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Joint submission by:

The PACT

A Vibrant Coalition of 152+ youth Organizations working collaboratively and strategically in the global HIV response. Since 2013, we have been building solidarity across youth organisations to ensure the health, well-being and human rights of all young people.

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Human Touch Foundation

Human Touch is a youth-focused and youth-serving organization based in Goa (India), working strategically and collaboratively within the areas of HIV, SRHR, substance abuse and tuberculosis to strengthen the movement to ensure the health, well-being and human rights to all young people. We advocate and enable youth-led accountability and participation for better services and policies.

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Executive Summary

1. This submission, prepared ahead of the 4th Cycle of the Universal Periodic Review (UPR) for the Republic of India, looks at the challenges faced by the adolescent and youth population in India in relation to their sexual and reproductive health and rights (SRHR), HIV and human rights. Three key issues, in particular, that affect the country's adolescents and young people, i.e., SRHR including abortion for adolescents and youth with disabilities and HIV (AL&YPLHIV) have been researched. The report also provides recommendations to the state of India with respect to these issues.
2. This report was prepared based on research from credible sources of information including the government, non- governmental organisations, media reports, and academic publications drawn from the public domain. In addition, input from experts and children and youth experts from youth focused/youth-led organizations from across India was sought through an online national consultation that was jointly conducted by Human Touch Foundation on February 23, 2022, held for the purpose of this submission. Approximately 32 participants from 8 states, all experts working substantially on HIV and SRHR, AL&YPLHIV, took part in the consultation and many remarks and input were consolidated during this process for drafting this report.
3. The report identified loopholes and human rights violations in legislation and policies, i.e. Medical Termination of Pregnancy (Amendment). Act, 2021 (MTPA Act), Protection of Children from Sexual Offences Act, 2012 (POCSO Act), the operational guidelines and policies of National AIDS Control Organization (NACO).
4. The report makes the following recommendations: firstly, the Ministry of Health and Family Welfare should work on liberal provisions with regards to women's right for abortion in the MTPA Act. Further, the MTPA Act and POCSO Act overlap, and should be re-looked from the perspective of adolescents and sexual health and rights. There should be national programmes for youth with disabilities about sexuality and implementation of the RPwD Act with regards to SRH. Further, in the area of HIV and AIDS, there should be a holistic appreciation of SRHR needs, concerns and aspirations of ALHIVs in the operational guidelines and policies of NACO.

Issues

5. India has made important gains in improving the SRH of women and young people, but there are some specific issues highlighted in this report where attention is still required, i.e., abortion, SRH of adolescents/young people with disabilities and HIV/AIDS. Sexual and reproductive health (SRH) are integral elements to the right of to the enjoyment of the highest attainable standard of physical and mental health for all. Many obstacles stand between individuals and their enjoyment of SRH. These obstacles are interrelated and entrenched, operating at different levels: in clinical care, at the level of health systems, and in the underlying determinants of health. A supportive and conducive legal and policy environment is critical for adolescents to access and benefit from HIV testing, counselling and linkage to appropriate treatment and care.

Abortion

6. Unfortunately, India did not receive any recommendations on abortion during the third cycle review. Safe abortion ought to be decriminalised, accessible to all and decided upon by the person who is pregnant. The current legal framework jeopardises the complete wellbeing of women, leaving them confused, scared and unable to attain medically safe and affordable abortion services.
7. When India enacted the Medical Termination of Pregnancy Act fifty years ago, it provided for exceptions under which abortion can be accessed, up to a gestational period of 12 weeks, and with the approval of a medical practitioner. The MTPA recently amended in April 2021¹, now allows for termination of pregnancy for all women, regardless of marital status. Additionally, it allows for termination of pregnancy up to 20 weeks by a medical practitioner, if they are of the opinion that:
 - (i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or
 - (ii) there is a substantial risk that if the child were born, it would suffer from any serious physical or mental abnormality.

The amendment also increases the gestation period from 20 to 24 weeks for abortions for special categories of women, including survivors of rape, victims of incest and other vulnerable women (women with disabilities, minors, among others) with the approval of two medical practitioners, and removed the upper gestation limit for abortions due to 'foetal abnormality'. Per the WHO, the new MTPA (Amendment) Act 2021 "expands the access to safe and legal abortion services on therapeutic, eugenic, humanitarian and social grounds to ensure universal access to comprehensive care".²

8. However there is a disconnect between MTPA and the Indian Penal Code. Abortion is still criminalized under the Indian Penal Code, 1860 (IPC) which makes abortion ('induced miscarriage') a criminal offence under Section 312. MTPA is now, therefore, a doctor-centric law which grants discretion to medical professionals in allowing or denying abortions, without paying regard to the will of pregnant persons. The criminal status of abortion is at odds with the Supreme Court jurisprudence in India, which has recognised the right to abortion as a fundamental right. This implicates the rights to equality and non-discrimination, bodily autonomy, health, dignity and reproductive choice.³
9. Further, trans, intersex and gender-diverse communities have indicated concern about the use of the word 'woman' used by the MTPA amendment to refer to all pregnant people, stating that the narrow framing jeopardises access to abortion services for persons other than cisgender women, despite judicial and legal recognition of the rights of the transgender and gender variant persons in India.

¹ Medical Termination of Pregnancy Amendment Act, No 8 of 2021, <<https://egazette.nic.in/WriteReadData/2021/226130.pdf>> Accessed 30 March 2022

²<https://www.who.int/india/news/detail/13-04-2021-india-s-amended-law-makes-abortion-safer-and-more-accessible>

³ <https://ohrh.law.ox.ac.uk/law-reforms-on-abortion-in-india-the-need-for-a-nuanced-collaborative-approach/>

10. The Pratigya Campaign, a coalition of individuals and organisations working for access to safe abortion care, has demanded that abortions up to 12 weeks should be allowed as per the request or decision of the pregnant person instead of being a conditional right available only based on the opinion of the doctor. Women should also be allowed autonomy in decision making in the case of later abortions due to any serious physical or mental abnormality instead of requiring them to approach medical boards, as lack of specialised healthcare experts to be appointed to these Boards complicates access. They also highlight that the law only caters to pregnant women and fails to address the needs of the transgender people.
11. Access to safe abortion is an integral part of a woman's bodily autonomy and integrity. It is estimated that 15.6 million abortions take place annually in India⁴, however, there are just 60-70,000 providers who can legally provide abortions under the MTP Act ⁵ which inevitably leads to a considerable number of unsafe abortions. The larger issues of access to safe abortion care and rights of adolescents and young people remain largely untouched. The true measure of success of the amendments is implementation, and how they are able to bridge gaps to access. Merely legalizing abortion does not guarantee accessibility nor necessarily translate into access.
12. Barriers to accessing safe abortion services in India include an inadequate number and skewed distribution of obstetricians and gynecologists, lack of facilities providing abortion care, equipment shortages, inadequate health care infrastructure, and onerous authorization requirements, all of which push abortion care out of reach for many throughout the country.
13. While the leading cause of restriction of women's access to safe and legal abortions in India is stigma, there are also other pertinent causes. Women's lack of awareness of, and education on, the law, doctors'/practitioners' refusal to provide abortions citing the law that prevents sex-selective abortion and delays in court decisions on abortions, are among them. There is a need to work towards advocating a more rights-based approach by giving women greater autonomy and choice, and to operationalise grassroots access through an expanded provider base.
14. Adolescents in India are exploring their sexualities and experimenting. However, the legislative framework in place penalises adolescents for said experimentation. Medical practitioners are given discretion in how to manage the obstacles posed by the POCSO Act, 2012 in providing services to adolescents. The challenge is that Section 19 of the Act requires any person aware of a minor engaging in sex to report the matter to the local police even if it was a consensual act, as the law pegs the age of consent at 18 years. In the case of a pregnancy of a minor, doctors are often caught between the conflicting provisions of the MTPA and the POCSO Acts. On one hand, the MTPA Act's confidentiality clause requires medical practitioners to protect the person's identity, but the POCSO Act mandates practitioners to report sexual offences against children.
15. Currently, the law states that a person found to have sexual relations, bodily contact or allied acts with someone below the age of 18 is liable for criminal sanctions including imprisonment. This is the case even where minors engage in consensual sex with each other. Recently, the

⁴ Guttmacher Institute. Abortion and Unintended Pregnancy in Six Indian States: Findings and Implications for Policies and Programs. 2018. <https://www.guttmacher.org/report/abortion-unintended-pregnancy-six-states-india>

⁵ Pratigya Campaign. Improving Access to Safe Medical Abortions: Why Expanding the Provider Base is Essential. 2019. <https://pratigyacampaign.org/wp-content/uploads/2019/09/improving-access-to-safe-medical-abortions-english.pdf>

Madras High Court (HC)⁶ acquitted a boy accused of aggravated penetrative assault under the POCSO Act, and kidnapping under the Indian Penal Code (IPC), following consensual sex with a minor classmate. While dealing with the same case, the court also asked the competent authorities to reconsider the definition of child and reduce the age of consent to sex from 18 years to 16.

16. The state must protect the right to safe and legal abortions for everyone between the ages of 16 and 18 who visit practitioners with accidental pregnancies and infections. While the MTP and the POSCO Acts mean consensual sex between matured⁷ adolescents must indeed be kept out of criminal purview. Mature adolescents who mutually choose to have sex must not be criminalised for a natural desire.

Sexual and Reproductive Health of Adolescents and Young People with Disabilities

17. India received and accepted two recommendations that focused on sexual and reproductive health and rights as a broad category:

- Finland 161.179: Continue furthering the sexual and reproductive health and rights of all women by immediately putting an end to camp-based sterilization operations in accordance with the Supreme Court order of 14 September 2016, by ensuring all women access to counselling on, and access to, the full range of modern contraceptives in a voluntary, safe and quality manner, and by providing comprehensive sexuality education.
- Colombia 161.181: Redouble its efforts in maternal health, sexual and reproductive health and comprehensive contraceptive services.

18. India also received and accepted two recommendations on advancing access to health for persons with disabilities:

- Laos 161.178: Continue its efforts to ensure that the universal health-care scheme covers disadvantaged groups, including persons with disabilities and persons living in remote rural areas, who still face obstacles in accessing basic health-care services
- Oman 161.240: Continue efforts aimed at improving the access of persons with disabilities to education, vocational training and health care (Oman);

19. India has partially implemented the above requirements. Although there seems to be a strong commitment to ensuring that the rights of PwDs are respected and protected, there is little in terms of tangible actions that have been implemented to address these especially in the area of SRHR in the country. Barriers to meeting the SRH needs of PwDs were identified as communication barriers, i.e. no IEC material available which is disability friendly and accessible, physical barriers, i.e. no specialised trained health workers and no signage in public health care facilities, psychological barriers, i.e. no trained SRH experts who can provide necessary counselling and services, social barriers, i.e. lack of community support, social norms and group conformity, attitudes by health professionals, illiteracy among deaf people, privacy and

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<https://theprint.in/judiciary/punishing-teen-romances-isnt-the-intent-behind-posco-says-madras-hc-suggests-amending-act/595274/>

⁷ As assessed by evolving capacities and age

confidentiality offered at SRH centres, and poor interpretation skills of sign language interpreters.

20. Article 23(1)(b) of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) states that persons with disabilities have the right to access reproductive and family planning education and decide freely and responsibly the number of children and spacing between them. Section 10(1) of the Rights of Persons with Disability Act, 2016 (RPwD) obligates the appropriate (state) government to make necessary information regarding reproductive and family planning accessible to persons with disability. Similarly, under Section 25(2)(k), the appropriate government should ensure that measures, schemes and programs, to promote healthcare and prevent disabilities must include sexual and reproductive healthcare for women.
21. Further, Section 39(2)(c) of the RPwD Act requires the appropriate government to undertake campaign and sensitization programs to "foster respect for the decisions made by persons with disabilities on all matters related to family life, relationships, bearing and raising children."
22. Despite the enactment of the RPwD Act, 2016, and the de jure recognition of the reproductive rights of persons with disability, the de facto reality is different. The gaps in relation to sexual health also remain: including inadequate access to comprehensive sexuality education, limited knowledge and training on the part of health care workers, and limited financial, human and other resources. Medical practitioners and the society largely consider persons with disability asexual or hypersexual. This not only leads to severe restrictions on their sexual behaviour and expressions of sexuality, and making them vulnerable to sexual abuse.
23. Persons with psycho-social disabilities are often not allowed to express their sexuality in any form, resulting in severe repression. For example, family and service providers reprimand girls with psycho-social disabilities if they dress up or use cosmetics. There is an erasure of sexuality, that restricts the bodily autonomy of persons with disabilities given the social perception that persons with disabilities are unfit for marriage. This argument is also used to deny them their sexual and reproductive health. Women with psycho-social disabilities are also often forced to undergo hysterectomy because of fears around vulnerability to sexual assault. Forced sterilisation or forced abortion of disabled women violated their right to bodily autonomy. Some accounts suggest that it is common for families in rural areas to get a daughter in-law with a disability only for purposes of procreation, and once a child is born, she is abandoned. The reports received by practitioners relate to hearing impairment, although there is indication that it is true of other disabilities too.
24. The RPwD Act, 2016 includes some aspects related to "sexual rights" such as personal liberty, protection against violence, abuse and exploitation etc, but there is no direct reference to the word as in the case of reproductive rights. In the same act in section 10 (1), the Government is mandated to ensure that persons with disabilities have access to appropriate information regarding reproductive and family planning measures, but there remains ambiguity about the appropriate information that is to be provided. This has excluded a large number of people from access to relevant sexuality and reproductive information.⁸
25. With regard to the barriers faced by persons with disabilities in pursuing their right to marriage and family life, the Committee on Economic, Social and Cultural Rights (CESCR) has noted that

⁸<https://www.youthkiawaaz.com/2019/03/intersection-of-disability-gender-sexuality-leading-to-social-exclusion-in-india/>

PwDs should have access to counselling services which would enable them to fulfil their rights and duties within the family.

HIV and AIDS

26. Unfortunately, India did not receive any recommendations on HIV/AIDS. Nevertheless, India has made significant progress in tackling its HIV epidemic over the past decade. For ongoing improvement in HIV response, India needs an effective prevention programme (PrEP), protection against discrimination, reduced stigma, strong leadership and advocates, greater access to routine HIV screening and testing and, most importantly, treatment and optimum patient care. The issue of HIV and AIDS in this report is primarily looked at from the lens of mandatory consent for HIV testing for minors, non-inclusion of PrEP in national HIV prevention strategy and of unmet SRH needs of ALHIVs.
27. Firstly, access to HIV testing is a crucial entry point to counselling on HIV risk, treatment and care for those who test positive, and an important component of prevention, especially for adolescent key populations including ALHIVs and high-risk minors such as street children.
28. As per the National HIV Testing Guidelines (2015), HIV testing is 'voluntarily' done at ICTCs (*Integrated Counselling and Testing Centres*)/private facilities through a mechanism of independent and "obligatory informed consent", and informed consent of a parent/guardian is required prior to testing minors for HIV.⁹
29. Adolescents within the age group of 16-18 years who do not have parents/guardians or who do not wish to involve their parents/guardians in decisions about their use of ICTC services, should be allowed to consent independently for testing. In other words, HIV testing for minors should be re-modelled in the true spirit of the "best interest of the child" and "evolving capacities", along with parallel strengthening of the health sector to assess their maturity to consent for HIV testing.
30. The WHO recommends HIV testing and counselling, with linkage to prevention, treatment and care, for all adolescents living in generalized epidemic settings, defined as countries where HIV prevalence is consistently over 1% among pregnant women.
31. Despite India having the third - highest HIV infection rate in the world,¹⁰ it does not have PrEP tool in its national HIV prevention strategy. PrEP, a boon of HIV prevention widely used in different countries, is still not implemented in India.
32. At the end of 2015, a PrEP demonstration project was rolled out in Asia's largest red-light zone, Sonagachi in Kolkata.¹¹ The daily use of tenofovir/emtricitabine (Truvada) combination as oral PrEP has been found to be effective in several clinical trials.¹² With no national PrEP policy or guidance at present, this ongoing demonstration project can be used to effectively inform the implementation of PrEP all over India.

⁹ National HIV Testing Guidelines (2015)

¹⁰ https://www.unaids.org/en/resources/presscentre/featurestories/2017/may/20170501_veena

¹¹ 10. The Economic Times. Anti-AIDS medicine project likely to take off at Sonagachi. 2015. [accessed on December 8, 2016]. Available from: <http://economictimes.indiatimes.com/news/politics-and-nation/anti-aids-medicine-project-likely-to-take-off-at-sonagachi/articleshow/45715559.cms>

¹² Nicol MR, Adams JL, Kashuba AD. HIV PrEP trials: the road to success. Clin Investing (Lond) 2013;3:3(3)

33. An estimated 120,000 children and adolescents aged 0-19 were living with HIV in India in 2017, the highest number in South Asia.¹³ Adolescents (ages 10–19 years) face a number of challenges as they transition from childhood to adulthood, including adjusting to physical and psychosocial transformations, as well as increasing independence¹⁴. For ALHIV, these challenges intensify pre-existing stressors related to HIV infection, such as HIV status disclosure and increasing personal responsibility for treatment adherence¹⁵. The initiation of sexual relationships and associated challenges of living with a lifelong communicable disease that can be sexually transmitted further complicates this time for many ALHIV. ALHIVs also face a range of unmet SRH needs. While adolescents are sexually active, they have limited access to information.
34. Current provision of services and information for adolescents is inadequate to meet their SRH needs. Access to information is limited without sexuality education and information in schools and from other sources. Social norms towards adolescent sexuality, HIV-related stigma and discrimination and insufficient coverage and coordination act as barriers to services.

Recommendations

1. Decriminalise abortion in order to allow women to have full power over decisions regarding their reproductive autonomy. Abortion ought to be removed from the criminal domain and be considered within the gender justice framework as an issue of equality and non-discrimination.
2. Amend POCSO to reduce the age of consent to 16 and remove the clause on mandatory reporting, especially for health service providers, to ensure confidentiality. Further, restore the age of sexual consent to 16 years, taking into account the evolving capacities of children. Introduce more liberal provisions in POCSO offences to distinguish the case of teenage relationships after 16 years from the cases of sexual assault vis-à-vis children.
3. Engage in public education and awareness raising on sexual health for marginalised and stigmatised adolescents and young PwDs, to dispel misconceptions and instil respect for human rights related to sexual health.
4. Sensitise healthcare service providers to the challenges faced by PwDs, and their sexual health rights.
5. Include the provision of independent consent of adolescents in the age group of 16 to <18 years in the existing policy and programmatic framework of the NACO, i.e National HIV Testing Guidelines (2015), to expand early identification and inclusion of all eligible and 'at risk' minors into the fold of vital HIV service provision.¹⁶
6. Develop a national PrEP policy, with a detailed plan for the operationalization and roll out of public sector models of PrEP, firstly in priority districts in collaboration- preferably not

¹³ <https://www.tribuneindia.com/news/archive/health/story-691302>

¹⁴ WHO. Adolescent Health. (2018). Available online at: http://www.who.int/topics/adolescent_health/en/

¹⁵ WHO. Adolescents Falling Through Gaps in HIV Services. (2013). Available online at: <http://www.who.int/mediacentre/news/releases/2013/hiv-adolescents-20131125/en/>

¹⁶ The services should be based on assessment of their evolving capacities to comprehend the nature and implications of HIV & AIDS and HIV test results, with the role being assigned to the ICTC counsellor.

as a vertical [stand-alone] programme but as part of a comprehensive sexuality education programme.

7. Include youth-friendly reproductive health services for AL&YPLHIVs which are comprehensive, repetitive, developmentally appropriate, and tailored-made, with linkages to SRHR in the Operational Guidelines for Treatment and Care by NACO.
8. Implement the HIV and AIDS (Prevention and Control) Act, 2017, with all state governments implementing state rules for the act and establishing dedicated offices and ombudsman to handle complaints. Allocate reasonable resources for implementation.