

Summary Submission to the UN Universal Periodic Review of

INDIA

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**Submitted by:
Center for Reproductive Rights
Human Rights Law Network**

1. Pursuant to Human Rights Council Resolution 5/1 (2007) and the guidelines for stakeholders, the Center for Reproductive Rights¹ (the Center) and Human Rights Law Network² (HRLN) submit this evaluation of the Government of India's (the Government) fulfillment of its human rights obligations and commitments, paying specific attention to issues related to the status of women's reproductive rights in India, notably maternal health and access to contraceptive information and services. This submission draws on two human rights reports--*Maternal Mortality in India: Using International and Constitutional Law to Promote Accountability and Reform*,³ published by the Center (Annex 1), and *2011 Update Maternal Mortality in India*,⁴ published by the Center and HRLN (Annex 2).

NORMATIVE AND INSTITUTIONAL FRAMEWORK

2. India has signed and ratified a host of human rights treaties, which establish and protect women's human rights, including their right to survive pregnancy and childbirth and to contraceptive information and services. However, there are serious gaps in compliance. India has not implemented the recommendation made during its 2008 Universal Periodic Review (UPR) that it sign the Optional Protocol (OP) to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), nor has it signed the OPs for the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. The Committee on the Elimination of Discrimination against Women (CEDAW Committee) has urged India to remove reservations to CEDAW⁵ but India has not withdrawn its reservations to articles 5(a) and 16(1)-(2) (relating to early marriage and equal rights for women within marriage, including to determine the number and spacing of their children).⁶ India has yet to ratify the Convention against Torture, signed in 1997, as well as to sign its OP, despite the recommendation to do so during the 2008 UPR.⁷ (See Annex 1, pp. 27-37.)
3. India's Constitution recognizes the right to non-discrimination, including on the basis of sex, and the right to life as fundamental rights. India's Supreme Court has interpreted the right to life to include the right to health, and has found that under the Constitution, international treaties should be considered binding in the absence of conflicting Parliamentary acts.⁸ (See Annex 1, pp. 39-52.)

PROMOTION AND PROTECTION OF HUMAN RIGHTS

4. The Government has introduced many policies and programs to improve women's reproductive health; however, lack of government accountability for effective implementation and a prevailing culture of impunity for human rights violations means that women's health needs remain neglected, notably in critical areas of maternal health and access to contraceptive information and services. (See Annex 2, pp. 10-13.)
5. India did not accept the 2008 UPR recommendation by Brazil encouraging OP-CEDAW ratification, claiming that its Constitution and statutes grant sufficient access to redress mechanisms, including the Supreme Court, High Courts, and the national and state human rights commissions.⁹ In practice, Indian High Courts allow cases to languish without hearings and the Government has failed to implement those court orders that have been issued directing systemic reform. (See Annex 2, pp. 20-25.) The National Human Rights Commission and National Commission on Women have not yet taken a clear stance prioritizing women's reproductive rights as human rights concerns, despite the scope and scale of violations under international and constitutional law. Ratification of the OP-CEDAW would be a clear sign of India's commitment to ensuring accountability for human rights violations.

Ongoing Impunity for Maternal Deaths

6. While India has experienced a decline in the number of maternal deaths in recent years, the country continues to account for the highest number of maternal deaths worldwide, as it has for decades, and is still not on track to meet its reduction targets under national policy or under Millennium Development Goal (MDG) 5.¹⁰ Although India has many programs and schemes concerning maternal health, the Government's failure to effectively implement them has resulted in the ongoing loss of an estimated 63,000 lives annually.¹¹ (See Annex 2, pp. 9-13.) The persistence of maternal mortality, including due to child marriage and unsafe abortion, reflects the low status of women in India and the lack of prioritization of gender equality (MDG 3).¹² India has introduced the National Rural Health Mission (NRHM), a government program with a significant maternal health component, but evaluations conducted by UNFPA, government agencies, and civil society have shown a widespread and troubling lack of implementation. (See Annex 2, p. 12.)
7. UN treaty monitoring bodies and experts have consistently expressed concern about India's maternal mortality figures,¹³ describing them as "alarming"¹⁴ and "shocking,"¹⁵ and noting specific concern about maternal mortality in rural areas and among women who belong to disadvantaged castes and tribes.¹⁶ UN bodies have urged India to accord "the highest priority" to reducing maternal mortality¹⁷ by establishing and ensuring access to obstetric services¹⁸ and by significantly increasing health expenditures. (See Annex 1, pp. 27-37.) The Committee on Economic, Social and Cultural Rights (ESCR Committee) has urged India to take steps to fully implement the NRHM.¹⁹ While the national government is clearly obligated under human rights treaties to ensure the right to survive pregnancy and childbirth, the national government has repeatedly attempted to absolve itself of this duty by claiming state-level governments are responsible for ensuring maternal health.
8. **Unsafe abortion.** Abortion is legal, but 60% of abortions occur in unauthorized facilities²⁰ and unsafe abortions cause significant numbers of maternal deaths, including half of all maternal deaths among girls ages 15-19.²¹ The CEDAW Committee has expressed concern about unsafe abortion in India, and urged India to prioritize ensuring access to safe abortion services to decrease maternal mortality.²² Despite the adoption of the Medical Termination of Pregnancy Act in 1971, significant obstacles to obtaining a safe and legal abortion in India remain, including prohibitive costs; a shortage of trained providers and adequate equipment; lack of confidentiality and informal demands for spousal consent; poor access to facilities; and lack of knowledge about the legal status of abortion and where to get safe services.²³ Petitions have been filed under the Right to Information Act seeking data on the number of licensed health facilities but the government has failed to provide a satisfactory response.
9. **Early marriage.** Child marriage is illegal, but 47% of women aged 18-29 report getting married before 18.²⁴ Child marriage is associated with early pregnancy, which exposes girls to a high risk of maternal death; in India, 50% of all maternal deaths occur before age 25.²⁵ UN bodies have repeatedly expressed concerns about early marriage in India, including its impact on adolescent health and education.²⁶ High rates of early marriage are impeding India's achievement of MDG 3.²⁷ The ESCR Committee has attributed early marriage and high rates of maternal mortality in India "largely to the lack of sex and reproductive education that is still viewed to be taboo in the State party."²⁸ The CEDAW Committee and the ESCR Committee have all called on India to address the very high percentage of early and forced marriages of girls in India.²⁹ The Committee on the Rights of the Child has urged India to implement legislation prohibiting child marriage, strengthen prevention programs, and strengthen and ensure accessibility of reproductive health education and counseling for adolescents.³⁰ Implementation of the Prohibition of Child Marriage Act and various pilot schemes and

programs have been wholly inadequate, as demonstrated by the fact that India has fallen far short of meeting its own policy goal to eliminate child marriage completely by 2010.³¹

10. India's courts have been inconsistent and often slow in ensuring accountability for the Government's failure to effectively implement laws and policies, due in part to resistance by relevant agencies and in part due to lack of judicial prioritization of these issues. The Madhya Pradesh and Delhi High Courts recently issued several orders and decisions directing the Government to take specific steps to address its failure to provide quality health services, denials of entitlements and benefits guaranteed in official maternal health programs, and discrimination against pregnant women who are poor. In Delhi, the Court ruled that the right to maternal healthcare constitutes an "inalienable survival right,"³² and directed the Government to effectively implement these programs, but the Government has been slow to do so. In Madhya Pradesh, the Court issued interim orders directing immediate action, such as the construction of a water tank to provide one health center with running water, but since then it has granted government agencies sixteen adjournments in response to their requests for additional time to respond to allegations of non-implementation. The Court recently fined the Madhya Pradesh government for delaying the process, but a response has yet to be filed.³³ Similarly, in Uttar Pradesh, the case of a poor woman who developed fistula, a preventable pregnancy-related injury, due to delayed medical care has languished in the system without a single hearing since 2008. (See Annex 2, pp. 17-25.)
11. The Government has repeatedly attempted to deny nutrition benefits to pregnant women. In July 2011, the Government filed an affidavit in the case of *PUCL v. Union of India* before the Supreme Court seeking approval to exclude women with more than two children and adolescent girls under 19 from nutrition benefits under current schemes.³⁴ This amendment, if granted, would constitute a retrogressive measure under international law. The Government's attempt to deny nutrition benefits to pregnant women and adolescent girls to prevent more than two births and the practice of child marriage constitutes a coercive measure. It is based in part on an ambiguous statement made by the Supreme Court in 2007 in the *PUCL* case, which indicated that denying such benefits might be justified for population control and to discourage child marriages.³⁵ As of November 2011, the Court had not heard this motion, demonstrating a lack of prioritization of the issue and concern for vulnerable groups of women and girls whose entitlements have been brought into question. (See Annex 2, p. 23.)

Impunity for Failure to Ensure Access to Contraceptive Information and Services

12. The World Health Organization found that Indian women lack access to a wide range of contraceptives, particularly modern, non-permanent contraceptives, often leading either to unwanted pregnancies that women are neither prepared nor equipped for, or to unsafe abortions.³⁶ Twenty-one percent of all pregnancies that resulted in births are unplanned.³⁷ Among the 49% of Indian women who use modern contraceptive methods, almost 80% rely on female sterilization,³⁸ indicating lack of access to a full range of contraceptive methods.
13. The lack of access to contraceptive information and services is of particular concern as India has committed both through its own National Population Policy (NPP) and MDG 5(b) to ensure universal access to contraception.³⁹ The NPP "affirms the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services,"⁴⁰ and sets a target of "universal access to information/counseling, and services for fertility regulation and contraception with a wide basket of choices" by 2010,⁴¹ which India has clearly failed to realize.

14. The CEDAW Committee has expressed concern regarding the inadequacy of contraceptive services in India and called for “gender-sensitive comprehensive contraceptive services.”⁴² As a signatory to the International Conference on Population and Development Programme of Action, India must ensure that “the aim of family-planning programs must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods.”⁴³ UN bodies have emphasized the obligation to ensure the full range of contraceptive methods and services, information, and counseling without discrimination, including to adolescents.⁴⁴
15. Although India is committed under CEDAW article 12 to ensure access to contraceptive information and services, India has maintained a reservation to CEDAW article 16(1) stating that where it would need to interfere “in the personal affairs of any Community” it is not obligated to ensure women have the ability to decide freely on the number and spacing of their children, and to have access to the information, education, and means to enable them to exercise this right.⁴⁵ This reservation is unacceptable considering that the Government has ignored its own policy of non-interference as it attempts to impose coercive measures on women who become pregnant after having two children or below the age of 19, including as discussed in the *PUCL* case above.
16. Despite national and international commitments to ensure universal, voluntary access to the full range of contraceptive methods, India has failed to adequately prioritize this access and to address the barriers to women’s access to contraception, such as cost, limited availability of certain methods, misconceptions about contraceptives and concerns about side-effects resulting in women discontinuing use, lack of follow-up care, and lack of confidentiality.

COOPERATION WITH HUMAN RIGHTS MECHANISMS

17. It is of great concern that India has not implemented several recommendations made in the 2008 UPR.
18. India granted the Special Rapporteur on the Right to Health’s (SRRH) request for an official visit to investigate maternal mortality in 2007. The SRRH’s report identified several barriers to maternal mortality reduction, including lack of data on the causes of maternal death, corruption, failure to invest adequate public funds into maternal health programs and to utilize such funds efficiently, and the “ yawning gulf between India’s commendable maternal mortality policies and their urgent, focused, sustained, systematic and effective implementation, reinforced by robust and independent monitoring, accountability and redress.”⁴⁶ The report strongly recommended that India establish an independent body to galvanize action and ensure “that those in authority properly discharge their responsibilities to reduce maternal mortality.”⁴⁷ These recommendations have yet to be fully implemented. (See Annex 2, pp. 14-15.)
19. There is an immediate need for India to take a human rights-based approach to maternal mortality, including by implementing accountability measures. In 2011, India also co-sponsored Resolution A/HRC/18/L.8, the Human Rights Council’s third resolution on maternal mortality. Meaningful implementation of this resolution will help lay the groundwork for India’s reduction of its maternal mortality figures. This may be facilitated through follow-up on the UN Commission on Information and Accountability for Women’s and Children’s Health’s 2010 report, which India has supported.

INDIA'S ACHIEVEMENTS AND BEST PRACTICES

20. As set out above, significant progress is needed to address the challenges faced by women in India in exercising their reproductive rights. However, one achievement is that after years of judicial inaction reflecting the lack of recognition of maternal mortality as a human rights concern, court orders mandating state agencies to immediately fix specific problems that contribute to maternal mortality and progressive judicial decisions have begun to emerge. The Delhi High Court has gone as far as to award individual compensation for denials of maternal healthcare. It has even acted *suo moto* (on its own motion) on a media report of the death of a destitute woman who gave birth and died in a crowded market, and ordered the construction of shelters for poor pregnant and lactating women. In response to state government agencies' refusals to fully cooperate in maternal health cases, the Delhi and Madhya Pradesh High Courts have both fined the concerned government bodies. (See Annex 2, pp. 17-24.)

RECOMMENDATIONS

As the country leading all others in the absolute number of maternal deaths, India urgently needs to do more to reduce preventable maternal deaths nationwide, promote contraceptive access, ensure safe abortion access, and prevent early marriage and pregnancy as a matter of achieving MDGs 5 and 3 and ensuring women's and girls' human rights. India must recognize that addressing socioeconomic barriers is as crucial to reducing maternal deaths as addressing medical causes. Specifically, the Government should:

1. Ratify the OP-CEDAW and remove the reservations on article 16(1) of CEDAW;
2. Cooperate fully in legal appeals brought to courts seeking accountability for denials of maternal healthcare to ensure pregnant women have access to quality maternal healthcare, are provided the benefits and entitlements promised by the Government, and are protected against discrimination;
3. The central and state governments should promptly and fully implement the systemic reforms ordered by the Delhi High Court and the Madhya Pradesh High Court and provide legal remedies without further delay in cases that have been filed in other states;
4. Take steps to implement the Medical Termination of Pregnancy Act in recognition of the high incidence of unsafe abortion as a leading cause of maternal mortality;
5. Take meaningful, practical steps to fully implement the Prohibition of Child Marriage Act;
6. Implement UN treaty monitoring bodies' recommendations on maternal health and contraceptive information and services, and the SRRH's recommendation to increase monitoring, accountability, and redress for maternal deaths by establishing an independent body to ensure implementation of government maternal health policies and programs and address barriers to maternal healthcare;
7. Ensure universal access to the full range of contraceptives as promised in the NPP and UN treaties, including access to information, counseling, and services, and create legal safeguards to ensure women's ability to make decisions about contraception voluntarily; and
8. Urgently prioritize and support the development of technical guidance for the implementation of a human rights-based approach to eliminating preventable maternal mortality and morbidity, in follow-up to the UN Human Rights Council Resolution A/HRC/18/L.8, and take concrete steps to implement this technical guidance once drafted.

- ¹ The Center for Reproductive Rights is an independent, non-profit organization (org.) with ECOSOC consultative status since 1997 that works to protect women's reproductive rights throughout the world.
- ² The Human Rights Law Network (HRLN) is a collective of lawyers and social activists dedicated to the use of the legal system to advance human rights in India and the sub-continent.
- ³ CENTER FOR REPRODUCTIVE RIGHTS, *MATERNAL MORTALITY IN INDIA: USING INT'L AND CONSTITUTIONAL LAW TO PROMOTE ACCOUNTABILITY AND CHANGE* (2008), available at <http://bit.ly/YaKH9>.
- ⁴ CENTER FOR REPRODUCTIVE RIGHTS, *2011 UPDATE MATERNAL MORTALITY IN INDIA: USING INT'L AND CONSTITUTIONAL LAW TO PROMOTE ACCOUNTABILITY AND CHANGE* (2011), available at <http://bit.ly/rcJ5yb>.
- ⁵ CEDAW Comm., *Concluding Observations (CO): India*, ¶ 11, U.N. Doc. CEDAW/C/IND/CO/3 (2007).
- ⁶ CEDAW Comm., *OTHER MATTERS: Declarations, reservations, objections and notifications of withdrawal of reservations relating to the CEDAW*, at 19, U.N. Doc. CEDAW/SP/1996/2 (1996).
- ⁷ Human Rights Council, *UNIVERSAL PERIODIC REVIEW: Report of the Working Group on the Universal Periodic Review (UPR): India*, ¶ 86(1), U.N. Doc. A/HRC/8/26 (2008).
- ⁸ INDIAN CONST. art. 51(c); see also *Gramophone Co. of India Ltd. v. Birendra Bahadur Pandey & Ors.*, (1984) 2 S.C.R. 664 (India).
- ⁹ *UPR: India*, *supra* note 7, ¶¶ 9, 28.
- ¹⁰ Millennium Dev't Goal (MDG) 5 commits India to bring the maternal mortality ratio (MMR) down to 200 by 2007, a goal that it was unable to reach, and to 109 by 2015. India's Nat'l Population Policy 2002 committed to bring its MMR below 100 by 2010. World Health Org. (WHO) and UN agencies estimate India's MMR as 230. See U.N., *TRENDS IN MATERNAL MORTALITY: 1990-2008: ESTIMATES DEVELOPED BY WHO, UNICEF, UNFPA, AND THE WORLD BANK* 17, 24, 29 (2010); Dep't of Health, Ministry of Health and Family Welfare (MOHFW), Gov't of India, *Nat'l Health Policy 2002*; CENTRAL STATISTICAL ORG., *MINISTRY OF STATISTICS AND PROGRAMME IMPLEMENTATION, GOV'T OF INDIA, MDGs - INDIA COUNTRY REPORT 2009* 60-65.
- ¹¹ U.N., *TRENDS IN MATERNAL MORTALITY: 1990-2008*, *supra* note 10, at 17.
- ¹² *MDGs, Goal 3: Promote gender equality and empower women*, U.N. DEV. PROGRAMME, <http://www.undp.org/mdg/goal3.shtml>.
- ¹³ CEDAW Comm., *CO: India*, *supra* note 5, ¶¶ 40-41; CRC Comm., *CO: India*, ¶ 52, U.N. Doc. CRC/C/15/Add.228 (2004); ESCR Comm., *CO: India*, ¶ 73, U.N. Doc. E/C.12/IND/CO/5 (2008); CERD Comm., *CO: India*, ¶ 24, U.N. Doc. CERD/C/IND/CO/19 (2007); Special Rapporteur on the Right to Health (SRRH), *Addendum, Mission to India*, ¶ 95, U.N. Doc. A/HRC/14/20/Add.2 (2010).
- ¹⁴ ESCR Comm., *CO: India*, *supra* note 13, ¶ 33.
- ¹⁵ SRRH, *Mission to India*, *supra* note 13, ¶ 93.
- ¹⁶ ESCR Comm., *CO: India*, *supra* note 13, ¶¶ 25, 37; CEDAW Comm., *CO: India*, *supra* note 5, ¶ 40; CERD Comm., *CO: India*, *supra* note 13, ¶ 24.
- ¹⁷ ESCR Comm., *CO: India*, *supra* note 13, ¶ 73.
- ¹⁸ CEDAW Comm., *CO: India*, *supra* note 5, ¶ 41.
- ¹⁹ ESCR Comm., *CO: India*, *supra* note 13, ¶ 73.
- ²⁰ WHO, *UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF THE INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2008* 22-23 (6th ed., 2011).
- ²¹ CENTER FOR DEV. AND POPULATION ACTIVITIES, *ADOLESCENT GIRLS IN INDIA CHOOSE A BETTER FUTURE: AN IMPACT ASSESSMENT 7* (2001).
- ²² CEDAW Comm., *CO: India*, *supra* note 5, ¶¶ 40-41.
- ²³ Ravi Duggal and Vimala Ramachandran, *The Abortion Assessment Project-India: Summary and Key Findings*, ¶¶ 5-8 (2004); CENTER FOR HEALTH AND SOCIAL JUSTICE, *REVIEWING TWO YEARS OF NRHM: OCT. 2007* 111 (2007); M.E. Khan et al., *Availability and Access to Abortion Services in India: Myths and Realities* 8-10 (2001); WHO, *UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF THE INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2003* 4 (5th ed., 2007).
- ²⁴ *Nat'l Family Health Survey (NFHS-3): Nat'l Fact Sheet—India*, INSTITUTE FOR POPULATION SCIENCES (IIPS).
- ²⁵ INSTITUTE FOR RESEARCH IN MEDICAL STATISTICS, *ESTIMATES OF MMRs IN INDIA AND ITS STATES: A PILOT STUDY* 25 (2003).
- ²⁶ CRC Comm., *CO: India*, *supra* note 13, ¶ 60.
- ²⁷ MINISTRY OF WOMEN AND CHILD DEV., GOV'T OF INDIA, *SUB GROUP REPORT: CHILD PROTECTION IN THE ELEVENTH FIVE YEAR PLAN (2007-2012)* 9.
- ²⁸ ESCR Comm., *CO: India*, *supra* note 13, para. 37.
- ²⁹ ESCR Comm., *CO: India*, *supra* note 13, ¶ 80; CEDAW Comm., *CO: India*, *supra* note 5, ¶ 57; CRC Comm., *CO: India*, *supra* note 13, ¶¶ 61(a)-(b).
- ³⁰ CRC Comm., *CO: India*, *supra* note 13, ¶ 61.
- ³¹ DEP'T OF WOMEN & CHILD DEV., *NAT'L PLAN OF ACTION FOR CHILDREN 2005* 18 (2005).
- ³² *Consol. Decision, Laxmi Mandal v. Deen Dayal Harinagar Hospital & Ors.*, W.P. (C) No. 8853/2008 & *Jaitun v. Maternal Home MCD, Jangpura & Ors.*, W.P. (C) Nos. 8853 of 2008 & 10700 of 2009 (Delhi H.C., 2010), ¶¶ 2, 64-68.
- ³³ *HC slaps penalty for lapses in checking high mortality*, HITVADA (Aug. 10, 2011).
- ³⁴ MOHFW Affidavit, *People's Union for Civil Liberties (PUCL) v. Union of India & Ors.*, ¶ 17 (July 22, 2011).
- ³⁵ Supreme Court Order, *PUCL v. Union of India & Ors.*, W.P. Civ. No. 196 of 2001, Supreme Court (case ongoing), ¶¶ 14(b), 15 (Nov. 20, 2007).
- ³⁶ See WHO, *Regional Office for Southeast Asia, India and Family Planning: An Overview*, http://www.searo.who.int/LinkFiles/Family_Planning_Fact_Sheets_india.pdf.
- ³⁷ IIPS AND MACRO INT'L, *NAT'L FAMILY HEALTH SURVEY (NFHS-3) 2005-06: INDIA* 108 (vol. 1, 2007).
- ³⁸ Susheela Singh et al., *Barriers to Safe Motherhood in India* 13 (2009), GUTTMACHER INSTITUTE.
- ³⁹ *MDGs, Goal 5: Improve Maternal Health*, U.N. DEV. PROGRAMME, <http://www.undp.org/mdg/goal5.shtml>; Nat'l Comm'n on Population, Gov't of India, *Nat'l Population Policy 2000, Objectives*.

⁴⁰ Nat'l Comm'n on Population, Gov't of India, Nat'l Population Policy 2000, Introduction, ¶ 6.

⁴¹ *Id.*, Objectives, box 2.

⁴² CEDAW Comm., *CO: India*, *supra* note 5, ¶ 41.

⁴³ *Programme of Action of the International Conference on Population and Dev.*, Cairo, Egypt, Sept. 5-13, 1994, ¶ 7.12, U.N. Doc. A/CONF.171/13/Rev.1 (1995).

⁴⁴ *See, e.g.*, CRC Comm., *CO: India*, *supra* note 13, ¶ 61(c); CEDAW Comm., *CO: India*, *supra* note 5, ¶ 41; CEDAW, arts. 10, 12(1); ESCR Comm., *General Comment No. 14*, ¶ 34, U.N. Doc. E/C.12/2000/4 (2000); *see also* CEDAW Comm., *CO: Ghana*, ¶ 32, U.N. Doc. CEDAW/C/GHA/CO/5 (2006); *Mexico*, ¶ 33, U.N. Doc. CEDAW/C/MEX/CO/6 (2006); *Philippines*, ¶ 28, U.N. Doc. CEDAW/C/PHI/CO/6 (2006); CRC Comm., *CO: Bolivia*, ¶ 50, U.N. Doc. CRC/C/15/Add.256 (2005); *Poland*, ¶ 43, U.N. Doc. CRC/C/15/Add.194 (2002); *Russian Federation*, ¶ 56, U.N. Doc. CRC/C/RUS/CO/3 (2005).

⁴⁵ CEDAW Comm., *Declarations, reservations, objections and notifications*, *supra* note 6, at 19.

⁴⁶ SRRH, *Mission to India*, *supra* note 13, ¶ 98.

⁴⁷ *Id.* ¶ 91.