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Human Rights Watch Submission to the CEDAW Committee

Consideration of India's Periodic Report, 58th Session

Human Rights Watch welcomes the opportunity to provide input to the Committee on the Elimination of Discrimination against Women (the Committee) on India's obligations under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

We would like to draw the Committee's attention to specific areas of women's rights drawn from Human Rights Watch's recent research in India. These include women's access to health care, including maternal health and post-rape care; child marriage and access to education; girls' access to education in conflict-affected areas; the status of women and girls with disabilities, especially psychosocial and intellectual disabilities; and abuses against women "manual scavengers."

I. Access to Health Care (Articles 1, 12, and 14)

This section provides information pertaining to women's and girls' access to maternal health care and the treatment and examination of women and girls who experience sexual violence.

A. Maternal Health

India has experienced overall declines in maternal mortality and greater coverage in maternal health services since India was last reviewed by the Committee in 2007. India has also taken a commendable step by withdrawing discriminatory eligibility criteria in its flagship maternal healthcare program, the Janani Suraksha Yojana, making adolescent mothers and mothers with more than two children eligible.

We draw the Committee's attention to three key problems hampering India's maternal healthcare programs and monitoring, none of which were addressed in India's report.

1. Unaddressed disparities

The number of registered maternal deaths due to birth or pregnancy-related complications per 100,000 registered live births has dropped from 301 in 2006 to 178 in 2012.¹ Reporting to the Committee, the Indian government provided data on overall declines citing proxy indicators, but did not provide disaggregated information. Disparity in access to maternal

¹ Office of the Registrar General of India, "Special Bulletin on Maternal Mortality in India 2004-2006, Sample Registration System," April 2009, http://www.censusindia.gov.in/Vital_Statistics/SRS_Bulletins/MMR-Bulletin-April-2009.pdf (accessed July 28, 2009) and "Maternal Mortality Estimates for India and States 2010-2012," January 2014, on file with Human Rights Watch.

health care still plagues the country, manifesting in differences in maternal mortality ratios both at the state and district levels. Remotely situated rural women, *adivasi* (tribal) women, and Dalit women are especially disadvantaged in their access to maternal health services.²

Human Rights Watch research in Gujarat state in 2012 showed that despite being classified as a “High Performing State” based on health criteria, women in remote rural parts of Gujarat struggled to access maternal health services guaranteed under government norms. In at least ten cases that resulted in maternal deaths from two remote districts from February through July 2012, women who attempted to give birth in health facilities had repeatedly been referred from one health facility to another, further delaying access to emergency obstetric care, and ultimately resulting in death.

2. Misleading and incomplete indicators on maternal health

In its combined periodic reports, the Indian government has provided information on maternal healthcare progress using proxy indicators: increased coverage of ante-natal and postnatal care and greater numbers of what the government describes as “safe deliveries.”³ The Indian government has also provided information about the number of beneficiaries under the government’s Janani Suraksha Yojana program, a scheme that provides cash assistance to women to promote childbirth in health facilities, stating that “there has been a phenomenal increase in the number of women accessing this scheme from 0.74 million in 2005-2006 to 4.729 million beneficiaries up to September 2011.”

The Indian government’s approach to tracking progress by citing the number of births in health facilities (“institutional deliveries”) is flawed. First, institutional deliveries are themselves sometimes counted based on cash disbursements made and not the actual numbers of births conducted in health facilities, leading to at least some degree of inflated numbers.⁴ Second, government officials equate “institutional deliveries” in the public health system with “safe deliveries,” which is often not the case for multiple reasons:

² See, for example, UNICEF, *Maternal and Perinatal Death Inquiry and Response, Empowering Communities to Avert Maternal Deaths in India* (New Delhi: UNICEF, 2008), p. 37. The UNICEF study in six northern states in India revealed that 61 percent of maternal deaths documented occurred in Dalit and tribal communities. See also, TORANG Trust and the National Alliance for Maternal Health and Human Rights, “Maternal Health and Nutrition in Tribal Areas: Fact-Finding Mission to Godda, Jharkhand 20-23 November 2013,” April 2014.

³ Combined fourth and fifth periodic reports of States parties, India, October 23, 2012, CEDAW/C/IND/4-5 http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/Ind/CEDAW_C_IND_4-5_5858_E.pdf (accessed May 5, 2014), paras. 78 and 79.

⁴ Human Rights Watch, *India—No Tally of the Anguish: Accountability in Maternal Health Care in India*, October 2009, <http://www.hrw.org/sites/default/files/reports/india1009web.pdf>, p. 13. While conducting field investigations in Uttar Pradesh in 2008-2009, Human Rights Watch found that the number of institutional deliveries at health facilities was counted

- i. *The lack of correlation of data between “institutional deliveries” and actual childbirth outcomes:* There is no consistent information on whether each institutional delivery results in a live birth, still birth, or infant death. This presents an anomaly that Indian officials have yet to rectify in their monitoring mechanism: an institutional delivery could be counted as a “success” even though it results in a still birth or infant death.
- ii. *The lack of data on the number of referrals behind every institutional delivery:* Existing government data collection and monitoring mechanisms do not analyze the number of health facilities that a woman was referred to before she could be admitted and provided obstetric and delivery care. As a result, the data is incomplete and anomalous: a woman could have been referred as many as six or seven times from one health facility to another before finally being admitted to a government health facility for an “institutional delivery.” This data on institutional deliveries is misleading on the extent of progress in access to maternal healthcare services. They also misinform the government’s own planning since the government has little information on referral system problems resulting in women travelling from facility to facility while in labor.
- iii. *Poor quality maternal health care:* Even though the Janani Suraksha Yojana has promoted institutional deliveries and increased a demand for such deliveries through cash incentives for poor women, there is no information to show a consistent improvement in the quality of maternal health services and skilled birth attendance. On the contrary, because there has been a sudden rise in the demand for “institutional deliveries” with limited capacities in rural health facilities, these health facilities are often over-crowded, under-staffed, and under-resourced. In research in 2009 in Uttar Pradesh state and in 2012 in Gujarat state, Human Rights Watch documented women’s complaints of overcrowding in health facilities—sharing beds, giving birth on hospital floors or corridors, and being turned away in part because of space constraints.

3. Need to strengthen accountability for maternal health care

Since late 2009-early 2010, the Indian government introduced maternal death reviews with a view to improving accountability for maternal health care. Following this, many states in India have gathered some level of information on maternal deaths. But the process as implemented today suffers from two main drawbacks. First, there is no mechanism to enable universal reporting of maternal deaths, so the numbers of maternal deaths analyzed are low. Second, even where state health authorities conduct maternal death reviews, Human Rights

by keeping track of the number of women who received cash assistance. In several instances, women from rural areas claimed that health workers had approached them saying that they could deliver at home but should tell authorities they delivered in the health facility, splitting the cash assistance with the health worker.

Watch has learned from civil society groups and from its research in Gujarat state that these are mostly focused on the medical causes of maternal deaths rather than the systemic gaps and failures that could be rectified.

Another key accountability feature—audits of referral systems to understand how effective maternal referrals are—has yet to be conducted in India. India has also yet to put in place any meaningful grievance redress for poor maternal health care.

4. Suggested Recommendations

We encourage the Committee to make the following recommendations on maternal health:

- A policy for mandatory reporting of maternal deaths should be adopted irrespective of whether the deaths occur in public or private health facilities, homes, or en route to a health facility.
- Better indicators for assessing maternal health progress should be developed in consultation with leading health experts in the country. The number of institutional deliveries should be supplemented by periodic referral audits and in-depth correlation of institutional deliveries and childbirth outcomes.
- A dedicated budget subhead should be created for accountability systems including maternal death reviews, referral audits, disaggregated data collection, and strengthening the capacity of national and state human rights commissions to take up issues of maternal health care.

B. Access to Healthcare Services for Survivors of Sexual Violence

Since 2013, the Ministry of Health and Family Welfare has developed detailed guidelines on the treatment and care of survivors of sexual violence, taking an important step forward. These guidelines outline the steps that medical professionals should take when women and girls who experience sexual violence approach them. They outline the nature of therapeutic care (reproductive, sexual, and mental health) that should be offered to survivors, paying attention to their special needs or vulnerabilities such as disability, gender identity, and caste. They call for eliminating questions pertaining to the so-called “two-finger” test, a degrading and humiliating practice in which a doctor made notes on the size and elasticity of the vaginal orifice and classified women as “habituated to sex.” The results of this test could later be used in criminal trials. India has also strengthened its evidentiary procedures to disallow questions about the sexual experience of rape survivors during criminal trials. While these are significant developments on paper, the Indian government should do more to ensure that the guidelines are implemented across the country.

Suggested Recommendations

We encourage the Committee to make the following recommendations to the Indian government on healthcare access for survivors of sexual violence:

- Demarcate a clear budget line for treatment and examination of survivors of sexual violence across the country as part of health programs in rural and urban areas.
- Institute a monitoring mechanism to track progress of implementation of the guidelines across India.
- Integrate, as part of the basic curriculum in medical colleges across India, a course on treatment and examination of survivors of sexual violence and revamp outdated forensics education materials that reinforce negative stereotypes about rape survivors.
- Integrate training and awareness about the guidelines and their implementation among other actors in the criminal justice system, including police and all levels of the judiciary.

II. Access to Education (Articles 1, 10, and 16)

A. *Child marriage and its impact*

This section provides information on the links between discriminatory treatment of girls in schools and child marriage. As India stated in its combined fourth and fifth periodic reports, in 2006 it updated a law prohibiting child marriage, setting 18 as the minimum age of marriage for girls. But even though India has appointed child marriage prohibition officers in many states, as it has pointed out, many states have struggled to eradicate child marriage.

The latest available data on child marriage preceded the new law, but as of 2006, on average 47 percent of girls were married or in unions before they attained age 18.⁵ Implementation of the 2006 law has been hampered by a complex set of factors. A significant contributory factor is government failure to retain girls in schools beyond the primary class (class III). The 2006 data also showed that 77 percent of women aged 20-24 with no education and 62 percent with primary education were married or in a union at age 18, compared to only 27 percent of women with secondary education or higher.⁶

In its submission to the Committee, India noted that it enacted the 2009 Right of Children to Free and Compulsory Education Act, which guarantees free and compulsory education for all

⁵ United Nations Population Fund, "Child Marriage Profiles: India," http://unfpa.org/files/live/sites/unfpa/files/embedfiles/tytw_v2/tytw_v2/assets/pdfs/india.pdf (accessed May 7, 2014), p. 1.

⁶ Ibid.

children between ages 6-14. It noted that the Act has special provisions for girls, including for those who are out of school.

While the Right to Education Act and government schemes have resulted in near-universal enrollment of girls in primary schools, millions of children from disadvantaged communities do not actually attend classes, often because their caste, ethnicity, economic condition, religion, or gender acts as a barrier to education.

The 2014 Human Rights Watch report, “‘They Say We’re Dirty’: Denying an Education to India’s Marginalized,” shows how children from poor and marginalized communities—Scheduled Castes, Scheduled Tribes, and Muslims—face discrimination in government schools.⁷ Discrimination by teachers and other school staff may lead to increased truancy among these children and eventually they stop going to school. According to 2013 government estimates, over 40 percent of the children enrolled are likely to drop out before completing eighth grade.⁸ Once these children drop out, they are often pushed into child labor or early marriage.

The school dropout rates among girls are far higher. According to government statistics from 2012, the dropout rate among adolescent girls is as high as 64 percent.⁹ A significant number of these are girls from Dalit, tribal, and Muslim communities, who leave school without completing eighth grade, usually when nearing puberty. They are particularly vulnerable to child marriage. Their largely low-income parents worry about leaving a teenage girl alone at home while they work, and prefer to marry them early, fearing that unmarried teenage girls face greater risks of sexual exploitation or abuse. Although the Right to Education Act proposes interventions to keep girls from vulnerable communities in the classroom, those mechanisms have not been effectively implemented.

B. Access to Education in Conflict-Affected Regions

Human Rights Watch has documented how government security forces—both police and paramilitary police—use school buildings as barracks and bases for operations, sometimes only for a few days but often for periods lasting several months, and even years. This practice endangers students’ safety and access to education, and girls are disproportionately negatively affected.

⁷ Human Rights Watch, *India – “They Say We’re Dirty”: Denying an Education to India’s Marginalized*, April 2014, <http://www.hrw.org/reports/2014/04/22/they-say-we-re-dirty>.

⁸ Planning Commission, Government of India, “12th Five-Year plan (2012-2017), Social Sectors, Volume III,” 2013, http://planningcommission.gov.in/plans/planrel/12thplan/pdf/vol_3.pdf (accessed July 1, 2013).

⁹ Ministry of Women and Child Development, Government of India, “Report of the Working Group on Child Rights for the 12th Five year Plan (2012-2017),” December 16, 2012, <http://www.wcd.nic.in/reportwgdtdo1032012.pdf> (accessed July 9, 2013).

During 2010, more than 129 schools were used as barracks or bases across the country, particularly in states affected by the conflict with Maoist rebels—Bihar, Chhattisgarh, and Jharkhand—but also in the country’s northeast, in Tripura, Manipur, Nagaland, and Assam, disrupting education for an estimated 20,800 students.¹⁰ In the same year, some security forces began complying with government and Supreme Court directives to vacate schools¹¹; however, security forces continued to use schools into 2012 and 2013.¹²

In some cases schools are occupied entirely, meaning that all educational functions at the school either stop completely or are displaced to alternative locations. However, in many cases, the security forces only occupy part of the school facilities, and the school is compelled to attempt to continue to operate in the remainder of the campus.

By placing military camps at schools, the security forces endanger children’s lives, because it raises the risk that students could be caught in the crossfire during attacks on the security force’s outpost.

Many girls, teachers, and parents shared with Human Rights Watch their concerns regarding the harassment of girl students by police based in schools. Students and teachers we interviewed described widespread harassment of girl students or shared specific examples of direct harassment. Sometimes people described generalized fear and anxiety about the police presence. Even without a specific instance of harassment, the mere presence of police in the school can result in some girls staying at home.

At some schools there is an almost immediate exodus of students in response to a police occupation. Girls, in particular, appear to drop out due to real or perceived concerns about gender-based harassment by the security forces. School occupations can also lead to decreased retention of students between school years (sometimes referred to as the “transition rate”).

¹⁰ Email from Rajesh Ranjan, Bihar police, to Human Rights Watch, December 10, 2010.; affidavit of Chhattisgarh government to the Indian Supreme Court, January 6, 2011, cited in J. Venkatesan, “Chhattisgarh Government Pulled Up for Misleading Supreme Court,” *The Hindu*, January 9, 2011.; *Exploitation of Children in Orphanages in the State of Tamil Nadu v. Union of India*, Writ Petition (Criminal), No. 102 (2007), Indian Supreme Court, order of March 7, 2011 and order of August 16, 2011; “SC asks Jharkhand, Tripura to Free Schools from Security Forces,” *Times of India*, March 7, 2011; “SC Pulls Up State for not Furnishing Details,” *Assam Tribune*, March 7, 2011; “Schools Occupied by Security Personnel in Manipur,” *The Hindu*, April 22, 2011.

¹¹ On September 1, 2010, the Supreme Court of India called for the Home Ministry to vacate all schools occupied by government security forces, adding that “the school buildings are not allowed to be occupied by the armed or security forces in future for whatsoever purpose.” *Exploitation of Children in Orphanages in the State of Tamil Nadu versus Union of India and Others*, Writ Petition (Criminal) No. 102 of 2007, Supreme Court Order of 1 September 2010.

¹² Human Rights Watch visit to Chonha Middle School, in Gaya, Bihar, in July 2013; Biswajit Roy, “Troops occupy, Maoists demolish schools,” *The Telegraph (Calcutta)*, January 27, 2013.

Not only do police use of schools prompt students to leave schools, they also create a disincentive for students to enroll in school.

Access to basic facilities, such as drinking water and toilets, has been demonstrated to be an important factor for retaining children, especially girls, at school.¹³ But in a number of cases investigated by Human Rights Watch, the occupying police refused to let the students use such facilities, even when the government had made the expenditure to invest in such facilities, because the police wanted to use them exclusively.

C. Suggested recommendations:

We encourage the Committee to make the following recommendations to the Indian government:

- Adopt a policy of non-discrimination against married girls who want to continue school education.
- Develop clear guidelines to address discrimination and other abuses of children by school authorities and staff to create a child-friendly environment in the classroom and set out appropriate disciplinary measures.
- Develop guidelines and manuals for teachers that set forth good practices for social inclusion and equity, such as encouraging children from marginalized communities to participate in school activities and ensuring more frequent collaboration between children of different castes.
- Take steps for the effective implementation of the Right to Education Act that focus not simply on enrollment, but on the retention of every child in school at least until age 14. Implement a system to monitor and track all children from enrollment through graduation from grade VIII, and adopt a uniform protocol for identifying children who are out of school or are at risk of dropping out.
- Enact domestic legislation or adopt security force policies explicitly prohibiting armed forces, police, and paramilitary police forces from using or occupying schools, school grounds, or other education facilities in a manner that either violates international humanitarian law or the international human right to education.
- Expediently rehabilitate and repair schools damaged through use by security forces.

III. Women and Girls with Psychosocial or Intellectual Disabilities

¹³ Ba'bara Herz and Gene B. Sperling, "What Works in Girls' Education: Evidence and Policies from the Developing World," Council on Foreign Relations (2004), pp. 63-64; Inter-Agency Network for Education in Emergencies' Minimum Standards for Education in Emergencies (2004), pp. 29 and 47-48. See also Bihar Primary Education (Amendment) Act 1959, art. 3(vi)-(vii).

This section outlines the extreme marginalization and complete lack of social support for women and girls with psychosocial or intellectual disabilities in India, which triggers a range of abusive practices including sexual violence, forced sterilization, and institutionalization. In its submission to the Committee, the Indian government describes its social assistance schemes and quotas, disability-related assistance to government employees, inclusion of persons with disabilities in secondary education, and vocational training for women with disabilities. But these do not adequately address concerns outlined below.¹⁴

A. Forced Sterilizations (Articles 1, 12, and 16(e)).

Human Rights Watch found that women and girls with intellectual disabilities continue to be sterilized without their consent in India. Although the decision to opt for sterilization is not taken lightly by parents or caregivers, we documented cases where sterilizations of women and girls with disabilities were carried out without their knowledge and for the purpose of ending menstruation or because of fear of sexual assault or exploitation resulting in unwanted pregnancies. Sterilization is not a substitute for proper education about family planning, the use of reversible contraceptive measures, and support during menstruation. Furthermore, sterilization can make women and girls with disabilities targets of sexual violence once it is known in the community that they cannot get pregnant.

B. Forced Institutionalization (Article 15)

Human Rights Watch found that due to stigma and the shortage of government community-based services, families are unable to cope with relatives with intellectual or psychosocial disabilities and subsequently institutionalize them.

Women and girls with psychosocial disabilities can be arbitrarily detained in government mental hospitals for up to 90 days with no or limited judicial oversight.¹⁵ Under both the Mental Health Act, 1987, and the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999, people with psychosocial or intellectual disabilities respectively can be stripped of their legal capacity and committed to institutions without their consent, and without any meaningful remedy or review. Many of the state-run residential institutions Human Rights Watch visited were exceptionally overcrowded, unsanitary, and lacked personal hygiene.

¹⁴ Combined fourth and fifth periodic reports of States parties, India, October 23, 2012, CEDAW/C/IND/4-5, paras. 13, 24, 52, 57, and 64.

¹⁵ There is judicial oversight for court-ordered admissions but the woman cannot effectively appeal because she is considered to be of unsound mind. In cases where families admit their relatives, there is no judicial oversight at all unless the duration of stay extends 90 days.

C. Poor Access to Mental Health Services (Articles 1 and 12)

Mental health and support services are severely lacking in India. Less than 20 percent of the people in India who need mental health care have access to treatment.¹⁶

In theory, women and girls with psychosocial and intellectual disabilities have access to all healthcare programs. But in practice the stigma, social exclusion, and discrimination they face thwarts any meaningful access. In India's submission to the Committee, the government fails to mention any specific measures it is taking to address the poor access to mental and general health care for women and girls with psychosocial or intellectual disabilities.¹⁷

Human Rights Watch found that women and girls with psychosocial or intellectual disabilities living within residential institutions do not have adequate access to general health care as well as to reproductive, dental, and eye care. In addition, they are subjected to involuntary treatment ranging from physical and chemical restraint to electroconvulsive therapy (ECT). Human Rights Watch documented many cases of women and girls – including 11 girls between the ages of 14-17 years – who, without consent, underwent ECT. In some cases, women were unaware of the treatment altogether as they were given ECT under anaesthesia and only discovered months later what had been done to them.

D. Violence and Access to Justice

India's submission to the Committee does not mention the high prevalence of violence against women and girls with disabilities. Based on research in six cities, Human Rights Watch found that women and girls with psychosocial or intellectual disabilities interviewed routinely experience verbal, physical, and sexual violence.

The Criminal Law (Amendment) Act, 2013, includes new criminal procedures to better assist women and girls with disabilities when they report violence. These amendments are new, and their level of implementation is yet to be seen.

E. Suggested Recommendations

We encourage the Committee to:

¹⁶ Prof. Srinivasa Murthy et al., "Mental Health Care by Primary Doctors," 4th Edition, Bengaluru, 2005, National Institute of Mental Health and Neuro Sciences, <http://www.nimhans.kar.nic.in/dmhp/manuals/man1.pdf> (accessed December 12, 2013), p.14.

¹⁷ Combined fourth and fifth periodic reports of States parties, India, October 23, 2012, CEDAW/C/IND/4-5.

- Set guidelines and establish monitoring mechanisms to improve conditions and prohibit arbitrary detention and involuntary electroconvulsive therapy.
- Develop a time-bound plan to shift progressively to voluntary community-based mental health, support, and independent living services.
- Recognize that women with disabilities have legal capacity on an equal basis with others and the right to exercise it. Provide accommodations and access to support where necessary to exercise legal capacity.
- Systematically collect disaggregated data on women and girls with disabilities to better inform policy and service provision and include women and girls with disabilities and disabled persons' organizations in decision and policy-making.
- Enable equal access to all health and social services for women and girls with disabilities, including with regard to reproductive, sexual health, and post-rape care.
- Ensure adequate and accessible redress mechanisms and access to justice on an equal basis for women with disabilities, including training of law enforcement and legal professionals.

IV. Women Engaged in “Manual Scavenging”

This section deals with India’s international obligations to end manual scavenging—the humiliating, caste-based practice requiring women to manually clean human excrement from toilets and open defecation areas. It draws the Committee’s attention to three significant challenges women face in leaving this practice: threats of violence, threats of displacement, and barriers to accessing alternate labor markets.

In addition to previous efforts to end manual scavenging, in September 2013 the Indian parliament passed The Prohibition of Employment as Manual Scavengers and their Rehabilitation Act (the 2013 Act). In March 2014 the Supreme Court held that India’s constitution requires state intervention to end manual scavenging and rehabilitate all people working as manual scavengers.¹⁸ But despite numerous initiatives, dating as far back as 1949, to address abuses faced by manual scavengers, manual scavenging persists.

In rural communities where manual scavenging continues, women do 95 percent of manual cleaning of unsanitary private and village latrines. As compensation, they collect food door-to-door from the households they serve. Women who refuse to perform this labor face resistance from their families and communities who depend on the handouts they receive.

¹⁸ Supreme Court, *Safai Karamchari Andolan & Ors. v. Union of India & Ors.*, March 27, 2014, <http://supremecourtindia.nic.in/outtoday/wc583.pdf> (accessed May 7, 2014). The Supreme Court has explicitly recognized India’s human rights obligations to end manual scavenging under CEDAW.

India did not explicitly address manual scavenging in its combined fourth and fifth periodic reports but did point to schemes that promote self-reliance for women entrepreneurs from marginalized classes living below the poverty line.¹⁹ Women engaged in manual scavenging and those who have left this practice within the last decade, however, report significant challenges in accessing government schemes. They face barriers to accessing information, lack required supporting documents, and confront active discrimination from officials tasked with implementing government schemes.

A. Threats of violence and access to justice

Not only has India failed to implement legal protections to stop manual scavenging and rehabilitate those engaged in it, those who try to leave manual scavenging voluntarily often suffer retribution. Human Rights Watch researchers met women who reported facing threats of violence when they attempted to leave manual scavenging. They also faced significant obstacles to accessing state support to deal with such threats, in part due to caste-based discrimination perpetuated by local government officials and police officers.

The Committee has previously recommended that India improve access to justice for Dalit women, focusing on the need for free legal services.²⁰ This guidance on ensuring free legal services and facilitating access to justice is particularly critical for women who try to leave manual scavenging work.

B. Threats of eviction and displacement

In addition to threats of violence, women who refused to practice manual scavenging report facing threats of denial of access to land for grazing or firewood, and eviction from their homes. They are particularly vulnerable to threats from upper caste neighbors or village council officials because they do not own the land where they have built their homes and can be displaced at any time.

C. Barriers to accessing alternate employment

Manual scavengers face significant—and sometimes insurmountable—barriers to accessing alternate labor markets.

¹⁹ Combined fourth and fifth periodic reports of States parties, India, October 23, 2012, CEDAW/C/IND/4-5, para. 17.

²⁰ Concluding comments of the Committee on the Elimination of Discrimination against Women: India, CEDAW/C/IND/CO/3, February 2, 2007, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/No7/243/98/PDF/No724398.pdf?OpenElement> (accessed June 13, 2014), para. 19.

Manual scavengers also report challenges in accessing employment under the Mahatma Gandhi National Rural Employment Guarantee Act, 2005, including lack of information, inability to access formal processes, and exclusion by local officials.

Ending manual scavenging requires government intervention to stop threats of violence, and facilitate housing and access to employment. While the 2013 Act includes housing and support to enter the labor market, these provisions are left to be implemented under existing schemes that to date have not succeeded in ending manual scavenging.

D. Suggested Recommendations:

We urge the Committee to make the following recommendations to the Indian government to realize their commitment to ending manual scavenging:

- Train district collectors and police officers to intervene where women face threats of violence for leaving manual scavenging and require that under no circumstances should police refuse to register a complaint, or dissuade or intimidate a complainant, with disciplinary consequences for those who do.
- Undertake a complete assessment and audit of all current schemes relevant to rehabilitating manual scavengers with attention to identifying existing implementation challenges; and create a rehabilitation scheme that corresponds with the provisions under the 2013 Act. In particular, this scheme should provide for both immediate and long-term access to sustainable livelihoods.