycle approach and that every stage of women's lives should therefore be addressed in government planning.[11] It makes eliminating discrimination and all forms of violence against women, adolescents and the girl child one of its main objectives.[12] Specifically, it calls for "urgent interventions to protect the girl child," who, along with adolescents, continues to be "a victim of various types of discrimination, both within and outside the family."[13]

The 2000 NPP acknowledges that the needs of adolescents have not been specifically addressed in previous policies. It calls for programs to encourage delayed marriage and child-bearing and to offer adolescents education about the risks of unprotected sex.[14] It calls special attention to adolescents in rural areas, where adolescent marriage and pregnancy are widely prevalent, citing the need 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.[15] The action plan to implement the National Population Policy calls for the development of a health-care package for adolescents.[16] It also encourages community education outreach to adolescents about the availability of safe abortion services and the dangers of unsafe abortion.[17] It requires states to ensure adolescents' access to information, counseling and affordable services, including reproductive health services.[18]

It is evident that the government does formally recognize the underlying social factors that predispose adolescents to serious reproductive health problems. However, the

persistently high incidence of child marriage, high rates of maternal death, continuing level of illiteracy and ignorance about safe sex and sexuality raise serious questions about the adequacy and effective implementation of the government's programs. There are over 10 million pregnant adolescents and adolescent mothers in India, with one in six girls aged 13-19 beginning childbearing.[19] The 1998-1999 National Family Health Survey found that 56% of adolescent girls are anemic and only 7.4 % of married girls aged 15-19 use contraception.[20] Among mothers under age 20, only 68.7% received prenatal care from a health care worker and 41.6% were assisted at delivery by a skilled birth attendant.[21] Statistics show that 50% of maternal deaths in girls aged 15-19 are due to unsafe abortions.[22] Only 37.2% of married women aged 15-24 have heard about HIV/AIDS.[23] Knowledge about care needed during pregnancy, lactation for the health of mother and child, and access to pre- and post-natal services is also limited.[24]

II. The Right to be Free from Traditional Practices that are Harmful to Children's Health (Article 24(3) of the Children's Rights Convention)

Article 24(3) requires states parties to take measures to abolish traditional practices that are harmful to children's health. The Committee has determined that child and forced marriage are both harmful traditional practices and forms of gender discrimination.[25] It has expressed its concern that "early marriage and pregnancy are significant factors in health problems related to sexual and reproductive health, including HIV/AIDS."[26] In a recent Concluding Observation on India, the Committee stated that it was concerned that "the health of adolescents, particularly girls, is neglected, given, for instance, a very high percentage of early marriages, which can have a negative impact on their health."[27]

The Child Marriage Restraint Act (CMR Act) requires that for a valid marriage, the bridegroom must be at least 21 years old and the bride at least 18.[28] Under the CMR Act, a man above the age of 21 marrying a child is punishable with imprisonment of up to three months with a fine,[29] but a man between 18 and 21 is subject to a punishment of up to 15 days with a fine, which may extend up to one thousand rupees.[30] In order to further discourage child marriages, the CMR Act also punishes any parent or guardian of a minor who promotes or permits a child marriage to be solemnized, or one who negligently fails to prevent it from being solemnized, with up to three months imprisonment with a fine.[31]

Despite the law, the minimum age of marriage in practice varies among communities and is governed by each community's respective personal laws. Consequently, the median age at first marriage among women aged 20-49 in India is 16.7, with a two-year difference between urban and rural women (18.7 versus 16).[32] In urban areas, 18% of females aged 15-19 have ever been married, compared with 3% of men of the same age group.[33] In rural areas, comparable statistics are 40% of women and 8% of men.[34] Women belonging to the lowest socio-economic level of society are more likely to suffer from reproductive health problems associated with early marriage. Since most of them end up marrying men significantly older, they are rarely in a position to assert their needs or seek appropriate health care, where available. Research on autonomous decision-making and freedom of movement among married women aged 15-19, clearly illustrates this point. According to the 1998-1999 National Family Health Survey, only 38.6% of

married women in this age group were involved in decisions about their own health care and 86% needed permission to go to the market.[35] Given that 72% of the total population in India is rural, early marriage, and the health and social problems associated with the practice, is indeed widespread.

III. The Right to Education on Sexuality and Family Planning (Articles 17 and 24 of the Children's Rights Convention)

The Committee, in evaluating state party compliance with the Children's Rights Convention, has recognized states' duty to ensure access to sexual and reproductive health education. In its General Comment on Adolescent Health and Development, the Committee has stated:

> States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs). In addition, States parties should ensure that they have access to appropriate information, regardless of their marital status and whether their parents or guardians consent.[36]

In numerous Concluding Observations, the Committee has recommended that states parties strengthen their reproductive health education programs for adolescents in order to combat adolescent pregnancy and the spread of HIV/AIDS and other STIs.[37]

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.[38] The 86th Amendment to the constitution makes free and compulsory education a fundamental right for children between the ages of 6–14.[39] The National Policy on Education of 1986 reiterates this constitutional directive.[40] 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.[41] It further recognizes the right of adolescents to education and the development of skills.[42] It specifically requires the state "to take appropriate measures to ensure that the education is sensitive to the rights of the girl child."[43]

Despite these provisions and several government programs aimed at promoting girls' education, only 32% of girls entering primary school ultimately complete schooling.[44] Forty million children have never entered schools.[45] This lack of exposure to formal education has deprived vast numbers of young women of knowledge about reproductive health and the skills they need to acquire such knowledge. Adolescents thus lack the means to protect themselves against unwanted pregnancy and sexually transmissible infections, including HIV/AIDS.

On average, most adolescent girls in India have little knowledge of menstruation, sexuality and reproduction.[46] According to the Nutrition Foundation of India, the average

age of menarche is 13.4, yet 50% of girls aged 12-15 do not know about menstruation.[47] This is true for the urban as well as the rural population.
India is currently in the midst of an HIV/AIDS crisis, which is expected to worsen in the near future. Current figures do not bode well for adolescents, particularly young women and girls who, due to their lack of information and status, are likely to be hit the hardest. Research has already indicated that amongst people aged 15-24, the percentage females living with HIV/AIDS (0.7%) outnumbers that of men (0.3%).[48] The number of children under the age of 15 with HIV/AIDS is estimated at 170,000.[49] Greater government action is needed to prevent further infections among this vulnerable age group, to address the stigma they face and to provide treatment.

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

1. What steps has the government taken to implement current laws and policies pertaining to adolescent health? Has the government allocated sufficient resources to implement the programs stated in current policies? What steps are being taken to monitor implementation of policies and evaluate their impact in order to make necessary policy changes and improvements?

2. What steps has the government taken to curb the high incidence of child marriage in India and to address the reproductive health and social problems associated with this practice? Has the government provided married adolescents with special opportunities for education and employment? Has it taken any measures to provide redress to young women in abusive marriages, sensitize service providers, and equip the health system to cater to the special health needs of this vulnerable group?

3. What concrete steps has the government taken to enable adolescents to protect themselves against unwanted pregnancies, maternal morbidity and death, STIs and HIV/AIDS? Have special steps been taken to reach illiterate or semi-literate girls and women, who constitute the majority?

There remains a significant gap between the provisions of the Children's Rights Convention and the reality of adolescents' reproductive health and lives. We appreciate the active interest that the Committee has taken in the reproductive health and rights of adolescents and the strong concluding observations and recommendations the Committee has issued to governments in the past, stressing the need to take steps to ensure the realization of these rights.

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

Sincerely,

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[1] *See e.g., Concluding Observations of the Committee on the Rights of the Child: Benin,* para. 25, U.N. Doc. CRC/C/15/Add.106 (1999); *Concluding Observations of the Committee on the Rights of the Child: Cambodia,* para. 53, U.N. Doc. CRC/C/15/Add.128 (2000); *Concluding Observations of the Committee on the Rights of the Child: Mexico,* para. 27, U.N. Doc. CRC/C/15/Add.112 (1999).
[2] *See e.g., Concluding Observations of the Committee on the Rights of the Child: Chad,* para. 30, U.N. Doc. CRC/C/15/Add.107 (1999); *Concluding Observations of the Committee on the Rights of the Child: Dominican Republic,* para. 37, U.N. Doc. CRC/C/15/Add.150 (2001); *Concluding Observations of the Committee on the Rights of the Child: Peru*, para. 24, U.N. Doc. CRC/C/15/Add.120 (2000).
[3] *See e.g., Concluding Observations of the Committee on the Rights of the Child: Chad, supra* note 2, para. 30; *Concluding Observations of the Committee on the Rights of the Child*: *Colombia,* para. 48, U.N. Doc. CRC/C/15/Add.137 (2000); *Concluding Observations of the Committee on the Rights of the Child: Guatemala*, para. 40, U.N. Doc. CRC/C/15/Add.154 (2001).
[4] *See e.g., Concluding Observations of the Committee on the Rights of the Child: Cambodia*, para. 52, U.N. Doc. CRC/C/15/Add.128, (2000); *Concluding Observations of the Committee on the Rights of the Child: Dominican Republic*, para. 37, U.N. Doc. CRC/C/15/Add.150 (2001); *Concluding Observations of the Committee on the Rights of the Child*： *Guinea*, para. 27, U.N. Doc. CRC/C/15/Add.100 (1999).
[5] *See e.g., Concluding Observations of the Committee on the Rights of the Child: Central African Republic*, para. 55, U.N. Doc. CRC/C/15/Add.138 (2000); *Concluding Observations of the Committee on the Rights of the Child: Guatemala*, *supra* note 3, para. 41, U.N. Doc. CRC/C/15/Add.154 (2001); *Concluding Observations of the Committee on the Rights of the Child: Yemen*, para. 24, U.N. Doc. CRC/C/15/Add.102 (1999).
[6] *See e.g., Concluding Observations of the Committee on the Rights of the Child: Guatemala, supra* note 3, para. 35； *Concluding Observations of the Committee on the Rights of the Child: United Republic of Tanzania*, para. 47, U.N. Doc. CRC/C/15/Add.156 (2001); *Concluding Observations of the Committee on the Rights of the Child: Yemen, supra* note 5, para. 24.
[7] Committee on the Rights of the Child, *General Comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child*, para. 31, UN doc. CRC/GC/2003/4 (2003) [hereinafter *General Comment on Adolescent Health*].
[8] The World Health Organization defines "adolescents" as people between the ages of 10 and 19 years of age. World Health Organization (WHO), *Child and Adolescent Health and Development, Overview of CAH*, available at http://www.who.int/child-adolescent-health/OVERVIEW/AHD/adh_over.htm (last viewed Jan. 7, 2004).
[9] DEPARTMENT OF FAMILY WELFARE, MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA, NATIONAL POPULATION POLICY 2000, para. 26 [hereinafter NATIONAL POPULATION POLICY].
[10] 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 id.,* at 8.
[11] *See* NATIONAL DEVELOPMENT COUNCIL, PLANNING COMMISSION, TENTH FIVE YEAR PLAN (2002–2007), vol. II, chap. 2.11, para. 2.11.2, *available at* http://planningcommission.nic.in/plans/planrel/fiveyr/10th/default.htm (last visited Sept. 23, 2003) [hereinafter TENTH FIVE YEAR PLAN].
[12] *Id.*, chap. 2.11, para. 2.11.57.
[13] *Id.*, chap. 2.11, para. 2.11.66.
[14] NATIONAL POPULATION POLICY, *supra* note 9, para. 26.
[15] *Id.*
[16] DEPARTMENT OF FAMILY WELFARE, MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA, NATIONAL POPULATION POLICY 2000, ACTION PLAN, app. 1, § iii, ¶ 12.
[17] *Id.,* app. 1, § iii, ¶ 13
[18] *Id.,* app. 1, § iv(c), ¶ 1.
[19] CEDPA, Adolescent Girls in India Choose a Better Future: An Impact Assessment 7 (Sept. 2001).
[20] *Id.*
[21] *Id.*
[22] *Id.,* at 7 n.3.

[23] *Id.,* at 7 n.4.
[24] *Id.,* at 7.
[25] *See e.g., Concluding Observations of the Committee on the Rights of the Child: Bangladesh,* para. 15, UN Doc. CRC/C/15/Add.74 (1997); *Concluding Observations of the Committee on the Rights of the Child:* Burkina Faso, para. 14, U.N. Doc. CRC/C/15/Add.19 (1994); *Concluding Observations of the Committee on the Rights of the Child: India*, paras. 32-33, U.N. Doc. CRC/C/15/Add.115 (2000).
[26] General Comment on Adolescent Health, *supra* note 7, para. 20.
[27] *Concluding Observations of the Committee on the Rights of the Child: India,* para. 50, UN Doc. CRC/C/15/Add.115 (2000).
[28] The Child Marriage Restraint Act, (1929), [CMRA] Section 2(a), as amended by the Child Marriage (Amendment) Act, (1978), (2 of 1978).
[29] *Id.*, sec. 4.
[30] *Id.*, sec. 3.
[31] *Id.*, sec. 6. Note that this Act expressly states that "…no woman shall be punishable with imprisonment."
[32] CEDPA, *supra* note 19, at 7, n. 1.
[33] INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES (IIPS) AND ORC MACRO, NATIONAL FAMILY HEALTH SURVEY (NFHS–2), 1998–1999: INDIA p. 20 (2000), *available at* http://www.nfhsindia.org/india2.html (last visited Sept. 29, 2003) [hereinafter INDIA NATIONAL FAMILY HEALTH SURVEY (NFHS–2) 1998–1999].
[34] *Id*.
[35] *Id.,* at 67.
[36] Committee on the Rights of the Child, *General Comment on Adolescent Health*, *supra* note 7, para. 28.
[37] *See Concluding Observations of the Committee on the Rights of the Child: Argentina*, para. 19, U.N. Doc. CRC/C/15/Add.35 (1995*); Concluding Observations of the Committee on the Rights of the Child: Egypt*, para. 44, U.N. Doc. CRC/C/15/Add.145 (2001); *Concluding Observations of the Committee on the Rights of the Child: Georgia*, para. 47, U.N. Doc. CRC/C/15/Add.124 (2000); *Concluding Observations of the Committee on the Rights of the Child: Latvia*, paras. 39-40, UN. Doc. CRC/C/15/Add.142 (2001); *Concluding Observations of the Committee on the Rights of the Child: Russian Federation*, para. 48, U.N. Doc. CRC/C/15/Add 110 (1999); *See also*, *Committee on the Rights of the Child, General Comment No. 3, HIV/AIDS and the rights of the child*, para. 16,UN Doc. CRC/GC/2003/3 (2003).
[38] INDIA CONST. art. 45.
[39] *Id.,* amend. 86.
[40] *Revised National Policy on Education* (1992), *in* R.C. SHARMA, NATIONAL POLICY ON EDUCATION & PROGRAMME OF IMPLEMENTATION 274 (2002).
[41] Draft National Children's Policy and Charter, ¶ 7 (a)–(b).
[42] *Id*., ¶ 12.
[43] *Id*., ¶ 7(e).
[44] CEDAW Committee, *Consideration of Reports Submitted by States Parties under Article 18 of CEDAW, Initial reports of States parties, India*, para. 29, CEDAW/C/IND/1, Mar. 10, 1999.
[45] TENTH FIVE YEAR PLAN, *supra* note 11, vol. II, ch. 2.11, ¶ 2.11.138.
[46] CEDPA, *supra* note 19, at 7 (Sept. 2001).
[47] *Id.*
[48] *See* United Nations Population Fund (UNFPA), The State of World Population 2003, at 71 (2003).
[49] *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).