Joint Submission to the Universal Periodic Review of

INDIA

41st Session of the UPR Working Group of the Human Rights Council

October 2022

Report on India's Compliance with its Human Rights Obligations

in the Area of Sexual and Reproductive Health and Rights

March 2022

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1. The undersigned non-governmental organisations (NGOs) and research organizations working on sexual and reproductive health and rights (SRHR) issues present this joint submission[1] to supplement the report of the Government of India (the Government), scheduled for review by the Human Rights Council during its 41st session in November 2022. We have been working to advance sexual and reproductive health and rights of individuals in India, including through research and advocacy, education, community outreach and empowerment, service delivery, and capacity-building.

2. This submission provides information regarding the status of implementation of specific recommendations accepted by India during its third cycle of the UPR that called for the Government to take effective measures to improve access to maternal health services to reduce maternal mortality[2], integrate gender perspective into laws and policies[3] and train law enforcement personnel, judiciary, and medical staff[4], improve SRHR of all women, including by providing comprehensive sexuality education (CSE)[5], define minimum legal age of marriage at 18 years[6], and continue strengthening institutions to protect adolescent boys and girls[7]. Since the previous UPR, India has taken important steps to improve SRHR, including access to safe abortion and adolescents' SRHR services. However, we note that India needs to address a range of legal and policy barriers to ensure non-discriminatory, available, acceptable, accessible, and quality (AAAQ) SRHR services for all. Specifically, India needs to address the continuing violations of the rights to life, health, dignity, and privacy arising from i) **lack of access to safe and legal abortion**, and ii) **failure to advance adolescents' sexual and reproductive health and rights (SRHR) in a manner consistent with their evolving capacities.**

3. Recognising the interconnectedness of SRHR issues and the intersectional ways in which these relate to persons based on their social location, for the purpose of this submission, we focus on these two issues which continue to be pressing, despite enacted law reform. We detail the concerns, backed by data, and first and secondhand information below. While we use "women and girls" most often, we also variously use the terms "individual", "person", "pregnant person" and "adolescent" throughout this submission. We recognise that cisgender women, transgender men, nonbinary, gender-fluid and intersex individuals with a female reproductive system and capable of becoming pregnant have the right to non-discriminatory SRHR services, and may face significant additional barriers that could not be adequately reflected in this submission.[8]

LEGAL, POLICY AND IMPLEMENTATION BARRIERS TO SAFE ABORTION ACCESS

1. In India, a third of all pregnancies are aborted.[9] Of the estimated 15.6 million abortion in 2015, 78% (12.3 million) were technically illegal under the Medical Termination of Pregnancy Act 1971 (MTP Act)[10] as 73% (11·5 million) of these were medical abortions accessed outside of facilities. While majority i.e. 95% (22% in the facility and 73% medication abortions) were considered safe, 5% which were conducted outside the facility using 'Other' methods were considered potentially unsafe. Though the Maternal Mortality Ratio (MMR) in India has consistently declined (103 in 2017-19 from 113/ 100,000 livebirths in 2016-18)[11], deaths due to unsafe abortions are considered preventable and continue to contribute to 5% of maternal deaths. Women living in rural settings were more likely to have an unsafe abortion and to die from abortion-related cause.[12] Approximately 56% abortion-related deaths were due to lack of access to appropriate healthcare.[13]

NATIONAL LEGAL FRAMEWORK

2. Section 312 of the Indian Penal Code (IPC) criminalises voluntarily "causing miscarriage" even with the pregnant woman's consent, except when the miscarriage is caused to save the pregnant woman's life. Intended as an exception to the penal provisions, the Medical Termination of Pregnancy Act 1971 (MTP Act) was amended in 2021 (MTP Amendment Act) along with the Medical Termination of Pregnancy Rules 2003 (MTP Rules). These amendments enumerate categories of women and girls who now qualify to seek abortions until 24 weeks, remove the marital requirement for seeking abortion on contraceptive failure, and clear provider and facility qualifications, among others. However, despite these advances, the MTP Amendment Act fails to secure access to safe and comprehensive abortion care for all. For instance, it fails to decriminalise abortion and place it within a rights-based framework, fails to move towards global public health and human rights standards grounded in the latest scientific knowledge, including through self-managed abortion with support if and when needed, institutionalises medical boards and prohibitive third-party authorisation requirements. Additionally, the MTP Act places various procedural and infrastructural restrictions on abortion provisioning. These restrictions, either operate in a standalone manner or intersect with a range of other legislations, notably, the Protection of Children from Sexual Offences Act, 2012 (POCSO Act) and the Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994 (PCPNDT Act) to create a circle of stigma and criminalization, severely curtailing access to safe abortions. Despite progressive constitutional jurisprudence, [14] the legal framework continues to advance a heteronormative, exclusionary, morality-laden, and ableist

understanding that fails to meet international human rights standards.

INTERNATIONAL FRAMEWORK & COOPERATION WITH INTERNATIONAL MECHANISMS

3. India has ratified both the International Covenant on Civil and Political Rights (ICCPR) and International Covenant on Economic Social and Cultural Rights (ICESCR) which guarantee the inherent right to life of every human being. [15] Any restrictions on the ability of people to seek and receive an abortion must not jeopardise their right to life. India is a state party to other key international human rights instruments in addition to the ICCPR and the ICESCR, including the Convention on Elimination of All Forms of Discrimination against Women (the CEDAW) and the Child Rights Convention (the CRC), among others. These human rights instruments, bodies, and their associated jurisprudence have provided clear guidance on the need to decriminalize abortion[16], highlighted the numerous legal, procedural, practical, and social barriers people face in accessing SRH services, and urged more attention and resources to tackle maternal mortality.[17] Specifically, they have expressed concern regarding the high rates of death resulting from unsafe abortion and lack of access to safe abortion in India. [18] These standards place international obligations on India to protect and fulfil SRHR including to safe abortion.

4. Proportion of unsafe abortions are significantly higher in countries with more restrictive abortion laws.[19] Liberalisation of abortion laws ensures pregnant people's right to life by removing barriers to abortion and thus decreasing preventable maternal mortality and morbidity rates. [2021]. The Human Rights Committee stated that restrictive abortion laws constitute violations of the right to life in its 2019 General Comment No. 36[22]. It referred to States' responsibility to remove existing barriers to effective access to safe and legal abortion, including barriers caused because of conscientious objection by individual medical providers[23]. The World Health Organisation (WHO) recommends removing medically unnecessary policy barriers to safe abortion, including criminalization, grounds-based approach, and gestation limits, highlighting that this can "lead to critical delays in accessing treatment and put women and girls at greater risk of unsafe abortion, stigmatization, and health complications, while increasing disruptions to education and their ability to work"[24].[25] We highlight some of these barriers in the Indian context below.

ISSUES OF CONCERN

5. ***Continuing criminalisation of abortion:*** A fact-finding study on legal barriers to accessing safe abortions ('Legal Barriers' study) confirms that despite the MTP Act amendments, the basic penal framework of the law

remains intact with both providers and women & girls seeking abortion continuing to remain liable for criminal penalties, including imprisonment, if the abortion is not as per the grounds and requirements under the MTP Act.[26] Thus, abortion continues to be regulated through a 'criminal law' framework rather than as a healthcare issue as has been recognized under international human rights law. The **'*chilling effect*' of this criminalization on service providers' willingness to provide abortion-related information and services and the extra-legal barriers** they then create to avoid legal liability has been well documented in the Indian context.[27] In the absence of clear guidelines, the overarching criminalization approach is likely to compound this 'chilling effect' even in cases where the law itself seeks to protect the pregnant person's rights, such as for a new clause requiring non-disclosure of pregnant women's identity and inviting penalties for violations[28]. Since abortion-related penal provisions remain under the Indian Penal Code, the 2021 amendments by recognising only a limited right to abortion under specified grounds and circumstances, fails to address these concerns.[29]

6. ***Limited recognition of medical methods of abortion (MMA), including ability to self-manage:*** Medical abortion (MA) is recommended by the WHO as a safe and effective method of ending a pregnancy in different settings, including through self-management with support if and when needed.[30] Under international human rights law, access to abortion medicines is specifically protected as part of the right to health and to enjoy the benefits of scientific progress.[31] MA is the most common method of abortion in India, with approximately 11.5 million abortions (73%) taking place using MA pills outside health facilities[32]. The amended Rules fail to support self-management of abortions (SMA) by requiring only trained medical practitioners in clinical settings to authorize and manage medical abortions. Thus, rather than taking a *woman-centered approach[33]*, the law in its current form, is not in line with public health and human rights standards, and **effectively criminalizes self-managed abortions** even in the earliest weeks of pregnancy.

7. Before the 2021 law reform, policy response on MA was restrictive and disjointed. While the Directorate General of Health Services (DGHS) in 2008 approved the MA combi pack for termination up to 9 weeks and the Comprehensive Abortion Care Guidelines, 2019 allowed home administration of misoprostol, the 2003 MTP Rules only referred to administration up to 7 weeks by a Registered Medical Practitioner (RMP) in their clinic with approved facility access. In 2019, the DGHS issued another advisory calling for effective implementation of a mandatory warning/label on the MA Kit for use "*only under the supervision of a service provider and **in** a medical facility[34].* While the newly amended MTP Rules take a limited step forward to expand MA access,[35] this **legal position is still not at par with WHO**

recommendations recognizing expanded access to MA, specifically on complete or supported self-management of medical abortion.

8. ***Abortion stigma compounds barriers to access:*** Furthermore, **abortion stigma and patriarchal assumptions about women's sexual and reproductive decisions continue to limit women's access to safe abortion**. India received a recommendation in its third cycle of UPR to "[p]rovide systematic training on women's rights to all law enforcement personnel, medical staff and judicial officials" (161.67: Belgium). But primary duty bearers, including medical professionals and the judiciary, continue to factor general abortion stigma into their decisions. For example, medical jurisprudence textbooks, commonly used in medical education in India and as reference material by practicing doctors, often contain statements about the law, grounded in patriarchal assumptions about women's sexual and reproductive behaviour.[36] Such assumptions are then normalised and often influence medical professionals' approach to abortion services. Service providers often use real or assumed health risks as a proxy for abortion stigma and perceptions about women's socio-economic status. For instance, in documented instances in the 'Legal Barriers study' where doctors state that "repeated abortion is used as contraception by a certain class of patients" (implying women from weaker socio-economic backgrounds) [37], or where women's access to abortion is made conditional on contraception[38]. It also found that provider perceptions label and shame all adolescent sex or sex outside marriage as "illegal sex" and "illegal pregnancy", and deny abortion care on this basis, thus pushing pregnant persons to seek unsafe abortions[39]In such situations, even if abortion is decriminalised, service providers may continue to deny abortion services[40] in the absence of an enabling legal and policy environment including rights-based education of medical professionals, judiciary and law enforcement personnel.

9. The **experiences of persons with disabilities (PwDs)** are generally invisible, with statistical data on women with disabilities (WwDs) accessing abortion services severely lacking[41]. Broadly, WwDs face additional access barriers because of an ill-equipped health system along with pervasive disability stigma and lack of rights-based understanding.[42]43 This is compounded by a disjointed policy response that creates arbitrary categories, between severe disabilities and others, or between "mentally-retarded" and "mentally ill" persons, thus, eroding the bodily and decisional autonomy of WwDs.

10. ***Prohibitive third-party authorisation requirements*:** The requirement that pregnant women and girls seek the opinion of two practitioners and a medical board for certain kinds of abortions is restrictive and given several reports of women being denied abortions on "moral" grounds by doctors[44] is a violation of their right to life. Section 3(2D) of the

MTP Amendment Act has provided statutory recognition to medical boards comprising specialist medical practitioners[45], which were earlier constituted either on case-to-case basis or in a few states within India. The **institutionalisation of such third-party authorization in the amended law infringes upon pregnant persons' rights to reproductive autonomy** under the Constitution and under international human rights law. Recent public health standards directly link such medically unnecessary barriers to increased risk of unsafe abortions and rights violations.[46]

11. Further, this new institutional structure **raises specific concerns of accessibility, delays in receiving urgent abortion care, and increased burden on the healthcare system**. For instance, the MTP Amendment Act and Rules require each State and Union Territory to constitute "a Board" at district level in "approved facilities".[47] A recent study found a "dire shortfall (of 80% or more) of obstetricians and gynecologists" within the public health system in most Indian states and UTs, which exacerbated by poor or absent data availability makes evidence-based constitution of Medical Boards practically impossible.[48] The disproportionate impact of these limitations is likely to be felt by the most marginalised abortion seekers, including those from *dalit* & tribal communities and those living in rural areas.[49] Further, the creation of a Board is likely to cause severe delays in the abortion process due to additional levels of approvals and permissions before a requested termination is authorised. Conflicting opinions amongst Board members who are not MTP providers, having multiple responsibilities, and required to give a decision within the statutorily mandated timeline have been highlighted as some of the key challenges to timely access to urgent abortion care.[50] Need for clarity and guidelines to implement the amendments for later-term abortions have also been highlighted by providers as creating specific legal and ethical concerns.[51] Therefore, although the MTP Amendment Act takes steps to remove barriers to abortion for women and girls, by imposing third party authorisation requirements, it fails to meet international human rights and public health standards.

12. ***Impact of COVID-19 and lockdown*:** On 24 March 2020, the Indian Government announced a country-wide lock down as part of its COVID-19 management strategy. During the pandemic, compromised access to safe abortion has **led to more women resorting to unsafe abortions and/or women continuing with their unwanted pregnancy**[52], with some estimating more than a million women in India lost access to safe abortion[53]. This is primarily due to a combination of factors impacting the health system, supply chain of medical abortion drugs and mobility of pregnant persons and their partners. In particular, the pandemic resulted in abortion pill shortages in several states surveyed by the Foundation for Reproductive Health Services India[54]. The 'Legal Barriers study' confirms that access to abortion pills is already severely restricted because of the conflation between the MTP Act and over-regulation under Pre-Conception and Pre- Natal Diagnostic

Techniques Act, 1994 (PCPNDT Act).[55] For instance, medical providers, CSOs, and women reported "onerous regulatory compliances and fear of "legal repercussions,"[56] and lack of clarity over "drug authorities placing a ban on stocking of MA drugs in retail pharmacies"[57] as some key reasons for non-availability of abortion pills. Conflicting policy guidelines further exacerbate this as referred to in para 7 above. The health infrastructure and systemic challenges were further compounded by a disjointed policy response.

13. While the Government notified contraception and safe abortion & post-abortion care as "essential services" and provided for a grievance redressal & service delivery monitoring mechanism[58], **comprehensive abortion care continues to remain excluded from the telehealth guidelines.**[59] UN human rights mechanisms have called for human rights to guide the public health response to the pandemic, with the CEDAW Committee clarifying that "[a]bortion and post abortion services…must be ensured to women and girls *at all times*, through toll-free hotlines and easy-to-access procedures such as online prescriptions." The UN TMBs have stressed that States must ensure that COVID-19 response plans and measures do not further exacerbate entrenched structural inequalities and inequities[60] while the WHO in its recent guideline has for the first time, specifically recommended telemedicine as an alternative to in-person interactions to deliver medical abortion services in whole or in part.[61]

14. ***Non-binary, Trans and gender diverse persons excluded*:** The MTP Amendment Act allows only "pregnant women" to terminate pregnancies under certain conditions. Thus, **abortions sought by trans persons, non-binary people, and gender diverse persons has been absent from the policy conversation** surrounding abortion in India. This is despite being highlighted by civil society and supported by progressive jurisprudence of the Indian Supreme Court, and legislations such as the Transgender Persons (Protections and Rights) Act, 2019 (Transgender Persons Act) that recognises transgender persons' right to non-discriminatory access to medical facilities and care[62]. Heteronormative understanding advanced by the MTP amendments also highlights the Government's failure to carry out consultations with all affected communities, despite the accepted recommendation from its 3rd UPR Cycle to effectively protect and implement the Transgender Persons Act[63].

15. RECOMMENDATIONS ON SAFE ABORTION ACCESS:

(a) Decriminalise and reframe abortion within a rights-based healthcare framework recognising pregnant person's dignity and bodily autonomy, and to prevent unsafe abortions that contribute disproportionately to preventable maternal mortality.

(b) Facilitate accessible, affordable, acceptable, and quality abortion within the public health system, including undertaking a comprehensive social audit of SRHR-related institutional infrastructure and documentary requirements.

(c) Move towards self-management of medical abortion in line with current global human rights and public health standards including the WHO 2022 Abortion Care Guideline.

LEGAL, POLICY AND IMPLEMENTATION BARRIERS TO ADOLESCENTS' SRHR ACCESS

16. India has one of the largest adolescent populations, with one in every five persons between 10 to 19 years.[64] Of the 2 million adolescent girls with an unmet need for modern contraception and who experience pregnancy, 53% end in abortions (approximately 930,000 abortions annually).[65] 78% of these abortions are considered unsafe and thus carry an elevated risk of complications.[66] Adolescents in India face additional barriers to accessing SRHR services, including to safe abortion, due to the continued operation of a legal framework that establishes mandatory reporting requirements and criminalizes adolescent sexuality. This is compounded due to significant existing impediments to quality education, lack of resources, social stigma that make adolescents more vulnerable to a range of violations, as detailed below.

NATIONAL LEGAL FRAMEWORK

17. The Protection of Children from Sexual Offences Act 2012 (POCSO Act) was enacted to comprehensively address child sexual abuse and defined a "child" as a person below the age of 18 years.[67] It fails to strike a balance between protection and autonomy, particularly the evolving capacities of older adolescents, and provides for blanket criminalisation of any form of sexual activity with a person below 18 years. The offences are punishable with high mandatory minimum sentences between 10 to 20 years imprisonment, extendable to life imprisonment and even death penalty for aggravated sexual assault. [68] Despite specific recommendations against it, the IPC was amended in 2013 to raise the age of consent from 16 to 18 years[69], placing adolescent sexual activity entirely within a punitive legal framework. Section 19(1) of the POCSO Act imposes a mandatory reporting obligation on *anyone* with knowledge or apprehension of child sexual offence to report to the police, and Section 21(1) punishes the failure to report[70]. Since the Act imposes a bright line rule at 18 years and has no close-in-age exemption from criminal liability, it exposes adolescents to criminalization with heightened prosecution risk for adolescent boys, and institutionalisation

for adolescent girls,[71] compromising adolescent girls' access to SRHR services. Allied provisions under the Juvenile Justice (Care and Protection of Children) Act, 2015 that allow adolescents between 16 and 17 years to be tried as adults for "heinous offences"[72] and IPC provisions on "kidnapping"[73] add compounding layers of criminalization. The Prohibition of Child Marriage Act 2006 (PCMA) prohibits the solemnization of child marriage below the age of 18 for girls and 21 for boys and makes it voidable at the option of either party.[74] In the absence of a comprehensive strategy to address child marriages, recent law reform proposals as seen below put adolescents' decisional autonomy at further risk.

INTERNATIONAL FRAMEWORK & COOPERATION WITH INTERNATIONAL MECHANISMS

18. India's domestic legal framework is incompatible with international standards relevant to SRHR. For instance, the ESCR Committee recognises state obligations to sexual and reproductive health, including the right to the highest standard of health. [75] It has emphasised that these obligations apply particularly to adolescents' access to health services.[76] Criminalization of sexuality, however, severely impedes the ability of adolescents to seek health services and undermines the state's responsibility to ensure accessible information about sexual reproductive health.[77]Human rights bodies recognize the "evolving capacities" of adolescents and the need to increase recognition of responsibility for their own wellbeing and safety as they get older.[78] The CRC has explicitly called on states to "avoid criminalizing adolescents of similar ages for factually consensual and non-exploitative sexual activity"[79], and has urged that they "take into account the need to balance protection and evolving capacities in determining the legal age for sexual consent."[80] It has also urged States to remove status offences such as consensusal sexual acts among adolescents from their statutes.[81] India has accepted recommendations from its 3rd UPR to strengthen institutions to protect adolescent girls and boys [82], prohibit all forms of corporal punishment for those under 18 years[83], and provide CSE[84].

19. India has also accepted recommendations from its 3rd UPR to take measures to end child marriage.[85] India has ratified the CEDAW which enshrines the right of women to not only enter a marriage based on equality with men but also the right to freely choose a spouse and marry only with their free and full consent.[86] This right has been reiterated by the CEDAW Committee as central to her life, dignity, and equality[87]. However, due to lack of a comprehensive rights-based child marriage policy, India falls short of complying with its international legal obligations.

ISSUES OF CONCERN

20. ***Failure to recognise adolescents' evolving capacities and blanket criminalization of their sexuality as barriers to accessing SRHR services:*** As highlighted in para 16 the existing laws regulating age of consent, marriage, mandatory reporting, and other allied provisions together underscore a criminal justice response to consensual non-exploitative sexual activity. National official statistics show that in as high as 46.6% reported cases of penetrative and aggravated penetrative sexual assault under the POCSO Act in 2020, the alleged offender was "Friends/Online-Friends or Live-in Partners on pretext of marriage".[88] Another study on functioning of special POCSO courts revealed that in at least 20% of decided cases, the victim admitted to being in a consensual relationship or marriage with the accused.[89] Yet another study found that the penal provisions under PCMA "is used twice as much against elopements or self-arranged marriages than it is used in relation to arranged marriages."[90] The penal provisions against "kidnapping" under the IPC are also found to be used disproportionately in such "elopement" cases. Although in several instances, there have been acquittals in such cases, following the Supreme Court's reading down of the 'marital rape' exception in *Independent Thought v. Union of India*,[91] some courts are recording convictions while invalidating minor's consent and imposing maximum statutory sentencing on younger adult males.[92] The higher judiciary has, however, drawn attention to problems due to criminalisation of adolescent sexuality and on 29 January 2021, the Madras High Court recognised that "*adolescent romance is an important developmental marker for adolescents' self-identity, functioning and capacity for intimacy" and adolescents need to be supported, not criminalised.* [93]On the whole, these studies and case law support that **unless grounded within a rights-based enabling framework, "laws meant to protect children [have] become an instrument to induce fear, regulate and control normative expressions of sexuality, and to punish adolescents** for engaging in relationships that families or society do not approve of."[94] Adolescents' reproductive and decisional autonomy has been further eroded with the recent phenomenon of *"Love Jihad"* laws passed by several states in India.[95] These laws target and penalize inter-faith relationships implicating constitutionally and internationally recognized human rights.

21. ***Mandatory reporting creates a chilling effect on adolescent girls' SRHR and contributes to stigma:*** Mandatory reporting complicates the access of adolescent girls to sexual and reproductive health services and information, and protection schemes aimed at pregnant persons. In the absence of close-in-age exceptions in the POCSO Act, as noted in para 17 earlier, girls in consensual sexual relationships are especially wary of exposing their partners to criminal prosecution while seeking SRH services, including contraception and safe abortion.[96] Given the wide-ranging social stigma attached to adolescent sexual activity, parents often do not want to report, preferring termination of the pregnancy in anonymity.[97] **Mandatory**

reporting to the police therefore, makes interface with the criminal justice system a pre-condition for accessing abortion services, and leaves girls vulnerable both to continuing exploitation as well as to worsening health outcomes from unmet sexual and reproductive health needs.[98] POCSO Act's blanket criminalisation of adolescent sexuality combined with mandatory reporting requirement also presents legal and ethical issues for service providers, such as the conflict between the reporting requirement and their duty of confidentiality. Providers, because of their lack of clarity and knowledge about the Act also take steps, such as seeking authorisation from courts or Child Welfare Committees. This further **impacts girls' SRHR and restricts their access** to a range of services including safe abortion and contraceptive information and services.[99]

22. ***A criminal justice approach to addressing child marriage, advancing gender equality and maternal health outcomes is problematic, and further erodes adolescent autonomy***: Research has highlighted the **harmful impact of using a criminal justice approach to address issues of maternal mortality/morbidity, child marriage, and other adverse maternal health outcomes** for adolescent girls. Instead, focus should be on school retention, stronger linkages between education and livelihood opportunities, community involvement in provision of adolescent sexual and reproductive health programs, and comprehensive sexuality education among others.[100] The Supreme Court of India most recently in the *Puttaswamy* case[101] and in earlier judgments[102], has recognized marriage, procreation and choice of family life as integral to individual dignity and autonomy, which is an inviolable aspect of the right to privacy.[103]

23. In December 2021, the Government cleared proposals to raise the minimum age of marriage for women from 18 to 21 years. By creating a restrictive standard when all other laws recognise 18 years as age of majority, this proposal **will impact the human rights of adult young women to privacy, decisional autonomy, to marry and form a family of their choice**.[104] Based on interviews with girls involved in "romantic cases"[105], a recent study concludes increase in age of marriage could result in "increased arrests, detention, breakdown of families, and institutionalisation of young people, which will come at a huge social, economic and health cost", while unlikely to deter early marriages. [106] In an Open Letter from Girl Citizens to Parliamentarians, signatories emphasised that increasing the minimum age of marriage for girls further takes away agency and adds controls to the lives of girls.[107] Despite the Government's commitments to end child marriage, there is no enabling and nuanced strategy to address its root causes while advancing adolescent-centric participatory decision-making. For instance, a WHO evaluation of a multi-sectoral Government intervention to address child marriage highlighted lack of clear directives and institutional support for inter-sectoral collaboration, monitoring and administrative

challenges, differing perspectives on strategy among district leaders and community resistance as key challenges.[108]

24. ***Lack of a comprehensive approach to strengthen adolescent SRHR, including SRHR-related information and sexuality education***: Reference has been made to India's accepted recommendation to continue strengthening institutions to protect adolescent girls and boys (para 13). As a signatory to the 1994 United Nations International Conference on Population and Development (ICPD) and as part of Sustainable Development Goals (SDGs)[109], India has committed to provide universal access to comprehensive SRHR education. Studies have shown that common strategies to improve SRHR related knowledge is through a diversification of strategies such as community-based outreach, peer education, school health education and adolescent-friendly health services.[110] Following the launch of the Rashtriya Kishor Swasthya Karyakram (RKSK) as part of the RMNCHA+ strategy, it was expected that the Government would mobilise resources to ensure maximum impact.[111] However, both programmes continue to be **limited by lack of convergence and buy-in from critical sectors**, such as education, social and familial barriers and engagement from the medical community.[112] The **lack of mainstream and comprehensive sexuality education** in Government programmes too has prohibited the advancement of adolescent SRHR and gender equality.[113]

25. ***Impact of COVID-19 and Lockdown***: Reproductive health services and access to supplies in India have suffered hugely throughout the pandemic. Many resources have been diverted to COVID-19 related care. Two in five (43%) of youth serving organisations reported that girls in their programmes had experienced difficulty in accessing sanitary napkins since lockdown was imposed.[114] Around 28% of organisations reported that pregnant girls had experienced difficulty in accessing ante-natal delivery and/or post-partum care since lockdown was imposed.[115] There have been reports of increase in child marriages, adolescent pregnancies, and violence against women & girls during COVID-induced lockdowns. 36% reporting organisations were approached by a girl who was being forced to marry against her will.[116] Policy response and investment has however, been inadequate. Budget for children decreased to only 2.46% of Union in 2021-22.[117] This has been declining over the years as has the share for education, health, and child protection. **Stemming the pandemic's intergenerational impact demands much higher investment**, including ensuring adolescent girls SRHR requirements, and access to emergency medical care and safe abortion as per the law without additional documentation or consent requirements.[118]

26. RECOMMENDATIONS ON ADOLESCENTS' SRHR ACCESS:

(a) Decriminalise consensual non-exploitative adolescent sexual activity and center their evolving capacities and autonomy in legal and policy interventions that aim to protect children from abuse and harm, and consider alternate models of balancing adolescents' autonomy with ensuring accountability for child sexual abuse.

(b) Review the mandatory reporting requirement under the POCSO Act to ensure that it is help-oriented, not punitive, and does not deter adolescents from accessing SRHR services.

(c) Ensure AAAQ sexual and reproductive health services for all adolescents without stigma, and towards this, harmonize policy response and its implementation.

(d) Review and take measures to address the increasing reliance on penal laws in relation to gender equality and health outcomes, including child marriage, early pregnancies, maternal mortality/morbidity and other related maternal health issues.

(e) Review the proposal to increase the age of marriage for girls from 18 to 21 years as it will violate their rights to life, personal liberty, and privacy, result in excessive criminalisation, and is likely to make them more vulnerable to patriarchal controls, re-victimisation, and compromised access to SRHR services and benefits.

(f) Review and consider repealing laws that are specifically targeted at or have a disproportionate impact on adolescents and their access to SRHR because of their marginalized status, including "love jihad" laws for inter-faith and inter-caste consensual (non-exploitative) relationships.

(g) Develop multi-sectoral strategies that support adolescents to develop stronger informed understanding of their sexuality and associated risks and address child marriage and early pregnancies.

27. OVERARCHING RECOMMENDATIONS:

(a) Prioritise medical education and training, guidelines for providers, and education of public officials such as judges, law enforcement, and program implementers with a view to address bias and stigma that compound barriers to accessing SRHR services.

(b) Consider institutionalizing comprehensive sexuality education as part of public education, developing stronger linkages between education and livelihood opportunities, and community participation and buy-in in law and policy implementation.

(c) Strengthen oversight and accountability mechanisms for 'AAAQ' SRHR services, including within the public health system and ensure adequate protection of confidentiality and privacy concerns of those who access such services. Specifically, undertake multi-stakeholder participatory monitoring of COVID-19's impact on SRHR access, especially of most vulnerable groups such as adolescents, persons with disabilities, LGBTQ+ persons, and persons from rural and tribal areas.

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[1] This joint submission has benefited from the key contributions of Dr. Aparna Chandra, Associate Professor, National Law School of India University, Bangalore, India, including her research work and insights on the issues highlighted in the submission.

[2]Human Rights Council Res. 36/1 U.N. Doc. A/HRC/36/10/Add.1, at 161.177 (6 September, 2017).

[3]Id. At 161.190, 161.192, 161.204.

[4]Id. At 161.67 (Belgium).

[5]Id. At 161.179, 161.180.

[6]Id. At 161.217.

[7]Id. at 161.231, 161.235. Also, see 161.197.

[8] Excerpted from World Health Organization, *Abortion care guideline* (2022).

[9]Susheela Singh et al, *The incidence of abortion and unintended pregnancy in India, 2015*, 6(1) The Lancet Global Health, e111 (2018).

[10]Ibid. (Reporting that in 2015 there were 144 pregnancies per 1000 women in the 15-49 age group, of which 70 pregnancies per 1000 women in this age bracket were unintended). Section 4 of the MTP Act provides that no pregnancy can be terminated under this Act except in the health care facilities provided in the Act or notified in the Rules. Therefore, all pregnancies that are terminated outside of health care facilities are per se illegal).

[11]Office of the General Registrar, SRS Bulletin, *Sample Registration System* (Volume 54 No.1 2019) available https://censusindia.gov.in/vital_statistics/SRS_Bulletins/SRS%20Bulletin%202019.pdf/.

[12]Ryo Yokoe, Rachel Rowe et al, *Unsafe abortion and abortion-related death among 1.8 million women in India*, BMJ GLOBAL HEALTH (2019) available https://gh.bmj.com/content/4/3/e001491#xref-ref-2-3/.

[13]Ibid.

[14]Meera Santosh Pal v. Union of India, (2017) 3 SCC 462. (The Supreme Court emphasized the right to bodily integrity and reproductive autonomy, adding that a woman may take any necessary step to preserve her own life.)

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