

COUNTRY ASSESSMENT ON HUMAN RIGHTS IN THE CONTEXT OF SEXUAL HEALTH AND REPRODUCTIVE HEALTH RIGHTS

A Study Undertaken for National Human Rights Commission

REPORT

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By

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LIST OF ABBREVIATIONS

A

AFHC	Adolescent Friendly Health Clinics
AFSPA	Armed Forces Special Powers Act, 1958
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Checkup
ANM	Auxiliary Nurse Midwife
ARSH	Adolescent Reproductive and Sexual Health Programme
ART	Anti-Retroviral Therapy
ARTs	Assisted Reproductive Technologies
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre

B

BMI	Body Mass Index
BPL	Below Poverty Line

C

C section	Caesarean Section deliveries
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CESCR	Committee on Economic, Social, and Cultural Rights
CHC	Community Health Centre
CLA	Criminal Law Amendment Act, 2013
CRC	Convention on the Rights of the Child
CrPC	Code of Criminal Procedure, 1973
CRPD	Convention on the Rights of Persons with Disabilities
CSE	Comprehensive Sexuality Education

D

DEPD	Department for Empowerment of Persons of Disabilities
DOTS	Directly Observed Treatment, Short Course

E

ESI	Employees State Insurance Act, 1948
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F

FPIS	Family Planning Indemnity Scheme
FRU	First Referral Unit

G

GBV	Gender Based Violence
GDP	Gross Domestic Product
GOI	Government of India

H

HIV	Human Immunodeficiency Virus
HPS	High Performing States
HRW	Human Rights Watch

I

ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IDP	Internally Displaced Person
IGMSY	Indira Gandhi Matritva Sahyog Yojana

IPC	Indian Penal Code, 1860
IPHS	Indian Public Health Standards
ITPA	Immoral Trafficking (Prevention) Act, 1956
IUCD	Intrauterine Contraceptive Device
IUD	Intrauterine Device
IVF	In Vitro Fertilisation
J	
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
L	
LGBI	Lesbian, Gay, Bisexual, Intersex
LHV	Lady Health Visitor/Lady Health Worker
LPS	Low Performing States
M	
MBA	Maternity Benefit Act, 1961
MBP	Maternity Benefit Programme
MCI	Medical Council of India
MDG	Millennium Development Goals
MDWS	Ministry of Drinking Water and Sanitation
MHRD	Ministry of Human Resource Development
MMR	Maternal Mortality Ratio
MoHFW	Ministry of Health and Family Welfare
MTP	Medical Termination of Pregnancy
MTPA	Medical Termination of Pregnancy Act, 1971
MWCD	Ministry of Women and Child Development
N	
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NCDs	Non-Communicable Diseases
NCERT	National Council of Educational Research And Training
NFHS	National Family Health Survey
NFSA	National Food Security Act, 2013
NHM	National Health Mission
NHP	National Health Policy
NHRC	National Human Rights Commission
NIMR	National Institute of Malaria Research
NLEM	National List of Essential Medicines
NPDCS	National Programme for Prevention and Control of Diabetes, Cardiovascular Diseases and Stroke
NPPA	National Pharmaceutical Pricing Authority
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organisation
NUHM	National Urban Health Mission
O	
Ob-Gyn	Obstetricians and Gynecologists
OOPE	Out of Pocket Expenditure
OSC	One Stop Centre
P	
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994
PDS	Public Distribution System

PHC	Primary Health Centre
PLHIV	People living with HIV
PLWHA	Persons Living with or affected by HIV/AIDS
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PMMVY	Pradhan Mantri Matru Vandana Yojana
PMTCT	Prevention of mother-to-child transmission
PNC	Postnatal Care
POCSO	Protection of Children From Sexual Offences Act, 2012
PPH	Postpartum Haemorrhage
PPP	Public Private Partnerships
PPIUCD	Postpartum Intrauterine Contraceptive Device
PPTCT	Prevention of parent-to-child transmission
PVTG	Particularly Vulnerable Tribal Group
PWDVA	Protection of Women from Domestic Violence Act, 2005
R	
RH	Reproductive Health
RHR	Reproductive Health Rights
RKSK	Rashtriya Kishor Swasthya Karyakram
RMNCH+A	Reproductive Maternal Neonatal Child and Adolescent Health
RMP	Registered Medical Practitioner
RSBY	Rashtriya Swasthya Bima Yojana
RTI	Reproductive Tract Infections
S	
SDG	Sustainable Development Goals
SN	Supervisory Nurse
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SRS	Sex Reassignment Surgery
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
T	
TB	Tuberculosis
THR	Take Home Ration
U	
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UOI	Union of India
UPR	Universal Periodic Review
V	
VHND	Village Health Nutrition Day
VHW	Village-level Health Worker
VIA	Visual Inspection with Acetic acid
W	
WHO	World Health Organisation

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Any errors in the information or the citation of references in this document are inadvertent and may be ignored.

EXECUTIVE SUMMARY

This report is the first national inquiry on sexual and reproductive health undertaken on behalf of the National Human Rights Commission. It maps critical concerns pertaining to sexual health and reproductive health as two distinct but partially overlapping concerns in the context of India. The distinct and separate elaboration of the two thematic domains have been dealt with in parts I and II of this report respectively.

Sexual and reproductive health rights have been progressively enshrined under various international covenants and policy instruments. This accords sexual and reproductive health recognition within a right based framework and obligates the State to ensure their protection, promotion and fulfillment.

Sexual health and well-being

Although sexual and reproductive health rights overlap to some extent, particularly in relation to information and services relating to contraceptives, abortion and sexually transmitted diseases; yet, the scope of sexual health is more expansive. Sexual health and well being is recognised as an indivisible aspect of human rights, with its roots in the right to health. The term ‘well being’ confirms that its domain is not limited to disease prevention and treatment, but includes aspects relating to autonomy and pleasure with reference to sexuality.

Recognised initially in conjunction with reproductive health, sexual health has evolved into a distinct thematic area that includes physical, psychological, social and epidemiological aspects relating to sexuality; and the linkages of each of these aspects with material and social conditions that shape access, experiences and health outcomes of diverse population groups. The intersections and linkages of sexual health with different thematic fields have been affirmed, elaborated by different thematic treaty bodies and special mechanisms. There is growing recognition that besides women – other victims of gender based violence include children, persons with non-normative sexual orientations or gender identities, and that vulnerability to violence is exacerbated by disabilities, marital status, conflict situations, and social and economic status.

The inter-dependant web of sexual health rights includes the availability of age appropriate, scientifically accurate sexuality education, information and health services, disease prevention and treatment such as of HIV/ AIDs and sexually transmitted diseases (STI). It also includes protection from gender-based violence, respectful of the evolving capacities of adolescents, and the needs of persons with disability.

International human rights standards demand that Sexual and Reproductive Health (SRH) services should be available, accessible, acceptable and of good quality (AAAQ). Stigma around sexuality, criminalisation of same-sex and adolescent sexual

expression, and legal ambiguity around sex work renders specific population groups such as LGBT persons, adolescents, persons with disabilities, and sex workers more vulnerable, alienating them from sexual health services, while magnifying abuse and violence in their lives. When the few do access these services, they confront a continuum of violations and degrading treatment that serves to punish those who seek health care. An assessment of access to healthcare services also revealed a lack of sensitivity among healthcare providers towards the sexuality of these population groups.

These factors also discourage these population groups from seeking health services such as blood tests for HIV and other STIs. The section on HIV AIDS prevention also underscores the need to expand the focus of intervention programmes to include adolescent girls and women, given that there is a disconnect between public health programmes on family planning and those on HIV/ AIDS.

Scientific and unbiased information around sexual health is a pre-condition for making informed sexual choices, engage in safe sex practices, prevent disease – all of which are fundamental to ensuring sexual health. Age-appropriate Comprehensive Sexuality Education (CSE), that encompasses issues such as gender relations, roles, identities, body and relationship of the self with the body, positive and negative sexual contact, harm and pleasure, disease prevention, amongst others, is widely recognised as the way of enabling children and young persons in schools to become aware about their bodies, personal hygiene, gender identities as well as safe sex practices. However, CSE as per international standards has not yet been implemented anywhere in India yet. Age appropriate sexuality education for adolescents has faced considerable resistance from some quarters.

Protection from sexual violence and from the regulation of one's sexual autonomy have also been recognised as intrinsic to sexual health rights. However, despite significant reforms, the law is still not consistent in distinguishing consensual sex from non-consensual sex. The law does not uphold sexual autonomy of adults since it neither criminalises all forms of non-consensual sexual contact, nor de-criminalise all consensual sex. Based on a moralistic understanding of good and bad sex, the law obstructs legal redress from sexual violence to persons with non-normative sexual orientations and gender identities, sex workers, and to women in relation to marital rape. Apart from limiting legal redressal, the quality of redressal has also been called into question, for inadequate victim care and compensation.

This section also highlights a pervasive discomfort with sexuality and sexual pleasure, which is reflected in punitive regulation and policing of sexuality. Expressions, and perceived expressions of sexuality, including choices in clothing, partners, digital access, etc. are strictly monitored by state and non-state actors, and are also apparent community regulation of sexuality, through moral policing, honour based backlash and female genital mutilation.

Reproductive health and rights

This part provides an elaborate and complex picture of compliance to reproductive health rights (RHR) through mapping and analysis of the diverse laws and policies, demographic data on reproductive health and rights in India. The assessment attempts to identify compliance, gaps and make recommendations for reform in law, policy and praxis.

RHR necessitates the intersection of a range of rights – including but not limited to the rights to food and nutrition, sanitation, livelihoods, education, non-discrimination, comprehensive information and informed consent, comprehensive healthcare, freedom from violence, coercion, etc. and therefore the need to study a vast spectrum of policies, programmes and laws that implicate RHR.

Reproductive rights as human rights have gradually been recognised since the International Conference on Human Rights Declaration in 1968 and by the International Conference on Population and Development in 1994. The International Covenant on Economic, Social and Cultural Rights, 1996 (ICESCR) and the Convention on the Elimination of All Forms of Discrimination against Women, 1979 (CEDAW) also fore-ground the focus on reproductive rights as necessary in realising the human rights of women. The Sustainable Development Goals (SDGs) and the preceding Millennium Development Goals (MDGs) also encompass several goals that directly as well as indirectly recognise reproductive rights.

India, being signatory to these covenants and conventions, is obligated to ensure that these goals are fulfilled in its policies and laws. Looking at national laws and policies relevant to RHR presents a mixed picture of compliance as well as huge gaps. For instance, contemporary evidence from the ground as well as the mapping of policies and programmes reiterates the continued implementation of targets in “family planning programme” leading to egregious forms of violation of reproductive rights and autonomy, particularly of women from marginalised communities.

Laws enabling medical termination of pregnancy (abortion), protection against forced or sex selection, maternity benefits, protection from domestic violence including sexual violence by an intimate partner, etc have direct or indirect impacts on the enjoyment of reproductive health rights by women. Several concerns have been raised regarding the inadequacy of these laws. However, that the implementation of these laws has also been grossly inadequate is clearly reflected through the case studies, government data, and independent research.

Some case laws from the High Courts and the Honourable Supreme Court have also taken cognisance of violations related to RHR and upheld the reproductive rights of women in the country.

While there has been a proposed widening of focus to include different life stages and go beyond maternal health, as in the National Health Mission (NHM) (2012-2017)

including Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) programme, the Rashtriya Kishor Swasthya Karyakram (RKSK) strategy as well as the recent in the National Health Policy 2017, ground realities and assessments of the public healthcare system provide evidence to the contrary. The narrow focus on very selective components of maternal health and family planning have flagged serious concerns about the deficit of care for other aspects of reproductive health and rights.

Further, the public health system in India is challenged by a range of issues including low public investment, poor infrastructure including medicines, diagnostics; inadequate skilled human resources, etc. Additionally, the past decades have witnessed increased privatisation and corporatisation of health care, and an absence of robust regulation. All of this has caused deterioration in the accessibility, affordability and quality of healthcare, including for reproductive health needs, creating further social, economic and geographical distances particularly for girls, women and marginalised communities. Inequities in access to reproductive healthcare and health outcomes in India are apparent for vulnerable groups, as well as between and within states. Even in states where overall averages are improving, marginalised communities and poorer economic quintiles of the population, and among them the women and girls, continue to fare poorly.

Assessment of government schemes and programmes related to reproductive health yielded a plethora of programmes cutting across the areas of family planning, maternal and child health, adolescent health, etc. An analysis of these programmes, however, consistently reflects the lack of implementation of a rights frame work, discrimination and exclusion of a range of persons that poses sustained barriers to access and quality of care and exacerbates the marginalisation of reproductive health and rights (RHR). Analysis of schemes, policies vis-a-vis the concerned issues of reproductive health and rights also pointed to the lack of comprehensive programmes and limited application of RHR in their implementation through health and other allied services. Reproductive morbidities remain grossly neglected within government schemes and policies. Similarly, access to safe, quality abortion services, including information, counselling and post abortion care are significantly lacking. Early marriage and its negative outcomes for reproductive health and rights has also remained a neglected area.

Recommendations based on the assessment towards amendments and strengthened law, policy and programme; improved access to quality healthcare and comprehensive information, enhanced capacities of human resources for health and redressal mechanisms towards accountability and quality, have been flagged for the consideration of the National Human Rights Commission.

INTRODUCTION

The National Human Rights Commission (NHRC) initiated a country assessment / national inquiry on human rights standards in the context of Sexual and Reproductive Health and Rights (SRHR) along with Partners for Law in Development (PLD) and Sama Resource Group for Women and Health (Sama), non-governmental organisations with long and relevant experience and expertise on sexual and reproductive health and rights issues, respectively.

Sexual and reproductive health are two distinct but partially overlapping concerns. Although the two overlap to some extent, particularly in relation to information and services relating to contraceptives, abortion and sexually transmitted diseases; yet, the scope of sexual health is more expansive. The understanding of sexual health evolved significantly through linkages with HIV/ AIDS, marginalisation and discrimination, particularly of sexual minorities. Both themes have been mapped distinctly in two parts of this report, for a fuller and holistic elaboration of the two thematic domains, making linkages between the two where they exist.

Part I of this report carries the country assessment of human rights in the context of sexual health and well-being, and Part II deals with the country assessment of human rights in the context of reproductive health and rights. Each part has a distinct methodology because while reproductive rights has an older history and stronger roots in law, sexual rights have evolved more recently in comparison, with contestations in domestic law still ongoing. Both parts of this report set out the findings of the country assessment in India against the existing international framework on human rights relating to sexual and reproductive health and well-being, pointing out the area of compliance, gaps with recommendations for moving ahead.

The report sets out the international legal framework on sexual health and reproductive health, while emphasizing that the fulfillment of these thematic rights are inter-dependent and indivisible on the realisation of all human rights. The respect and fulfillment of all human rights is an essential precondition to realisation of sexual and reproductive health by all persons, without discrimination. That is to say, the realisation of sexual and reproductive health rights is dependent, such as the right to life, right to food, the right to adequate housing, the right to education, as well as freedom from violence and discrimination on the basis of gender, sexuality, ability, age, etc, in addition to the core thematic rights relating to health care and services. The human rights are universal, enshrined in the UN human rights treaties and consensus conference documents that India is party to and are protected by the Constitution of India. The State therefore bears the obligation to respect, protect, promote and fulfill these rights, with particular attention to vulnerable and marginalised population groups without any discrimination.

To assess the compliance with the specific thematic domains of this study, the report identifies key indicators relevant to each theme for evaluation on the basis of data,

programmes, policies, and laws. The implementation, access and quality of each of these has been reviewed through accounts of key stakeholders, experts, civil society actors who work with affected population groups, and government data. Specific attention has been paid to address status of these rights in relation to vulnerable and marginalised population groups, and identification of obstacles that impede or deny access to comprehensive, quality information and services.

The report concludes with a consolidated summary of recommendations on both sexual health and reproductive health rights, under broad heads of law reform, government schemes and programmes, convergence, capacity building, monitoring and data collection, cooperation with civil society, and budgetary allocations. The report recommends comprehensive law and policy reform to ensure access to healthcare, protection from and redressal for gender based violence, ensure sexual autonomy, while emphasizing the importance of access to information on sexual and reproductive health, as well as constitutional entitlements and legal rights, especially those of marginalised groups. Towards this end, the report also underscores the need for training and sensitisation of teachers and healthcare providers. The recommendations also touch upon the need for convergence in the functioning of various government ministries to effectively carry out these reforms. Annexures A and B list out the recommendations pertaining to Parts I and II respectively.

PART I
COUNTRY ASSESSMENT ON HUMAN RIGHTS IN THE CONTEXT
OF SEXUAL HEALTH AND WELL-BEING

CHAPTER 1: INTRODUCTION TO SEXUAL HEALTH AND WELL-BEING

Sexual health and well being (referred to as sexual health in this report) is recognised as an indivisible aspect of human rights, with its roots in the right to health. Recognised initially in conjunction with reproductive health, sexual health has evolved over a period of two decades into a distinct thematic area that includes physical, psychological, social and epidemiological aspects relating to sexuality; and the linkages of each of these aspects with material and social conditions that shape access, experiences and health outcomes of diverse population groups. Thus sexual health is as an aspect of the right to health, the enjoyment of which is inter-dependent on and indivisibly linked to the fulfillment of other human rights. The term ‘well being’ as an adjunct to sexual health, confirms that its domain is not limited to disease prevention and treatment, but includes aspects relating to autonomy and pleasure with reference to sexuality.

Objectives, Scope and Limits of the study

As a first national inquiry, this report seeks to elaborate the priority concerns are necessary for realisation of sexual health in the context of India. The significance of commissioning a report on human rights aspects related to sexual health by the NHRC, is in the recognition it accords to the concerns within the domestic arena. It signals the start of an engagement, that potentially could include a range of initiatives from raising awareness, organizing multi-stakeholder dialogues, monitoring, formulating recommendations and guidance notes to ministries, departments, including for law reform and seeking accountability.

Being the first such exercise in relation to sexual health, the focus of the study has been on mapping key or priority concerns in relation to sexual health in the context of India. The coverage under the circumstances is far from comprehensive, although a more expansive coverage of sexual health was enabled opting for two separate reports on sexual and reproductive health, for purposes of a human rights inquiry. The focus of this is on sexual health alone, recognizing that overlapping concerns related to reproductive health, are covered in the companion report. Accordingly, this report must necessarily be read with and informed by the report on reproductive health and well being – for a full understanding of the interplay and overlap between the two companion domains.

Methodology

The inquiry involved a combination of desk research on law, journal articles, news

reports and other materials, interviews with civil society stakeholders who work with affected population groups, and experts engaging with policy. The identification of priority components of sexual health itself emerged from discussions, and the assessment drew from interviews, reports and analysis from secondary sources.

The outlining of sexual health framework within international human rights law was carried out through desk research of reports of expert agencies, reports of the UN human rights mechanisms, including from treaty bodies and the UN Special Rapporteurs. The desk research involved looking at domestic framework, involved looking at judgments from Indian courts, and policies, programmes and schemes, which have a direct or indirect bearing on the issues.

Interviews with stakeholders was enabled by field visits enabled to Chennai and Kolkata, respectively, to draw from their engagement with diverse population groups such as sex workers, women and persons living with HIV, women with disability, trans and queer/ LGBTI communities, in relation to sexual health. Interviews with key stakeholders were also carried out during the civil society consultations held by Partners for Law in Development for preparation of joint-stakeholder report on gender equality (covering concerns relating to women and sexual minorities) towards India's 3rd UPR in August-September 2016. Some of the inputs through this consultation were sent on email and some during the convening organised for the purpose. Some interviews were conducted on phone. Civil society inputs for India's 3rd UPR, where relevant, was also drawn upon for purposes of assessing India's compliance with human rights pertaining to sexual health. A list of organisations and persons interviewed, along with a list of subject-specific reviewers is attached as Annexure C.

The draft versions were circulated to select experts for inputs and comments, not all of which have been received. It is recommended that this report be tabled for discussion at an expert group meeting convened by the NHRC, for discussion and inputs that contribute towards finalizing the report.

Structure

The report is divided into seven chapters – after the introduction, the second chapter outlines the scope of sexual health, identifying the human rights framework and the four components on which sexual health will be assessed in the context of India. The assessment of key components related to sexual health are structured chapter-wise. Each such chapter introduces the value of the key concern, sets out the human rights standards pertaining to it based on Constitutional and legal framework, and where relevant, programme interventions; followed by a critical discussion on the gaps, the challenges these pose in general and to specific population groups. Each such chapter concludes with a list of recommendations. The seventh or the final chapter consolidates the recommendations from all the chapters.

The four key components of sexual health and human rights on which this country

assessment is based are as follows:

1. Non-discrimination and equality in access to sexual health services
2. Information, knowledge to enable exercise of informed choice to exercise satisfying safe sexual relations
3. HIV/ AIDS and STI prevention
4. Protection from sexual violence and regulation of sexual autonomy

Sexual health cannot be fully understood without reference to contraception and abortion. However, they raise concerns that pertain to both sexual, as well as reproductive health rights. Given the commonality to the themes of sexual and reproductive health, contraception and abortion have been exhaustively dealt with in the companion report on reproductive health rights, produced by Sama Resource Group for Women and Health. Both the studies, on sexual health and on reproductive health have been undertaken by PLD and Sama respectively for the NHRC, and are intended to be read together.

CHAPTER 2: SCOPE OF SEXUAL HEALTH AND WELL-BEING

Sexual health refers to physical, emotional, psychological and social well-being in relation to sexuality that includes control over fertility, protection from sexually transmitted diseases (aspects that are also part of reproductive health) as well as protection from sexual coercion, stigma, censorship and violence, and the possibility of pleasurable and safe sexual experiences. The understanding of sexual health has evolved over time, through the recognition of its interconnections with diverse thematic areas of human rights. This section traces the expansion in the understanding of sexual health within human rights and development, through consensus documents, general comments of treaty bodies, the work of the special mechanisms and UN resolutions, the World Health Organisation (WHO) and the 2030 Sustainable Development Goals.

Evolution of the definition of sexual health

The earliest reference to sexual health was in International Conference on Population and Development (ICPD) Programme for Action (Cairo, 1994), which stated that reproductive health, *“also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.”*¹ It further stated that *“people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to*

¹ UN Population Fund (UNFPA), *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994*, 1995, A/CONF.171/13/Rev.1.

have access to safe, effective, affordable and acceptable methods of family planning of their choice...”

In 1995 at the Fourth World Conference on Women, sexual health found mention as an aspect of sexuality, over which women’s autonomy was recognised thus: “*The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.*”² These early articulations established that sexual health is related to sexuality, sexual relations including but also independent of reproduction and disease prevention; that it entailed the ‘availability, accessibility, acceptability and quality’ of information, knowledge and services, to enable making informed choices for satisfying and safe sex. Importantly, sexual health was recognised as an aspect of women’s rights and gender equality.

The Committee on Economic, Social, and Cultural Rights (CESCR) General Comment 14 (2000) elaborates the state obligations in relation to sexual and reproductive health.³ Affirming that these are an aspect of the right to the highest attainable standard of health (Article 12), it notes the “*need to develop and implement a comprehensive national strategy for promoting women’s right to health throughout their life span ... [to] include interventions aimed at the prevention and treatment of diseases affecting women ... including sexual and reproductive health services.*” It elaborates that State obligations in this context is “*to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect ... in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence.*” It further, calls upon States to refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information.

As with the right to health, the CESCR recognises that the outcomes of sexual health (and indeed, reproductive health), are shaped by underlying material and social determinants that vary across population groups, across rural-urban contexts, regions and cultures.

Determinants of sexual health

The material determinants of (sexual) health include “*access to safe and potable water, adequate sanitation, adequate food and nutrition, adequate housing, safe and healthy working conditions and environment, health-related education and information.*”

² United Nations, *Beijing Declaration and Platform of Action, adopted at the Fourth World Conference on Women*, 27 October 1995.

³ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

The sexual health outcomes are equally shaped by “*social determinants*” that refer to social norms and structures that stigmatise, oppress or marginalise persons on account of their sex, sexual orientation or gender identity, marital status, age, ability or caste, ethnicity or minority status. As a result, vulnerabilities and health outcomes of these population groups depends considerably on legal protection against violence, torture and discrimination. As summed up by the CESCR in the General Comment no. 22 (2016) the right to sexual and reproductive health is an integral component of the right to health, and interdependent on fulfillment of all other human rights.⁴

Definition of sexual health

WHO defines sexual health as: “...*a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.*”⁵

Consensus on the definition of sexual health by the WHO (2010) has been growing, and the right is now understood to include within its scope linkages with positive sexuality, sexual relationships and sexual rights.

As sexuality in all its diversity shapes the sexual health outcomes of people, it has a significant bearing on fulfilment of sexual health. The following working definition of sexuality has been proposed by the WHO:

“...*a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.*”⁶

Intersections of sexual health within human rights and development

The intersections and linkages of sexual health with different thematic fields have been affirmed, elaborated by different thematic treaty bodies and special mechanisms. The inter-related web of sexual health rights include the availability of age

⁴ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 22: The Right to Sexual and Reproductive Health (Art. 12 of the Covenant)*, 2 May 2016, E/C.12/GC/22.

⁵ “Defining Sexual Health”. 2006. Geneva: World Health Organisation.

http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf.

⁶ *Ibid.*

appropriate, scientifically accurate sexuality education,⁷ information and health services,⁸ disease prevention and treatment such as of HIV/ AIDs and sexually transmitted diseases (STI). It also includes protection from gender-based violence, respectful of the evolving capacities of adolescents, and the needs of persons with disability.⁹ The realisation of sexual health has been recognised as integral part of the 2030 Sustainable Development Goals (SDGs) relating to health,¹⁰ education,¹¹ and gender equality.¹²

International law notes the importance of access to age-appropriate comprehensive sexuality education and information that covers a wide range of issues,¹³ specifically for women,¹⁴ children,¹⁵ and disabled persons,¹⁶ and sexual minorities¹⁷ in enabling self-awareness and reproductive autonomy, preventing gender-based violence, and promoting responsible sexual behaviour.

SDGs also call for provisioning of sexual health services into national strategies and programmes, to be measured by indicators such as access to and use of contraception, availability, accessibility and acceptability of quality sexual and reproductive health (SRH) services,¹⁸ knowledge about sexual and reproductive health rights (SRHR), adolescent fertility, quality of care, prevention of STIs and abortion.¹⁹

⁷ UN Human Rights Council, *Report of the Special Rapporteur on the right to education*, 23 July 2010, A/65/162.

⁸ UN Human Rights Council, *Human rights, sexual orientation and gender identity : resolution / adopted by the Human Rights Council*, 14 July 2011, A/HRC/RES/17/19; UN Human Rights Council, *Human rights, sexual orientation and gender identity : resolution adopted by the Human Rights Council*, 2 October 2014, A/HRC/RES/27/32; UN Human Rights Council, *Protection against violence and discrimination based on sexual orientation and gender identity : resolution / adopted by the Human Rights Council*, 15 July 2016, A/HRC/RES/32/2.

⁹ UN Committee on the Rights of Persons with Disabilities (CRPD), *General comment No. 4 (2016), Article 24: Right to inclusive education*, 2 September 2016, CRPD/C/GC/4. Para 38-46.

¹⁰ UN High Commissioner for Refugees (UNHCR), *The Sustainable Development Goals and Addressing Statelessness*, March 2017. Target 3.7, Goal 3.

¹¹ UN High Commissioner for Refugees (UNHCR), *The Sustainable Development Goals and Addressing Statelessness*, March 2017. Target 4.7, Goal 4.

¹² UN High Commissioner for Refugees (UNHCR), *The Sustainable Development Goals and Addressing Statelessness*, March 2017. Target 5.6, Goal 5.

¹³ UN Committee on the Rights of the Child (CRC), *General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, 17 April 2013, CRC/C/GC/15.

¹⁴ UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979. 10(h), 16(1).

¹⁵ UN Committee on the Rights of the Child (CRC), *General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, 17 April 2013, CRC/C/GC/15.

¹⁶ UN General Assembly, *Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly*, 24 January 2007, A/RES/61/106.

¹⁷ UN Human Rights Council, *Report of the Special Rapporteur on the right to education*, 23 July 2010, A/65/162.

¹⁸ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

¹⁹ *Addressing Statelessness*, March 2017. Target 3.7, Goal 3.

The linkages between the establishment of education programmes and information campaigns,²⁰ and the deployment of trained medical personnel for performing SRH services,²¹ in preventing STIs have been recognised. International law recognises the indirect and direct adverse effects of criminalisation of HIV non-disclosure, of consensual sexual activities,²² of transgender identities, and consequently, criminalisation of SRH services and information on the prevention and treatment of HIV AIDS and STIs, and thus, the right to sexual health.

Sexual violence against girls and women has been recognised as a violent manifestation of gender based discrimination in international human rights law,²³ which has a profound impact on physical, emotional, mental health and social consequences. There has been a growing recognition of persons other than women, who are victims of gender-based violence, such as children,²⁴ persons with non-normative sexual orientations or gender identities,²⁵ and the role disabilities,²⁶ marital status,²⁷ conflict situations, and social and economic statuses in exacerbating their vulnerability. Given the different forms and manifestations of sexual violence, a broad definition of the same has been necessitated.²⁸

Recognising that economic disparities, poverty, basic needs and social inequalities are barriers to realisation of rights, sexual health is interdependent on fulfillment of equality and non-discrimination particularly in relation to marginalised or stigmatised population groups. That non-discrimination in access to health services, and access to education and information is crucial for the realisation of sexual health rights of all persons including adolescents, persons living with HIV/ AIDS, persons living with disability, women and children, has been recognised in international law.²⁹

²⁰ UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966. 12; *Ibid.*

²¹ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 22: The Right to Sexual and Reproductive Health (Art. 12 of the Covenant)*, 2 May 2016, E/C.12/GC/22.

²² UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 27 April 2010, A/HRC/14/20.

²³ UN Committee on the Elimination of Discrimination against Women (CEDAW), *CEDAW General Recommendation No. 19: Violence against women*, 1992; UN Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No. 35: Gender-based violence against women*, 14 July 2017, CEDAW/C/GC/35.

²⁴ UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989. 19.

²⁵ UN Human Rights Council, *Human rights, sexual orientation and gender identity : resolution / adopted by the Human Rights Council*, 14 July 2011, A/HRC/RES/17/19; UN Human Rights Council, *Human rights, sexual orientation and gender identity : resolution adopted by the Human Rights Council*, 2 October 2014, A/HRC/RES/27/32; UN Human Rights Council, *Protection against violence and discrimination based on sexual orientation and gender identity : resolution / adopted by the Human Rights Council*, 15 July 2016, A/HRC/RES/32/2.

²⁶ UN General Assembly, *Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly*, 24 January 2007, A/RES/61/106.

²⁷ UN Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No. 35: Gender-based violence against women*, 14 July 2017, CEDAW/C/GC/35.

²⁸ International Criminal Court (ICC), *Elements of Crimes*, 2011, ISBN No. 92-9227-232-2.

²⁹ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

Framework for assessment of sexual health for this study

In view of the scope of sexual health outlined above, this report will examine compliance and gaps in relation to the following components of sexual health in the context of India. The key aspects in relation to each component are identified in bullet points in relation to each.

- *Access to education and information*
 - Make available age appropriate comprehensive sexuality education, including accessible and understandable health information, as part of standard school curriculum, as well as outside of formal school setting, without parental consent and regardless of marital status, to all population groups.
 - Ensure full information to adolescents about SRH, including contraception, family planning, STIs including HIV/ AIDS and dangers of early pregnancy.
- *Healthcare Services*
 - Ensure that full range of quality sexual and reproductive health care services and information are available, accessible (physically, economically, and informationally), acceptable to all, especially vulnerable groups including adolescents, disabled persons, and persons with non-conforming gender identity and sexual orientation, and remove any legal and policy impediments to the same.
 - Prohibit discrimination in access to health care on grounds of sex, age, disability, race, religion, nationality, economic status, sexual orientation, health status including HIV, etc.
- *Prevention of HIV AIDS and STIs*
 - Establish education and prevention programmes as well as information campaigns for addressing STIs particularly HIV/ AIDS and other SRH issues.
 - Ensure that there are no indirect or direct impediments to realisation of SRH, such as criminalisation of SRH services and information, HIV non-disclosure, exposure and transmission of STIs, criminalisation of consensual sexual activities between adults, sex work, and transgender identity and expression.
- *Protection from Sexual violence and regulation of sexual autonomy*
 - Criminalise non-consensual sexual contact in all its forms and manifestations, and adopt measures necessary to prevent, investigate and punish acts of sexual violence, or violence based on sexuality, whether committed by state or non-state actors.
 - Provide effective remedies, a mechanism for seeking redress, and comprehensive reparative justice for sexual violence to all population groups.
 - Recognise the legitimate right to consensual sexual relations, including

that of adolescents in accordance with their evolving capacities, as well as of persons with non-confirming sexual orientations and gender identities.

CHAPTER 3: NON-DISCRIMINATION AND EQUALITY IN ACCESS TO SEXUAL HEALTH SERVICES

Introduction

International Human rights standard demand that Sexual and Reproductive Health (SRH) services should be available, accessible, acceptable and of good quality (AAAQ).³⁰ States need to ensure that not only there are adequate number of health care facilities, services, goods and programmes **available** to serve the entire population, across rural urban contexts; and that these available services are **accessible** to all, especially the poor and the most marginalised. This includes physical accessibility (within safe and reasonable distance), economic accessibility (services, both private and public should be affordable for all) and information accessibility (individuals and groups should be able to seek and disseminate SRH issues without any barriers).

Acceptability ensures that health services available are respectful of diversity of the population in terms of culture, ethnicity, gender, age, sexual orientation and other differences. Service providers should also respect medical ethics of confidentiality and informed consent. Lastly, **quality** should be maintained in provision of all health services and goods.

The CESCR General Comment 14 (2000), on right to health, emphasises the importance of non-discrimination in enabling access to health services, noting in this context the social and legal barriers that impede access of adolescents, persons living with HIV/ AIDS, persons living with disability, women and children, thus aggravating their vulnerability. CESCR General Comment 22 (2016) specifically elaborates the states' responsibility to ensure full information to adolescents about SRH, including contraception, family planning, STIs including HIV/ AIDS and dangers of early pregnancy. It further notes that such information should be given to adolescents regardless of their marital status or parental consent and respect their privacy and confidentiality. Notably, it recognises the vulnerability of marginalised groups to accessing SRH, including poor women, persons with disability, ethnic and indigenous minorities, LGBTI, adolescents and persons living with HIV/ AIDS.

³⁰ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4, available at: <http://www.refworld.org/docid/4538838d0.html> [accessed 10 October 2017].

Criminalisation of certain behaviors such as non-penovaginal sex without regard to consent, and of populations such as sex workers and homosexuals severely impedes their ability to seek health services. The Special Rapporteur on the Right to Health dedicates an entire report³¹ to the need to decriminalise such activities in order to enable those who are vulnerable to HIV/ AIDS and other sexually transmitted infections seek healthcare services and actively participate in health programmes. Criminalisation is known to drive problems underground, makes the concerned populations highly vulnerable to abuse and forces them into silence.³²

Since access to prevention and treatment is of particular concern for vulnerable groups, this section will briefly outline how stigma, criminalisation in India renders specific population groups more vulnerable groups, alienating them from sexual health services. While stigma and to some extent, criminalisation, is attached to each of these groups, their experiences are heterogeneous and differentiated, on account of class/ economic status, caste, tribal and HIV status (HIV positive people within each vulnerable group face an added level of vulnerability and marginalisation).

Status of compliance

Transgender persons

The National AIDS Control Organisation (NACO) in 2015-16 noted rate of HIV prevalence amongst trans population to be 8.82%, the second highest amongst the high risk groups.³³ This stems from the multiple barriers that trans persons confront in accessing public and private sexual health services. Stigma and discrimination specific to them combined with traditional customs and beliefs within trans communities are serious barriers to accessing sexual as well as general health services. When the few do access these services, they confront a continuum of violations and degrading treatment that serves to punish those seek healthcare.

In a government hospital a trans person has to face four types of violence. First is from the Group D staff who will look at you and make some comment. Then, at the ticket counter the official will not listen to your name properly, because they want to bully you. Then comes the nurse who will look at you and make a face and ask the doctor, which ward do I put this person in. And then finally comes the doctor whose hands will stop once he looks at you and realises you are a trans person.

- Transgender Rights Activist, Member of the West Bengal Transgender Welfare Board

³¹ UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 27 April 2010, A/HRC/14/20, available at: <http://www.refworld.org/docid/4c076fb72.html> [accessed 10 October 2017].

³² Ibid.

³³ “Annual Report (2015-16)”. 2015. Department of Health and Family Welfare, Ministry of Health and Family Welfare, Government of India. <http://naco.gov.in/sites/default/files/Annual%20Report%202015-16.pdf>.

Section 377 of the Indian Penal Code, Immoral Trafficking Prevention Act (ITPA), public nuisance and anti-beggary laws have often been used by the police to harass trans people, especially those involved in sex work and begging.³⁴ Criminalisation and stigma increases their vulnerability to poverty which in turn exacerbates vulnerability to contracting HIV and other STIs. Trans people are often forced to engage in unsafe sex work due to lack of other employment options. With stigma, degrading behavior and harassment being routine experiences, it is not surprising that they are apprehensive about accessing sexual health services in hospitals or health centres.

Sex Reassignment Surgery (SRS) and other gender affirming procedures such as endocrine therapy, are other under addressed issues concerning trans populations low down in official priority, which is important for the overall well-being of trans people. While a few states such as Tamil Nadu have made provision to provide free SRS services to trans women, there is no comprehensive national policy on the same, nor availability of these services to transgender men in the states where trans women have provision of free services.³⁵ In the absence of a national policy, and ambiguity over the legality of SRS, several doctors have been charged with criminal offences for performing this surgery, as ‘emasculatation’ falls within the purview of Section 320 of the Indian Penal Code, which defines ‘grievous hurt.’³⁶ With few doctors skilled to do so, it has led to malpractices within the medical community and a hike in cost of surgery. In face of high costs of SRS, reports suggest that trans PLHIV self-administer hormones for SRS, without disclosing this to the doctor administering anti-retroviral therapy (ART) medication, exposing them to liver and kidney damage on account of interactions between the two sets of drugs.³⁷

Doctors at government hospitals can be so inhuman and insensitive. They don't understand their ethical responsibilities. So I feel that HIV intervention will not work. Some of them treat transgender persons like guinea pigs. They give different combination of drugs to different transgender persons to check the results.

- Transgender Rights Activist, Member of the West Bengal Transgender Welfare Board

The Supreme Court affirmed the equality of trans people in NALSA vs. Union of India in 2014,³⁸ recognizing the right to self-determine gender regardless of SRS and other gender affirming procedures, stipulating protection and welfare by state,

³⁴ PUCL-K. 2003. “Human Rights Violations against Sexuality Minorities in India”. Bangalore: PUCL-K. [http://feministlawarchives.pldindia.org/wp-content/uploads/sexual-minorities.pdf??](http://feministlawarchives.pldindia.org/wp-content/uploads/sexual-minorities.pdf?).

³⁵ Chakravorty, Amritananda. 2017. Interview for NHRC Study on Sexual Health and Well-Being. In person. New Delhi.

³⁶ Dr. Venkatesan Chakrapani, Sex Change Operation and Feminising Procedures for Transgender Women in India: Current Scenario and Way Forward in Nothing to Fix: Medicalisation of Sexual Orientation and Gender Identity (Arvind Narrain and Vinay Chandra eds., 2016).

³⁷ Centre for Sexuality and Health Research and Policy (C-SHaRP), India. 2012. “Feminisation Practices among Hijras and other Male-To-Female Transgender People in India”. Chennai: Centre for Sexuality and Health Research and Policy (C-SHaRP), India.

³⁸ National Legal Services Authority vs. Union of India. (2014) 5 SCC 438.

including through affirmative action (as part of constitutionally recognised Other Backward Classes).³⁹ Yet, coming shortly after the re-criminalising of homosexuality by the Supreme Court in 2013,⁴⁰ the effect of this landmark judgment was muted, since the sexuality of an entire population group continued to be criminalised, even as the NALSA decision promised non-discrimination. Nonetheless, States like Odisha, Manipur, Kerala, Maharashtra, Chandigarh, and Chhattisgarh have formulated welfare policies and schemes for trans-persons as a step forward. These include free SRS facilities in select government hospitals and HIV sero-surveillance clinics to address sexual health needs of trans people. Kerala is the only state, which has implemented a comprehensive transgender policy after conducting a survey to map the issues of trans people in the state.⁴¹ The policy takes a rights-based approach and comprehensively addresses employment, health, political participation, education and violence.⁴² Similar comprehensive policies have been drafted in Karnataka and Odisha but are awaiting finalisation and/or implementation.

The central government's Transgender Persons Protection of Rights Bill, 2016, is not in compliance with the positive aspects of the NALSA judgment. The Bill stipulates the constitution of a District Screening Committee, which would include a medical officer as well as a psychiatrist, for the purposes of recognising a person's trans identity.⁴³ By mandating a medical screening, the bill denies self-determination of gender identity, instead pathologising it and making gender identity a matter of external validation by District Screening Committees that include medical offices on the panel. The Bill fails to prescribe affirmative action to reverse historic discrimination and exploitation, even as it criminalises traditional support systems and lifestyles associated with the lived realities of transgender people. Rather than adopt a rights based approach to reverse entrenched discrimination, the bill proposes rehabilitation as a framework, which is unacceptable to the transgender and intersex communities.⁴⁴ In wake of widespread criticism, the Bill was referred to a Parliamentary Standing Committee, which has called taken serious note of these shortcomings. The Committee report faults the bill's silence on reservations for trans people in government institutions, lack of recognition of marriage and adoption, the need for HIV sero-surveillance units and career services. The committee's report also talks about the need for introducing non-discrimination policies to safeguard trans people from abuse faced in medical establishments, educational institutions and other spaces.⁴⁵ The Standing Committee report also fails to address a critical lacuna in the

³⁹ The NALSA decision was reaffirmed by a nine-judge bench of the Supreme Court in the landmark case of Justice K.S. Puttaswamy (Retd.) v. Union of India AIR 2017 SC 4161.

⁴⁰ Suresh Kumar Koushal vs. Naz Foundation. (2014) 1 SCC 1.

⁴¹ Chakravorty, Amritananda. 2017. Interview for NHRC Study on Sexual Health and Well-Being. In person. New Delhi.

⁴² Department of Social Justice, Government of Kerala. 2015. "State Policy for Transgenders in Kerala, 2015". Government of Kerala.

⁴³ Chapter III, Transgender Persons (Protection of Rights) Bill, 2016.

⁴⁴ Ramakrishnan, L. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. Chennai.

⁴⁵ Ministry of Social Justice and Empowerment. 2017. "Forty Third Report of the Standing Committee on Social Justice and Empowerment (2016-17)". New Delhi: Lok Sabha Secretariat.

Bill that is in contravention of the Supreme Court NALSA judgement, i.e. the ability of transgender persons to self-identify as male, female or third-gender.

Most doctors don't know how to treat trans bodies having received medical training that is based on the binary sex-gender system.⁴⁶ Consequently, there are reports of cases where doctors have refused to touch trans patients or have asked them to undress to display their bodies as human specimen for their colleagues. Despite some policy level advances, the *de facto* experience of a trans person's encounter with the health system remains degrading, posing a severe barrier to accessing services.

Lesbian, Gay and Bisexual persons

Lesbian, Gay and Bisexual (LGB) people face stigma and discrimination in accessing sexual health services. This stems from cultural and societal attitudes as well as stigma against sexual activities involving LGB persons. Section 377 of the IPC criminalises 'acts against the order of nature' and has often been used to harass, threaten and blackmail the community. This colonial law was instituted in the Indian criminal system by Lord Macaulay, head of the first law commission. Its origins can be traced back to Henry VIII's Buggery Act of 1533, which criminalised sexual acts deemed abominable by Victorian morality.⁴⁷

The British decriminalised same-sex relations by passing the Sexual Offences Act in 1967, however, several former British colonies, including India, continue to retain this offence in their penal codes.⁴⁸ By criminalising consensual same-sex activities, the law reinforces the stereotype of LGB people being 'sexually perverse' and 'abnormal'. This law is the serious barrier to providing sexual health information and services within these communities, despite prevalence of rate of HIV among Men having sex with Men (MSM). The latest NACO data showed that the HIV prevalence rate amongst MSM is 4.3%.⁴⁹ An example of the draconian impact of the law on sexual health work, and the risk it puts the health workers under is evident from the case in Lucknow in 2001. The police raided the offices of Bharosa Trust and Naz International, two NGOs working on HIV/ AIDS amongst MSM community. They arrested the staff members and closed the offices, using Section 377.⁵⁰ After the re-criminalisation of homosexuality (by the Supreme Court in *Koushal vs. Naz Foundation* in December 2013), there were reports of increase in harassment, threats and abuse by family members, police as well as health workers. There have also been

⁴⁶ Banerjee, Aparna. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. New Delhi.

⁴⁷ Wintemute, Robert. 2011. "Same -Sex Love and Indian Penal Code 377: An important Human Rights issue for India". NUJS Law Review, No. 31. <http://nujlawreview.org/wp-content/uploads/2016/12/robert-wintemute.pdf>.

⁴⁸ Ashford, Chris. 2017. "The story behind how gay sex was decriminalised in Britain". The Wire,, 2017. <https://thewire.in/162469/story-gay-sex-decriminalised-britain/>.

⁴⁹ "Annual Report (2015-16)". 2015. Department of Health and Family Welfare, Ministry of Health and Family Welfare, Government of India. <http://naco.gov.in/sites/default/files/Annual%20Report%202015-16.pdf>.

⁵⁰ Naz Foundation. 2001. "Joint Statement on the recent joint raids at the Bharosa Trust and Naz Foundation International offices in Lucknow". <http://feministlawarchives.pldindia.org/wp-content/uploads/Email-dated-14-July-2001-containing-Joint-statement.pdf??>.

reports of an increase in extortion cases following the Koushal judgment.⁵¹ An evaluation study by the HIV/ AIDS Alliance India on their HIV prevention programme with MSM and trans populations found that 73 out of 883 (8.3%) faced discrimination after reinstatement of Section 377.⁵² Even though a nine-judge bench of the Supreme Court has held that sexual orientation is an integral part of the fundamental right to privacy and dignity under Art. 21, and also part of the fundamental right to equality and non-discrimination under Arts 14 and 15,⁵³ same-sex sexual contact continues to be criminalised under Sec. 377 as the challenge to the Koushal judgment is pending before a larger bench.

Lesbian and bisexual women suffer doubly, since women's sexuality in any case is not acknowledged in society, except in their reproductive roles. Most sexual and reproductive health services in public and private hospitals are designed for heterosexual married women, making it very difficult for lesbian and bisexual women to access these services. Typically, health workers and doctors ask women if they're married, rather than ask whether they are sexually active. For even single women to seek health services, this risks embarrassment, open ridicule or just bafflement. In this context, the situation of lesbian and bisexual women who are not married to man, this is magnified, as it becomes risky and difficult to reveal that they don't have a male partner. They also face discrimination because of the way they appear or dress. This discrimination is implicitly reinforced by the state as budget for sexual health is allocated under Reproductive and Child Health (RCH). This excludes single women including Lesbian and Bisexual (LB) women. Public health practitioners talked about cases where unmarried woman were punished for availing reproductive services meant only for married women.⁵⁴

Moreover, all the domestic laws and policies reinforce a hetero-normative framework of family and the society, rendering same-sex relationships invisible and thus illegitimate. This makes it not only difficult for LGB people to express their sexuality freely, but creates an environment of isolation, stigma and fear which scars the self esteem and dignity of individuals, with detrimental effect on their overall well-being.

Societal discrimination and harassment negatively impacts the mental health of LGB people. Internationally, rates of suicide attempts amongst youth who engage in consensual same-sex conduct have been variously reported as between three and seven times higher than for youth who identify as heterosexual; the rates are similar for adults.⁵⁵ Given the widespread myths against homosexuality being a mental

⁵¹ Chakravorty, Amritananda. 2017. Interview for NHRC Study on Sexual Health and Well-Being. In person. New Delhi.

⁵² India HIV/ AIDS Alliance. 2015. "Pehchan Programme Endline Study of men who have sex with men, Transgender, and Hijra Communities in India.". India HIV/ AIDS Alliance.

⁵³ Justice Puttaswamy (Retd.) vs. Union of India. 2017, (WP(C) No. 494 of 2012). Supreme Court of India.

⁵⁴ Dhall, Pawan. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. Kolkata.

⁵⁵ Mahon, Claire. 2009. "Sexual Orientation, Gender Identity and the Right to Health". In *Realizing The Right to Health* (Swiss Human Rights Book). Zurich: Ruffer and Rub.

illness, LGB people fear expressing their mental health issues and approaching health professionals. Despite the Indian Psychiatric Association's guidelines ruling out homosexuality as a mental disorder⁵⁶ there have been cases of mental health professionals and quacks giving medicines and electric shock therapies to LGB people to change their orientation and turn them heterosexual.⁵⁷ The Mental Healthcare Act, 2017 mandates the determination of mental illness in accordance with internationally accepted guidelines, thus outlawing conversion therapy.⁵⁸ However, the impact of this Act on the sexual health rights of LGB persons remains unclear.

Adolescents

Despite the onset of puberty in early adolescence, and with its development of sexual consciousness, the laws do not recognise adolescents as a category of persons, and are in denial of their adolescent sexuality until 18 years. The legal protection extended to child sexual abuse also criminalises all consensual sexual contact involving or with an adolescent, while within the domain of education, the strong resistance towards Comprehensive Sexuality Education and an ill-equipped teaching staff, have only reinforced taboos on the subject. The State must be faulted for neglecting to acknowledge and contribute to the evolving capacities of children in relation to sexuality, a human rights obligation it bears. The health sector has an initiative for providing sexual and reproductive right information to adolescents and youth, which has little impact on account of its limited focus and inadequate capacities.

Lack of information about safe sex practices has led to the burden of HIV/ AIDS and other STDs falling on children and young adults. Research has shown that one in four cases of HIV transmission in India is amongst younger individuals due to unsafe sex practices.⁵⁹ A Study amongst adolescent girls in Maharashtra showed that 54% of them did not know the modes of transmission of HIV. This is especially disconcerting because Maharashtra has one of the highest rates of HIV transmission in India, despite which the state does not have provision for sex education in schools.⁶⁰

A youth-led audit of Sexual and Reproductive Health services in Lucknow found that the public health sector seriously lacks the infrastructure required to provide quality sexual health services to young people. Service providers are overburdened with work and are highly conservative when it comes to providing information and services on sexual health matters. This includes provision of emergency contraceptive pills, HIV counseling and abortion services. Young people are often subjected to invasive

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1274544.

⁵⁶ "Indian Psychiatric Society Official Statement: Homosexuality is not a mental illness".

2014. Orinam. <http://orinam.net/indian-psychiatric-society-homosexual-not-mental-illness/>.

⁵⁷ Sebastian, Sangeeth, and Astha Saxena. 2015. "Gay Cure Racket: Delhi Orders Probe against Doctors". India Today. <http://indiatoday.intoday.in/story/gay-cure-racket-delhi-orders-probe-against-doctors/1/440638.html>.

⁵⁸ Section 3, Mental Healthcare Act, 2017.

⁵⁹ Khubchandani, Jagdish, Raman Kumar, and Jeffrey Clark. 2014. "Beyond Controversies: Sexuality Education for Adolescents in India". *Journal Of Family Medicine And Primary Care* 3 (3): 175. doi:10.4103/2249-4863.141588.

⁶⁰ *Ibid.*

questions about their private life when they try to access these services, including their marital status and sexual preferences. This is not only a humiliating experience for them but also impedes their health-seeking behavior.⁶¹

As mentioned in the section on information, the right to sexuality and access to sexual health services has been made worse by POCSO which criminalises all sexual contact for persons under 18 years, ranging from touching to penetration. The law is in clear contradiction with government's schemes like Rashtriya Kishor Swasthya Karyakram (RKSK) and the Adolescent Reproductive and Sexual Health Programme (ARSH) clinics, which attempt to outreach sexual health information and services to adolescents. Doctors assigned to ARSH clinics are unable to address queries around homosexuality, and tend to further stigmatise adolescents of non-heterosexual orientations.⁶² Further, there is a clear dissonance between different laws when it comes to confidentiality of a patient.⁶³ While the MTP Act makes it mandatory for the doctors to keep all the information in abortion cases confidential, POCSO makes it compulsory to report any sexual activity involving minors to the police. This serves as a strong deterrent for adolescent girls seeking abortions after having consensual sex with their partners.⁶⁴ The provision of mandatory reporting in POCSO compromises the professional ethics counselors, doctors and social workers have of confidentiality towards their clients. Service providers interviewed express the risk of committing the offence of under POCSO, if they extend confidentiality or treat information from client as privileged – which was the case prior to the enactment of POCSO. This has compromised the ability of many service providers and professionals to provide any sexual health counseling or services to adolescents, including those in crisis.

Adolescents from small towns, rural contexts, and those more disadvantaged on account of caste, poverty, tribal status, disability, sexual orientation or gender identity are even more distanced from the prospect of accessing sexual health services.

Sex Workers

Sex workers constitute one of the high risk groups in the HIV/ AIDS context with prevalence amongst them being 2.2%.⁶⁵ While sex work per se is not a crime in India, soliciting for sex work and living off the wages of a sex worker is criminalised by the

⁶¹ The YP Foundation. 2017. "Seen, Not Heard". New Delhi. Accessed October 10. <https://static1.squarespace.com/static/5837d4b3725e25680b8b758e/t/58737e16e6f2e14a35267a17/148396>.

⁶² Ramakrishnan, L. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. Chennai.

⁶³ Rege, Sangeeta. 2017. Interview for NHRC Study on Sexual Health and Well-being. Telephone. New Delhi.

⁶⁴ N, Jagadeesh, Padma Bhate-Deosthali, and Sangeeta Rege. 2016. "Ethical Concerns Related to Mandatory Reporting of Sexual Violence". Indian Journal of Medical Ethics. <http://www.cehat.org/cehat/uploads/files/A325%20Ethical%20concerns%20mandatory%20reporting%20of%20sexual%20violence%281%29.pdf>.

⁶⁵ "Annual Report (2015-16)". 2015. Department of Health and Family Welfare, Ministry of Health and Family Welfare, Government of India. <http://naco.gov.in/sites/default/files/Annual%20Report%202015-16.pdf>.

Immoral Trafficking Prohibition Act (ITPA), 1956. This makes them vulnerable to police harassment and directly implicates their family members.⁶⁶ The recently proposed Trafficking of Persons (Prevention, Protection and Rehabilitation), 2016 Bill by the Ministry of Women and Child (MWCD)⁶⁷ relies on the ineffective 'raid-rescue-rehabilitation' model for addressing trafficking and runs the risk of compromising the rights of women who voluntarily choose sex work as a profession. This is especially true in the context of protective homes under ITPA where government officials were found abusing women and girls and colluding with pimps and brothel owners.⁶⁸

Brothel raids directly impede upon sexual health well-being of sex workers. When brothels are raided, sex workers are either forced to run away or are forcibly sent to 'protection' homes. Without the sanctuary of brothels and its accompanying support network, sex workers are rendered more vulnerable on the streets, where they lose the bargaining power to negotiate condom usage with a client or get protection from violence.⁶⁹ Without brothels they lose access to organised sexual health services. When they are forcibly put in a protection home, sex workers lose their livelihood and get separated from their families, including young children, and those who are HIV positive lose access to health centers where they get their Antiretroviral Therapy (ART).⁷⁰

Practitioners express concern about cases where sex workers are been picked up by the police while they're out late at night and found carrying a condom. This directly affects their ability to engage in safe sex practices, particularly of them who are not part of a brothel or union and engage in sex work on the streets or from their home. They find it particularly difficult to negotiate with the customer or protect themselves from violence. Further, despite the unambiguous direction for voluntary testing under the National AIDS Control Programme (NACP), sex workers are still subjected to mandatory testing for sexually transmitted diseases, including HIV under Section 15(5A), ITPA.⁷¹

Stigma and discrimination against sex workers makes it difficult for them to access health services in general. They face discrimination by service providers and are often forced to go to quacks to get treated. There are other health issues of sex workers, which are rarely addressed. For example, sex workers are more prone to cervical

⁶⁶ Chakravorty, Amritananda. 2017. Interview for NHRC Study on Sexual Health and Well-Being. In person. New Delhi.

⁶⁷ Ministry of Women and Child Development, Government of India. 2016. "Draft Trafficking of Persons (Prevention, Protection And Rehabilitation) Bill, 2016."

⁶⁸ Kotiswaran, Prabha. 2016. "Empty Gestures: A Critique of India's New Trafficking Bill". Open Democracy, 2016. <https://www.opendemocracy.net/beyondslavery/prabha-kotiswaran/empty-gestures-critique-of-india-s-new-trafficking-bill>.

⁶⁹ Chakravorty, Amritananda. 2017. Interview for NHRC Study on Sexual Health and Well-Being. In person. New Delhi.

⁷⁰ Chakravorty, Amritananda. 2017. Interview for NHRC Study on Sexual Health and Well-Being. In person. New Delhi.

⁷¹ The Immoral Traffic (Prevention) Act. 1956.

cancer because of engaging in sexual activities more often than other women.⁷² But information about this is difficult to disseminate amongst sex workers, except in those regions where they are collectivised properly, like in West Bengal under the Durbar Mahila Samanwaya Committee (DMSC).

Persons with disability

Despite the enactment of the Rights of Persons with Disabilities Act, 2016, and within it recognition of reproductive rights of persons with disability, the de facto reality is different. The gaps in relation to sexual health also remain.⁷³ Medical practitioners and the society largely consider persons with disability asexual or hypersexual. This not only leads to severe restrictions on their sexual behavior and expressions of sexuality, and making them vulnerable to sexual abuse.

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 well and apply cosmetics. There is an erasure of sexuality, or enforced asexuality, given the social perception that they are unfit for marriage and therefore must not dress up or look good. This argument is used to deny them their sexual and reproductive health. Women with psycho-social disabilities are also often forced to receive a hysterectomy because of fears around vulnerability to sexual assault.

Some accounts suggest that it is common for families in rural areas to get a daughter-in-law with disability only for purposes of procreation, and once a child is born, she is abandoned. The reports received by practitioners relate to hearing disability, although there is indication that it is true of other disabilities too.

There are contradictory beliefs and practices regarding men with disability. Some view celibacy as a way of preserving normalcy and order, and active sexuality is pathological, to enforce asexuality. There is contrary perception that sex will cure a person's disabilities, compelling families to get their sons with psycho-social disabilities married off to girls from poor families.

Recommendations

1. Redraft the Transgender Bill in order to comply with the Supreme Court NALSA verdict, and safeguard the rights of the transgender community in India.
2. Non discrimination guidelines must be formulated for hospitals to enable sexual health services to be responsive and respectful of diverse sexual orientations and practices, and gender identities.
3. Medical textbooks that include information on trans bodies, with guidelines for SRS in consonance with international guidelines must be formulated.

⁷² Ramakrishnan, L. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. Chennai.

⁷³ TARSHI. 2010. "Sexuality and Disability: In The Indian Context". TARSHI. http://www.tarshi.net/downloads/Sexuality_and_Disability_in_the_Indian_Context.pdf.

4. Repeal Section 377 of the Indian Penal Code (IPC) and take steps to combat discrimination against the LGBT community.
5. Decriminalise sex work by amending the ITPA to categorically distinguish and separate sex work from trafficking.
6. 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.
7. Widespread public education and awareness on sexual health for marginalised and stigmatised populations like LGBTI, sex workers, adolescents and persons with disability, to dispel misconceptions and instill respect in human rights related to sexual health.

CHAPTER 4: INFORMATION, KNOWLEDGE TO ENABLE EXERCISE OF INFORMED CHOICES

Introduction

Scientific and unbiased information around sexual health is a pre-condition for making informed sexual choices, engage in safe sex practices, prevent disease – all of which are fundamental to ensuring sexual health. The importance of sexuality information and education has evolved as a means of addressing widespread taboos and misconceptions around sexuality, the persistence of systemic sexual violence against women, high levels of sexually transmitted diseases and socio-cultural values/practices that discriminate and stigmatise persons on grounds of gender and sexuality. For these reasons, sexuality education has been affirmed as intrinsic to fulfillment of human rights across thematic domains of health, education, rights of women, sexual minorities, children and persons with disability.

Age appropriate Comprehensive Sexuality Education (CSE) is widely recognised as the way of enabling children and young persons in schools to become aware about their bodies, personal hygiene, gender identities as well as safe sex practices. Notably, this helps build capacities to recognise sexual harm and abuse, enabling young and adults alike to secure help to seek protection and redress. In adults, scientific, accurate and non-judgmental sexuality information is foundational to making informed choices, exercise of affirmative consent, safe sex; and for addressing stigma, prejudice and discrimination on grounds of gender, gender identity, and sexual orientation. Thus, sexuality education is not about biological reproduction as is commonly understood through terms like ‘sex education’, but about gender relations, roles, identities, body and relationship of the self with the body, positive and negative sexual contact, harm and pleasure, disease prevention, amongst others.

The Special Rapporteur on the right to education has dedicated an entire report⁷⁴ on the right to sexual education to emphasise the importance of Comprehensive Sexuality Education (CSE), particularly in a patriarchal context, noting that it not be limited to reproduction and disease prevention. The report underscores the value of sexuality education in developing respect for diverse expressions of sexuality and in enabling safety and responsibility in interpersonal relationships. The value of CSE has been reinforced by the Committee on the Elimination of Discrimination against Women (CEDAW), the Committee on Economic, Social and Cultural Rights (CESCR) and the Committee on the Rights of the Child, in reduction of the risk of STIs, unwanted pregnancies and violence against women; and in making sexual relationships more fulfilling.⁷⁵

Status of compliance

Comprehensive Sexuality Education (CSE) as per international standards has not yet been implemented anywhere in India yet. Age appropriate sexuality education for adolescents has often faced considerable resistance in the country, as for instance the backlash against sex education for being ‘immoral and inappropriate’ by certain sections. However, the Adolescence Education Programme (AEP) implemented by the National Council of Educational Research and Training (NCERT) in partnership with UNFPA does address issues around gender and sexuality. After facing some initial backlash on its content, the NCERT along with the UNFPA revamped the AEP syllabus in 2010, which is currently implemented in the Kendriya Vidyalayas (1120 schools) and Jawahar Navodaya Vidyalayas.⁷⁶ This programme contains curriculum for adolescents from class nine onwards covering changes in the body, gender stereotypes, substance abuse, recognizing and reporting abuse and HIV/ AIDS.⁷⁷

The programme, however, does not comprehensively cover all the sexuality related topics like gender diversity and same-sex relations. It is also limited by the fact that it does not cover students below class 9. Experts working with child abuse note that children may have already gone through abuse by the time they reach puberty as abusers often target younger girls who have not begun menstruating.⁷⁸ An evaluation of the AEP programme by UNFPA has also recommended the need to implement the programme in upper primary grades. This has been taken on board by the NCERT which has developed curriculum and resource materials for this age group.⁷⁹

⁷⁴ UN Human Rights Council, *Report of the Special Rapporteur on the right to education*, 23 July 2010, A/65/162, available at: http://www.right-to-education.org/sites/right-to-education.org/files/resource-attachments/UNSR_Sexual_Education_2010.pdf [accessed 10 October 2017].

⁷⁵ *Ibid.*

⁷⁶ Nagaraj, Prabha. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. New Delhi.

⁷⁷ *Ibid.*

⁷⁸ Nagaraj, Prabha. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. New Delhi.

⁷⁹ Sharma, Jaya. 2017. "Status and Potential of School-Based Adolescence Education Programmes". Presentation, Mumbai, 2017.

Another serious gap in this area is the inadequate teacher training and unwillingness amongst teachers to talk about sexual health issues, especially related to safe sex and contraception.⁸⁰ They also tend to focus only on menstrual hygiene and biological development, advocating abstinence rather than information as a means of protecting adolescents. The resistance by teachers is based on social misconceptions and cultural prejudice, as many believe that students will stop respecting them. Another reason for reluctance of teachers is the work overburden, as a result of which they avoid additional responsibility.

Approaches outside of formal education, to educate and inform on sexuality and sexual health concerns are of paramount importance in the context of poverty, low literacy and high dropout rates. As many children have no access to school education; and also because vulnerable population groups of adults, are exposed to high risk of abuse and harm, information must be made available through drop-in centers, peer educators and health workers who work with communities.

Lack of information around sexual health well-being from a young age increases the vulnerability of adolescents to engage in unsafe sex practices and increases their risk of contracting Sexually Transmitted Infections (STIs). The official estimates show that 44% of the reported AIDS cases in India are in the age group 15-29 years.⁸¹ A recent study by Lady Hardinge Medical College reported increase in the rate of STIs amongst adolescents (below the age of 19) from 1% to 4.9%.⁸² This was attributed to lack of comprehensive sex education as well as sexual abuse. Further, according to UNICEF girls are twice at more risk of facing abuse than boys.⁸³ Research on Gender and HIV has shown that women have less knowledge about HIV/ AIDS, STIs, modes of transmission and prevention as compared to men.⁸⁴

The health ministry has initiated the Rashtriya Kishor Swasthya Karyakram (RKSK) to cover health needs of adolescents, which are increasingly being considered an important demographic for country's development. The RKSK has a provision of establishing Adolescent Friendly Health Clinics (AFHCs) to provide counseling on different adolescent concerns including Sexual and Reproductive Health (SRH), certain key commodities and referral. Reports suggest a varied and patchy implementation of AFHCs that is contingent on the orientation and training of the functionaries. Further, practitioners report that AFHCs clinics are often not functional on account of lack of trained counselors to provide proper information on sexual

⁸⁰ Nagaraj, Prabha. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. New Delhi.

⁸¹ "Adolescence Education Programme". 2017. UNICEF.
<http://unicef.in/PressReleases/333/Adolescence-Education-Programme>.

⁸² Sharma, Neetu. 2014. "Rising Sexually Transmitted Diseases in Teens Alarm Doctors". India Today, , 2014. <http://indiatoday.intoday.in/story/sexually-transmitted-diseases-in-teens-alarm-doctors/1/403735.html>.

⁸³ UNICEF. 2017. "FACT SHEET: CHILD SEXUAL ABUSE". Accessed October 10.
[https://www.unicef.org/lac/Break_the_Silence_Initiative-Fact_sheet\(1\).pdf](https://www.unicef.org/lac/Break_the_Silence_Initiative-Fact_sheet(1).pdf).

⁸⁴ UNDP. 2006. "Gender Impact of HIV and AIDS in India". New Delhi: UNDP.
<http://www.undp.org/content/dam/india/docs/gender.pdf?>

health issues.⁸⁵ Often, it is only adolescent girls who are referred to these clinics for menstrual health hygiene or other reproductive health issues, excluding boys from the programme. The programme has narrowed its focus solely to reproductive health instead of looking at sexual and reproductive health more broadly.⁸⁶

The scope and professional ethics of educational, counseling and related support services have become compromised on account of some provisions in the law on child sexual offences, the POCSO. The increase in age of legal consent from 16 to 18 years by POCSO has criminalised consensual sexual acts involving adolescents, rendering them vulnerable to retribution and punishment for any degree of consensual sexual contact, from touching to penetrative sex. The legal requirement for mandatory reporting of any sexual contact involving persons under 18 yrs, as these are now deemed offences, has become a barrier to accessing stigma-free sexual health services, approaching service providers. Importantly, it does not allow counselors and health workers to respect confidentiality, altering a fundamental tenant of their professional ethics. This is also in contradiction with the United Nations Convention on the Rights of the Child (UNCRC), which India ratified in 1992. Article 12 of the UNCRC states: “States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.”⁸⁷

Recommendations

1. Comprehensive Sexuality Education needs to be implemented as an important aspect to address Sexual and Reproductive Health. This should be integrated with the life skills education programme and needs to be a part of the formal school curriculum.
2. The government, through its different ministries must adopt consistent approaches and converge their efforts towards providing scientific and quality information services on sexual health to all population groups, For example, while it must be incorporated as CSE or life skills education within the formal school curricula, it needs to be made available and accessible to those outside formal schooling, to adults and to vulnerable population groups through community health workers, local health centers and peer educators.
3. Information must be appropriate to the age, context of all population groups and respectful of gender and sexual diversity. It is important that information is also linked to or is able to facilitate access to services.

⁸⁵ Ramakrishnan, L. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. Chennai.

⁸⁶ Rege, Sangeeta. 2017. Interview for NHRC Study on Sexual Health and Well-being. Telephone. New Delhi.

⁸⁷ Ayarkar, Sujata, and Aarthi Chandrashekhar. 2016. "Who Decides the “Best Interests” of the Child?". *Indian Journal of Medical Ethics* 3.
<http://www.cehat.org/cehat/uploads/files/A323%20Who%20decides%20the%20best%20interest%20of%20the%2>

4. Teacher training on Comprehensive Sexuality Education needs to focus on not just imparting information but also capacitate teachers on the content, the importance of the subject matter and tactical ways to navigate cultural resistance to these topics.
5. POCSO should be amended to remove the clause on mandatory reporting in order to provide professional privilege of confidentiality to teachers, service providers and counselors. This is especially important for adolescents whose sexuality and sexual health needs should be handled with empathy and dignity, not shunned punitively.

CHAPTER 5: HIV/ AIDS AND STI PREVENTION

Introduction

India has the third largest HIV epidemic in the world with 2.1 million people in the country living with the infection as of 2016⁸⁸. 87.4% of the infection is driven by sexual contact and it is concentrated amongst vulnerable populations at high risk of HIV. The government of India setup the National AIDS Committee in the Ministry of Health and Family Welfare following the report of the first case of HIV in 1986. In 1991, the country launched its first National AIDS Control Programme (NACP) and setup the National AIDS Control Organisation (NACO) to implement it. NACO has been working with multilateral and bilateral agencies as well as civil society organisations to bring down the HIV prevalence and provide comprehensive medical services and access to socio-legal protection for those living with HIV.

Human rights principles are closely linked to the HIV/ AIDS epidemic in relation to both, creating the conditions that render people vulnerable to contracting HIV/AIDS, and once infected, the nature of discriminations and violations that follow. Globally, the work on HIV/ AIDS has brought out sharply, ways in which denial of human rights in relation to sexual health renders specific population groups vulnerability to contracting infection – while consigning those living with HIV/ AIDS to a continuum of violations and discrimination in all fields of life. This being especially true for populations most materially impoverished, whose sexuality is stigmatised particularly through law, namely sex workers, men having sex with men, trans persons, women and children. These populations suffer discrimination as well as criminalisation and are hence at greatest risk of contracting the disease.⁸⁹

⁸⁸ “The Gap Report”.2014. UNAIDS.
http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf.

⁸⁹ OHCHR. (n.d.). *HIV/AIDS and Human Rights*. [online] Available at:
<http://www.ohchr.org/EN/Issues/HIV/Pages/HIVIndex.aspx> [Accessed 11 Oct. 2017].

The International Covenant on Economic, Social and Cultural Rights (ICESCR) in its Article 12 talks about the right to health. Its General Comments 14, (2000) on highest attainable right to health, emphasises the importance of establishing education and prevention programme as well as information campaigns for addressing STIs particularly HIV/ AIDS and other SRH issues.⁹⁰ CESCR General Comment 22 (2016), on sexual and reproductive health calls for trained medical personnel to perform SRH services including prevention and treatment of HIV/ AIDS. Further, it expresses grave concern about the ways by which laws indirectly or directly interferes with access to realisation of SRH, by criminalizing SRH services and information, HIV non-disclosure, exposure and transmission; and by criminalizing consensual sexual activities between adults, as well as transgender identity and expression.⁹¹

The Special Rapporteur on Right to Health (2010) the negative impact of criminalisation of same-sex activities, sex work and HIV transmission on realisation of right to health.⁹² Criminalisation of same-sex activities reinforces the stigma of unnatural and deviant, severely damaging individual self worth. Similarly the criminalisation of sex work, or activities integral to sex work, has a deleterious effect on the sexual and mental health of sex workers, and their access to services and legal redress, while magnifying abuse and violence in their lives. It discourages them from seeking health services including blood tests for HIV and other STIs and legitimises violence by both state and non-state actors.⁹³

Status of compliance

India is currently implementing the fourth National AIDS Control Programme (NACP) and the focus is on targeted interventions with high risk populations to reduce the rate of infection.⁹⁴ There are, however, concerns around funding of this programme. In 2012, India committed to financing 90% of HIV/ AIDS programmes on its own while decreasing reliance on international funding. However, the NACP budget falls short of the government's commitment and is reflected by a 22% decline of government funding between 2014-15 and 2015-16. This is also complemented by the fact that HIV prevalence rate has fallen in the country from 0.41% in 2001 to 0.26% in 2015.⁹⁵

⁹⁰ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

⁹¹ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 22: The Right to Sexual and Reproductive Health (Art. 12 of the Covenant)*, 2 May 2016, E/C.12/GC/22.

⁹² UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 27 April 2010, A/HRC/14/20.

⁹³ *Ibid.*

⁹⁴ National AIDS Control Organisation. (n.d.). NACP-IV Components. [online] available at: <http://naco.gov.in/nacp-iv-components> [Accessed 11 Oct. 2017].

⁹⁵ Sharma, Sanchita. "New HIV infections fall in India, but stigma remains: UNAIDS". 21 November 2016. Hindustan Times. <http://www.hindustantimes.com/india-news/new-hiv-infections-fall-in-india-but-stigma-remains-unaid/story-IYMZhkelYTKXzwVVuPTJUI.html>.

Respondents in the study have expressed serious concerns not just over reduction in budget allocations but also the time lag in release of funds leading to delay in release of payments to government supported programmes. They believe that this will, and might already have, lead to an increase in HIV infection rates. This reduction in budgets has severely impacted peer led work in the vulnerable communities, which has dipped considerably or closed down completely. The delay in release of funds has made it difficult for community workers to survive pushing them back into sex work for income. Lack of economic security and service provision compels them towards risk taking behavior.

Practitioners in the field of HIV prevention are critical of the epidemiological approach of the HIV prevention programmes, which has serious negative consequences not only for well being of those living with HIV, but for sexual health of women and adolescents, who are not typically deemed as ‘high risk’. Such targeted intervention programming has also resulted in bifurcation of family planning and STI prevention from HIV related work. This fragmentation as described below, is a necessary outcome of the target driven approach of the HIV programming, whose main focus remains HIV infections of vulnerable groups alone, even at the cost of their overall well-being and human rights. For example, HIV programmes focus on intake of ART medication for PLHIV without taking into account the overall nutrition of the person who may come from a lower income background.⁹⁶

The seeming disconnect between public health programmes on family planning and those on HIV/ AIDS, are apparent in the focus of family planning on vaginal sex alone, within which condoms are promoted mainly for avoiding pregnancies, without much mention of their role in preventing STD/ HIV infections. Added to this is the fact that the primary burden of family planning falls on women, through sterilisation programmes as well as contraceptive pills. Studies have shown that women from lower socio-economic background lack access as well as information on contraceptives, which makes sterilisation camps the most viable option for them.⁹⁷ While these methods are successful in preventing pregnancies, they are not successful in preventing STIs or HIV. Data from National Family Health Survey (NFHS) 2015-16, shows that the most common method of Family Planning remains female sterilisation (35.7%), while male sterilisation is the most uncommon method (0.3%).⁹⁸

Moreover, targeted interventions focusing on High Risk Groups (HRGs) tends to be carried out at the cost of awareness and education programmes to inform general

⁹⁶ India HIV/AIDS Alliance. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. New Delhi.

⁹⁷ Dipika and Rozario, Natassia M. “Voices from the Field: Access to Contraceptive Services and Information in the State of Haryana, India”. 2013. Centre for Health Law, Ethics and Technology, Jindal Global Law School. <http://feministlawarchives.pldindia.org/wp-content/uploads/Voices-From-the-Field-Access-to-Contraceptive-Services-and-Information-in-the-State-of-Haryana-India-by-Jindal-Global-Law-School.pdf>.

⁹⁸ International Institute for Population Sciences. 2017. "National Family Health Survey - 4 (2015-2016)". Ministry of Health and Family Welfare. <http://rchiips.org/nfhs/pdf/NFHS4/India.pdf>.

public about HIV/ AIDS and ways to prevent it. This runs a risk of ignoring a demographic like adolescent girls who are often unaware about HIV and other STIs and catch the infection from their partners and later transfer it to their children.⁹⁹ UNICEF statistics (2003–2008) show that only 36% of adolescent males in India have comprehensive knowledge of HIV, while their female counterparts lag behind with just 20% of them having complete and accurate HIV information.¹⁰⁰

According to the NFHS-4 data only 28.1% of the women in India have a comprehensive knowledge about HIV/ AIDS. The National policy on Prevention of Parent-To-Child Transmission (PPTCT) talks about general education as a means of preventing women from infection in reproductive age. Yet this vital component on education has been neglected, focusing solely on testing women at the time of pregnancy.¹⁰¹ And while India has committed to elimination of parent to child transmission, a UNAIDS publication noted that only 38% of pregnant women living with HIV received preventing mother-to-child transmission (PMTCT) treatment.¹⁰²

There is also lack of information around the use of prophylactics for disease prevention for women (like female condom) or for anal sex amongst heterosexuals. Although studies show that anal sex is increasingly being practiced by heterosexual couples to prevent pregnancies, for sex during menstruation and for preserving the appearance of girls' virginity, there is little effort in inclusive and integrating responses to HIV, STD and family planning.¹⁰³ The National Family Health Survey (NFHS) 2015-16 notes that despite high levels of women (67%) and men (81%) knowing that consistent use of condoms can reduce risk to HIV/ AIDS, only 9% used it as a means of family planning.¹⁰⁴ This is also true because in Indian society, women have very little negotiating power in intimate relationships.¹⁰⁵

There is also a lack of integrated information and service provision on sexual health and general health issues which makes individuals more vulnerable to diseases. For example, Persons living with HIV (PLHIV) are often not given information on TB and other STIs despite the fact that HIV can increase a person's susceptibility to contracting TB and other STIs. From interviews with practitioners it was also found

⁹⁹ Ramakrishnan, L. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. Chennai.

¹⁰⁰ https://www.unicef.org/infobycountry/india_statistics.html.

¹⁰¹ Periasamy, Kousalya. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. Chennai.

¹⁰² "Prevention Gap Report". 2016. UNAIDS.

http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf.

¹⁰³ Matheou, Alexander, "A Blind Spot in HIV Prevention – Female Anal Sex". International HIV/AIDS Alliance in India. http://www.allianceindia.org/wp-content/uploads/2014/09/2014_AllianceIndia_A-Blind-Spot-in-HIV-Prevention-Female-Anal-Sex.pdf.

¹⁰⁴ International Institute for Population Sciences. 2017. "National Family Health Survey - 4 (2015-2016)". Ministry of Health and Family Welfare. <http://rchiips.org/nfhs/pdf/NFHS4/India.pdf>.

¹⁰⁵ Natarajan, Shyamla. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. Chennai.

that it is often difficult for patients to access integrated services in one place and they are forced to travel to different places to access different services.¹⁰⁶

Another important concern around prevention of HIV includes the re-criminalisation of same-sex activities by the Supreme Court in 2013¹⁰⁷ reversing the Delhi High Court's judgment¹⁰⁸ which decriminalised it. There is a curative petition that the Supreme Court has admitted, which will once again re-open the question, but the Constitutional bench to hear the matter has yet to be constituted.¹⁰⁹ Similarly, there have been no steps taken to decriminalise sex work, leaving sex workers vulnerable to HIV/ AIDS and other STIs.

Some positive steps have, however been taken in the country for trans persons as well as those affect by HIV. The Supreme Court affirmed the right to self-determination of gender in the NALSA vs. Union of India judgment, recognizing a category of 'third gender.' Thereafter, the Rights of Transgender Persons Bill 2016 was tabled in the lower house of the parliament, despite serious concerns about its shortcomings and is inconsistencies with NALSA judgment.¹¹⁰ This bill was therefore referred to the parliamentary standing committee, which has submitted its report. The committee has asked government to take steps to ensure access to health, education, employment and political participation to trans people. This includes special HIV sero-surveillance clinics for trans people given that they are vulnerable to sexual health problems.

The HIV and AIDS (Protection and Prevention) Bill has recently been passed to safeguard the rights of Persons Living with HIV (PLHIV). Provisions in the bill include, making Anti-Retroviral Therapy (ART) a legal right, criminalizing all forms of discrimination against PLHIV and making it illegal to test someone for HIV without their consent. The Act puts the onus of preventing transmission of the HIV on a person aware of their HIV status, and allows them to adopt risk reduction strategies for the same, such as disclosure of HIV positive status before sexual contact with another person.¹¹¹ While it is a positive step in protecting rights of PLHIV, civil society groups have objected to use of the phrase 'as far as possible' in the section on service provision for those living with HIV. They believe that this phrase opens an escape route to state governments to not fulfill their responsibilities.¹¹²

¹⁰⁶ Dhall, Pawan. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. Kolkata.

¹⁰⁷ Suresh Kumar Koushal vs. Naz Foundation. 2013, CA NO.10972 OF 2013. Supreme Court of India.

¹⁰⁸ Naz Foundation vs. Government of NCT of Delhi. 2009, WP(C) No.7455 of 2001. High Court of Delhi.

¹⁰⁹ Rajagopal, Krishnadas. "Five-judge Constitution Bench to take a call on Section 377". 2 February 2016. The Hindu. <http://www.thehindu.com/news/national/Five-judge-Constitution-Bench-to-take-a-call-on-Section-377/article14056992.ece>.

¹¹⁰ India HIV/AIDS Alliance. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. New Delhi.

¹¹¹ Sec. 10, HIV AIDS (Prevention and Control) Act, 2017.

¹¹² Dey, Sushmi. "Rajya Sabha Passes Bill to ensure rights of HIV and AIDS patients", 21 March, 2017. Times of India. <http://timesofindia.indiatimes.com/india/rajya-sabha-passes-bill-to-ensure-rights-of-hiv-and-aids-patients/articleshow/57756483.cms>.

Recommendations

1. Make substantial budgetary allocations as well as facilitate international resources where necessary for HIV prevention work, especially community-based work with vulnerable groups given that some of these activities are still criminalised by the law.
2. Implement the HIV/ AIDS Bill and ensure non-discrimination and equal participation in all spheres of life for persons living with HIV. Central and state governments should ensure they provide free of cost Anti-Retroviral Therapy (ART) to all PLHIV.
3. Integration of family planning efforts along with HIV/ STI prevention work in order to address non-target groups as well as infection amongst heterosexual and married couples. Moreover, family planning and disease prevention programmes must be designed for the diverse sexual practices like anal sex and not focus only on peno-vaginal sex.
4. Ensure integration of services and programmes between education and health ministries to educate general public about STIs and ways to prevent them. They should also be informed about the nearest available sexual health clinics where they can access services
5. Repeal Section 377 of the Indian Penal Code (IPC) to decriminalise same-sex relations and ensure the enactment and implementation of the Rights of Transgender Persons Bill.
6. Universal access to comprehensive care for people living with HIV which not only provides them with ART medication but also nutritious food and other medical facilities.

CHAPTER 6: PROTECTION FROM SEXUAL VIOLENCE AND REGULATION OF SEXUAL AUTONOMY

Introduction

Sexual violence is a means of maintaining a gender-hierarchical social order that creates an environment of fear and inequality by positing men either as protectors or predators in relation to women. Laws against sexual violence are recognised as necessary for correcting sexual and gender inequalities in society, towards fulfilment of the Constitutional guarantees of life and equality. For this reason, such laws are expected to shun patriarchal stereotypes that judge a women's worthiness to legal protection based on her dress, conduct and chastity.

Sexual violence against women has been recognised as a violent manifestation of gender based discrimination in international human rights law,¹¹³ which has a

¹¹³ UN Committee on the Elimination of Discrimination against Women (CEDAW), CEDAW General Recommendation No. 19: Violence against women, 1992; UN Committee on the Elimination of

profound impact physical, emotional, mental health and social consequences.¹¹⁴ International law recognises that while sexual violence is primarily directed against women as a form of punishment and control, it stems from several forms of inequalities that reinforce hierarchies of power, such as gender, gender identity and sexual orientation, age, marital status, class, caste, profession, and so on, and thus, is also directed against children,¹¹⁵ persons with disabilities,¹¹⁶ transgender persons and men, especially those identified or perceived as homosexuals.¹¹⁷ Similarly, certain groups of people may be more vulnerable to sexual violence on account of the context in which the violence occurs, such as conflict situations,¹¹⁸ custodial detention, etc. International law therefore calls for securing legal protection to all persons against rape and sexual violence in all its forms and manifestations.

It imposes the obligation of recognising a wider definition of rape that encompass all forms of non-consensual penetrative sex, that is anal/vaginal/ penetration with penis/object/finger; and oral sex with penis/ vagina.¹¹⁹ The obligation entails extending legal protection and redress to all persons, regardless of their age, marital status, sexual orientation or gender identity.

International law uses freely given consent as the fulcrum upon which the legitimacy and legality of sexual contact is to be determined. State obligation in international law includes prevention,¹²⁰ prosecution, investigation, redress, and reparations¹²¹ for sexual violence – that is to say, the state needs to eliminate causes, address manifestations of sexual violence and provide victim care to ensure reparative justice, while recognising the legitimate right to indulge in consensual sexual relations, as the criminalisation of consensual sexual contact is an obstacle to the attainment of the

Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 35: Gender-based violence against women, 14 July 2017, CEDAW/C/GC/35.

¹¹⁴ General Recommendation No. 19, Ibid.

Article 1 of CEDAW was clarified by Recommendation 19 to include gender based violence:- “The definition of discrimination includes gender based violence, i.e., violence that is directed against woman because she is a woman or that affects woman disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Gender based violence may breach specific provisions of the Convention regardless of whether those provisions expressly mention violence...”

¹¹⁵ UN General Assembly, Convention on the Rights of the Child, 20 November 1989. 19, 34.

¹¹⁶ UN General Assembly, Convention on the Rights of Persons with Disabilities : resolution / adopted by the General Assembly, 24 January 2007, A/RES/61/106.

¹¹⁷ UN Human Rights Council, Protection against violence and discrimination based on sexual orientation and gender identity : resolution / adopted by the Human Rights Council, 15 July 2016, A/HRC/RES/32/2; Principles 5, 9, International Commission of Jurists (ICJ), Yogyakarta Principles - Principles on the application of international human rights law in relation to sexual orientation and gender identity, March 2007.

¹¹⁸ N Security Council, Security Council resolution 2122 (2013) [on women and peace and security], 18 October 2013, S/RES/2122 (2013); UN Security Council, Report of the Secretary-General on conflict-related sexual violence, 15 April 2017, S/2017/249.

¹¹⁹ International Criminal Court (ICC), Elements of Crimes, 2011, ISBN No. 92-9227-232-2.

¹²⁰ UN Human Rights Council, Accelerating efforts to eliminate all forms of violence against women: ensuring due diligence in prevention, 23 June 2010, A/HRC/RES/14/12.

¹²¹ UN Human Rights Council, Report of the Special Rapporteur on violence against women, its causes and consequences, 23 April 2010, A/HRC/14/22.

highest attainable standard of health.¹²² States are also required to provide effective remedies, compensation and a mechanism for seeking redress. Given that sexual violence is considered to be gender-based, the procedures for prosecution are also required to be gender sensitive and provide effective legal protection, including sanctions on perpetrators and reparations to victims/survivors.

Status of compliance

This section looks at the extent to which law protects against all forms of sexual violence, especially those groups that are more vulnerable to sexual violence, while simultaneously protecting the right to consensual sexual relations. It also highlights the difficulties in prosecution resulting from the profession of a victim, or the status of the perpetrator.

In the past 5 years, several legislative changes have transformed the landscape of protection from sexual violence. The Indian Penal Code, 1860 (IPC), and the Protection of Children from Sexual Offences Act, 2012 (POCSO), criminalise sexual assault on women and children respectively. Supreme Court judgments, pertaining to criminalisation of homosexuality and recognition of rights of transgender persons, along with verdicts to make procedures more sensitive to victims of rape also shape the law on this subject. Despite significant reform, the law is still not consistent in distinguishing consensual sex from non-consensual sex. It does not criminalise all forms of non-consensual sexual contact, and criminalises some forms of consensual sexual contact. The extent to which the law protects and the gaps in such protection are discussed in relation two parts in this section – the first relating to vulnerable groups, and the second relating to aspects in relation to legal protection that are inadequately addressed and call for greater attention.

Vulnerable groups

Women

As a result of Criminal Law Amendment, 2013, the rape law was expanded to respond to all types of penetrative sexual acts, in addition to offences of stalking, sexual harassment, disrobing and voyeurism, amongst others. A statutory definition of ‘consent’ was introduced to address a history of judicial stereotyping that invoked women’s previous sexual history and conduct to imply consent. Despite these advances (outlined below), the statutory law remains rooted in notions of good sex and bad sex, embedded in what is socially sanctioned or taboo, rather than being based on consent.

Sec. 375 of the IPC defines rape as an offence by a man upon a woman only, and while including a range of circumstances that are aggravating, it excludes marital rape amongst cohabiting spouses from its scope. Therefore, rape committed by a husband against his wife, unless the wife is below fifteen years of age or separated from her

¹²² UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 35: Gender-based violence against women, 14 July 2017, CEDAW/C/GC/35.

husband, cannot be prosecuted as rape under this provision. While normatively, redress for rape between cohabiting spouses should be possible as cruelty against a married woman under section 498A, in the absence of a precedent, compounded by continuous backlash against the use of domestic violence laws, it is unclear how legal protection from forced sexual relations within marriage can be assured.

The husband's absolute control over the wife's sexuality has been established by inter-locking provisions in family and criminal law that are extremely worrying, as these are at the cost sexual autonomy, an integral aspect of sexual health. For instance, the law imposes the condition of fidelity and abstinence on wife for claiming economic rights. Thus, a husband may use the criminal justice system to penalise a wife's lover for consensual sex under the offence of adultery;¹²³ seek to restore conjugal relations with a wife through judicial intervention,¹²⁴ or deny her maintenance (despite desertion) and alimony (after separation or divorce) on grounds of being 'unchaste'.¹²⁵

Children and Adolescents

The fact that sexuality manifests during puberty,¹²⁶ itself necessitates an obligation on the State and non-State actors like the family and community to contribute towards developing age-appropriate capacities with respect to sexuality and sexual health. Yet, the Protection of Children from Sexual Offences Act, 2012 (POCSO), a very significant step in protection against child sexual abuse, does not differentiate between capacities of 'child' between 1 to 18 years, treating all under 18 as a flat undifferentiated category. This is contrary to international human rights standards, that co-relate the best interests of the child with, amongst other things, the child's evolving capacities.¹²⁷

¹²³ Indian Penal Code, 1860.497. This section states that consensual sex between a married woman and her lover is prosecutable on a complaint by husband, unless it was undertaken with his consent; Joint Statement by the United Nations Working Group on 'Discrimination against women in law and in practice' of 18 October 2012.

<http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=12672&LangID=E>.

¹²⁴ As per this law, a spouse is entitled to petition for restitution of conjugal rights, which includes sexual intercourse, if the other abandons without sufficient cause. Hindu Marriage Act, 1956. 9; Special Marriage Act, 1954. 22; Indian Divorce Act, 1869. 32, 33; Parsi Marriage and Divorce Act, 1936. 36; and classical Muslim personal law.

¹²⁵ Code of Criminal Procedure, 1973. 125(4); Hindu Adoptions and Maintenance Act, 1956. 18(3).

¹²⁶ Article 5, UN General Assembly, Convention on the Rights of the Child, 20 November 1989.

UN Committee on the Rights of the Child (CRC), General comment No. 4 (2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child, 1 July 2003, CRC/GC/2003/4; UN Committee on the Rights of the Child (CRC), General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), 17 April 2013, CRC/C/GC/15; UN Committee on the Rights of the Child (CRC), General comment No. 20 (2016) on the implementation of the rights of the child during adolescence, 6 December 2016, CRC/C/GC/20.

¹²⁷ The CRC does not seek to criminalise sexual activities of young adolescents who are discovering their sexuality and engaging in sexual experiences with each other in the framework of sexual development. Nor is it intended to cover sexual activities between persons of similar ages and maturity. UN Committee on the Rights of the Child (CRC), General comment No. 4 (2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child, 1 July 2003, CRC/GC/2003/4.

The statute criminalises a wide spectrum of sexual acts, from touching, caressing, and kissing, to penetrative sexual intercourse.¹²⁸ Read with corresponding provisions in the IPC, consensual sexual intercourse involving a minor can be treated as aggravated rape in certain circumstances,¹²⁹ creating absolute liability at the cost of fair trial to the accused, who may well be of proximate age (for example, 18 years) in a consensual relationship with the adolescent girl.¹³⁰ Comparative jurisdictions however, have addressed this anomaly by reducing the age of statutory rape, and through age proximity clauses that shield adolescents in consensual sexual contact, from the harshness of the law.¹³¹

Ironically, while the capacity of adolescents to engage in sexual relations is not recognised, juveniles between 16-18 years are deemed to be culpable like adults under the amended Juvenile Justice Act 2015.¹³² As such, while the law does not recognise the capacity of adolescents to consent to sexual intercourse, it recognises the capacity of adolescent boys to be subject to punishment rather than correction for commission of rape. Judgments under POCSO show that it is most commonly being used by parents to punish their daughters' partners. This misconceived criminalisation of consensual adolescent sexual relations is contributing to early marriage, as young couples elope to marry as a means of acquiring social legitimacy to escape parental retribution, but are prosecuted nonetheless.

Mandatory reporting of all cases of sexual contact involving a minor is another feature of POCSO that has severely compromised adolescents' access to healthcare and other services.¹³³ POCSO imposes criminal liability for failure to intimate the authorities about the occurrence of or the apprehension that sexual abuse may occur. Given that the scope of criminalisation includes consensual sexual contact involving adolescents, the law places a duty to report this as well.¹³⁴ As a result, service providers, including health care workers, and indeed, every ordinary person, who are either unwilling to report such an incident without the consent of the adolescent, or because it involved consensual sexual contact, is often unable to help for fear of criminal liability.¹³⁵

The mandatory reporting requirement directly obstructs access to health care and other support services, undermining the best interests of the child. It is also inconsistent with other state initiatives, such as the ARSH clinics, that seek to

¹²⁸ Protection of Children from Sexual Offences Act, 2012. 3,5.

¹²⁹ Indian Penal Code, 1860. 376(2)(i).

¹³⁰ Indian Evidence Act, 1872. 114A.

¹³¹ *Criminal Law Consolidation Act, 1935* (South Australia). 49(4); *Crimes Act, 1958* (Victoria). 45(4); *Crimes Act, 1900* (Australian Capital Territory). 55(3). *Criminal Code* (Canada). 150.1(2)–(2.1); *Swiss Federal Criminal Code*. 187(2).

¹³² Juvenile Justice (Care and Protection of Children) Act, 2015. 14.

¹³³ Protection of Children from Sexual Offences Act, 2012. 19; Code of Criminal Procedure, 1973. 357C.

¹³⁴ Protection of Children from Sexual Offences Act, 2012. 21.

¹³⁵ Rege, Sangeeta. 2017. Interview for NHRC Study on Sexual Health and Well-being. Telephone. New Delhi.

dispense healthcare services, including abortion services, to adolescents.¹³⁶ Similarly, the mandatory reporting requirement is contrary to the need to maintain confidentiality of the patient's information, which is the hallmark of other laws regulating healthcare services.¹³⁷

Lesbian, Gay and Bisexual, and Trans persons

Reports of sexual violence faced by transgender persons and MSM under police custody are not uncommon.¹³⁸ Cases of sexual violence against lesbian and bisexual women, either committed by, or abetted by their own family members, with the objective of 'curing' them of their non-normative sexual orientation and 'normalising' them, have also been reported.¹³⁹ While the Protection of Women from Domestic Violence Act, 2005 (PWDVA), technically can be used by such women, it has rarely been used for this purpose. There may also be domestic and sexual violence within same-sex relationships, which is not recognised as such.¹⁴⁰ Persons with non-normative sexual orientations and gender identities, are either not recognised as victims of sexual assault in the law,¹⁴¹ or face difficulties in reporting and prosecuting from crimes committed against them due to fear of persecution. This effectively denies redress and reparations to victims, other than women and minors, of sexual assault.

At the same time, all non-peno-vaginal sexual contact is criminalised as being "against the order of nature," irrespective of consent, under Sec. 377 of the IPC.¹⁴² This section has historically been used to persecute persons with non-conforming sexual orientations and gender identities.¹⁴³ Even though the right to self-

¹³⁶ Rege, Sangeeta. 2017. Interview for NHRC Study on Sexual Health and Well-being. Telephone. New Delhi.

¹³⁷ Medical Termination of Pregnancy Regulations, 2003. 4; Code of Medical Ethics Regulations, 2002. 1.2, 2.2; Rege, Sangeeta. 2017. Interview for NHRC Study on Sexual Health and Well-being. Telephone. New Delhi.

¹³⁸ "Human Rights Violations against Sexuality Minorities in India: A PUCL-K fact-finding report about Bangalore". 2001. PUCL-Karnataka. <http://feministlawarchives.pldindia.org/wp-content/uploads/sexual-minorities.pdf?>. "Unnatural Offences" Obstacles to Justice in India Based on Sexual Orientation and Gender Identity". 2017. International Commission of Jurists. <https://www.icj.org/wp-content/uploads/2017/02/India-SOGI-report-Publications-Reports-Thematic-report-2017-ENG.pdf>.

¹³⁹ "Vio-Map: Documenting and Mapping Violence and Rights Violation Taking Place in Lives of Sexually Marginalised Women to Chart Out Effective Advocacy Strategies". 2011. Sappho for Equality. <http://www.sapphokolkata.in/wp-content/themes/responsive/core/images/Vio-Map%20Report.pdf>. Chakravorty, Amritananda. 2017. Interview for NHRC Study on Sexual Health and Well-Being. In person. New Delhi. Shankari. 2017. Interview with Nirangal for NHRC Study on Sexual Health and Well-being. In person. Kolkata.

¹⁴⁰ Mohan, Sunil. "Towards Gender Inclusivity: A Study on Contemporary Concerns Around Gender". 2013. Alternative Law Forum and LesBiT. <http://feministlawarchives.pldindia.org/wp-content/uploads/Gender-Inclusivity-by-Sumathi-and-Sunil.pdf>.

¹⁴¹ Indian Penal Code, 1860. 354A (sexual harassment), 354B (assault or use of criminal force with the intention to disrobe), 354C (voyeurism), 354D (stalking), 375 (rape), 376C (sexual intercourse by person in authority), and 376D (gang rape).

¹⁴² Indian Penal Code, 1860. 377.

¹⁴³ "Unnatural Offences" Obstacles to Justice in India Based on Sexual Orientation and Gender Identity". 2017. International Commission of Jurists. <https://www.icj.org/wp-content/uploads/2017/02/India-SOGI-report-Publications-Reports-Thematic-report-2017-ENG.pdf>.

determination of one's gender has been recognised,¹⁴⁴ the gay, lesbian, and bisexual persons within the transgender community are desexualised given the criminalisation of their sexual orientations.¹⁴⁵

In 2010, the suspension of Dr. Ramchandra Siras, a professor at Aligarh Muslim University on account of his sexual orientation brought to light existence of institutional persecution and the potential of legal redress if homosexuality is decriminalised. A forced entry into the residential quarters of Dr. Siras by persons from the university with some journalists took place while he was in the company of a male partner. He was forcibly disrobed, photographed, physically humiliated followed by shaming through news-reports, thus setting a pretext for his suspension and eviction from the University position and his residence respectively - rather than initiating inquiry into the house-break and assault. Since this event occurred while homosexuality had been decriminalised (by the Delhi High Court), the Allahabad High Court issued a stay against Dr Siras's suspension and an order to reinstate him in his official residence.¹⁴⁶ Dr Siras was found dead soon after the court order in his favour.

In another case of public shaming of gay men, a Telugu news channel - TV9 - ran a three day story on '*Gay culture rampant in Hyderabad*' in 2011. As a part of this story, the channel made public the social media profiles, photographs, and contact details of several men who were registered on the gay dating website planetromeo.com. Following complaints, the News Broadcasting Standards Authority fined the channel and directed it to issue a public apology for violation of journalistic ethics.¹⁴⁷

Favourable decisions by authorities in both the above two cases were possible only due to the reading down of Sec. 377 by the Delhi High Court to exclude consensual sexual intercourse from the purview of criminalisation.¹⁴⁸ However, its re-criminalisation by the Supreme Court in 2013,¹⁴⁹ set back the self esteem, confidence of youth who 'came-out' following the Delhi High Court judgment, exposing them to high risk of harassment and prosecution.¹⁵⁰ Recently, the Supreme Court has

¹⁴⁴ National Legal Services Authority vs. Union of India. 2014, W.P. No. 400 of 2012. Supreme Court of India.

¹⁴⁵ Kavi, Ashok Row. 2017. Interview for NHRC Study on Sexual Health and Well-being. Telephone. New Delhi; Banerjee, Aparna. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. New Delhi.

¹⁴⁶ "Policing Morality at AMU: An Independent Fact Finding Report". 2010. <http://feministlawarchives.pldindia.org/wp-content/uploads/Amumoralpolicingfinal10.03.pdf>.

¹⁴⁷ Narrain, Siddharth. "Exposing an Expose", 21 March 2012, The Alternative. <http://www.thealternative.in/society/exposing-expose/>.

¹⁴⁸ Naz Foundation vs. Government of NCT of Delhi. 2009, WP(C) No.7455 of 2001. High Court of Delhi.

¹⁴⁹ Suresh Kumar Koushal vs. Naz Foundation. 2013, (SLP (C) No.15436 of 2009). Supreme Court of India.

¹⁵⁰ "According to the NCRB, 1279 persons in 2014 and 1491 in 2015 were arrested under section 377. However, it is not clear how many of these cases involve real or purported consensual sex and how many involve non-consensual sex." India HIV/AIDS Alliance. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. New Delhi.

recognised the impediments created by Section 377 to the enjoyment of one's right to privacy.¹⁵¹ Apart from being inconsistent with the rights to privacy, equality, dignity, freedom of expression, criminalisation of consensual sexual intercourse discourages MSM from seeking healthcare services and reporting sexual violence, due to fear of being stigmatised, arrested and prosecuted, resulting in health problems including untreated STIs.

Persons with disability

Practitioners have noted high levels of sexual harassment and sexual violence cases against all persons with disability regardless of gender, by the hospital staff. This includes, but is not limited to sexual assault by inmates and hospital staff and inappropriate touching during check-ups.¹⁵² Sodomy is a commonly reported in mental health institutions, by another inmate or by the Group D staff. However, Group D staff tend to get more suspensions as compared to the doctors, who are known to perpetrate sexual harassment. There are reports of psychiatrists checking breast palpitations of female patients without their being any need for it. In one case, when a girl asked a doctor to stop touching her breasts, he withdrew all her antipsychotics.

When I was young, I went to a doctor and he started touching my back. Then I shouted and my mother came in. So this happens very often with female patients. Once I remember I went for a muscle test, and they were checking my thigh muscles. Then, suddenly they started touching my private parts and I was like, why are you doing this. I didn't finish my test and left.

- Disability Rights Activist¹⁵³

Persons with certain disabilities may be more vulnerable to sexual violence as compared to others, such as those with invisible disabilities like hearing or visual impairment, or where a person may not be able to communicate or recount an experience of sexual assault. There are multiple challenges depending upon the nature of the disability.¹⁵⁴

Sex workers

While the law applies to all women, there are particular difficulties in relation to sex workers. On the face of it, while the law reforms of 2003¹⁵⁵ and 2013¹⁵⁶ have

““Unnatural Offences” Obstacles to Justice in India Based on Sexual Orientation and Gender Identity”. 2017. International Commission of Jurists. <https://www.icj.org/wp-content/uploads/2017/02/India-SOGI-report-Publications-Reports-Thematic-report-2017-ENG.pdf>.

¹⁵¹ Justice Puttaswamy (Retd.) vs. Union of India. 2017, (WP(C) No. 494 of 2012). Supreme Court of India.

¹⁵² Disability Rights Activist. 2017. Interview for NHRC Study on Sexual Health and Well-being. Telephone. New Delhi.

¹⁵³ *Ibid.*

¹⁵⁴ Nagaraj, Prabha. 2017. Interview for NHRC Study on Sexual Health and Well-being. In person. New Delhi.

¹⁵⁵ Indian Evidence Act, 1872. 155.

¹⁵⁶ Indian Evidence Act, 1872. 53A, 146.

prohibited the use of previous sexual history, or its consideration in relation to rape cases, sex workers rarely have recourse to legal protection.¹⁵⁷ The stigmatised nature of sex work poses a barrier, making it impossible for sex workers (across genders) to seek redress from sexual violence in the course of or outside of their work. In fact, they are reportedly turned away by the police even when they seek to register a routine complaint.¹⁵⁸

Sex work *per se* is not a crime in India, but soliciting for sex work and living off the wages of a sex worker is criminalised by the Immoral Trafficking Prohibition Act (ITPA), 1956. This makes them vulnerable to police harassment and directly implicates their family members. It also reinforces stigmatisation of sex work. Despite the Supreme Court's directions in the case of Budhadev Karmaskar, to ensure that 'rehabilitation' of sex workers is not coercive but voluntary,¹⁵⁹ the legal framework has mostly been used to impede upon the rights and well-being of sex workers and has rarely been used to protect them.¹⁶⁰

Aspects related to legal protection and redress

Victim care and Reparative Justice

Currently, the only form of support available to victims of sexual assault from the state is victim compensation, which includes costs incurred by the victim for medical treatment, judicial remedies and other disruptions caused by the assault. As such, the law on victim care does not take into the full extent of consequences that a survivor of sexual assault may face, including abandonment by intimate partner/ family, forced marriage, loss of livelihood, lack of access to medical treatment and services, hostility from state authorities, including the police, in reporting the offence, etc. The survivor does not receive assistance in reporting the offence, or access to efficient prosecutors. Under municipal law, there is no obligation upon the state to provide shelter to the survivor, medical treatment for injuries suffered during the assault, or counselling.

Reparations/ compensation by the state is an acknowledgement of the injury caused to the victim, and contribution towards the recovery of and healing of the survivor. There are state-wise compensation schemes for rape victims, under S. 357A, Code of Criminal Procedure, 1973 (CrPC), which are not uniform and under which interim

¹⁵⁷ Chakravorty, Amritananda. 2017. Interview for NHRC Study on Sexual Health and Well-Being. In person. New Delhi.

¹⁵⁸ Seshu, Meena and Aarthi, Pai, "Violence against People in Sex Work in India". 2013. Veshya Anyay Mukti Parishad. "Violations Faced by Sex Workers in India: Joint Stakeholders Submission".2016. Sangram.

https://www.sangram.org/resources/violence_against_people_in_sex_work_in_india.pdf;

[https://www.upr-info.org/sites/default/files/document/india/session_27_-_](https://www.upr-info.org/sites/default/files/document/india/session_27_-_may_2017/js9_upr27_ind_e_main.pdf)

[_may_2017/js9_upr27_ind_e_main.pdf](https://www.upr-info.org/sites/default/files/document/india/session_27_-_may_2017/js9_upr27_ind_e_main.pdf)

¹⁵⁹ Budhadev Karmaskar v. State of West Bengal, Criminal Appeal No. 135 of 2010 in the Supreme Court of India.

¹⁶⁰ Chakravorty, Amritananda. 2017. Interview for NHRC Study on Sexual Health and Well-being. In Person. New Delhi.

compensation although mandated, is rarely given.¹⁶¹ A study conducted on pre-trial and trial stages of rape trials in Delhi shows that most victims are not aware of their right to claim compensation owing to the absence of any actor who is mandated to inform and facilitate the victim's access to these rights/ procedures.¹⁶²

The One Stop Crisis Centres scheme envisaged for victims of violence,¹⁶³ has in its implementation been reduced to a centre for MLCs, and been re-named therefore as One Stop Centres. There is considerable gap in victim care in terms of counselling, relocation, livelihood support, and a guarantee of non repetition, to survivors of violence.

Difficulties in prosecution in 'disturbed areas'

Difficulties in registration and prosecution of sexual violence are also reported by victims of sexual violence when committed by state actors in conflict areas.¹⁶⁴ Demands to bring sexual violence committed by armed personnel in 'disturbed areas'¹⁶⁵ have not been accepted so far. Although a sanction is not required for the prosecution of a public servant,¹⁶⁶ whether armed forces, especially those deployed in disturbed areas under the Armed Forces Special Powers Act, 1958 (AFSPA) fall within the purview of 'public servant' is questionable and open to interpretation, and thus does not guarantee the prosecution of every accused person upon a complaint.

Moral policing of sexuality

Punitive regulation and policing of sexuality is rampant in India. Discomfort with the expression of intimacy in public has led to the misuse of laws on obscenity,¹⁶⁷ indecency, and public nuisance¹⁶⁸ to police couples. Expressions, and perceived expressions of sexuality, including choices in clothing, partners, digital access, etc. are strictly monitored by state and non-state actors.

For instance, in 2009, the police picked up two youngsters who were allegedly found kissing at a metro station, and registered a criminal case of obscenity and nuisance

¹⁶¹ "Towards Victim Friendly Responses and Procedures for Prosecuting Rape: A Study of Pre-Trial and Trial Stages of Rape Prosecutions in Delhi (2014-15)". 2017. Partners for Law in Development. https://www.academia.edu/34262450/A_STUDY_OF_PRE-TRIAL_AND_TRIAL_STAGES_OF_RAPE_PROSECUTIONS_IN_DELHI_2014-15_.

¹⁶² Ibid.

¹⁶³ "One Stop Centre Scheme". Department for Women and Child Development. <http://www.wcd.nic.in/sites/default/files/ProposalforOneStopCentre17.3.2015.pdf>.

¹⁶⁴ Section 6 of the Armed Forces Special Powers Act, 1958 requires sanction from the Central government to prosecute any member of the armed forces for an act done by them in exercise of powers conferred by the Act, including sexual violence.

¹⁶⁵ "Report of the Committee on Amendments to Criminal Law". 2013. Justice Verma Committee on Amendments to Criminal Law. <http://www.prsindia.org/uploads/media/Justice%20verma%20committee/js%20verma%20committe%20report.pdf>.

¹⁶⁶ Code of Criminal Procedure, 1973. 197.

¹⁶⁷ Indian Penal Code, 1860. 294.

¹⁶⁸ Indian Penal Code, 1860. 268.

against them.¹⁶⁹ In August 2015, the Mumbai police raided hotels in Madh Island and Aska, and rounded up about forty couples for ‘indecent behaviour in public’.¹⁷⁰ It was only after the incident gained traction in the media that the police accepted that they had been overzealous.

The state of Uttar Pradesh has institutionalised such policing in Anti-Romeo Squads, despite compelling evidence that these squads specifically target young consenting adults, and have little effect on sexual harassment.¹⁷¹

Sexuality is also policed by non-state actors such as political groups, khap panchayats, or even families that often adopt criminal means with impunity against those perceived as transgressing the boundaries of acceptable behaviour. Familial opposition to inter-caste and inter-religious marriages resulting in the murder of young couples in the name of “honour” is a common phenomenon.¹⁷² Moral policing also involves targeting by violent vigilante groups against same and different-sex couples in public places, particularly during Valentine’s day.¹⁷³ There have also been cases in which Hindu women in consensual relationships with Muslim men, have been coerced by to register cases of forced religious conversion and sexual exploitation, in the name of love jihad, in order to criminalise Muslim men and at the same time, deny agency to women.¹⁷⁴

Harmful Traditional Practices

Discomfort with sexuality and sexual pleasure is also apparent in the practice of female genital mutilation of Bohra girls.¹⁷⁵ While there is a paucity of literature on FGM in India, surveys conducted within the community suggest that almost 80% of Bohra women were subjected to FGM at a young age. In most cases, women who have undergone FGM are unable to experience any sexual pleasure not only because of the physical mutilation, but also because of its adverse psychological effects.

Recommendations

1. Make sections 354A (sexual harassment), 354B (assault or use of criminal force with the intention to disrobe), 354C (voyeurism), 354D (stalking), 375 (rape), 376C (sexual intercourse by person in authority), and 376D (gang rape)

¹⁶⁹ “It is inconceivable how, even if one were to take what is stated in the FIR to be true, the expression of love by a young married couple, in the manner indicated in the FIR, would attract the offence of “obscenity” and trigger the coercive process of the law.”

A & B vs. State through N.C.T. of Delhi. CRL.M.C. 283/2009. High Court of Delhi.

¹⁷⁰ Bombay Police Act, 1951. 110.

¹⁷¹ Gaurav Gupta vs. State of U.P. 2017, P.I.L. CIVIL No. 6779 of 2017. High Court of Allahabad.

¹⁷² “Courting Disaster: A Report on Inter-Caste Marriages, Society and State”. 2013. People’s Union for Democratic Rights. http://www.pudr.org/sites/default/files/pdfs/courting_disaster.pdf?

¹⁷³ Bangalore Mirror. 2009. “A Red Red Day”, 25 February, 2009.

<http://feministlawarchives.pldindia.org/wp-content/uploads/Newspaper-clippings.pdf>

¹⁷⁴ Ali, Mohammad. 2016. “For Meerut’s ‘Love Jihad’ Couple, 3-Year Courtship Ends In ‘Nikah’”. The Hindu, 12 April, 2016. <http://www.thehindu.com/news/national/other-states/for-meeruts-love-jihad-couple-3year-courtship-ends-in-nikah/article7953238.ece>.; Asokan. K. M vs. State Of Kerala. 2017, WP(CrL).No. 25 of 2016. High Court of Kerala.

¹⁷⁵ Mariya Taher. 2017. “Understanding Female Genital Cutting in the Dawoodi Bohra Community”. Sahiyo.

- gender neutral with respect to the victim, retaining the gender specific male perpetrator.
2. Clarify that sexual violence within matrimonial home will be covered under section 498A IPC, and remove Exception 2 of Section 375 to criminalise marital rape.
 3. Decriminalise adultery by amending or repealing Sec. 497 of the Indian Penal Code.
 4. Repeal the provisions enabling restitution of conjugal rights in the Hindu Marriage Act (section 9), the Special Marriage Act (section 22), the Parsi Marriage and Divorce Act (section 36), and the Indian Divorce Act (sections 32 and 33).
 5. Repeal section 377 of the IPC; alternatively, amend section 377 to exclude consensual sexual intercourse from its ambit.
 6. Restore the age of sexual consent (including for statutory rape) to 16 years, taking into account the evolving capacities of children, as was the case in the IPC prior to the 2013 amendments.
 7. Remove the requirement of mandatory reporting from POCSOA (sections 19 and 21) and IPC (section 357C).
 8. Decriminalise soliciting and earning from the income of sex work, and avoid conflating sex work with trafficking. Accordingly, exclude consensual sex work from the Immoral Traffic (Prevention) Act, 1956.
 9. Establish an independent specialised agency to provide comprehensive support services to victims of sexual assault, including informing them of their right to avail reparations.
 10. Sensitise healthcare service providers to the challenges faced by persons with disabilities, and their sexual health rights.
 11. Address patriarchal socio-cultural attitudes towards sexuality that contribute towards domestic violence, sexual abuse within and outside marriage, and practices such as female genital mutilation, by making transformatory interventions on masculinity.
 12. Repeal section 6 of the Armed Forces Special Powers Act, 1958 that requires prior sanction to prosecute armed forces for sexual assault, to make it consistent with section 197 CrPC.

PART II
COUNTRY ASSESSMENT ON HUMAN RIGHTS IN THE CONTEXT
OF REPRODUCTIVE HEALTH AND RIGHTS

CHAPTER 1: INTRODUCTION TO REPRODUCTIVE HEALTH AND RIGHTS

The main aim of commissioning an assessment of human rights in the context of SRHR by the NHRC was in keeping with its mandate to “study treaties and other international instruments on human rights” as well as to “review the safeguards provided by the Constitution or any law . . . for the protection of human rights” and to make recommendations for their effective implementation (Section 12 of the Protection of Human Rights Act, 1993). Although sexual and reproductive health rights are interdependent and often overlap, sexual rights are frequently subsumed under reproductive rights. Hence, there is a separation of these rights with the caveat that the two reports be read together, in light of the overlaps between the two themes.

The right to reproductive health is an integral and inextricable part of human rights, all of which are universal, inalienable, indivisible, and interdependent. The realisation of these rights is dependent on underlying determinants that include the right to life, the right to food, the right to adequate housing, the right to education; as well as freedom from violence and discrimination on the basis of gender, caste, religion, sexuality, class, ability, age, ethnicity, etc.; and, most importantly, the right to health care and services. In discussing the importance of reproductive health rights, particularly for women in India, it is imperative to locate these rights within the larger framework of issues that women confront on a regular basis. In this context, it bears pointing out that women are not a monolithic category. They live in very different economic, cultural, and social circumstances. This fact has been completely ignored by policy makers in India, which has resulted in the targeting of the poor and other underprivileged sections – particularly women – for forced sterilisation and coercive adoption of other family planning measures.

Objectives

The key objectives of the assessment was to

- document existing domestic and international frameworks on human rights relating to reproductive health and well-being, and to analyze the compliance of the legislative and policy frameworks in India to such rights and obligations.
- map and analyze legal and policy frameworks, as well as demographic data on reproductive health and rights in India, in order, to identify violations and gaps in implementation.

The findings emerging from the assessment are envisaged to be disseminated by NHRC through a range of initiatives; through dialogues with different constituencies, through formulating recommendations and guidance notes to ministries, government departments, including for law reform, implementation and also seeking accountability.

Methodology

The assessment involved a combination of the following methods:

Desk review

The desk review included mapping analysis of¹⁷⁶:

- a. Reports of the UN Human Rights mechanisms, UN treaties, bodies, declarations, covenants
- b. The Constitution of India along with the relevant domestic laws and judgments
- c. Government policies, programmes, guidelines and schemes
- d. Parliamentary Standing Committee (PSC) reports
- e. Fact-finding reports and other relevant literature

Data collection

The collection of primary data and case studies involved:

- a. Field visits and interviews with affected families and patients
- b. Meetings with representatives of various health networks and organisations working on reproductive health issues.

Structure of report

The report has been organised into different chapters. Chapter one includes background, objectives, methodology and scope of this assessment. Chapter two illustrates and analyzes existing international and domestic laws, human rights frameworks, guidelines and policies pertaining to reproductive health and rights in the context of India. It investigates and presents the contextualisation of reproductive health as a right. Chapter three analyzes various key indicators and evidence related to the reproductive health and rights. Chapter 4 focuses on the recommendations suggested to NHRC emerging from the assessment towards directions to specific Ministries such as Health and Family Welfare, Women and Child, Finance, Home and relevant others at the centre and state levels.

Limitations

Given the broad range and the intersectionality of reproductive health and rights, it was not possible to cover all indicators in the report. The report, thus, presents selective indicators of reproductive health and well-being to highlight the status of these issues and concerns.

The limited availability of disaggregated data also posed challenges to a nuanced analysis of reproductive health and rights, particularly of marginalised communities.

¹⁷⁶ Data sources include websites of Ministry of Health and Family Welfare, the Ministry of Women and Child Development, the Ministry of Human Resource Development, the Ministry of Youth Affairs and Sports, and the Ministry of Drinking Water and Sanitation. Apart from this, statistical data from the National Family Health Survey [NFHS-4] (2015–16), NSSO, DLHS, HMIS etc

CHAPTER 2: NATURE AND SCOPE OF HUMAN RIGHTS WITH RESPECT TO REPRODUCTIVE HEALTH AND WELL-BEING

Reproductive rights are enshrined in the United Nations (UN) human rights treaties and in the consensus conference documents to which India is a party, and are protected by the Constitution of India. These treaties and documents point to the obligations of the State to respect, protect, promote, and fulfill rights related to reproductive health, with particular attention to vulnerable and marginalised population groups, without any discrimination. This chapter analyzes how reproductive rights were addressed in international frameworks and in the Constitution of India and identifies the compliance and gaps.

First formulation of reproductive rights

The first formulation of reproductive rights as human rights is found in the International Conference on Human Rights, which was held in Tehran in 1968 to further the principles and aims of the Universal Declaration of Human Rights (UDHR). India was part of the preparatory committee and participated in the conference. The outcome of the conference was the Proclamation of Tehran, Final Act of the International Conference on Human Rights, 1968.¹⁷⁷ Section 16 of the Final Act recognises the human rights of couples to decide freely and responsibly on the number and spacing of their children and to have access to the information and education to do so. Principle 12 of the Declaration of Mexico on the Equality of Women and their Contribution to Development and Peace¹⁷⁸ reiterates this right of couples and individuals to decide freely and responsibly whether to have children and when to do so, and to have access to information and education that would enable them to make these decisions. The Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights in 1993, emphasised the right of women, on the basis of equality with men, to access the widest range of family planning services and to have adequate health care.¹⁷⁹

However, Reproductive rights are comprehensively defined in the 1994 **International Conference on Population and Development's (ICPD) Programme of Action** in Cairo.¹⁸⁰

As per paragraph 7.1 in Programme of Action, reproductive rights are defined as *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they*

¹⁷⁷Final Act of the International Conference on Human Rights. Teheran. U.N. Doc. A/CONF. 32/41. 1968.

¹⁷⁸Adopted at the World Conference of the International Women's Year, Mexico City, Mexico, on 2 July 1975.

¹⁷⁹UN. General Assembly Resolution A/RES/48/121. 1993. Section 3, Para. 41.

¹⁸⁰UN. UNFPA. *Report of the ICPD*. Doc. A/CONF.171/13. 1994.

have the capability to reproduce and the freedom to decide if, when and how often to do so.

The Paragraph 7.3 also reiterates reproductive health as a Women's right to control their fertility and the State's duty to enhance women's sexual and reproductive health and education. This was again reaffirmed in the Beijing Declaration and Platform for Action,¹⁸¹ adopted at the Fourth World Conference on Women in 1995. It says, "*the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents*".

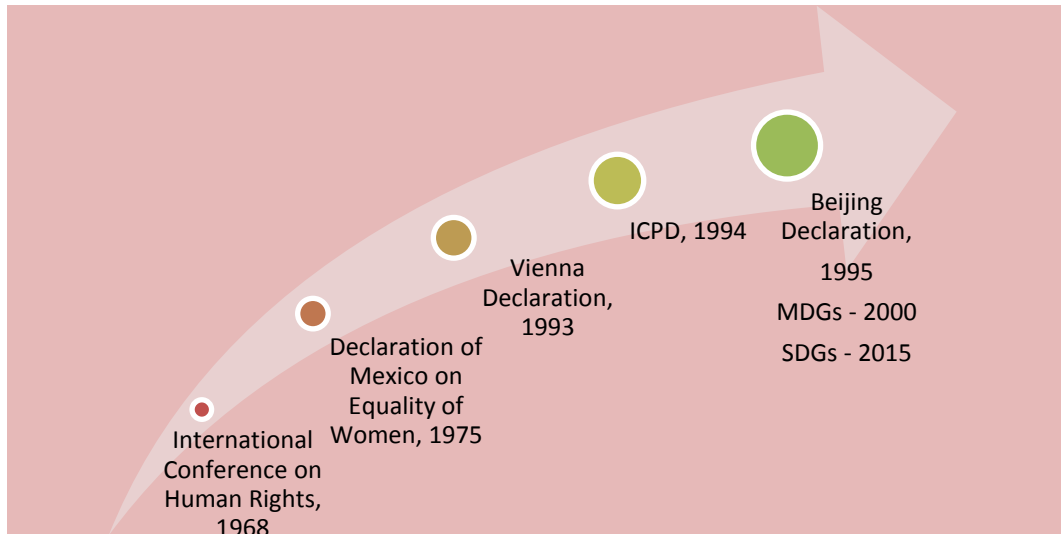
Following the Millennium Summit in 2000 in New York, the General Assembly of the United Nations adopted the Millennium Declaration¹⁸² with the vision of eradicating poverty and ushering in development for all. Eight **Millennium Development Goals (MDGs)** were established to realise this vision by 2015 and to guide the implementation of the Declaration. Several goals of the MDGs relate to reproductive health and rights. However, the MDGs came under criticism because they created silos of intervention in development strategies and plans. The MDGs completely avoided a health systems approach and ignored the deepening crisis within health systems, including underfunding of public health, weakening of the public health system, commercialisation of health care, and the role of the drug industry. Instead, the 'verticalised' approach to complex and systemic problems, far from making the necessary linkages with the social determinants of health, did not even consider the determinants of the health system.

The focus was on attaining lower infant mortality rates (IMR) and maternal mortality rates / ratios (MMR), and on reducing tuberculosis (TB), malaria, and HIV/AIDS, based on the assumption that these goals could be achieved in isolation, while ignoring the larger systemic issues. The MDGs did not take into account the diversity of women's backgrounds, experiences, needs, demands, and realities: women with disabilities, women from religious minorities, female adolescents, indigenous women, lesbians, and others who generally belong to the poorest groups and who have limited or no access to health, education, and other services.

¹⁸¹"Beijing Declaration and Platform for Action." Proceedings of the Fourth World Conference on Women, China, Beijing. 1995. Paras 17 and 30.

¹⁸²UN. General Assembly Resolution. Res. A/55/L.2. 2000.

Figure 1 Reproductive Rights through International Treaties and Commitments



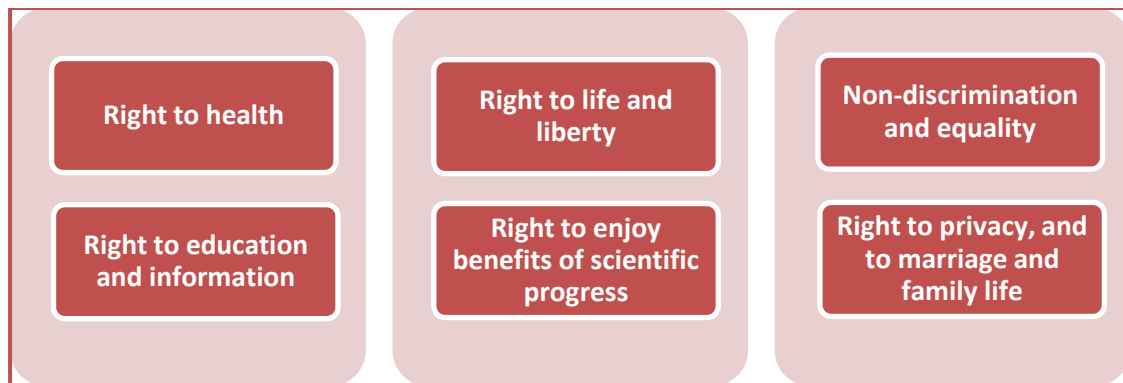
Like their predecessor MDGs, the **Sustainable Development Goals (SDGs)** are a statement of aspirations that are sought to be achieved in a ‘targeted’ fashion and are measured on the basis of particular indicators. Among the 17 goals, it is important to particularly treat SDG5 on gender equality as integral to all the other goals and not as a stand-alone goal. Ending poverty (SDG 1), ending hunger (SDG 2), and education (SDG 4) impact health-seeking behavior, water and sanitation (SDG 6), clean energy (SDG 7), decent work (SDG 8), reduction of inequality, promotion of peace (SDG 10 and 16 respectively), safe industrialisation and sustainable production, safe settlements and cities, combating climate change, sustainable ecosystems (SDG 9, 12, 11, 13, 14, and 15 respectively). All these SDGs are interlinked, having implications for reproductive health and rights. However, the targets and the indicators are neither exhaustive, nor do they present any transformative potential apart from identifying piecemeal changes that are meant to be achieved in the course of 15 years.¹⁸³ The call to ‘leave no one behind’ distracts from the need to emphasise equity and the redistribution of resources for the benefit of the most marginalised sections.

Locating reproductive health rights: Acknowledging and embracing different human rights

The various human rights that intersect with reproductive rights, and that give form and content to these rights, are examined below. The legal basis of these rights is described and their relevance to reproductive rights and health are discussed.

¹⁸³Hickel, Jason. "The Problem with Saving the World." Jacobin. 2015. <https://www.jacobinmag.com/2015/08/global-poverty-climate-change-sdgs/>.

Figure 2 Different Human Rights obligations linked to Reproductive Rights



Right to Health

The **Committee on Economic, Social and Cultural Rights (CESCR)** has deliberated on the right to health in its General Comment No. 14.¹⁸⁴

It defines the right to health as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.

The CESCR has elaborated on these four essential elements in the context of sexual and reproductive rights in its General Comment No. 22.¹⁸⁵

Availability: Health services, facilities, goods, and programmes must be available in adequate number, must be equipped with trained medical personnel and staff, and should provide the full range of reproductive and sexual health care facilities. These facilities also include those that are necessary for addressing the underlying determinants of health such as clean drinking water and sanitation.¹⁸⁶ Essential medicines, including contraceptive methods, medicines for abortion, and those required for post-abortion care, and drugs (including generic medicine) for preventing and treating STIs and HIV/AIDS must be made available to all.¹⁸⁷

Accessibility: The health services, facilities, goods, and programmes must be physically accessible by all, and should be accompanied by the adoption of positive

¹⁸⁴UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*. Doc. E/C.12/2000/4. 2000.

¹⁸⁵ UN Committee on Economic, Social and Cultural Rights, General Comment no. 22 on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights), 2nd May 2016, E/C.12/GC/22, Para 11-21

¹⁸⁶ Ibid. para 12

¹⁸⁷ Ibid. Para. 13.

measures by the State to address the needs and limitations of vulnerable groups such as disabled persons and people living in rural and remote areas. Regarding economic accessibility, the Committee notes:

*Publicly or privately provided sexual and reproductive health services must be affordable for all. Essential goods and services, including those related to the underlying determinants of sexual and reproductive health, must be provided at no cost or [should be] based on the principle of equality to ensure that individuals and families are not disproportionately burdened with health expenses.*¹⁸⁸

States must remove all impediments that prevent health professionals from providing health services to people affected by conflict, and must protect and prevent harm to health facilities, goods, services, and workers.¹⁸⁹

Acceptability: Reproductive health facilities, goods, and services must be culturally appropriate and acceptable, and should be sensitive to gender, age, disability, sexual diversity, and life-cycle requirements.¹⁹⁰

Quality: Lastly, health services, goods, and facilities must be of good quality and should be medically and scientifically appropriate. This condition requires the inclusion of technological advances that benefit and advance reproductive health.¹⁹¹ All individuals and groups have the right to seek, obtain, and disseminate evidence-based information on all aspects of reproductive and sexual health, and they also have the right to information on their health status, personal health data being subject to privacy and confidentiality.¹⁹² It must be ensured that all vulnerable and affected groups and communities have the ability to seek and disseminate information pertaining to their health, and that they have the right to participate in all decisions affecting their health.¹⁹³

States should ensure that private health care providers do not limit or hamper the availability, accessibility, acceptability and quality of health care services and facilities.¹⁹⁴

¹⁸⁸Ibid. Para. 17.

¹⁸⁹UN. General Assembly. *Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Doc. A/68/297. 2013, para. 70.

¹⁹⁰UN Committee on Economic, Social and Cultural Rights, General Comment no. 22 on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights). Doc. E/C.12/GC/22. 2016. para 20.

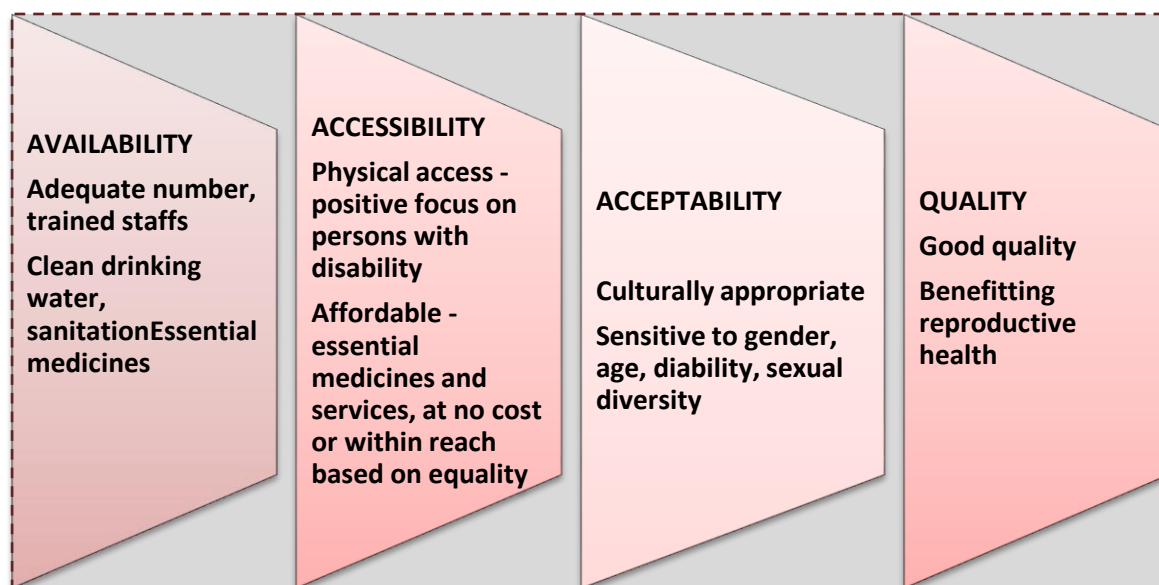
¹⁹¹Ibid. para. 21.

¹⁹²Ibid. para. 18–19.

¹⁹³UN. General Assembly. *Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Doc.A/68/297. 2013. para. 12.

¹⁹⁴UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*. Doc. E/C.12/2000/4, 2000. Para. 34–35.

Figure 3 3A's and Q of Healthcare Services and Facilities



Right to Life and Liberty

Article 3 of the **Universal Declaration of Human Rights (UDHR)** recognises the right to life of every person. The right to life is reiterated in Article 16 of the **International Covenant on Civil and Political Rights (ICCPR)**, and Article 6 of the **United Nations Convention on the Rights of the Child (UNCRC)** enjoins States to ensure to the maximum extent possible the survival and development of the child. The right to life is a fundamental human right, a necessary condition for the enjoyment of all other rights, and must be understood broadly, and States must take all possible measures to reduce infant mortality and to increase life expectancy.¹⁹⁵ Preventable deaths attributable to maternal mortality and infant mortality are violations of the right to life of mothers and their children. Extremely restrictive abortion laws result in unsafe abortions, which lead to higher risks of maternal mortality.¹⁹⁶

Right to non-discrimination and equality

From the perspective of health, well-being, and dignity, social discrimination can be construed as one of the prime reasons for ill health. Social discrimination is manifested most clearly in the life-experiences of women, tribals, dalits, and religious minorities who live in fear; the disabled who are treated with apathy and exclusion; sex workers who face violence almost every day; and sexual minorities who are

¹⁹⁵UN Human Rights Committee (HRC), *CCPR General Comment No. 6: Article 6 (Right to Life)*, 30 April 1982, para 5.

¹⁹⁶UN. General Assembly. *Report of the Committee on the Elimination of Discrimination against Women*, Doc. A/50/38, Para. 158.

perpetually harassed. In addition, social discrimination creates barriers to leading a life of dignity, which in itself is a social barrier to the enjoyment of good health and to the universal access to health care.¹⁹⁷ Social discrimination, embedded in the unjust social arrangements of societal structures, perpetuates the cycle of discrimination, marginalisation, and ill health.¹⁹⁸

Discrimination is defined as *any distinction, exclusion, restriction or preference which is based on any ground such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms.*¹⁹⁹

Discrimination can be both direct and indirect. Direct discrimination occurs when a person is treated less favorably compared to another similarly situated person for a reason related to a prohibited ground. It also includes detrimental treatment on any of the prohibited grounds when there is no comparable similar situation. Indirect discrimination occurs when laws and policies might appear *prima facie* neutral, but disproportionately and detrimentally affect the enjoyment of rights by any person or group on any of the prohibited grounds.²⁰⁰

The right to non-discrimination and equality is grounded in all international human rights instruments, and is a crucial component in the enjoyment and realisation of all other human rights. Article 2 of UDHR, Article 2 of ICCPR, Article 2 of UNCRC, and Article 2(2) of **International Covenant on Economic, Social and Cultural Rights (ICESCR)** protect against discrimination on any ground such as sex, race, color, social origin, nationality, language, or religion. Caste discrimination can be considered as discrimination based on social origin, and India has been urged to take more measures to combat this form of discrimination.²⁰¹ Article 7 of UDHR further states “All are equal before the law and are entitled without any discrimination to equal protection of the law.” This right is reaffirmed in Article 26 of ICCPR.

Other international instruments prohibit specific forms of discrimination. Article 3 of the **Convention on the Rights of Persons with Disabilities (CRPD)** includes the principles of non-discrimination and equality between men and women as general principles in the context of disability. Article 5 of the CRPD obliges States to take all appropriate measures to repeal or modify laws, policies, customs, and practices that

¹⁹⁷Pinto, E. Premdas, and Manish Gupte. *Social Discrimination in Health (with Reference to Caste, Class, Gender and Religious Minorities)*. Report. Medico Friend Circle. 2014.

¹⁹⁸ Ibid

¹⁹⁹UN Human Rights Committee (HRC), *CCPR General Comment No. 18: Non-discrimination*, 10 November 1989, para. 7.

²⁰⁰UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)*, 2 July 2009, E/C.12/GC/20, Para. 10.

²⁰¹UN Committee on Economic, Social and Cultural Rights (CESCR), *Consideration of Fifth Periodic Report of India, Fortieth Session, Summary Record of 14th Meeting*, 13 May 2008, E/C.12/2008/SR.14, Para 24, Para 66.

constitute discrimination against persons with disabilities, and also recognises the right to equal protection of the law without any discrimination. Addressing the intersectional and manifold forms of discrimination faced by women with disabilities, Article 6 asserts that States must take all necessary measures to ensure that women with disabilities are able to enjoy all human rights. Further, Article 23 of the CRPD obliges States to eliminate discrimination against persons with disabilities in matters relating to family and parenthood.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) has expressed concern about the absence of a comprehensive anti-discrimination law in India, which addresses all aspects of direct, indirect, and intersectional discrimination against women.²⁰² Prohibition against discrimination and promotion of equal rights of men and women are the principal aims of CEDAW. CEDAW Article 12 with General Recommendation 24 encourages States Parties to address the issue of women's (including girls' and adolescents') health throughout their lifespan. It also elaborates the measures to be taken by State Parties "to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services including those related to family planning". Article 12 directs States Parties to "ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation." Vide Article 2; State Parties are obliged to take all appropriate measures to eliminate discrimination against women, including discrimination perpetrated by private actors (Article 2(e)). Article 16(1) obligates State Parties to remove all discrimination against women in matters relating to family and marriage.

Non-discrimination also encompasses the rights of all persons to be respected for their sexual orientation and identity. Criminalisation of consensual sexual relationships between persons of the same sex or criminalisation of the expression of a particular gender identity is a violation of the right to sexual and reproductive health, and States have an obligation to effectively address homophobia and transphobia.²⁰³

The obligation to protect against discrimination and to provide health services and facilities to women on the basis of equality with men is essential for the realisation of the reproductive rights of women.²⁰⁴ States must eliminate discrimination against women in their access to health care services throughout their life cycle, particularly in the areas of family planning, pregnancy, and confinement during the post-birth and

²⁰²UN Committee on the Elimination of Discrimination against Women, *Concluding Observations on the combined fourth and fifth periodic reports of India*, 24th July 2014, CEDAW/C/IND/CO/4-5, Para. 8.

²⁰³United Nations Committee on Economic, Social and Cultural Rights, *General Comment No. 22 on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, Doc. E/C.12/GC/22. 2006. Para. 23.

²⁰⁴Office of the United Nations High Commissioner for Human Rights and World Health Organization, *The Right to Health, Fact Sheet no. 31*, page 24, available at <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>

postnatal periods.²⁰⁵ Health services that do not address the specific reproductive health needs and interests of women,²⁰⁶ or where the State Parties refuse to legally provide for certain reproductive health needs of women,²⁰⁷ constitutes discrimination against women. Further, health care systems must have services and programmes that are able to prevent, detect, and treat illnesses specific to women in order for measures to eliminate discrimination against women to be considered effective and appropriate.²⁰⁸

Discrimination must be eliminated both formally and substantively. For the elimination of formal discrimination, States must ensure that their laws and policies do not exclude or discriminate on any of the prohibited grounds, while the elimination of substantive discrimination requires that States address the underlying social and cultural norms, practices, and attitudes that impair the enjoyment of rights on the basis of equality.²⁰⁹ Substantive equality requires that the sexual and reproductive health needs of particular groups such as those living in poverty, those engaged in sex work, migrant or refugee women, and women with disabilities receive special consideration and are specifically addressed.^{210,211}

Right to Education and Information

Article 19 of ICCPR recognises the right of all persons to “seek, receive and impart information and ideas of all kinds” and Article 17 of UNCRC provides that children have the right to access information and material that promote their mental and physical health. Article 10(h) of CEDAW emphasises the importance of guaranteeing access to educational information that ensures the health and well-being of families, including information on family planning, for the elimination of discrimination against women in the field of education, while Article 16(e) obliges the state parties to ensure that women have access to information and education that enables them to exercise their right to decide freely and responsibly on the number and spacing of children, so as to eliminate discrimination against women in matters relating to marriage and family relations.

The ability to decide if, when, and how often to have children requires access to information on contraceptives, prevention and treatment of sexually transmitted infections, reproductive morbidities, risks of pregnancy, and methods of conception.

²⁰⁵UN Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, Doc. A/54/38/Rev.1. 1999. Para. 2.

²⁰⁶UN Committee on the Elimination of Discrimination against Women, *Views. Communication. 17/2008*, 49th Session, Para. 7.6..

²⁰⁷UN Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, Doc., A/54/38/Rev.1. 1999. Para. 11.

²⁰⁸*Ibid.*

²⁰⁹UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, Para. 2, of the International Covenant on Economic, Social and Cultural Rights)*, Doc. E/C.12/GC/20. 2009. Para. 8.

²¹⁰United Nations Committee on Economic, Social and Cultural Rights, *General Comment No. 22 on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*. Doc. E/C.12/GC/22. 2016. Para. 24.

²¹¹UN Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, Doc. A/54/38/Rev.1. 1999. Para. 14.

Access to such information is also essential for practicing safe sex. The right to education and information also includes guaranteed access to reproductive and sex education.²¹² This education and information must be “comprehensive, non-discriminatory, evidence-based, scientifically accurate and age appropriate”.²¹³

CEDAW, in its General Recommendation No. 24, has noted that sexual health information, services, and education must be available to all women, even those women who are not legally residents of a country. This would ensure access to information for victims of trafficking.

States should also ensure that adolescent girls and boys have access to information and education on reproductive and sexual health, which must be imparted on the basis of respect for their right to privacy and confidentiality.²¹⁴ Such education should include information on contraceptives, risks of early pregnancy, and prevention and treatment of HIV/AIDS and sexually transmitted infections (STIs). The information must be available regardless of the adolescents’ marital status and the consent of parents.²¹⁵

Right to enjoy benefits of scientific progress

Article 27 of UDHR guarantees the right of everyone to share in scientific advancements and their benefits, and Article 15(1) (b) of ICESCR recognises the right of everyone to benefit from scientific progress and its applications.

Advancements in science and technology have played an important role in the social and economic development of nations and people. However, technology and its applications can also impede and threaten the enjoyment of human rights. Keeping this in mind, the Declaration on the Use of Scientific and Technological Progress in the Interests of Peace and for the Benefit of Mankind by the UN General Assembly in 1975²¹⁶ proclaims that States shall take all necessary measures, including legislative measures, to ensure that scientific and technological achievements promote the fullest realisation of human rights and fundamental freedoms without any discrimination, and States must take all steps to prevent technology from causing harm to, or resulting in the detriment of, human rights and freedom.

Guidance on the normative content of the “right of everyone to benefit from scientific progress and its applications” can be found in the UNESCO Universal Declaration on

²¹²UN Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No. 21: Equality in Marriage and Family Relations*. 1994. Para. 22.

²¹³UN Committee on Economic, Social and Cultural Rights, *General Comment No. 22 on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*. Doc. E/C.12/GC/22. 2016. Para. 9.

²¹⁴UN Committee on the Elimination of Discrimination against Women (CEDAW), *CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health)*. Doc. A/54/38/Rev.1. 1999. Para. 18.

²¹⁵UN Committee on the Rights of the Child (CRC), *General Comment No. 4 (2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, Doc. CRC/GC/2003/4. 2003. Para. 24.

²¹⁶UN General Assembly Resolution 3384, 10th November 1975.

Bioethics and Human Rights, 2005.²¹⁷ Article 15 of the Declaration states that the benefits of scientific knowledge and its applications may include access to quality health care, provision of new diagnostic and therapeutic modalities or products stemming from research, support for health services, and access to scientific and technological knowledge. The benefits must be shared with society as a whole and should not constitute improper inducements to participate in research. The provision of reproductive and sexual health care and services has been recognised by CESCR in its General Comment No. 22. Referring to the State obligation to provide good quality, medically appropriate, and up-to-date health services, goods, and information, the Committee notes and underscores that failure or refusal to incorporate medical and technological advances in sexual and reproductive health care, such as medication for abortion, management of infertility, assisted reproductive techniques, and treatment of HIV/AIDS, would impair the quality of care.²¹⁸

Right to privacy, and to marriage and family life

Article 16 of UDHR and Article 23 of ICCPR affirm the right of men and women to marry and to found a family. They recognise the fundamental importance of the free and full consent of the parties to the marriage and foreground equality between spouses. Similarly, Article 10 of ICESCR considers the family as the natural and fundamental group unit of society which deserves the fullest protection and assistance. Recognizing the particular needs of women arising from maternity, it further stipulates “*Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period [,] working mothers should be accorded paid leave or leave with adequate social security benefits.*” Article 25(2) of UDHR also provides that mothers and children are entitled to special assistance.

Article 16 of CEDAW reiterates the centrality of consent and equality within marriage and obligates State Parties to ensure that women have the same rights to decide freely and responsibly on the number and spacing of their children.

Article 12 of UDHR, Article 17 of ICCPR, Article 16 of UNCRC, and Article 22 of CRPD guarantee that no one shall be subjected to “arbitrary or unlawful interference with his privacy, family, home or correspondence, or to unlawful attacks on his honor and reputation”

A woman’s right to choose her partner is integral to the fulfillment of her right to life, dignity, and reproductive rights, and the State must protect and enforce her right to choose if, when, and whom to marry.²¹⁹ In order to ensure that marriage is entered into with the full consent of both parties, the age of marriage should be such that it

²¹⁷Adopted by UNESCO’s General Conference on 19 October 2005.

²¹⁸United Nations Committee on Economic, Social and Cultural Rights, *General Comment No. 22 on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*. Doc. E/C.12/GC/22. 2016. Para. 21.

²¹⁹UN Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No. 21: Equality in Marriage and Family Relations*, 1994, Para. 16.

enables both the parties to give their full and free consent.²²⁰ Child marriage should be prohibited, as children cannot be considered to give their free consent to marry and to have the autonomy to choose their spouse. Child brides have less negotiating power in sexual and reproductive matters, are more vulnerable to violence, are more likely to have children early and frequently, and are at a greater risk of maternal mortality and morbidity.²²¹ Prohibition of child marriage would safeguard reproductive rights and the right to marry with full and free consent.

The notion of the family should be interpreted broadly, and the equality of women both in their legal status and entitlements and in their private lives must be ensured, irrespective of the customs and religious practices prevalent in a country.²²² Women living in *de facto* unions should also have equal rights and responsibilities with men for the raising and caring of children.²²³

Equality within marriage and respect for the privacy of women are also central to the fulfillment of the reproductive rights of women. The right to be protected from arbitrary and unlawful interference with one's privacy, family, or home extends to the right to protection not only from attacks by State authorities, but also from attacks by natural and legal persons (i.e. non-state entities such as private individuals and corporations).²²⁴

Requiring the husband's permission for the sterilisation of the wife, imposing conditions for the sterilisation of women (such as having a given number of children or the children being of a certain age), and imposing legal duties on health personnel to report women who have undergone abortions are all violations of women's right to privacy.²²⁵ Forcing women to undergo pregnancy tests by private actors before hiring them also violates the women's right to privacy.²²⁶

States have an obligation to respect, protect, and fulfill women's right to choose the number and spacing of children. Due to women's reproductive functions and the gendered division of work, women bear an unfair burden of childbearing, childcare, and related domestic work. This has a direct impact on their rights to education, livelihood, and the highest attainable standard of health. Women's autonomy in deciding the number and spacing of children should not be curtailed either by their

²²⁰UN Human Rights Committee (HRC), *CCPR General Comment No. 19: Article 23 (The Family) Protection of the Family, the Right to Marriage and Equality of the Spouses*, 27 July 1990, Para. 4.

²²¹UN Committee on the Elimination of Discrimination against Women and UN Committee on the Rights of the Child, *Joint General Recommendation No. 31 of CEDAW/General Comment No. 18 of CRC on Harmful Practices* Doc. CEDAW/C/GC/31/CRC/C/GC/1. 2014. Para 22.

²²²UN Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No. 21: Equality in Marriage and Family Relations*, 1994, Para. 13.

²²³UN Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No. 21: Equality in Marriage and Family Relations*, 1994, Para. 19-20.

²²⁴UN Human Rights Committee (HRC), *CCPR General Comment No. 16: Article 17 (Right to Privacy)*. 1988.

²²⁵UN Human Rights Committee (HRC), *CCPR General Comment No. 28: Article 3 (The Equality of Rights between Men and Women)*. CCPR/C/21/Rev.1/Add.10. 2000. Para. 20.

²²⁶*Ibid.*

partners or by governments, and coercive practices such as forced sterilisation and forced abortion must be prohibited.²²⁷

States should liberalise restrictive abortion laws and provide access to safe abortion services and good post-abortion care.²²⁸

With regard to the barriers faced by persons with disabilities in pursuing their right to marriage and family life, the CESCR has noted that persons with disabilities should have access to counseling services which would enable them to fulfill their rights and duties within the family, and that women with disabilities should have the right to protection and support. Forced sterilisation of disabled women or performance of abortion on disabled women without securing their informed consent is violations of their right to protection in the pre-natal and postnatal periods.²²⁹

Locating reproductive health rights within the constitutional provisions

The realisation of reproductive rights is interrelated with, and dependent on, the protection and fulfillment of various human rights like the right to life, the right to health, the right to non-discrimination, and the right to protection from gender-based violence. In India, the reproductive rights of individuals and couples can be located in a constellation of laws and policies relating to health, employment, education, provision of food and nutrition, and protection from gender-based violence.

Certain **fundamental rights** are guaranteed under Part III of the **Constitution of India**. Article 13 prohibits the State²³⁰ from making any law that takes away or abridges the fundamental rights. The right to life, the right to equality before law, the right against non-discrimination, and the right to freedom and expression are some of the fundamental rights recognised in Part III of the Constitution of India. Article 14 prohibits the State from denying to any person equality before the law or the equal protection of the law within the territory of India. Article 15(1) prohibits the State from discriminating against any citizen on grounds of religion, race, caste, sex, place of birth, or any of them. Article 15(2) and Article 15(3) permit the State to make special provisions for women and children, and for any socially and educationally backward classes of citizens or for Scheduled Castes and Scheduled Tribes. Article 16 guarantees equality of opportunity in matters of public employment, and provides that no citizen shall, on grounds of religion, race, caste, sex, descent, place of birth, residence, or any of them, be ineligible for, or discriminated against, in respect of any employment or office under the State. Article 21 provides that no person shall be

²²⁷UN Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No. 21: Equality in Marriage and Family Relations*, 1994, Para. 21-22.

²²⁸UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 22 on the right to sexual and reproductive health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*. Doc. E/C.12/GC/22. 2016. Para. 28.

²²⁹UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 5: Persons with Disabilities*, Doc. E/1995/22. 1994. Para. 30-31.

²³⁰Article 12 defines the State as including the “Government and Parliament of India and the Government and the Legislature of each of the States and all local or other authorities within the territory of India or under the control of the Government of India.”

deprived of his life or personal liberty except according to procedure established by law.

While the right to health (or reproductive rights) is not expressly recognised as a fundamental right in the Constitution of India, several Supreme Court decisions have interpreted the right to health and the right to timely and adequate medical treatment as integral to the right to life. In *Parmanand Katara v Union of India*,²³¹ which was a public interest litigation (PIL) pertaining to the provision of emergency medical treatment to injured victims of motor accidents, the Supreme Court held that Article 21 obligates the State to preserve life, and doctors at government hospitals are duty-bound to extend medical assistance for preserving life. No law, procedure, or State action can void or impede this obligation of medical professionals. In *Paschim Banga Khet Samity v State of West Bengal*,²³² it was held that the State is obligated to provide adequate medical facilities, and denial of timely medical intervention to a person in need of such treatment by a government hospital is a violation of Article 21.

The Supreme Court in *Suchita Srivastava and Another v Chandigarh Administration*²³³ stated that reproductive autonomy is a dimension of personal liberty as guaranteed under Article 21. It held:

“It is important to recognise that reproductive choices can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that a woman’s right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman’s right to refuse participation in sexual activity or alternatively the insistence on [the] use of contraceptive methods. Furthermore, women are also free to choose birth-control methods such as undergoing sterilisation procedures. Taken to their logical conclusion, reproductive rights include a woman’s entitlement to carry a pregnancy to its full term, to give birth and to subsequently raise children.”

Several provisions in Part IV of the Constitution (Directive Principles of State Policy) are related to issues of health. Vide Article 47; it is among the primary duties of the State to raise the level of nutrition and the standard of living of its people and to improve public health. Article 39(e) proclaims that the State should direct its policy towards ensuring that the health and strength of both men and women workers, and of children, are not abused and that citizens are not forced by economic necessity to enter vocations unsuited to their age or strength. Article 39(f) provides that States must take steps to ensure that children are given opportunities and facilities to develop in a healthy manner. Article 42 provides that the State shall make provisions for securing just and humane conditions for work and for maternity relief. Article 45 states that the State shall endeavor to provide early childhood care and education for all children until they complete the age of six years. These provisions are not

²³¹1989 SCC (4) 286.

²³²1996 SCC (4) 37.

²³³(2009) 9 SCC 1.

enforceable in any court, but the State is obligated to apply these principles in making laws and policies because they are fundamental to the governance of the country.²³⁴

²³⁴Article 37, The Constitution of India.

CHAPTER 3: ASSESSMENT OF KEY AREAS OF REPRODUCTIVE HEALTH AND RIGHTS: ISSUES, GAPS AND COMPLIANCE

Reproductive and sexual health rights are a part of comprehensive health rights. To ensure the fulfillment of these rights, a nation country needs to have in place a well-developed public health system that is capable of providing health care services that are comprehensive, of good quality, accessible to all, free at the point of access, and, above all, accountable to citizens. Unfortunately, the public health system in India is challenged by a range of issues, including low public investment, poor infrastructure, including medical and diagnostic facilities, and inadequately skilled human resources. Additionally, the past decades have witnessed increased privatisation and corporatisation of health care and an absence of robust regulation. This has led to a sharp deterioration in the accessibility, affordability, and quality of health care, resulting in further social, economic, and geographical distances from health care, particularly for girls, women, and marginalised communities.

Further, the interface between the health system and women reveals the various forms of social discrimination that influence the formulation, implementation, and operationalisation of biased health policies. The treatment of women, especially those from marginalised sections, at public health facilities is often inadequate, indifferent, and callous, stripping them of their dignity and agency. This results in women's reluctance to seek treatment at public health facilities, thus impacting access and reach. The upholding of reproductive rights and the provision of sexual and reproductive health services are essential to protect the human rights of women, particularly those belonging to marginalised and excluded groups like sex workers, LGBTIQ (lesbian, gay, bisexual, transgender/transsexual, intersex, and queer/questioning) groups, women with disabilities, and ageing women. In this chapter, we will address the major areas of concern related to reproductive health rights by highlighting the gaps in policies and programmes, supported by data and case studies.

The Public Health Context: Major Challenges

India has one of the lowest gross domestic product (GDP) expenditures on health in the world coupled with high out-of-pocket expenditure. The government spending on health care in India is only 1.2 per cent of GDP, or about Rs. 1,300 per capita (2016–17). As a result, the public health care system ends up providing services to less than one-fourth of outpatients. More than two-thirds of the expenditure on health care is borne out of pocket (OOPE), with the cost of medicines alone accounting for 40–70 per cent. It is estimated that about 55 million people are pushed into poverty due to expenses on health care. NSSO 71st Round, conducted in 2014, indicates that the average OOPE for outpatient department (OPD) services is about Rs. 509 per ailment in rural areas and Rs. 639 per ailment in urban areas, with medicines accounting for 70 per cent of this cost. For hospitalisations, the OOPE is Rs. 18,268 per case. The

continuing underfunding of the public health system and the mushrooming of unregulated private sector facilities has contributed to the rising household expenditure on health care.

Similarly, the shortage of trained medical personnel is another factor that hampers the functioning of the public health system in India. The government has stepped back from setting up new medical and nursing colleges and has permitted private medical and nursing colleges to fulfill the requirement of trained and qualified professionals. As of 31 March 2016, 8 per cent of the functioning Primary Health Centers (PHCs), which form the backbone of health services delivery in rural areas, were run without a single doctor.

The implications and effects of the current ills of the public health system are being experienced by women and girls with regard to access to health care, including for reproductive health. As per NFHS-3 (2005–06), 17.3 per cent of women have come in any contact with a health worker. Only 17.9 per cent of PHCs in India have the services of offer the services of a woman doctor.

The National Health Mission (NHM) was conceived as a comprehensive health scheme aimed at guiding the states towards providing universal access to health care through the strengthening of health systems, institutions, and capabilities. NHM consists of two sub-missions, the National Rural Health Mission (NRHM), which was launched in 2005, and the National Urban Health Mission (NUHM), which was launched in 2013. In financial year 2016–17, the Government of India (GOI) allocated Rs. 19,437 crore to NHM. This was a 2 per cent increase over the 2015–16 allocations, but this remains a dismal 1.18 per cent of the GDP expenditure. Initially, 75 per cent of the funds came from the GOI, and the rest from the states. Since 2015–16, however, the allocation from the GOI has dropped to 60 per cent.

Another initiative, the National Adolescent Strategy or the Rashtriya Kishor Swasthya Karyakram (RKSK) in 2014²³⁵, a national level health programme for adolescents envisages the strengthening of the health system to respond to adolescent health and development needs. The programme focuses on age groups 10-14 years and 15-19 years towards improving nutrition, improve sexual and reproductive health, enhance mental health, prevent injuries and gender based violence and prevent substance misuse. While such a programme offers tremendous possibilities to improve the access to information and health care of SRH needs of adolescents, the lack of adequate resources and the poor implementation of the initiative has been a common refrain across states.²³⁶

The Union Cabinet approved the National Health Policy on 15 March 2017. The new policy is perceived as a mixed bag, with some measures that reiterate the role of the

²³⁵ *Operational Framework for Rashtriya Kishor Swasthya Karyakram*. Adolescent Health Division. Ministry of Health and Family Welfare. Government of India. 2014

²³⁶ Unpublished reports on assessments of DISHA clinics. Sama. 2015, 2016.;

Seen, Not Heard Youth Led Audit of Sexual and Reproductive Health Services in Lucknow. Report. The YP Foundation.

public health system in the provisioning of health care. The policy is not clear as to what proportion of the projected increase in public finances (which is estimated to increase from 1.15 per cent of GDP currently to 2.5 per cent of GDP by 2025) would be allocated for the expansion and strengthening of public health facilities. The insufficient allocation of resources is a major barrier to ensuring the health and well-being of all. Reluctance to invest in the establishment of public health institutions is paving the way for the private sector to fill the gap and flourish. But the question remains: can the private sector step in place of the public sector? Can private sector initiatives replace the need for an affordable and effective public health system? Over the years, rather than strengthening the public health system, we have moved towards allowing the private sector to take over this essential space.

Further, committing the requisite budgets both at the central and state levels is imperative to even begin to bridge the existing gaps in the system. As a country we still do not guarantee the right to health as a fundamental right, and with time this stance has come to permeate our policies and programmes.

The overall approach in policy preparation and implementation should be to uphold the principles of inclusiveness, responsiveness, and transparency, with an emphasis on setting up mechanisms for participatory monitoring, review, and accountability at all levels. Limited access to quality health care, information and communication, and other basic facilities in rural, tribal, and even urban settings—especially areas inhabited by tribals, dalits, migrant populations who are often socio-economically disadvantaged and who face social exclusion—denies citizens the opportunity of living their lives with dignity. Moreover, the health system's orientation is largely limited in terms of its understanding of the health needs and the rights of persons with disabilities or persons with diverse sexuality and gender identities. This often results in biased and inequitable policy and programmes that create barriers to information and care. For example, in the context of the rights of transpersons, despite the NALSA judgment upholding their rights to self-determine their gender identity, the binary understanding of gender continues to exist within the health system adversely impacting access to health care.

The Rashtriya Swasthya Bima Yojana (RSBY) is a state-funded insurance scheme that was launched in 2008. The scheme was targeted at poor families (below poverty line [BPL] families). The RSBY gives five members of a family access to cash-free inpatient health care from empanelled facilities for up to Rs. 30,000 per year. The scheme was meant to provide financial protection against catastrophic health costs by reducing the OOPE for hospitalisation and to improve access to quality health care for BPL households. Under the RSBY scheme, public and private health care institutions are empanelled to provide services to patients, which are based on 'packages' for each service. The idea behind the inclusion of both private and public institutions was to provide the patient a 'choice' in accessing health care from either of the two types of facilities.

The scheme, however, has several design-related issues. First, it caters only to inpatients, while the vast majority of patient's access health care as outpatients, especially those patients who have non-communicable diseases (NCDs) like hypertension or diabetes. Second, empanelled private hospitals claim that the cost packages allocated under the scheme do not meet the cost of the treatment incurred by the facility, and hence patients often are made to purchase medicines from outside or are made to pay cash in addition to the entitlements of the scheme. Third, over the years, it became evident that the provisions of the scheme were being used for over-diagnosis and for the irrational use of surgeries to benefit the private hospitals enrolled in the scheme. Several states like Bihar, Andhra Pradesh, and Chhattisgarh reported a surge in unnecessary hysterectomies (removal of uterus) performed by the private hospitals in order to benefit from the insurance money (Arogyasri, Rashtriya Swasthya Bima Yojana).

In this context, it is crucial to locate reproductive health care services within the larger framework of comprehensive health, since the health system plays an important role in enabling the rights related to reproductive health.

Maternal health

Poor maternal health continues to be an unjustifiable, but significant problem in India. This is in spite of the issue garnering significant attention and being the focus of policies and programmes of the GOI as well as international bodies. Maternal mortality is considered a key indicator of maternal health. While maternal health is much more than a matter of maternal deaths alone, maternal mortality is widely accepted as an indicator of a country's maternal health status. While the maternal mortality ratio (MMR) in India has improved over the years, it continues to remain extremely high. Further, there are inter and intra-state differences in MMR that reflect the existing inequalities in access to factors that determine maternal health, including health care services. The approach to addressing maternal health in India is fragmented and focused on promoting institutional deliveries alone, while overlooking the broader framework of sexual and reproductive rights.

Table 1 Maternal mortality ratio: National and state wise figures

Major State	MMR (SRS) (2007-09)	MMR (SRS) (2010-12)	MMR (SRS) (2011-13)
India Total*	212	178	167
Assam	390	328	300
Bihar	261	219	208
Jharkhand	261	219	208

Madhya Pradesh	269	230	221
Chhattisgarh	269	230	221
Odisha	258	235	222
Rajasthan	318	255	244
Uttar Pradesh	359	292	285
Uttaranchal	359	292	285
Andhra Pradesh	134	110	92
Karnataka	178	144	133
Kerala	81	66	61
Tamil Nadu	97	90	79
Gujarat	148	122	112
Haryana	153	146	127
Maharashtra	104	87	68
Punjab	172	155	141
West Bengal	145	117	113
*Others	160	136	126 ²³⁷

(Source: RGI (SRS), 2007–09, 2010–12, 2011–13)

The absence of ANC during pregnancy; lack of emergency obstetric care at tertiary centers; lack of skilled care during childbirth; inadequate equipment and shortage of drugs and blood banks at facilities; lack of PNC services are the most common problems in many public health settings in the country, leading to poor maternal health and resulting in high rates of maternal mortality.

Several factors that affect maternal health—such as access to safe abortion services, access to choice of contraception, dignified childbirth, poverty, and nutrition—remain blind spots in policy.²³⁸ There is lack of accountability when it comes to ensuring the provision of essential services like emergency obstetric care. Women are forced to travel great distances in difficult conditions to access care during delivery in order to be eligible for the incentive provided under the cash incentive scheme, the Janani Suraksha Yojana (JSY). This has further resulted in the complete neglect of the already poor and inadequate antenatal and postnatal care services. The high rate of

²³⁷Government of India. Ministry of Health and Family Welfare. "Achievements Under Millennium Development Goals." News release, July 24, 2015. Press Information Bureau.

²³⁸ *Policy Recommendations for Maternal Health in India*. The Delhi Statement. CommonHealth.2013.

maternal mortality is, above all, an indication of the vulnerable condition of women and the highly patriarchal and gender-based relations that regulate Indian society.

What interventions has the GOI adopted?

Several schemes are currently being implemented by the Union Ministry of Health and Family Welfare (MoHFW) and the Ministry of Women and Child Development (MWCD) to address maternal health and the issues related to it. These are:

- a. Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A)
- b. Janani Suraksha Yojana (JSY)
- c. Janani Shishu Suraksha Karyakram (JSSK)
- d. Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)
- e. Pradhan Mantri Matritva Vandana Yojana

a) Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A): RMNCH+A was initiated in 2013, with a ‘continuum of care’ approach to the health needs of adolescents, mothers, and children. This entails coordinated and integrated delivery of health services through various life-cycle stages, such as childhood, adolescence, reproductive age, pre-pregnancy, childbirth, and postnatal. The ‘continuum of care’ approach also includes integrating service delivery in places where health care is provided, that is, at home, at the community level, and at health facilities. The RMNCH+A approach attributes maternal mortality to three broad reasons, namely medical, socio-economic, and health system-related factors. The medical causes of maternal mortality include hemorrhage, infections during the pregnancy, labor, and postpartum periods, and unsafe abortions.

b) Janani Suraksha Yojana (JSY):²³⁹ MoHFW launched JSY in 2005 to promote institutional delivery by providing monetary incentives. The scheme offers cash assistance to pregnant women and to mothers for post-delivery care, and is applicable nationally. While all pregnant women, including women belonging to Scheduled Castes and Scheduled Tribes in the low-performing states,²⁴⁰ are eligible under JSY, the scheme in high-performing states covers pregnant women aged 19 years or above and those belonging to BPL families, and all pregnant women belonging to Scheduled Castes and Scheduled Tribes. Accredited Social Health Activists (ASHAs) are the core functionaries of the scheme. The ASHA was responsible for identifying pregnant women, counseling them, facilitating antenatal care (ANC), accompanying the women for institutional delivery, arranging for transport to the health centre at the time of delivery, and ensuring disbursement of the cash assistance to the women. The strategy or rationale of JSY was based on the belief that the proposed incentives would lead to higher numbers of pregnant women registering their pregnancy,

²³⁹ "Janani Suraksha Yojana- Background." The National Health Mission. <http://nhm.gov.in/nrhmc-components/rmnch-a/maternal-health/janani-suraksha-yojana/background.html>

²⁴⁰ Eight states with low institutional delivery rates have been identified as Low Performing States (LPS) requiring special focus (Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa, and Jammu and Kashmir).

receiving ANC, being monitored for complications, and undergoing safe delivery at institutions. States also set up emergency ambulance facilities (under the 108 Seva, later modified to the 102 Seva) to transport women from remote and far-flung areas to nearby institutions.

However, the linkage of monetary incentive to the fulfillment of institutional delivery has led to institutional delivery being the exclusive focus, while drawing attention and resources away from ANC, and even postnatal care (PNC), which has led to additional problems. Further, the infrastructural and human resource inadequacies of the public health institutions have led to compromises in the quality of care. The case of maternal deaths of women from marginalised communities in Barwani district, Madhya Pradesh due to unnecessary referrals, institutional inadequacy and lack of preparedness in handling huge numbers of institutional deliveries, and lack of attention to ANC and PNC²⁴¹ are all indicative of the shortfalls of such an approach.

c) Janani Shishu Suraksha Karyakram (JSSK): MoHFW launched JSSK in 2011. JSSK complements the goals and objectives of JSY. The scheme entitles pregnant women to free and cashless deliveries at government facilities and institutions. JSY and JSSK between them provide the following free entitlements to pregnant women: (i) free and cashless delivery; (ii) free C-section; (iii) free drugs and consumables; (iv) free diagnostics; (v) free diet during their stay in health institutions; (vi) free provision of blood; (vii) exemption from user charges; (viii) free transport from home to health institutions; (ix) free transport between facilities in case of referral; (x) free drop-back from health institutions to home after 48 hours of stay. These benefits are in addition to the financial assistance provided under JSY. They are meant to be provided to all women who deliver in government health facilities, regardless of age, number of children, and/or economic status. However, according to the report submitted for the Universal Periodic Review (UPR)

Among the maternal deaths documented, bewildered family members were asked to negotiate the complex procedures of the blood bank and families were made to pay large amounts for medicines, transportation and services in public hospitals despite the JSSK. Emergency transport is unavailable or delayed [,] leading to delays in reaching health facilities. (Case of Garli²⁴²). Post-partum care is unavailable, even though this is the most crucial period where mortality occurs. Lack of blood continues to be a critical gap despite

²⁴¹ Subha Sri, Sarojini N., and Renu Khanna. *Maternal Deaths and Denial of Maternal Care in Barwani District, Madhya Pradesh: Issues and Concerns*. Publication. Delhi, Delhi: Sama, 2011.

²⁴² When Garli (name changed), an adivasi woman in Rajasthan, delivered her fifth baby in a Community Health Centre, the placenta was retained. The nurse gave Garli some injections and waited for one hour before calling the doctor. The doctor waited another one and a half hours before referring her further. Garli was not provided a vehicle although she was bleeding, nor did any health care provider take the responsibility of accompanying her. By the time her husband arranged money and got a vehicle to transport her, another one and a half hours had elapsed. Garli died on the way to the referred facility.

plans to establish blood banks in every district and blood storage units in every First Referral Unit (Case of Salma²⁴³).²⁴⁴

d). Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA): MoHFW launched the PMSMA²⁴⁵ in 2016 to reduce maternal mortality by promoting general wellness, and to provide free ANC for pregnant women on the 9th of every month across the nation. PMSMA is aimed at strengthening the ANC services through the participation of the private sector. This raises questions about the availability of qualified health care professionals in the public sector and also raises doubts about the extension of the scheme to include user fees for ANC services in the future. This underlines the fact that the ANC services provided currently through outreach and at public health facilities are inadequate (the approach of limiting this service to ‘certain government health facilities’ raises questions about its accessibility, especially for women living in ‘remote areas’). The scheme encourages private-sector involvement—both as pro bono partners and as outsourcing partners—to meet the quality standards that the public health system is unable to meet. This approach, however, raises questions about the availability of health for all, as it indicates the shift in the role of the government from provider of services to ‘purchaser’ of services. It reveals a change in the nature of ‘health care’ from a public good to a private good, and it also indicates the introduction of user fees for services that were formerly ‘free’.

e). Pradhan Mantri Matritva Vandana Yojana, which was launched in 2017, is intended to deposit a cash incentive of Rs. 5,000 directly into the accounts of Pregnant Women and Lactating Mothers (PW&LM) for the first living child of the family in an attempt to improve the health-seeking behavior of beneficiaries. The eligible beneficiaries would receive the remaining cash incentives as per the approved norms towards maternity benefits under JSY after institutional delivery, so that, on an average, a woman would get Rs. 6,000.²⁴⁶

Implementation of existing schemes: The ground reality

Despite these various schemes and programmes, NFHS-4 (2015–16) reveals that only 21 per cent of women across the nation have received full ANC. The already huge disparity between different regions may even be growing (see Table 2). The inequities between different regions and their impact on the reproductive health and rights of women are matters of deep concern.

²⁴³ Salma was admitted in a civil hospital in Assam in the fifth month of her second pregnancy with bleeding. Her family was told that she needed a D&C and was asked to arrange blood. By the time they managed to do so, the doctor had left, so Salma could not receive the transfusion and she died soon after.

²⁴⁴ *Maternal and Reproductive Health; Joint Stakeholder Report to UNHRC for India's UPR – III.* NAMHHR, CommonHealth and Jan Swasthya Abhiyan. September 22, 2016. Submitted on Behalf of the Coalition of Organizations on Sexual and Reproductive Rights, India (SRHRIndia)

²⁴⁵ "Pradhan Mantri Surakshit Matritva Abhiyan." National Health Portal. <https://pmsma.nhp.gov.in/>.

²⁴⁶ Government of India. Ministry of Women and Child Development. "Maternity Benefits Under Pradhan Mantri Matru Vandana Yojana." News release, December 28, 2017. Press Information Bureau.

Table 2 Status of antenatal care (ANC) across states: NFHS 4

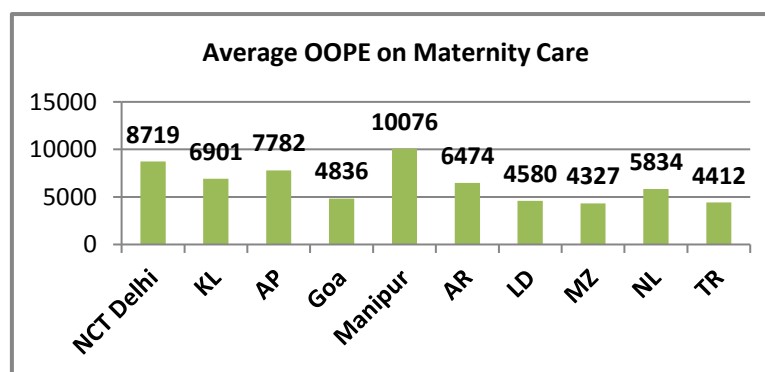
Women who received full antenatal care during pregnancy (per cent) – NFHS-4			
Lakshadweep	66.4	Daman and Diu	29.9
Goa	63.4	Jammu & Kashmir	26.8
Kerala	61.2	Meghalaya	23.5
Puducherry	55.6	Odisha	23.1
Andaman & Nicobar	53.6	West Bengal	21.8
Tamil Nadu	45	Chhattisgarh	21.7
Andhra Pradesh	43.9	Haryana	19.5
Telangana	42.2	Assam	18.1
Manipur	39.9	Uttarakhand	11.5
Sikkim	39	Madhya Pradesh	11.4
Mizoram	38.5	Rajasthan	9.7
Delhi	37.3	Jharkhand	8
Himachal Pradesh	36.9	Tripura	7.6
Chandigarh	34.7	Uttar Pradesh	5.9
Dadra and Nagar Haveli	33.1	Arunachal Pradesh	3.6
Karnataka	32.9	Bihar	3.3
Maharashtra	32.4	Nagaland	2.4
Gujarat	30.7	Punjab	30.7

The provision of ANC is a critical opportunity for health providers to deliver care, support, and information to pregnant women, including but not restricted to the detection and prevention of diseases; and to support women who may be experiencing

domestic or spousal violence. Further, anemia is another primary condition that antenatal check-ups aim to identify and treat in the attempt to promote maternal and child health. However, the data indicate that currently almost 20 per cent of Indian women have below-normal BMI, and almost 50 per cent of both non-pregnant and pregnant women in the country are anemic.²⁴⁷ NFHS-4 also reveals that only 30.3 per cent of mothers consumed iron and folic acid tablets for 100 days or more when they were pregnant. The existing scenario points to the need for launching programmes to extend coverage and for establishing strong monitoring and evaluation systems for low-performing states.

Further, NFHS-4 also highlights that only 36.4 per cent of mothers received financial assistance under JSY for births delivered in a public institution, while the average OOPE at a public health facility remains as high as Rs. 3,198 per delivery.²⁴⁸ A study on “high spending on maternity care in India” (2016),²⁴⁹ found that out of the 14,482 deliveries analyzed, no costs were incurred in only 0.14 per cent of the deliveries, despite the availability of health schemes such as JSY and JSSK. The study highlights that maternity entitlements under JSY are not sufficient to put a check on catastrophic expenditure on maternity care; the mean spending on maternity care was found to be ten times higher than the amount of the JSY voucher. The evidence indicates that there are many indirect costs involved as well, like wage loss of the accompanying family members, which further increases the financial burden on the family from a poor socio-economic background. Survey data show that OOPE on maternal health have not fallen, despite the introduction of some of the above-mentioned schemes.²⁵⁰ The states with the highest OOPE are shown in Figure 4.²⁵¹

Figure 4 OOPE on maternity care: Top ten states



This was clearly illustrated in the following case study of Farida Begum, a 21-year-old woman from Assam who died while giving birth to her first child at the Silchar

²⁴⁷Global Nutrition Report 2017: *Nourishing the SDGs*. Report. Development Initiatives. Bristol, UK.

²⁴⁸ *National Family Health Survey 4*. Ministry of Health and Family Welfare, Government of India. Mumbai: International Institute for Population Sciences, 2015-16.

²⁴⁹Goli, Srinivas, Jalandhar Pradhan, Shruti, and Anu Rammohan. "High Spending on Maternity Care in India: What Are the Factors Explaining It?" *PLoS ONE*, June 24, 2016.

²⁵⁰India Brand Equity Firm. *Healthcare*, August 2015.

²⁵¹*National Family Health Survey 4*. Ministry of Health and Family Welfare, Government of India. Mumbai: International Institute for Population Sciences, 2015-16.

Medical College and Hospital (SMCH). Her experience highlights how many people are compelled to incur large and onerous OOPE and the extreme conditions that drive them to do so.

Farida had been married for almost a year. It was her first pregnancy. She was registered at the Banskandi primary health centre (PHC) (Assam) and received two ANC check-ups. During the ANCs, she received 100 iron tablets and a tetanus toxoid injection. On 24 June, at 3:00 p.m., Farida's labor pains began. Her husband called the ASHA worker and asked her to accompany the family to the Banskandi PHC for Farida's delivery. The PHC was located 2 kilometers away from their residence, but the ASHA asked them to wait till the morning. Farida's husband called for an ambulance later, but there was no ambulance on duty that day. In the absence of an ambulance and other transport facilities, Farida had no option but to wait through the night, suffering in pain.

The next morning, at around 6.00 a.m., Farida's condition deteriorated. She and her husband somehow managed to reach the PHC and learnt that there was no doctor or nurse available at the time. The doctor and nurses would arrive only at around 10.00 a.m. The Medical Officer (MO) of the PHC, who arrived a little later, examined Farida and suggested that she and her husband should wait there for the delivery. The family requested the doctor to check Farida for the second time, but he refused. The general nurse and midwife (GNM) performed the delivery and an episiotomy was done. Farida delivered a baby girl. However, as complications arose, the doctor referred Farida to the SMCH at 4:00 p.m. The PHC could not provide a vehicle to transport Farida for the referral because the drivers of the 102 ambulance service were on strike.

However, the doctor provided the family some money so that they could travel by a private vehicle to Emanuel Rural Hospital, run by Christian missionaries. Throughout this time, Farida continued to bleed. Her family members decided to go to the missionary hospital given the poor condition of the roads to Silchar and the proximity of the missionary hospital compared to SMCH, which was located nearly 27 kilometres away and which is almost impossible to reach on time because of the terrible roads. They reached the missionary hospital at 5:30 p.m. Farida Begum was admitted there. On 25 February, at around 4:30 a.m., her condition deteriorated and she was ultimately referred to SMCH. The family then hired a private car and took her to SMCH. At SMCH, Farida received seven units of blood. Her husband had to arrange for blood at the cost of Rs. 3,300 per unit. In total, he paid Rs. 23,100 for blood. He took loans from his relatives to cover the expenses. The hospital continued to observe Farida, but she died on 28 February at 6:15 p.m.

(Source: Seeking Sexual and Reproductive Health Services and Rights. Prayas)²⁵²

Farida Begum's case is a clear example of a wide range of violations of the fundamental rights guaranteed under the Constitution of India where the state failed to provide the minimum health services that would have prevented her death. In the absence of specialists and gynecologists, she faced two deadly delays during referral (from the PHC to the Emanuel Rural Hospital and then further to SMCH). In addition, further delays resulted due to lack of ambulance service.

Conclusion

In spite of the increase in the number of institutional deliveries in recent years, quality of care remains a serious concern. Vulnerable women from marginalised caste groups and from geographically remote areas continue to be excluded from public health programmes. Maternal health needs to be addressed within the larger framework of the collapsing health systems in the country, and should be seen on a continuum of other repressive policies and programmes that address the socio-political context of health.

The other areas of concern are the lacunae in the implementation of schemes, including non-portability of schemes across states, especially in the context of inter-state migrants, overlapping of schemes, and incomplete data collection under JSY. These gaps were noted by the Delhi High Court in the case of *Laxmi Mandal vs Deen Dayal Harinagar²⁵³ Hospital and Ors*. It directed that “if a person is declared below poverty line (BPL) in any state of the country and is availing of the public health services in any part of the country, such person should be assured of continued availability of such access to public health care services wherever such person moves.” The Delhi High Court identified a place where the woman could avail of all schemes related to maternal and infant health; called for the setting up of monthly camps in rural areas for health check-ups of pregnant women and infant children; recommended improving the system of referral to private hospitals; and called for ensuring prompt ambulance service to and from the residence and the health facility. The court also held that a woman in a family who is a homemaker should be recognised as a primary breadwinner under the National Family Benefit Scheme, and in the case of maternal death, her family should avail the cash benefit.

Farida Begum's tragic death underlines the imperative need to strengthen the health care infrastructure, to improve the skills of human resources, and to raise the quality of care at all levels of health facilities along with better transportation and reliable availability of blood supplies. Her death was due to the unavailability of proper health care, including the absence of health care providers and the lack of ambulance services at the time of her delivery, while incurring a cost that compelled her husband

²⁵²Mukherjee, T., & Sisodia, K. (Eds.). (n.d.). Seeking Sexual and Reproductive Health Services and Rights. Prayas.

²⁵³ *Laxmi Mandal vs Deen Dayal Harinagar Hospital and Ors*, W.P. (C) 8853/2008, High Court of Delhi, judgment dated 04.06.2010

to take loans from his relatives to support her treatment. This case study reveals clearly that the indicators for measuring and monitoring maternal health are not based on data, information, or feedback on the quality of care and completely neglect the experiential narratives of women. The women's actual experiences with the health care system need to be one of the primary bases for formulating and amending policies and schemes, and for improving the reproductive health policies of the country.

Maternity benefit programmes

In India, 95 per cent of women workers are employed in the informal and unorganised sector, and do not receive any wage compensation during pregnancy and after childbirth, although they are expected to rest, to gain weight, to improve their own health, and then to provide the baby with exclusive breastfeeding for six months. The Economic Survey 2016–17 (Ministry of Finance, GOI) notes that “42.2 per cent Indian women begin pregnancy too thin and do not gain enough weight during pregnancy” and recommends that “some of the highest economic returns to public investment in human capital in India lie in maternal and early life health and nutrition interventions.”²⁵⁴

While India has several schemes as well as various laws that provide maternity benefits (at least on paper), on the ground, however, more than 90 per cent of working women in this country end up having little or no access to such entitlements. Even more alarmingly, in the absence of any data, it is difficult to estimate if anyone is receiving the budgeted maternity benefits.

Maternity benefits of at least Rs. 6,000 for all pregnant and lactating women (except those working in government/public sector undertakings) have been a legal entitlement for almost four years now, guaranteed under the National Food Security Act (NFSA), 2013. However, in 2017, the cabinet approved the Maternity Benefits Programme (MBP), which goes against the spirit of the NFSA. Firstly, it is restricted to only the first birth. There is no justification for this condition other than the need to keep the financial obligations to the minimum. Conditionalities like the two-child norm and the age of marriage have been shown to be fundamentally discriminatory against both women and children, affecting in particular the most marginalised and vulnerable women, largely from socially discriminated communities such as the Scheduled Castes (SC), the Scheduled Tribes (ST), and minorities, thereby putting their lives at risk. Second, in another unwarranted move, the MBP has also been linked to institutional delivery, possibly to further reduce the funds allocated, and therefore was merged with the JSY. JSY is an older scheme that was launched with an entirely different purpose, which was to incentivise institutional deliveries; whereas the MBP is intended to provide wage compensation, just as it does in the formal sector, and has been included in the NFSA as a minimum incentive of Rs. 6,000 for that purpose alone. Based on data from the latest NFSA, 21 per cent of children born at home are ineligible for JSY.

²⁵⁴ *Economic Survey 2016–17*. Ministry of Finance. Government of India.

The MBA was recently amended to expand the duration of maternity leave from 17 weeks to 26 weeks. While this was a welcome move, the MBA covers only about 18 lakh women in the organised sector, whereas over 2.7 crore deliveries take place in India each year. The MBA does not include in its ambit more than 95 per cent of women in the country who are in the informal sector. When the requirement of six months of paid leave has been accepted for women in the formal sector (public and private), it is unacceptable that a wage compensation of less than half of minimum wages, and that too only for one birth, should be the norm for the rest of the women in the country. In fact, the modest maternity entitlements under the MBP are barely the equivalent of five weeks of minimum wages in Bihar State (compared to the paid leave of more than six months offered in the formal sector). Such meager wage compensation in the light of the amendment to the MBA would, in fact, amount to discrimination and inequality before the law under Article 14 of the Constitution.

Maternity entitlements for women in all sectors must be universal and unconditional, and should not be linked to the number of children borne by the woman or to the age of the woman, as these conditions are fundamentally discriminatory against both women and children.

Access to Information and Utilisation of Contraception Services

Guaranteeing access to available, acceptable, and comprehensive information about safe contraception and services, free from coercion, discrimination, and violence is critical towards ensuring the realisation of the reproductive rights of women. The right to comprehensive information about contraception and safe, quality contraceptive services is recognised by multiple human rights, including the right to life, the right to the highest attainable standard of health, the right to decide the number and spacing of one's children, the right to privacy, the right to information, and the right to equality and non-discrimination, under various international laws, treaties as discussed in previous sections of this report.

CEDAW advocates that women should be enabled to make informed decisions regarding the contraceptive method that is appropriate for them-“women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services”.²⁵⁵ The Programme of Action from International Conference on Population and Development (ICPD) 1994, recognised contraceptive information and services as essential to ensuring human rights pertaining to reproductive health. Further, the Committee on the Rights of the Child has indicated “States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs).”²⁵⁶

²⁵⁵CEDAW Committee, General Recommendation 21, supra note 24, para. 22.

²⁵⁶*The Right to Contraceptive Information and Services for Women and Adolescents-Briefing Paper*. Centre for Reproductive Rights and UNFPA.2010.

Access to accurate information about contraceptive options, including information about possible side-effects and potential failures of contraceptive methods are essential preconditions for a person to exercise their reproductive autonomy, plan whether and when to have children and decide the spacing of children freely and responsibly. *The Supreme Court of India in Suchita Srivastava & Anr. vs Chandigarh Administration*²⁵⁷ has recognised women’s rights to access contraception services and choose birth control methods freely:

“The crucial consideration is that a woman's right to privacy, dignity and bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively the insistence on use of contraceptive methods. Furthermore, women are also free to choose birth-control methods.” (Para 11 of the judgment)

Unfortunately, the perception of control of women’s fertility towards controlling or stabilizing the population rather than ensuring their rights to enjoy safe and fulfilling sexual relations, has been the overarching motivation for the ‘family planning’ programme in the country. This continues to drive the family planning programme and the access to contraception – directing preference for long term, permanent contraceptive methods, with primary focus on women. This is evident from the table given below which presents the extremely gendered and focus on long term contraceptive methods for women.

Table 3 Family planning services utilisation

Use of family planning methods in India (per cent)		
Indicators (per cent)	NFHS 4 (2015-16)	NFHS 3 (2005-06)
Any method	53.5	56.3
Any modern method	47.8	48.5
Female sterilisation	36.0	37.3
Male sterilisation	0.3	1.0
IUD/PPIUD	1.5	1.7
Pill	4.1	3.1
Condom	5.6	5.2

²⁵⁷Suchita Srivastava & Anr. vs Chandigarh Administration. (SC 2009). Available online at <http://www.globalhealthrights.org/wp-content/uploads/2012/11/SC-2009-Suchita-Srivastava-v.-Chandigarh-Administration.pdf>

The trends in the current and the past use of contraceptives indicates that 66.0 per cent of currently married women (aged 15-49 years) have used some method of contraception in their life, and female sterilisation is the most widely used method with 37.4 per cent of women reporting it. Use of pills, IUDs and condoms was at 11.1 per cent, 6.3 per cent and 13.9 per cent respectively.²⁵⁸ The data reveals that the median age when women underwent sterilisation was 25.5 years, and 81 per cent of the women who underwent sterilisation were below 30 years.²⁵⁹ Availability and stress on irreversible methods of contraception, rather than on short-term methods is a significant issue, especially since a substantial number of women are undergoing sterilisation at a very young age. The data also indicates almost negligible levels of men using temporary and permanent methods of contraception.

The total unmet need of family planning in India is 12.9 per cent nationally and unmet need for spacing is 5.7 per cent (NFHS 4). The unmet need of accessing contraceptive information and services means that people particularly women and adolescents are unable to protect themselves from HIV and other sexual transmitted infections (STIs), or to control their fertility and reproduction.

Further, 'family planning' has primarily been perceived in the context of marriage and procreation; thus, norms around gender and sexuality pose barriers or stigmatise access to contraception for young people and adolescents, single women and others who are outside the domain of marriage.

Right to contraception information and services

India, as a signatory to various international human rights covenants and instruments, is obligated to ensure that information and services for contraception are available, accessible, acceptable, and of good quality. These services must be free from coercion and discrimination. Comprehensive information must be made available as a right to all regardless of marital status to enable informed and autonomy in decisions regarding contraception. Systems to ensure access to contraceptive information and services are made available through the public health system, while allocating sufficient resources in building the infrastructure of the public health system as well as capacities of the health care workers at varied levels of the health system to offer contraception knowledge and services in a non-discriminatory manner, and free from practices which are in violation of the human rights of people, for instance coercing a woman to undergo sterilisation without proper informed consent as is described later in the section.

Comprehensive information about contraceptives, including possible side effects is a huge deficit. Legal and practical barriers to contraceptive information and services lead to unwanted pregnancies, harboring the risk of unsafe abortion, or maternal mortality and morbidity that violate the rights to life and health. Data points to the

²⁵⁸ National Family Health Survey 3, *Family Planning*, Chapter 5, Table 5.4

²⁵⁹ National Family Health Survey 3, *Family Planning*, Chapter 5, Table 5.11.1

unacceptably low levels of information available to users of contraceptives. Women who were using modern contraceptives methods were asked whether they had been informed about the possible side effects or problems of the method - 32.2 per cent reported in the affirmative; whether they were told what to do if they experienced side effects - 26.0 per cent reported in the affirmative; and whether they were informed about other methods they could use - 27.9 per cent reported in the affirmative. Female sterilisation users were the least likely to be informed about the consequences of the method, possible alternatives and the steps to take if they experienced side effects of sterilisation (NFHS3).²⁶⁰

In terms of the quality of family planning services, latest available data indicates that 46.5 per cent of current users have talked about side effects of the method they are using, and majority of current users are women in the country (NFHS 4).

Young people or adolescents are one such group who most frequently encounter significant barriers leading to the high risk of unintended pregnancy and high risk of contracting HIV, STIs etc. Stigma around adolescent sexuality or requirement of parental consent deters adolescents from seeking contraceptive services when required. The cost involved in accessing contraceptive services could also play a significant obstacle as they frequently lack their own source of income or control over their finances to be able to afford contraceptives.²⁶¹

Autonomy and informed consent in the context of contraception

The autonomy of women to make informed decisions about contraception is severely curtailed at the point of the health system in the absence of access to comprehensive information about the contraceptive method, the contraindications, the risks, possible adverse effects and alternatives available to the woman who is accessing contraception.

Contraceptive targets, coercive application of contraceptive methods flout the principle of informed consent and violates the rights, health and well being of women. Such instances of violation are not uncommon and reflect the orientation of the health system, motivated by the perception of women's bodies (especially from marginalised communities) as sites of control of fertility and targets for contraception. The following case study reflects all these issues that impact access to safe, quality contraception.

Anjali Devi, a resident of Sikat gram panchayat, Barari block, Katihar district, Bihar died on 17th November 2016, at the block level public health facility following the delivery of her child and forceful post partum insertion of intra-uterine contraceptive device (PPIUCD) by the hospital staffs. Anjali Devi was 30 years old, worked as agricultural wage laborer in the village. Her husband, Bablu Chaudhary, is a migrant

²⁶⁰ National Family Health Survey 3, *Family Planning*, Chapter 5, Table 5.17

²⁶¹ *The Right to Contraceptive Information and Services for Women and Adolescents-Briefing Paper* by Centre for Reproductive Rights and UNFPA.2010.

worker in Punjab and Delhi areas. She was mother to five daughters (including the newborn girl child on 17th November, 2016).

Anjali Devi was taken to the Barari referral hospital (FRU) for her delivery around 10 am on 17th November, 2016. She was accompanied by her father-in-law, mother-in-law, aunt and midwife (dai) to the hospital. The family reserved an auto for 500 rupees to take her to the hospital, as the ambulance facility was not available.

Barari referral hospital (FRU) is located around 7-8 kilometres from Sikat gram panchayat. It is a 30 bedded hospital having five medical officers and four staff nurses. The hospital does not have facilities for storage of blood units, oxygen cylinder, or any linkage with any blood bank. The next referral contact for this hospital is the District Hospital, Katihar which is located at a distance of about 20 kilometres.

Anjali Devi was admitted in the hospital, but the family members had to buy some of the medicines from an external pharmacy as it was not available in the facility and they were also charged Rs 200 for administering injections. She had a normal delivery and gave birth to a baby girl around 11:20 am. Immediately after the delivery, when Anjali Devi was semi-conscious, the nurse asked the family members whether they would want a PPIUCD for her. They denied permission and told her that Anjali Devi's husband was not present there and she and her husband would jointly take this decision later on whether to go for an IUCD or sterilisation operation. The family members then went to meet Anjali Devi in the labor ward, where she was semi-conscious; she asked for some water to drink from her family. The family members then with the permission of the nurse, gave her some water, tea and biscuits. Anjali Devi seemed exhausted at this time, so the family members left her to rest, while they also went out of the hospital to have breakfast. Around 12.15 pm, when the family members returned to the ward they found that Anjali Devi was throwing up her hands and legs in pain. Anjali Devi's aunt went up to her bed and when she uncovered the sheet, they found it covered in blood. The aunt and other family members in shock and distress started asking around and calling the staffs to find out what had happened to Anjali Devi. It is then when they found that the IUCD had been inserted, despite being told not to do so, following which her condition had worsened. The PPIUCD was inserted around 12 noon as told by the hospital staff.

At this point, Anjali Devi was profusely bleeding but no one at the hospital was attending to her. The family, feeling helpless and sensing some foul play at the hospital, called for help from the village, they called the gram panchayat mukhiya (head) and PACS²⁶² president from the village for help. The PACS president sought help of the police and asked them to go to the Barari hospital to look into the matter. Meanwhile, an hour and half had passed and Anjali Devi kept bleeding profusely; when her condition deteriorated, the hospital authorities told the family members to take her to District Hospital Katihar. They were not provided an ambulance. The hospital staffs got an auto and told the family members to take her soon to Katihar District Hospital. The hospital didn't provide any referral slip or report to Anjali Devi's family members.

²⁶²Primary Agricultural Credit Cooperative Society

On way to the district hospital in the auto, family members realised that Anjali Devi had died, following which they immediately returned to the Barari hospital. Anjali Devi died around 1.30 pm. By this time the police also reached the Barari hospital, and made their enquiries.

(Source: Personal interactions were held with woman's family members; and health staffs, local organisation-Jan Jagaran Shakti Sangathan (JJSS); Jan Swasthya Abhiyan (JSA) activists in Bihar)

The police report cleared the hospital of all responsibility, despite family member's narratives insisting otherwise. The police refused to lodge an FIR on the incident of death terming it as "normal death" and that "such deaths keep happening during linked to maternal deliveries and child birth". Several attempts by Anjali Devi's husband, along with the local organisation and community members were made and finally succeeded in filing an FIR against the hospital at the local police *thana* on 23rd November, 2016. In the maternal death report, it was opined that she died due to post partum hemorrhage (PPH). The family members strongly feel that Anjali Devi had probably passed away on her hospital bed itself, following which the hospital authorities had insisted that she be taken to the DH.

The forceful PPIUCD administration by the hospital clearly violated Anjali Devi's right to free and informed consent to contraception as well as the available guidelines for PPIUCD in this case. As per the PPIUCD reference manual by MoHFW (2010), informed consent of the woman is mandatory before PPIUCD insertion – '*...the PPIUCD must only be placed after the woman is counseled and has given informed consent.*'²⁶³ Further, as per the *WHO Medical Eligibility Criteria*, the woman must be screened for clinical situations including the high individual risk of PPH and such a screening should take place in the antenatal period, as well as immediately prior to insertion, in the immediate postpartum period.²⁶⁴ But Anjali Devi was not screened for PPIUCD during ANC or in the hospital, evident from absence of any document at the facility.

A larger concern was the continuation of targets at the health facility level for family planning methods. During the hospital visit to Barari referral hospital, on being asked about the expected level of achievement (ELA) for the hospitals under family planning, the hospital staffs shared that the ELA for IUCD is 267 for one month, which was same target for sterilisation as well. Barari hospital handles around 250-300 maternal deliveries per month, making it around 10-12 per day. However, the hospital lacked a blood storage unit against the IPHS norms for an FRU facility. This also raises issues of skills of staff to be able to manage PPH or other complications that are required at an FRU.

²⁶³*Post Partum IUCD Reference Manual*. Family Planning Division, Ministry of Health and Family Welfare.
Government of India. November 2010.

²⁶⁴*Ibid.* Page 5.

The right to make a decision without coercion, with comprehensive information and counseling was violated in this case with an extremely tragic outcome. Further, compensation for such a death, available in the case of failure or deaths following sterilisation is not available in the context of PPIUCD.

Sterilisation: camp approach a violation of human right

The tragic deaths of the 13 women, all in their 20s or 30s and the critical condition of the 70 other women, following procedures of laparoscopic sterilisation in camps held in November, 2014 in Bilaspur district, Chhattisgarh, raised grave questions once again about the callous treatment of women, the poor and marginalised as well as the clear violations of ethical and quality norms in the health care system. Following is the narrative based on discussions with the family members of Rekha who was amongst one of the 13 women who had died.

Rekha was one of the 13 women who died following the procedures of laparoscopic sterilisation in a camp in Bilaspur, Chhattisgarh in November 2014. Rekha belonged to a marginalised caste background dependent on daily wage labor for her family's sustenance. Rekha had studied till Class 10 and was married to Jagdish Nirmalkar who had studied till Class 8. They had two children - the older one was two and a half years and the younger one was four months old. The nurse from the local PHC in their village Amsena, informed Rekha about the sterilisation camp on 8th November. Rekha's grandmother accompanied her to the camp where she was registered and some tests were conducted before taking her inside around 4 pm. Her grandmother mentioned that when they arrived, there was someone sweeping the place to get it ready for the surgeries. Rekha left the camp around 6 pm and returned home with some medicines, which she took around 9 pm. Sometime close to midnight, Rekha began vomiting repeatedly. The family checked with others in the village who had gone to the same camp and found that they were all very sick. The next morning all the women reached the PHC and Rekha was admitted and was on IV fluids. Around 1.30 pm, they were all moved to the Bilaspur District Hospital by ambulance. While being treated there, Rekha's condition worsened, so they arranged for her to be shifted to the Apollo hospital, but she passed away as she was being taken to the ambulance.²⁶⁵

Another case from Maharashtra also raises critical issues with regard to sterilisation camps that continue to be organised at great peril to the women who access these services:

A family planning camp was organised by the Medical Officer of Belora PHC in Yavatmal, Maharashtra, where at least fifteen women from the village underwent tubectomy. However, after the procedure, health of at least three women deteriorated,

²⁶⁵Camp of Wrongs-The mourning afterwards - A fact finding report on sterilisation deaths in Bilaspur.Sama Resource Group for Women and Health, Jan Swasthya Abhiyan, National Alliance for Maternal Health and Human Rights. 2014.

following which their relatives rushed them to the government hospital in Pusad and then to GMC Hospital in Yavatmal on the advice of doctors. While one woman named Sharada was brought dead to the hospital, two other women were admitted in GMC Hospital in Yavatmal.

(Source: Through online source at <http://www.dnaindia.com/india/report-two-months-on-no-fir-in-Yavatmal-botched-tubectomy-case-2360818>. January 19, 2017)

This case study represents gross medical negligence at the hands of the doctor conducting the operations on women. These procedures are repeatedly carried out without adequate care and adherence to the safety of women, which leads to adverse events, including death, a gross violation of the right to life, and therein the right to access safe and quality health care including for contraception. The attitude of the health system towards the rights of women and girls in these cases, points to the preoccupation of the health system with achieving targets even at the cost of lives and health of women and girls.

Failure of implementation of standards and guidelines

The Supreme Court in *Devika Biswas*²⁶⁶ recognised that the “*sterilisation programme is virtually a relentless campaign for female sterilisation*”, and that a system of informal targets for the sterilisation programme was in place. It reasoned that men were given fewer incentives to undergo sterilisation as compared to women, and this contributed to the low level of male sterilisations. It directed the Union of India to address this issue on grounds of gender equity. The Court also held that the sterilisation procedures under scrutiny imperiled the right to health and reproductive rights of a person, which were important components of the right to life under Article 21. Importantly, the Court drew attention to the harmful effects that State policies such as setting informal targets and offering incentives to undergo sterilisation have on the reproductive rights of vulnerable groups whose impoverished socio-economic conditions makes them susceptible to coercion and leaves them bereft of meaningful choice. The Court held that in order to eliminate discrimination and ensure substantive equality, policy and incentive schemes for sterilisation must be made gender neutral and “*unnecessary focus on female sterilisation [be] discontinued*”. The Court further directed each state and union territory to ensure that no targets are fixed and health-workers do not coerce anyone to undergo sterilisation to meet their targets.

The grievance redressal mechanisms have also proven to be inadequate in instances when the women have sought administrative or judicial remedy over the violations of their human rights with respect to their life and health. The Bilaspur High Court order in the case of sterilisation related deaths of 13 women (as discussed in previous sections) exemplifies this in the manner the accused doctor was set free on ‘technical grounds’.

²⁶⁶ Writ Petition (C) 95/2012, judgment delivered on 14.09.2016

On February 15, 2017 the Bilaspur High Court ordered that all charges be dropped against Dr RK Gupta, who was accused in the case of Bilaspur sterilisation deaths of 13 women that happened in November 2014. The court opined that the investigators had failed to take permission from the state government to prosecute the doctor who was a government employee at the time of the incident. The long-standing expectation of the guilty being punished and seeking justice has been belied. In this case, the contravention of reproductive rights of the women led to an extreme form of violation leading to the loss of their lives. And, consequent lack of rendering any conviction to the guilty or improvement in the family planning and health services to women points to the non-recognition of women's reproductive rights and justice by the government and allied systems of justice as well.

(Source: 'Sterilisation deaths: The doctor is off the hook and the Chhattisgarh government's apathy continues', March 04, 2017, <https://scroll.in/pulse/830723/sterilisation-deaths-the-doctor-is-off-the-hook-and-the-chhattisgarh-governments-apaty-continues>).

It is important to note here that several enquiry committees including a judicial commission, and fact findings by human rights activists, civil society members who looked into the case and documented the issues highlighted the gross violation of government norms and guidelines by the operating doctor. Dr. R K Gupta who performed the laparoscopic tubectomies failed miserably in taking the necessary precautions against infections while providing sterilisation services.

Such episodes of gross violations of human rights of women flag the non-compliance of the health system towards various existing guidelines and standard procedures that have been adopted by the Ministry of Health and Family Welfare. In 2005, the Supreme Court in *Ramakant Rai and Anr v Union of India and Ors*²⁶⁷ had passed directions to regulate the sterilisation procedures of men and women. The Supreme Court had directed the introduction of a system of an approved panel of doctors to carry out sterilisation in states/districts/regions, requiring doctors to fill in a checklist of patient information relating to age, health and other relevant information, and setting up of a State Quality Assurance Committee, which would monitor compliance of guidelines for pre-operative measures, operational facilities and post-operative care. The Court had also directed for compensation in cases where patients died or suffered post-operative complications.

Following these directions, the MOHFW has issued several guidelines and implementing protocols, including Standards for Male and Female Sterilisation (2006), Quality Assurance Manual for Sterilisation Services (2006), Standard Operating Procedures for Sterilisation in Camps (2008) and Fixed Day Static Approach for Sterilisation Services (2008).

While the strategic approach (2013) under NHM for the family planning programme positions a target-free approach based on unmet needs for contraception; mentions equal emphasis on spacing and limiting methods; and promoting 'children by choice'

²⁶⁷ (2009) 16 SCC 565

in the context of reproductive health²⁶⁸ Post-partum family planning has been recognised as another priority area for action and much impetus is being given to the Post Partum Intra Uterine Contraceptive Device (PPIUCD) insertion following institutional deliveries as well as to post-partum sterilisation. The prevailing concerns about the state's obsession with population stabilisation and its coercive and targeted provisioning of contraceptive methods continue to be extremely relevant especially given the largely non- implementation of the protocols and guidelines meant to protect the rights of those accessing contraceptive services.

The Government of India (GOI) has initiated the Family Planning Indemnity Scheme (FPIS) to provide for compensation in case of death or failure as a result of sterilisation operations.²⁶⁹ However, evidence points to big lapses in their implementation.

Gita Bai, a 37 years old woman, lives in a village called Nannana in Bhadesar tehsil in the district of Chittorgarh, Rajasthan. She lives with her husband, Satya Narayan Sain and five children- one girl and four boys. The eldest is 16 years old with the youngest 11 years old. They belong to the scheduled tribe community. Raising their kids due to their poor socio economic status has been extremely challenging. There have been times when they have both stayed hungry and fed their children. Every day is a struggle for them to earn enough that would last a week. They had not planned to have five children. After their third child they decided to opt for a permanent contraceptive method. On 24th of July, 2004 Gita underwent a process of tubectomy. But two years later she became pregnant. Her pregnancy was detected very late at five months because of which Gita Bai and her husband were advised not to terminate the pregnancy. Gita and her husband had not come out of this shock of having another child when in 2008 they learned that Gita was pregnant again. She learned about her pregnancy only in the 4th-5th month. Again she was advised not to get medical termination done and Gita gave birth to the child. After this, Satya Narayan decided to undergo sterilisation. It has been nine years since their fourth child was born and Gita and Satya Narayan but they haven't received any compensation from the health facility due to sterilisation failure. As per the Family Planning Indemnity Scheme, she is entitled to receive a sum of Rupees 30,000. Her sterilisation failure took place in the year 2006. They filed a representation to the Government authorities but there was no response. They were in the process of filing a writ petition in the high court of Rajasthan.

(Source: Case study contributed by Prayas for this report)²⁷⁰

²⁶⁸ A Strategic Approach To Reproductive, Maternal, Newborn, Child And Adolescent Health (RMNCH+A) in India. Ministry of Health & Family Welfare, Government of India. January 2013.

²⁶⁹ Government of India. Ministry of Health and Family Welfare. "Compensation for Tubectomy and Vasectomy Victim." News release, July 18, 2014. Press Information Bureau.

²⁷⁰ Seeking Sexual and Reproductive Health Services and Rights. Edited by Tushita Mukherjee & Kshitiz Sisodia, Published by Prayas

Denial of sterilisation

Restrictive policies of the government and/or administrative procedures also pose barriers for women and girls, particularly from the poor socio-economic backgrounds, to access quality contraception services from public health facilities. The following case study presents an example of restrictive policies of the government that have deprived Baiga tribal women in Chhattisgarh from exercising their reproductive autonomy and rights. The reason behind this denial is the government's policy that mandates the Baiga as "protected" tribal community, as a result of which they are not permitted to access sterilisation services. A government order was originally issued in 1979 by the Department of Public Health and Family Welfare, Government of Madhya Pradesh which restricts sterilisation services for tribal people belonging to certain communities, who were earlier referred to as primitive tribal groups (PTGs) and are now administratively determined as particularly vulnerable tribal groups (PVTGs). Ironically, this order is no longer in force in Madhya Pradesh and sterilisation services are being provided to the PVTGs communities, but it still continues to be implemented in Chhattisgarh, which was an erstwhile part of Madhya Pradesh till 2000. It is paradoxical given the aggressive push of sterilisation by the state on the one hand, while on other hand it takes a pro-natalist stance and completely denies the services to a marginalised community and violates their rights.

Ranichand Baiga from the Baiga tribal community in Chhattisgarh is a resident of Chhapparwa village. Ranichand had conceived soon after her marriage, which resulted in a miscarriage after 3 months. Consequently, Ranichand has 5 living children from 7 pregnancies, while 2 resulted in miscarriages. Amongst her living children, the eldest child is 12 years old, and the youngest child around 1 month old. Ranichand had gone to the health center seeking a tubectomy operation, but she was denied the same.

The primary source of income for Ranichand's family is through making and sale of bamboo brooms, which gets them approximately 600 rupees per week and 2400 rupees for the entire month. No other livelihood opportunities are available in their village and the economic situation of the family is extremely difficult.

Seeking sterilisation services, Ranichand Baiga has filed an application in the Bilaspur high court, seeking dismissal of this ban. This public interest litigation (PIL) challenges the restrictive government order of 1979. The petition is filed under Article 226 of the Indian Constitution, and their challenge to the government order 1979 is based on the ground that such an order is arbitrary and violates the right to life and liberty of the tribal people, especially women who have to suffer chronically owing to the lack of contraception services and arbitrary denial of sterilisation services.

The case study of Ranichand Baiga and many others like her are directly linked to the violation of human rights in the context of reproductive health and well being. Such policies deny marginalised tribal communities from exercising their free and informed reproductive choices, and particularly violates the autonomy of the women who have

to consistently bear the burden of denial of sterilisation services.

(Source: Jan Swasthya Sahayog, Ganiyari, Bilaspur District, Chhattisgarh, 2017)

Access to voluntary contraceptive services and information is critical to upholding women's and girls' reproductive rights, as it provides women the right to decide whether to have children, and the number and spacing of children thereby preventing unwanted pregnancies, and minimizing their adverse impact on the women's health and well-being. However, it is essential to ensure that the adoption of contraceptive methods is informed and voluntary, and that standards of care are guaranteed.

The GOI plans and budgets in the context of contraception, in reality promote female sterilisation. Evidence clearly shows that female sterilisation continues to be the method that is pushed by the government's programmes although women continue to be unaware of side effects and possible complications of the surgical procedure and are therefore not in a position to make any informed choices²⁷¹. The current promotion of Post-partum IUCD²⁷² is also fraught with similar issues - indications are that women are not being counseled about PPIUCDs in the antenatal period and insertion takes place without their full and informed consent and sometimes even without their knowledge, only to be discovered later following an infection or a related medical problem.^{273, 274}

Moreover, the state emphasis on terminal contraceptive methods is unsuitable for a largely young population. The neglect of male responsibility for contraception exacerbates the continued violation of women's reproductive health and rights.²⁷⁵ Statistics show that female sterilisations as a proportion of the total annual sterilisation operations (male or female), have increased from 78.6 per cent in the

²⁷¹ Community based Monitoring on Family Planning and Quality of Care done by Uttar Pradesh Health Watch Forum and Bihar Health Watch Forum. The study was done in 10 districts of UP and Bihar in 2014.

²⁷² A spacing method inserted immediately after delivery

²⁷³ Even though there is no systematic study documenting this evidence, such stealth procedures have been reported by field practitioners from both Madhya Pradesh and Uttar Pradesh.

²⁷⁴ Case of PPIUCD insertion without information or consent from Uttar Pradesh: B, resident of Badhya village, delivered in a CHC in Maharajganj district of Uttar Pradesh in January 2016, after which PPIUCD was inserted by someone from the hospital staff without her knowledge nor by the consent of anyone in her family. After returning home she used to regularly experience pain in her stomach. Her husband informed the ASHA of the pain and that is when the ASHA told him that the PPIUCD had been inserted which may be causing the pain. She advised him to wait for a few days for it to get better on its own. B wanted to get the PPIUCD removed but did not know how and from where. Her husband contacted the staff nurse at the CHC who advised him against getting it removed. However, B was in immense pain and they approached the CHC again. On her second visit she was told by the staff nurse that the PPIUCD had gotten removed on its own. But the pain did not go away and therefore B met the staff nurse again who asked B to get an ultrasound done from a private lab. The report revealed that the PPIUCD was still in the body and was 'stuck'. The PPIUCD was removed at the private facility. B incurred an expenditure of 6500 rupees in the whole process and she still feels physically weak

²⁷⁵ The growth in absolute numbers is owing to the phenomenon of "population momentum" meaning that the 'extra' population growth that we see is not due to women and couples having more babies, but more women and couples having babies, because our population comprises mostly of youth.

early 1980s to 98.1 per cent in 2015. Similarly, there has been an inappropriate focus on female sterilisations in the budgets.²⁷⁶

Although there are no targets as per policy, they underlie the implementation of programmes. Furthermore, Quality Assurance Mechanisms mandated by Court orders continue to be flouted. According to the Guidelines on Female Sterilisation issued by the Government of India (2005), a detailed plan for quality assurance has been laid out. Despite this order, violations of the standards of care continue to take place. The death of 13 women who had been operated in Chhattisgarh in November 2014²⁷⁷ is a clear indication of this.

Access to abortion care and services

Nearly five decades after the Medical Termination of Pregnancy Act 1971 (MTPA) was initiated, the majority of women and girls in India continue to experience delays or denials in accessing safe, quality and legal abortion care. Poverty, gender-inequality, stigma, a weak, unresponsive, biased health care system as well as an unfavorable legal and policy environment are perceived as major barriers in accessing safe abortion. The absence of an adequate number of trained, legally registered health care providers throughout the country and the necessary facilities also continue to pose significant challenges to those accessing abortion care. Moreover, evidence points to the abysmal access to information and knowledge about the legal provisions of the MTPA amongst girls and women as well as among health care providers, often compromising access to abortion care.

Findings from a recent study²⁷⁸ indicate that 15.6 million abortions (14.1 million–17.3 million) occurred in India in 2015. The abortion rate was 47.0 (42.2–52.1) per 1000 women, aged 15–49 years.²⁷⁹ About 3.4 million abortions (22 per cent) took place in health facilities, 11.5 million (73 per cent) were abortions through medication, and 0.8 million (5 per cent) abortions were done outside of health facilities using methods other than medication.²⁸⁰ Another study highlights that more than half of the 6.4 million abortions performed each year in India were unsafe and

²⁷⁶For instance in the year 2011-12, 2% of the total planned family welfare expenditure was spent on sterilisations and 1.9% was spent on female sterilisations.

²⁷⁷In November 2014, following a ‘mass sterilisation camp’ performed under shockingly negligent conditions, 13 young women in Bilaspur, Chhattisgarh state, lost their lives due to a negligent national family planning programme funded by the Government of India. (*Jan Swasthya Abhiyan, NAMHHR and SAMA (2014) Camp of Wrongs: The Mourning afterwards- a fact-finding report on sterilisation deaths in Bilaspur, 16-18 November 2014*) Despite such an incident there was no acknowledgement of failure by the Central Government Ministry which funded these ‘camps’ and no announcement of a shift in the policy of targeting women. The state government instituted a one-member judicial enquiry commission that made no effort to reach the survivors’ and bereaved families. After the Commission report was tabled, there was no further public announcement of culpability. Redress was limited to providing a one-off cash amount to the families.

²⁷⁸Singh, Susheela et al. "The Incidence of Abortion and Unintended Pregnancy in India, 2015." *The Lancet. Global Health*. 2018

²⁷⁹Ibid.

²⁸⁰Ibid

almost 5000 abortion-related deaths occur each year in India²⁸¹. Abortion related morbidity and mortality is very high and unsafe abortions are believed to contribute to²⁸² 9 per cent to 13 per cent of the maternal mortality in India and as much as 50 per cent of the maternal mortality in some of the districts in India.²⁸³

Another study estimated that among the six million abortions that take place annually in the country only one million are legal.²⁸⁴ This makes access to safe, comprehensive and legal abortion a critical public health issue across India.

The current law in India that regulates access to abortion is the Medical Termination of Pregnancy Act 1971 (MTPA), which directs when and under what conditions an abortion is permissible, where it may be conducted and by whom. As per Section 3 of the MTPA, a woman can terminate her pregnancy through a registered medical practitioner (RMP) if the RMP believes in good faith that the continuation of the pregnancy poses a risk to the life or of grave injury to the physical or mental health of the woman; or if there is a substantial risk that the child might be severely mentally or physically handicapped. Explanation 1 and 2 of the Section provides for situations which may be considered as constituting grave harm to the mental health of the woman. Firstly, mental suffering caused by pregnancy alleged by the woman to be a result of rape *shall* be construed as grave injury to the mental health of the woman. Secondly, in situations where pregnancy results from the failure of any family planning device or method used by a married woman and her husband for limiting the number of children, then such unwanted pregnancy *may* be considered as causing grave injury to mental health of the woman. Further, the woman's actual or foreseeable environment may be considered for determining whether the pregnancy constitutes grave risk to her health. The opinion of one RMP is sufficient where the duration of the pregnancy is less than twelve weeks, but the opinion of two RMPs is required where the pregnancy is more than twelve weeks but does not exceed twenty weeks. Termination of pregnancy is permitted beyond twenty weeks only in cases where the RMP believes, in good faith, that the termination of pregnancy is immediately necessary to save the life of the pregnant woman.²⁸⁵

Currently, unless conducted as per these conditions laid down by the MTP Act, termination of pregnancy is considered to be an offence under the Indian Penal Code (IPC). The IPC penalises causing miscarriage (Section 312), acts done with the intent to prevent a child being born alive (Section 315) and causing death of an unborn child

²⁸¹Banerjee, S. K., Andersen, K. L., Navin, D., & Mathias, G. Expanding availability of safe abortion services through private sector accreditation: a case study of the Yukti Yojana programme in Bihar, India. *Reproductive health*, 12(1), 104. 2015.

²⁸²Dixit, Neha. "Shamed and Scarred: Stories of 'legal' Abortions in India." *Firstpost*, October 18, 2013.

²⁸³Srivastava, P. C. et al. "Unsafe Abortion: A Study in a Tertiary Care Hospital." *Journal of Indian Academy of Forensic Medicine* 35, no. 3. 2013.

²⁸⁴Duggal, Ravi, and V. Ramachandran. "The Abortion Assessment Project India: Key Findings and Recommendations." *Reproductive Health Matters*, November 2004.

²⁸⁵ Section 5, The Medical Termination of Pregnancy Act 1971

(Section 316). Under the Act, a woman cannot simply choose to terminate the pregnancy, unless there are predicated reasons mentioned above.

As per Section 4 of MTPA, abortion can only be carried out by a RMP in a hospital established or maintained by the Government or in a facility approved for this purpose by the Government or a District Level Authority. Failure to comply is punishable with imprisonment. Section 5(2) provides for punishment for those who are not RMPs and carry out termination of pregnancy, or where the termination of pregnancy takes place in any place not authorised under Section 4. Owners of places which are not authorised under Section 4 and where an abortion takes place are also liable to be punished.

Consent of the pregnant woman to terminate the pregnancy is an essential condition as per Section 3(4) of the MTPA, and in cases where the pregnant woman is below eighteen years or is “mentally ill”, then the consent of her guardian is required. The Supreme Court has reaffirmed the centrality of consent to abortion in *Suchita Srivastava and Anr v Chandigarh Administration*.²⁸⁶In this case,

A woman with an intellectual disability who was living in a Government-run welfare institution in Chandigarh became pregnant following sexual assault. The Chandigarh administration filed a petition before the High Court of Punjab and Haryana and sought its opinion on whether an abortion was necessary. A Court-appointed medical board examined the pregnant woman and found that she was physically capable of continuing with the pregnancy, that there were no indications that the foetus had any abnormalities and that the woman had expressed her wish to have the child. It recommended continuation of the pregnancy. The High Court, however, directed for termination of the pregnancy. An appeal was filed before the Supreme Court challenging this decision. The Supreme Court quashed the order of “the High Court. It distinguished between a “mentally ill” person and a “mentally retarded” person under the MTPA, and held that the State must respect the personal autonomy of a “mentally retarded” woman concerning decisions about terminating her pregnancy. In this case, the pregnant woman had clearly expressed her wish to have the child. It further reasoned that the requirement of consent could not be diluted since it would “amount to an arbitrary and unreasonable restriction on the reproductive rights of the victim. [...] Also be mindful of the fact that any dilution of the requirement of consent contemplated by Section 3(4)(b) of the MTP Act is liable to be misused in a society where sex-selective abortion is a pervasive social evil.” The Court also deliberated on the application of the “best interest” test under the Parens Patriae jurisdiction of the court for making reproductive decisions on behalf of “mentally retarded” persons. The Parens Patriae doctrine is applied in those cases where the persons are unable to take decisions for themselves (as in cases of minors or mentally ill persons) and the State must take decisions to protect the interests of such persons. The Court held that “best interests” means interests of the person alone, and not the

²⁸⁶ (2009) 9 SCC 1

person's guardians or society at large. Concerns of expenditure on care and assistance of "mentally retarded" persons and their children is not a ground for denying the exercise of reproductive rights, the Court opined.

Linking a woman's reproductive right to her right to life and liberty under Article 21, the Supreme Court held that reproductive rights were a dimension of a woman's liberty and her right to "privacy, dignity and bodily integrity" should be respected. A woman's reproductive rights included her right to see the pregnancy to its full term.

To emphasise its views on personal autonomy, "mental retardation" and the MTP Act, the Court referred to the United Nations Declaration on the Rights of Mentally Retarded Persons, 1971 where it is stated that mentally retarded persons have the "same rights as other human beings." The Court also referred to the Convention on the Rights of Persons with Disabilities, 2007 the contents of which was binding on India.

While the case law is significant in its interpretation of consent as well as other issues in the context of abortion, it also reflects the need for further understanding and debate with regard to psychosocial disability, and the perception of capacity of the person with disability as well as the process of consent in the context of disability; for example, between "mental disability" and "mental retardation".

The judgment also reiterated that women have a right to reproductive choices but that there is a compelling State interest in protecting the life of the unborn child, and regulating abortions is a reasonable restriction on the exercise of reproductive autonomy.²⁸⁷

The MTPA permits abortions beyond twenty weeks of pregnancy only in cases when it is immediately necessary to save the life of the pregnant woman. The exception to the twenty week rule is not extended to cases where severe foetal abnormalities (as under S. 3(2) (b) (ii)) have been detected after twenty weeks of pregnancy. However, the twenty-week limit is arbitrary and severely restrictive as women who discover foetal abnormalities after the statutory twenty weeks and whose termination of pregnancy is medically possible, are unable to legally terminate their pregnancy. In the context of reproductive autonomy, women's health must not be limited merely to the physiological aspects but also by their social and psychological aspects.²⁸⁸ Women are as a result, forced to continue with their pregnancies with the knowledge that the foetus will not survive, thus suffering mental trauma and anguish and violation of their right to live with dignity. It may also force women to seek unsafe abortion services.

In the case of *Nikita Mehta*, severe foetal abnormalities which posed a risk to the survival of the foetus were detected in her 22nd week of pregnancy, and the

²⁸⁷ Suchita Srivastava and Anr v Chandigarh Administration, (2009) 9 SCC 1

²⁸⁸ Nadimpally, Sarojini, and Sneha Banerjee. "Why Do Women Need a Medical Board to Sign-Off on Abortion?" *The Wire*, August 16, 2016.

abnormalities were confirmed by medical diagnosis in the 24th week of pregnancy. She sought to terminate the pregnancy, but because of the statutory limitation of twenty weeks, she was unable to do so despite medical advice, which supported her decision. Nikita Mehta, through her obstetrician Dr. Nikhil Datar, filed a petition²⁸⁹ before the High Court of Mumbai challenging Section 5 of MTPA as *ultra vires* for non-inclusion of the eventuality of foetal abnormality and also seeking termination of her pregnancy. The Court denied permission to terminate the pregnancy, citing the limitation under Section 5 and lack of conclusive medical opinion to the effect that the child, if born, it would suffer from severe mental and physical handicaps. It also held that reading down Section 5 to include conditions given under Section 3(2) (b) (ii) would amount to legislating upon the Act and was thus impermissible. Denied permission to terminate her pregnancy, Nikita Mehta suffered a miscarriage a few days after the judgment was pronounced.

In other cases, the Supreme Court has allowed termination of pregnancies beyond the statutory twenty week limit. In *Ms. X vs Union of India*²⁹⁰, the Supreme Court allowed the petitioner to terminate her 24 weeks foetus, following the recommendations of a Medical Board which found that continuation of the pregnancy posed a grave risk to her physical and mental health. The Court considered the case to be within the terms of Section 5 of MTPA. In the subsequent case of *Meera Santosh Pal and Ors v Union of India*²⁹¹, the petitioner sought permission from the Supreme Court to terminate her 24-week pregnancy on the ground that the foetus suffered from Anencephaly, an untreatable defect which made the foetus unable to survive outside the womb and that the continuation of the pregnancy also endangered the petitioner's life. The Court-appointed Medical Board found that the foetus would not survive birth, that the continuation of the pregnancy would gravely endanger the petitioner's physical and mental health and that the risk of termination of pregnancy was within acceptable limits. The Court deliberated on the dimensions of personal liberty and reproductive autonomy, and considering the medical report and the danger to the petitioner's life, permitted the petitioner to terminate the pregnancy. It held that she had a right a right to bodily integrity, and to protect and preserve her life, and exercise of the right was "within the limits of reproductive autonomy."

Often, however, the implementation of the law and the orientation of the health system in providing abortion care create barriers to access services. For instance, the law does not require spousal or relative or any third party consent for termination of pregnancy except in the case of minors. Nevertheless, medical practitioners frequently insist on such consent, claiming this necessary to pre-empt any socio-legal complications that may arise from the abortion, infantilizing women seeking abortion on the one hand while thrusting the responsibility of child rearing on her, on the other.

²⁸⁹ Dr. Nikhil D. Dattar and Ors vs Union of India and Ors, Writ Petition (L) 1816/2008

²⁹⁰ Writ Petition (C) 593/2016, judgment dated 25th July 2016

²⁹¹ Writ Petition (C) 17/2017, judgment dated 16th January 2017

The case study below highlights the denial of abortion services to a 19 year old woman, a survivor of domestic violence, for want of spousal consent.

A 19 year old woman approach a tertiary care hospital in Delhi for abortion, expressing the mental agony and trauma she was experiencing from her pregnancy which had resulted from a forced sexual intercourse by her husband. She had been married to a 40 year old man a year before. She was against the marriage and had resisted or avoided sexual relations with her husband prior to the assault. She had first approached the hospital when her pregnancy was about 10 weeks. The hospital on learning about the domestic and sexual violence asked the woman to register a police complaint, which she refused to do. She was very scared of her husband or any other family member getting to know about her reaching out to the hospital for abortion. The hospital insisted on a police requisition, and also kept counseling her about how she should re-consider the abortion, as it was her first pregnancy. The woman not having secured the abortion shared the situation with a social organisation that she was familiar with. The organisation facilitated her visits to other hospitals for the abortion – by now the woman was already in her 13th week of pregnancy but did not receive the necessary care and was denied termination of pregnancy on similar grounds. The denials by the hospitals pushed her to resort to purchase an over the counter drug to terminate the pregnancy, which she was able to get. This however led to complications of severe bleeding and she had to be rushed to the hospital for healthcare and treatment.²⁹²

The doctors' failure to perform their role as per the MTP Act caused grave risks to the woman's health and life. The hospital, however, claimed that the delay and denial of abortion was in keeping with the provisions of the MTPA. This highlights that narrow and subjective interpretation of the MTPA that is a common practice but a gross infringement upon the reproductive autonomy of the women accessing abortion care.²⁹³ Other issues that emerge here are the need for a better understanding and implementation of guidelines for use of medication for abortion to ensure that they are available along with the requisite information as well as within their permissible limits.

A study reported that less than 1 percent of primary health centres provide abortion services, 95 per cent of centers do not have a trained doctor and nearly all lack necessary equipment or even basic infrastructure like water and electricity²⁹⁴. Further, many public sector facilities do not provide abortion services because of a shortage of trained and certified providers, which is exacerbated by the frequent practice of transferring trained providers to facilities not equipped for the provision of abortion services. Meanwhile, the cost of abortion services in private facilities is unaffordable

²⁹² Sama,2016; Sama got the knowledge of this case in June 2016, when a local organisation had approached Sama seeking assistance in accessing abortion services for this woman.

²⁹³Ibid.

²⁹⁴Ganatra, Bela. "Availability of Medical Abortion Pills and the Role of Chemists: A Study from Bihar and Jharkhand, India." *Reproductive Health Matters*. 2005

for many women.²⁹⁵ Because of these barriers, many women in India turn to uncertified facilities or unsafe methods of abortion that may be more affordable.

Denial of abortion care has more recently also been reported on the grounds of the absence of the Aadhar identity, which is in violation of the MTPA.

In 2017, in Chandigarh, media reports highlighted that a woman who was a domestic worker was denied abortion care because she could not produce her Aadhar card. A government hospital at Chandigarh had sought the woman to submit her Aadhar card for ultrasonography test, which she could not provide. The woman had three children and did not want to go ahead with the current pregnancy. The hospital required the ultrasonography report for termination of pregnancy. However, it did not allow her to undergo the ultrasonography, as she did not have an Aadhar card. She ultimately approached an unqualified local physician for an abortion but the procedure did not go well and she had to be hospitalised following severe bleeding and for a blood transfusion.²⁹⁶

Such denial of services is a violation of the right to privacy and the right to health. To procreate or to abstain from procreating forms a part of women's reproductive choices. It is important to respect a women's right to privacy, dignity and bodily integrity. Further, the disclosure of personal health information has the potential to be embarrassing, stigmatizing and discriminatory. Insisting on the Aadhar card for provision of health services by hospitals is a gross violation, and highly arbitrary.

Initiatives for safe and comprehensive abortion care (CAC) services under the National Health Mission (NHM) is claimed to be provided through the reproductive, maternal, newborn, child, and adolescent health (RMNCH+A) programme. The NHM is expected to provide support to the states for CAC through facilitating the implementation of the CAC guidelines, improving access to comprehensive abortion care, including post abortion contraceptive counseling and services by expanding the network of facilities providing Medical Termination of Pregnancy (MTP) at First Referral Unit (FRU) level.²⁹⁷ Further, it also includes provisioning of funds to the States for the operationalisation of services at health facilities including procurement of equipment and drugs for medicated abortion, training of health care providers such as medical officers in safe abortion techniques as well as of ANMs and ASHAs (Accredited Social Health Activists) to provide information and counseling, including

²⁹⁵ Duggal R. The political economy of abortion in India: cost and expenditure patterns. *Reproductive JHealth Matters*.2004

²⁹⁶"Activists Slam Mandatory Linking of Aadhaar to Health Services After Woman Denied Abortion." *The Wire*, November 1, 2017.

²⁹⁷"Activities under National Health Mission." Delhi Government.

[http://delhi.gov.in/wps/wcm/connect/doit_dceastupdated/DC of East Delhi Updated/Home/District Health Society/](http://delhi.gov.in/wps/wcm/connect/doit_dceastupdated/DC_of_East_Delhi_Updated/Home/District_Health_Society/)"

for post abortion care.²⁹⁸ These initiatives of the government while appreciable need to be monitored to assess their implementation and progress in the respective states.

The Medical Termination of Pregnancy (Amendment) Bill, 2014

The MTP Amendment Bill, 2014 proposes to increase the time limit for the termination of pregnancy, from the existing 20 weeks to 24 weeks. It also proposes that the words “registered medical practitioners” be replaced with “registered healthcare providers”. This implies that pregnancy can be terminated not only by practitioners with allopathic medical qualifications, but also practitioners qualified in homeopathy, ayurveda, unani or siddha, nurses or auxiliary nurse midwives. The amendments, however, have been long delayed and should be accompanied by public health budget, infrastructural and skilled human resources.

Conflation with other regulations - the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act 1994 (PCPNDT)

Though the purposes of the PCPNDT laws (prohibiting sex determination) and the MTP Act (ensuring safe abortion) are distinct, they are almost inappropriately linked. PCPNDT prohibits sex selection before or after conception, and criminalises the use of pre-conception and pre-natal diagnostic techniques for sex determination. Sex selection is defined as including any procedure, technique or test that ensures or increases the probability that an embryo will be of a particular sex.²⁹⁹ There is no conflict between PCPNDT Act and MTP Act, as PCPNDT Act prohibits any practice which would have the effect of sex selection or sex determination leading to termination of the foetus, and MTP Act gives a conditional right to abortion (sex selection being an impermissible ground for seeking abortion under the MTP Act).

The MOHFW guidance document “Ensuring Access to Safe Abortion and Addressing Gender Biased Sex Selection” recognises the inter-linkages and conflation between the two Acts, and the challenges in “simultaneously addressing gender biased sex selection while protecting women’s access to safe, legal abortion services”³⁰⁰ However, the misinformation and lack of clarity on the laws, allegedly cumbersome reporting procedures under PCPNDT Act and harassment by governmental implementing agencies appointed under the PCPNDT Act has led several medical practitioners to deny women access to abortions, particularly when the women are in their second trimester of pregnancy as that is when the sex of the foetus can be determined.³⁰¹ This forces women to seek unsafe abortions from unregistered practitioners, leading to higher risk of mortality and morbidities.

²⁹⁸Government of India. Ministry of Health and Family Welfare. "Abortions." News release, January 5, 2018. Press Information Bureau

²⁹⁹ Section 2(o), PCPNDT Act

³⁰⁰*Guidance: Ensuring Access to Safe Abortion and Addressing Gender-Biased Sex Selection.* Ministry of Health and Family Welfare. Government of India. February 2015

³⁰¹Menaka Rao, Why getting a safe abortion by a registered gynaecologist has become almost impossible, *Scroll.in*. 12th October 2015

Access to abortion under the Medical Termination of Pregnancy Act (MTP Act) was passed by the Parliament in 1971.³⁰² However, the MTPA recognises abortion as a qualified right with several conditionalities for access as well as excluding several women who may require to access abortion care. The MTPA, for example, wrongly presumes that only married women would be using contraceptives, and excludes unmarried, widowed and single women under the conditionality of “failure of contraceptives”. The proposed amendments (2014) provide an important opportunity to ensure that such gaps and problems are not repeated.

More than 80 percent of women in the country do not know that abortion is legal and available.³⁰³ Even many of the medical students for instance, either do not know about the MTP Act³⁰⁴ or do not have the right attitudes towards abortion services for women. There is an absence of information and accessible services for abortion or post-abortion/miscarriage complications, compelling women to use unsafe methods with no supervision and inadequate knowledge of danger signs.

The situation has been made more challenging in the last decade with the vigorous implementation of the PCPNDT Act³⁰⁵ whose posters, slogans as well as visual information resources have made it seem as though all abortions were illegal, rather than conveying that sex determination is illegal³⁰⁶.

Overall, availability of safe, legal comprehensive abortion care in the public health system is abysmal plagued by the larger issues of infrastructure, human resources, knowledge, and skills. Absence of or severely limited implementation states initiatives further restrict access. Specific provisions in the current MTPA as well as biased perspectives about abortion amongst health care providers also affect access for girls and women. For example, the requirement of a second medical opinion for termination of pregnancy if beyond 12 weeks also restricts access severely, especially in rural settings. As a result of all these restrictions, most women are deprived of access to safe and legal abortion services, forcing them to seek services for abortion that are unsafe and often have implications for the health and even the lives of women. Besides, several public health facilities are known to provide abortion services only on the condition that women adopt either sterilisation or copper IUD³⁰⁷ after the procedure.

³⁰² Medical Termination of Pregnancies Act, 1971

³⁰³ Banerjee, S. K., and K. Andersen. "Exploring the Pathways of Unsafe Abortion in Madhya Pradesh, India." *Global Public Health. An International Journal for Research, Policy and Practice*, August 13, 2012. doi:<https://doi.org/10.1080/17441692.2012.702777>.

³⁰⁴ Palo, Lal Bahadur et al. "Awareness regarding Abortions and Medical Termination of Pregnancy Act among Medical Students in Puducherry, India." *International Journal of Research in Medical Sciences* 3, no. 10 (October 2015). doi:dx.doi.org/10.18203/2320-6012.ijrms20150822.

³⁰⁵ The Pre-Natal Diagnostic Techniques (Prohibition of Sex-Selection), Act, 1994 Act no. 57 of 1994

³⁰⁶ Gupte, Manish. *A Walk Down Memory Lane. An Insider's Reflections on the Campaign against Sex-Selective Abortions*. Centre for Genetics and Society. July 31, 2003.

³⁰⁷ Iyengar, Sharad D., Kriti Iyengar, and Virendra Suhalka. *Situation Analysis of Abortion Services in Rajasthan*. Action Research & Training for Health (ARTH). 2005.

Further, the MTPA mandates consent of the guardian for girls seeking abortion below the age of 18 years. This poses a huge barrier for girls seeking safe and abortion services as many times the guardians could be abusers themselves and seeking their consent would be more torturous. In such situations many girls are forced to seek services that maybe unsafe, leading to morbidities and even mortality. Similarly, the Protection of Children from Sexual Offences (POCSO) Act criminalises sexual relations below 18 years, even when the sexual intercourse was consensual and obliges mandatory reporting by all institutions, including the health system. As a consequence, access to abortion, privacy and confidentiality is hugely compromised for girls.

The IPC continues to criminalise abortion, specifying punishments for the provider as well as the woman.³⁰⁸ This despite the declaration of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, during the 66th General Assembly of the United Nations, (October 2011). The Rapporteur had said “Criminal laws penalizing and restricting induced abortion provide examples of State interference with women’s right to health,” adding that such laws restricts women’s control over their bodies, undermines their dignity and infringes on their autonomy.^{309,310}

Two-child norm: Violation of reproductive health and rights

Another manifestation of India’s coercive and target-driven approach towards ‘population control’ or ‘population stabilisation’ is the promotion of the two-child norm. This norm is in clear violation of the National Population Policy (2000) that emphasises voluntary and informed choice and consent of citizens while availing reproductive health services, and continuation of the target- free approach in family planning services. The norm also violates a Declaration adopted at the conclusion of a colloquium on population policy, organised by the National Human Rights Commission, the Ministry of Health and Family Welfare, and the United Nations Population Fund (2003). The Declaration explicitly recognised the two-child norm as a violation of human rights:

“Population policies framed by some State Governments reflect in certain respects a coercive approach through [the] use of incentives and disincentives, and are violative of human rights. The violation of human rights affects, in particular [,] the

³⁰⁸ See section 312 of the Indian Penal Code: “312. Causing miscarriage.--Whoever voluntarily causes a woman with child to miscarry, shall if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both; and, if the woman be quick with child, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine. Explanation.-A woman who causes herself to miscarry, is within the meaning of this section.” Available here: <http://indiacode.nic.in/>

³⁰⁹ *Special Rapporteur on the Right to Health Links Decriminalisation of Abortion to the Right to Health*. International Service for Human Rights. November 9, 2011.

³¹⁰ *Maternal and Reproductive Health; Joint Stakeholder Report to UNHRC for India’s UPR – III*. Report. NAMHHR, CommonHealth and Jan Swasthya Abhiyan. September 22, 2016.

marginalised and vulnerable sections of society, including women; [and] the propagation of a two-child norm and [the] coercion or manipulation of individual fertility decisions through the use of incentives and disincentives violate the principle of voluntary informed choice and the human rights of the people, particularly the rights of the child.”

The Declaration directed state governments to remove discriminatory and coercive measures from their population control policies, and to adopt a right-based population policy that protected and promoted human rights.³¹¹

The GOI endorsed the ICPD plan of action in 1994, which called for a paradigm shift from target-oriented population policies to a target-free approach, based on voluntary and informed choice and consent for availing of reproductive health care services. The ICPD had firmly established that family planning programmes must be free of coercion and must allow couples to freely decide for themselves their fertility goals without the threat of government interference. However, the two-child norm continues to be implemented by several states in India and also continues to be a part of reproductive and welfare schemes and programmes. States including Gujarat, Odisha, Rajasthan, and Maharashtra³¹², have continued to propagate this coercive and discriminatory norm by barring persons with more than two children from contesting municipal and panchayat elections. Assam is the latest amongst the states to initiate the two-child norm that disqualifies persons from being elected or nominated to local bodies or government jobs. State governments have also pushed for a two-child policy through various incentives and disincentives.

The adoption of the two-child norm is motivated largely by the state’s perception of a ‘population explosion’ and the need to control or stabilise this supposedly uncontrolled demographic growth through aggressive population policies. However, this perception is misplaced given that the total fertility rate (TFR) in India is 2.23 only marginally above the desired level of 2.1. Twenty states and union territories are almost at replacement level TFR, and about 11 states are indicating reduced TFRs.³¹³

The two-child norm violates the reproductive autonomy of women and couples, and interferes with their right to determine the number of children they wish to have. Evidence points to the direct linkages between the two-child norm and negative outcomes for women, including forced abortions, sex-selective abortions, divorce, desertions, and disowning of the third child. The gendered consequences of the norm also emerged clearly; in several instances, when the third child was given up for

³¹¹*Declaration Adopted at the Colloquium on Population Policy – Development and Human Rights.* Proceedings of National Colloquium on Population Policy, Development and Human Rights, New Delhi. 9th and 10th January 2003.

³¹²*Nine Facts about “Two-Child Norm”* The Hunger Project. June 2013.

³¹³Government of India Ministry of Health and Family Welfare, Department of health and family welfare, Rajya Sabha unstarred question no. 2958 to be answered on 28th march, 2017 population control measures for states with high TFR; Sharma, Kanika, Mohit Gandhi, Navneet Wadkar, and Sayan Das. "A Two-Child Policy Won't Take India Closer to 'Vikas'." *The Wire*, March 20, 2018. <https://thewire.in/health/a-two-child-policy-wont-take-india-closer-to-vikas>.

adoption was a girl child.³¹⁴ The norm is discriminatory and disempowering; it has created barriers to participation in governance by women and men, and particularly by young people, especially from marginalised communities, in local such as the Panchayati Raj Institutions (PRIs), regional and state governance institutions. The findings of a study on the implications of the two-child norm in Madhya Pradesh³¹⁵ showed that 50 per cent of disqualified candidates belonged to constituted representations from the Scheduled Caste (SC), Scheduled Tribe (ST), and Other Backward Caste (OBC) categories. Elected representatives in local governance, particularly those from marginalised communities and women, had been disproportionately impacted - many of them were unaware of the two-child norm prior to their disqualification, and in several instances disqualifications based on the two-child norm related disqualifications in several instances were politically motivated. Evidence also showed that the two-child norm did not actually result in a shift to smaller families. Instead, in cases where a third child was born, in some instances the child was given up for adoption. In others, it resulted in the denial of paternity, or desertion of the wives, neglect of the girl children, forced abortions, and sex-selective abortions.

Certain central and state schemes also make the provision of welfare benefits and social services contingent on the intended beneficiary having two children or fewer. Such schemes include the National Maternity Benefit Scheme (cash assistance to pregnant women above the age of 19 years for the first two live births); the Indira Gandhi Matritva Sahyog Yojana (cash assistance to pregnant women and lactating mothers, women above 19 years of age for the first two live births); Odisha's Mamata Scheme (a conditional cash transfer maternity benefit scheme for pregnant women and lactating mothers aimed at improvement in maternal and infant health and nutrition, limited to the first two live births); Karnataka's Bhagyalakshmi Scheme (financial assistance to girl children born in below poverty line BPL families, eligibility limited to families with no more than two girl children). These are some schemes that are directed by the two-child norm through a system of incentives and disincentives, which is discriminatory. Such a norm threatens people's civic and political rights to participate in an electoral democracy and poses tremendous barriers to accessing information on reproductive health information, care, and the benefits of social welfare programmes. They are unconstitutional because they violate the right to equality guaranteed to all citizens of the country under Article 14 of the Constitution of India. Further, the two-child norm penalises people for their reproductive decisions and deprives them or their children of social benefits and even denies them access to employment. The implementation of the two-child norm must be immediately discontinued; the State must focus on the well-being of people by providing opportunities to all, rather than following a policy of coercion and instituting the "system of incentives and disincentives".

³¹⁴*Beyond numbers: Implications of the Two Child Norm*; Sama Resource Group for Women and Health., 2004.

³¹⁵ Ibid

The two-child norm fails to recognise that attainment of economic prosperity and human development is based on how effectively the government invests on its people, giving them better facilities in the spheres of general and reproductive health, education, and political and economic opportunities. It also overlooks the fact that the poor human development indicators have their roots in the denial of opportunities, discriminations against marginalised groups, and other socio-economic barriers to the accessing of health care.

Early and child marriage

Marriage in India continues to be largely characterised by its imperative, universal nature. Strict prescriptions by social kin groups and communities, often reinforced by governance, legal and other institutions, shape norms and values governing marriage.

The imperative nature of marriage is reinforced by demographic data – for example, by 29 years, amongst women, 84.2 percent of all women and 92.1 per cent of rural women were married and between the ages of 30-34 years 92.5 per cent of all women and 94.8 per cent of all rural women were married. Amongst men, 53.9 per cent of men between 24-29 years were married, with 68.7 per cent from rural areas and in the age group of 30-34 years, 83per cent were married, with 88.7 from rural areas and between 35-39 years it was 92.9 per cent of all men were married.³¹⁶

Attempts to negotiate or breach patterns of marriage are met with negative repercussions, including sanctioned or condoned violence. For instance, exogamy marriages (inter-caste self-choice marriages and intra-caste marriages that violate village norms) are targeted through honor killings. Even when such marriages are arranged by the family, women are perceived as being taken away by those who are not eligible to do so, which thus denies men who are 'eligible'. This is intrinsically linked to the shortage of women for marriage—the 'marriage squeeze' that is happening due to the skewed sex ratio in certain parts of the country.³¹⁷

According to the law in India, 'child marriage' is defined as marriage involving girls younger than 18 years and boys younger than 21 years (Child Marriage Prohibition Act, 2006). A marriage that involves someone younger than these ages is referred to as a child marriage and is thus voidable by law. 'Early marriage', however, continues to be a relative concept, remaining outside the parameters of a clear and consistently applied definition. 'Early marriage' takes into account consent and choice of parties to the marriage. It recognises that even when parties to the marriage meet the legal threshold of marriageable age, they might not be in a position to give informed consent to the marriage. This is especially true for women and girls in India who are vulnerable to family and societal pressures to marry young, without due consent of theirs in the marriage. Vulnerability of women to early marriage is related to their

³¹⁶*National Family Health Survey 4*. Ministry of Health and Family Welfare, Government of India. Mumbai: International Institute for Population Sciences, 2015-16.

³¹⁷ Kaur, Ravinder. "Marriage as Oppression." *Info Change*, December 2012. <http://infochangeindia.org/agenda/gender-bias/marriage-as-oppression.html>.

socio-economic status, level of education, prevailing gender norms, societal perceptions of honor and chastity and vulnerability to humanitarian crises.³¹⁸ Evidence links early marriage to poverty, migration, gender and sexuality norms (related to virginity, motherhood and family honor).

The median age of marriage for girls is 19 years, and for boys is 24.5 years.³¹⁹ Marriage before the legal age of 18 is 27 percent for women age 20-24, whereas 40 percent of women age 20-49 marry before the legal minimum age of marriage of 18 years.³²⁰ As per Census 2011 data, almost 20 per cent of all 15-19 year old girls were currently married. This percentage rose to almost 70 per cent of 20-24 year old girls being currently married.³²¹ Of particular concern is the fact that 78.5 lakh girls below the age of ten are either currently married or have been married.³²²

Early and child marriage increases the vulnerability of girls and women to early and unplanned pregnancies and pregnancy related complications, to reproductive tract and sexually transmitted infections because of lack of awareness and access to information and gaps in healthcare.³²³

Population politics drives age-at-marriage concerns

The continued preoccupation with fertility and demographic transitions has drawn attention to women in early marriages and toward increasing use of contraception to control fertility. Women, and to some extent men, in early marriages are thus viewed instrumentally for achieving larger public health goals. Programmes and schemes providing incentives for the delay of marriage for girls contain conditionalities that allow access to those families that do not have more than two children and/or have opted for a permanent method of contraception, according to a study that carried out an analysis of several schemes.³²⁴ The focus of these initiatives is on improving the status of girl children and adolescents, but they create contradictory situations by adoption of the two-child norm, which has proven to have extremely negative implications, particularly for girls and women.

More recently, some plans, policies and programmes to address the particular needs of young people have started to evolve. However, the perspectives on the health of young people within these plans, policies and programmes remain limited, falling

³¹⁸ *Dataspeak: Early Marriage and Health*. Sama Resource Group for Women and Health. 2015, pg 6.

³¹⁹ *National Family Health Survey 4*. Ministry of Health and Family Welfare, Government of India. Mumbai: International Institute for Population Sciences, 2015-16.

³²⁰ National Family Health Survey-3

³²¹ *C-2 Marital Status By Age And Sex*. Census of India. Office of the Registrar General & Census Commissioner. Ministry of Home Affairs, Government of India. 2011.

³²² *C-4 Ever Married And Currently Married Population By Age At Marriage And Duration Of Marriage*. Census of India. Office of the Registrar General & Census Commissioner. Ministry of Home Affairs, Government of India. 2011.

³²³ Santhya, K.G., S.J. Jejeebhoy and S. Ghosh. *Early marriage and sexual and reproductive health risks: Experiences of young women and men in Andhra Pradesh and Madhya Pradesh*, India. New Delhi: Population Council. 2008

³²⁴ Examples of such schemes include Bhagyasri Kalyan Bima Yojana (1999), Janani Shishu Suraksha Yojana (2011) and Dhanalakshmi Yojana (2008).

largely within the frame of fertility control and/or maternal and child health. Such programmes and schemes do not substantively address aspirations and concerns of adolescents or their overall physical and mental well-being. Nor do they substantially address the range of issues related to early and child marriage. A range of other health issues that are likely connected to early marriage do not feature in the discourse of health and early marriage in India, such as nutritional status, vulnerability to sexually transmitted diseases, abortion, sterilisation, hysterectomies and mental health issues. This is likely due to the manner in which the discourse of early marriage and health has emerged. For example, the analysis of maternal health outcomes discusses how women who experience early pregnancy and childbirth and have compromised nutrition levels are particularly vulnerable. The data highlights that early pregnancy, in addition to having adverse consequences for the health of the mother, had far-reaching consequences for the health of infants and children. The infant mortality rate was higher for children born to very young mothers than for children born to older mothers.

That early marriage has implications for the mental health of young married women is also acknowledged. However, the nature and extent of the impact on mental well-being, particularly when an early marriage is a 'forced' marriage, needs in-depth study and understanding. A report³²⁵ on early marriage stated that the abrupt end of adolescence, forced sexual relations, early pregnancies and the denial of freedom and personal development have profound psychological and emotional consequences. Young brides often feel isolated, rejected and depressed in the marital home. Loss of childhood and adolescence, the opportunity to play, develop friendships and be educated affects the development of girls. The NFHS and DLHS data do not provide any information on the impact of early marriage on women's mental health. This is an important aspect of health that should be covered in future surveys. Data on the mental health consequences of early marriage would be helpful in formulating appropriate programmes to address these consequences.³²⁶

The data on decision making and mobility for women clearly indicate power hierarchies and demonstrate that younger women are particularly marginalised from decision making in both their natal and marital homes. Decision making and mobility are extremely gendered and, in addition to age at marriage, are important determining factors to be considered in the context of understanding health-seeking behavior, access to health care and other health determinants. The silence on the links between marriage and age is reflective of social fears surrounding women in their reproductive roles. Akin to the kind of anxiety teenage pregnancies have generated, more in relation to a pointed socio-medical discourse on adolescent reproductive health that positions young adolescent mothers as 'social rejects' (rather than focusing on their

³²⁵ *Early Marriage: Child Spouses*. Innocenti Research Centre, United Nations Children's Fund (UNICEF). 2001.

³²⁶ Sama is conducting exploratory qualitative research to explore the factors that affect mental health among young women, including in the context of early marriage.

health and reproductive rights), in India the stifling of data on the age of the young mother is to bring her in to the 'legitimate' category of the 'ever-married'. The lack of data on the variables that link age with marriage and the associated health consequences for women are seemingly subsumed under larger approval accorded to the 'married' status as a legal, absolute category.³²⁷

Young women in early marriages are also more likely to be socially isolated and more vulnerable to intimate partner violence. Eighty-five percent of ever-married women (15-49 years), who had experienced violence since the age of 15 years had experienced it from their current husband. 88 percent of ever married women in the age group of 15-49 years reporting any sexual violence had experienced such violence at the hands of a husband, while 2 percent reported sexual violence by a relative, 1 percent by a friend/acquaintance, and about half a percentage each, reported sexual violence by a boyfriend, an in-law, a family friend, or a stranger.

Health programmes largely do not identify early marriage as a health concern. Most strategies to address early marriage mostly operate outside the health sector, focusing largely on population planning, and in some instances, on non-discrimination and human rights or adolescent development. Although some programmes that have addressed the health of girls and young women referred to child marriage, they did not treat such marriage as a public health concern.

The Rashtriya Kishor Swasthya Karyakram (RKSK) or the National Adolescent Health Strategy was launched by the Ministry of Health and Family Welfare (MoHFW) in 2014 includes strategies to be operationalised through educational and health institutions and indicators that specifically focus on offering a continuum of care for adolescent health and development needs. Interventions in the strategy are designed to provide information, commodities and services at the community level, by strengthening the public health system for effective communication, capacity building and influencing adolescents social environment and cultural norms to reduce early child marriage'. However, poor implementation does not cater to the needs of unmarried adolescents' sexual and reproductive health needs; for example the operational framework talks about reducing teenage pregnancies on one hand but is silent on provision of safe abortion services for unmarried adolescents at facility level. While such initiatives offer important opportunities for the health system to engage on the issue of early and child marriage, given the complex linkages between early marriage and health, the implementation of the programme needs to be strengthened.

³²⁷*Dataspeak: Early Marriage and Health*. Sama Resource Group for Women and Health.2015.

Reproductive Morbidities

Tuberculosis (TB) and SRH

A report published by the World Health Organisation (WHO) in collaboration with UNICEF and UNDP³²⁸ states that although more men than women are diagnosed with pulmonary tuberculosis, more than half a million women die each year from TB. This data also bring to light the persisting socioeconomic, cultural, and health service-related barriers in accessing health services that disproportionately affect timely diagnosis and treatment in women.³²⁹ Many women depend on their husbands, sons or fathers to take them to a clinic, either because they are discouraged to go alone, or because they do not have the information about where to seek treatment. Meera, a resident of Delhi, did not get herself checked for nearly four months because her husband would not give her money. "I was coughing violently for about four months and had high fever," she said, but her husband refused to give her money to go to the hospital. "He would instead complain that I couldn't do any work at home. He would throw vessels at me, and sometimes even the entire gas stove," the 25-year-old said. She was diagnosed with multi-drug resistant tuberculosis, where the patient is resistant to the first line of TB drugs and the treatment lasts two years. Meera now receives treatment from a clinic run by non-profit group Operation Asha that works with TB patients in the area.³³⁰

Another reason for higher under reporting by women with TB is because of stigma and discrimination often translates to women being ostracised by their families and communities as well.³³¹ The unmarried girls and women want the diagnosis of the TB to be kept confidential to avoid being labeled as TB patients. It has been documented very well that having TB can affect marriage prospects or break engagements, or even marriages.

In some settings, stigma and discrimination often translate to women being ostracised by their families and communities as well.³³² Further, cultural and financial barriers, can act as major obstacles for women seeking care or completion of treatment, resulting in delayed presentation, development of Drug Resistant TB (DR-TB) or more severe co-morbidities³³³.

It requires to be highlighted that structural determinants inform people's vulnerability to TB. These include poverty and systemic inequality leading to under-nourishment. In terms of law the Food Security Act has to be implemented with vigor and political

³²⁸ *Gender and Tuberculosis: Cross-site Analysis and Implications of a Multi-country Study in Bangladesh, India, Malawi, and Colombia*. World Health Organization. 2006.

³²⁹ Ibid.

³³⁰ "Why There Might Be More Women Suffering from Tuberculosis in India than We Think." *Scroll.in*, October 22, 2015. <https://scroll.in/pulse/760849/why-there-might-be-more-women-suffering-from-tuberculosis-in-india-than-we-think>.

³³¹ *Tuberculosis in Women*. World Health Organization, 2013

³³² Ibid.

³³³ Ibid.

will for it to be meaningful. But it may also require to be amended in relation to TB by expanding the sort of food covered under it - not just food grains and cereals but also quality proteins as part of the assured supply of food. Other welfare schemes such as PDS, rations etc. also need to be linked to TB nutritional support so that food assurance is fundamentally an issue of not just assistance when one has TB, but for life time so that those dealing with poverty do not fall back into undernourishment and TB, after they have recovered. And, monetary policy as reflected in budgets need to be robust in order to look after families affected by TB in the long term, not just individuals living with TB for as long as they have it.³³⁴

The Government of India in collaboration with Stop TB partnership and WHO, organised the Delhi End-TB Summit in March 2018 launched Tuberculosis Free India Campaign How this will be implemented in next couple of years to ensure that every TB patient has access to quality diagnosis, treatment, and support to be examined/watched.

The Government of India announced Direct Benefit Transfer of Rs. 500 per month from April 2018, to ensure nutritional to TB patients.³³⁵ The strategy was implemented partly for identifying unreported cases and partly to supplement the income of a family in which the breadwinner is suffering from the disease.³³⁶ The outcome of this scheme with regard to health seeking behavior among women is yet to be discussed in the future, keeping in the mind systemic oppression that exists within the family structure, coupled with the stigma faced by women suffering from the disease.

Access to diagnostics and treatment of TB is an issue, which needs to be addressed urgently. There are medications available for MDR-TB, which are exorbitant and unavailable due to intellectual property strangleholds.

Multiple Drug Resistant TB (MDR-TB): India in the recent past has witnessed a rise in the prevalence of Multiple Drug Resistant TB (MDR-TB), accounting for almost 25 per cent of world's disease burden.³³⁷ Bedaquiline and Delamanid are such medicines, and the government needs to issue compulsory licenses under the Patents Act to ensure multiple local manufacturers and affordable prices. The patents granted for these medicines should also be reviewed to make sure they comply with the requirements of the Patents Act. For diagnostics, CBNAAT or Genexpert testing is rapid and efficacious but expensive and inaccessible. This requires transfer of technology so that local manufacturers can make the machinery for these tests at much cheaper rates that can be widely used. All of this requires government action. The government also needs to secure the health system with the full range of

³³⁴ Personal Communications with Vivek Divan (lawyer and researcher) over email.

³³⁵ Ghosh, Abantika. "TB Patients to Get Rs 500 per Month during Treatment." *Indian Express*, December 27, 2017.

³³⁶ Ibid.

³³⁷ Raghavan, Prabha. "World TB Day: Over 25per cent TB Patients in India Are Resistant to at Least One Anti-TB Drug." *The Economic Times*, March 24, 2018.

diagnostic facilities for TB, including culture tests to accurately determine drug resistance. The full range of treatment options also need to be provided free, including medicines to cope with side-effects, supplements for TB care, and nutrition requirements. Systemic change is also required - training of private and public healthcare workers on latest treatment, and greatly augment counseling within the TB response to ensure proper information is conveyed to people with TB, and adherence improves.³³⁸

Tuberculosis and Sexual and Reproductive Health of Women

Coalescence of TB and sexual and reproductive health also brings to light poor health implications of the disease in the life of women suffering from it. TB among mothers is associated with a six-fold increase in perinatal deaths and a two-fold risk of premature birth and low birth-weight. Further, TB in pregnant women living with HIV increases the risk of maternal and infant mortality by almost 300per cent.³³⁹ Evidence from within India has found that TB among mothers living with HIV, is associated with more than double the risk of vertical transmission of HIV to the unborn child. Contraction of the disease also often places the women in a socially precarious position as the health and welfare of children is closely linked to that of their mothers, and disease can have serious repercussions for families and households in terms of societal response.³⁴⁰

Thus, to bridge the gap in healthcare provision for women living with TB, it is important to foster strategic partnerships and synergies across the health system. TB, HIV, maternal, neonatal and child health programmes and primary care services should collaborate to maximise the entry points to TB care for women at all levels. The existing health programme should seek to integrate TB screening and investigation into reproductive health services, including family planning, antenatal and postnatal care.³⁴¹ Further, it is also important to mobilise support at a national level to remove underlying risk factors and assure gender-equitable access, including women friendly services for TB prevention, diagnosis, treatment, care and support.³⁴²

Cancer

The Global Cancer Country Profiles,³⁴³ developed by the World Health Organisation (WHO) in 2014, lists breast, cervix, and uterine cancer among women as accounting for the most instances of cancer-related mortality in India. A 2017 study³⁴⁴ found that breast cancer was ranked as the number one cancer among Indian women, with the age-adjusted rate as high as 25.8 per 100,000 women and with a mortality rate of 12.7 per 100,000 women. Further, cervical cancer in India is ranked as the second most

³³⁸ Personal Communications with Vivek Divan (lawyer and researcher) over email.

³³⁹ *Tuberculosis in Women*. World Health Organization, 2013

³⁴⁰ Ibid.

³⁴¹ Ibid.

³⁴² Ibid.

³⁴³ *Cancer Country Profiles: India*. World Health Organization. 2014.

³⁴⁴ Malvia, Shreshtha, Sarangadhara Appalaraju Bagadi, Uma S. Dubey, and Sunita Saxena.

"Epidemiology of Breast Cancer in Indian Women." *Asia-Pacific Journal of Clinical Oncology* 13, no. 4, 289-95. 2017. doi:https://doi.org/10.1111/ajco.12661.

common cancer in women, with its rate of incidence standing at 12.1 per cent in 2012. In the same year, 122,844 women are diagnosed with cervical cancer in India and 67,500 of these women died of the disease. Misinformation, absence of knowledge, and low trust in public cancer care services remain major obstacles to early diagnosis and treatment. Further, the stigma associated with the cultural belief that screenings for breast and cervical are meant for only sexually active/married women has caused women to retreat from availing facilities.³⁴⁵ Thus, the stigma associated with cancer and the lack of availability of cancer-screening facilities at the primary level of care is significant contributory factors for the relatively late stage of disease presentation and high mortality.

Programmes

In 2010, the GOI initiated the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) to address this growing burden of cancer through a promotive, preventive, and curative approach. This was done through the integration of the already existing National Cancer Control Programme (NCCP) with the National Programme for Prevention and Control of Diabetes, Cardiovascular Diseases and Stroke (NPDCS) for integration of non-communicable diseases interventions in the National Health Mission (NHM) framework. Provision has been made under the programme to provide free diagnostic facilities and drugs to patients attending the Non Communicable Diseases (NCDs) clinics at District Hospitals (DHs) and Community Health Centers (CHCs).³⁴⁶

In 2016, the ‘Operational Guidelines: Prevention, Screening and Control of Common Non-Communicable Diseases: Hypertension, Diabetes, and Common Cancers (Oral, Breast, Cervix)’] were outlined, for screenings by public health care providers at the primary level for adults over the age of 30 years.³⁴⁷ However, NFHS-4, which captures values for women in the age group of 15–49 years who have ever undergone examinations of the cervix, breast, and oral cavity for cancer, shows that only 22.3 per cent of women underwent examination of the cervix, while 9.8 per cent and 12.4 per cent of women underwent examinations of the breast and oral cavity respectively.

Evaluating issues of infrastructure and human resources

The health system in India currently lacks uniform criteria for prevention, early diagnosis, evidence-based treatment, and follow-up of patients with cancer. The lack

³⁴⁵Singh, Sandeep, and Sorabh Badaya. "Factors Influencing Uptake of Cervical Cancer Screening among Women in India: A Hospital Based Pilot Study." *Journal of Community Medicine & Health Education*, June 25, 2012.

³⁴⁶"*National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)*." Directorate General of Health Services. http://dghs.gov.in/content/1363_3_NationalProgrammePreventionControl.aspx.

³⁴⁷*Operational Guidelines; Prevention, Screening and Control of Common Non-Communicable Diseases: Hypertension, Diabetes, and Common Cancers (Oral, Breast, Cervix)*. National Health Mission. Ministry of Health and Family Welfare, Government of India. 2016.

of a functioning primary-level screening programme and poor access to services result in a weak system of early diagnosis and curative treatment for cancer in India.³⁴⁸

This disparity has been manifested primarily because of the absence of an established network of cancer centers across the country to implement common standard management guidelines.³⁴⁹ As a result, there are wide variations in the incidence and mortality rates related to cancer in different parts of India because standards of cancer diagnosis and treatment vary considerably across institutions, states, and geographical regions. Currently, there is a significant shortage of oncologists in India, with only one oncologist per 1,600 new cancer patients in the country.³⁵⁰ Further, only 30 per cent of cancer centers in India have advanced imaging technologies such as PET-CT, which are essential for the accurate diagnosis, staging, and response monitoring of cancer, and are therefore critical to providing comprehensive cancer care.³⁵¹ As per the Directorate General of Health Services (DGHS),³⁵² till March 2017, 388 district-level NCD clinics and 2,115 CHC NCD clinics have been established in the country. There are also about 27 regional cancer centers and 300 other multispecialty hospitals providing comprehensive cancer care.³⁵³ However, these developments are insufficient as they amount to serving only 0.2 per million population in India - 40 per cent of these services are present in eight metropolitan cities and fewer than 15 per cent of these are government-operated. In addition because most districts do not have the facilities required to provide quality care to people who rely on them, this results in patients having to travel long distances to be treated at the centers located in metropolitan cities and being forced to wait for long periods of time, leading to further escalation in the cost of treatment.

The issue of this **epidemiological migration** needs to be addressed by increasing financial and capacity-building support to regional cancer centers with mandated authority to provide affordable/free cancer care and prevention services, while also recognizing the key role of effective early detection and screening programmes in reducing the cancer burden.³⁵⁴

³⁴⁸Mallath, Mohandas K. et al. "The Growing Burden of Cancer in India: Epidemiology and Social Context." *The Lancet* 15, no. 6 (May 2014). doi:[https://doi.org/10.1016/S1470-2045\(14\)70115-9](https://doi.org/10.1016/S1470-2045(14)70115-9).

³⁴⁹Pramesh, C. S., Rajendra A. Badwe, and Ratan Kumar Sinha. "The National Cancer Grid of India." *Indian Journal of Medical and Paediatric Oncology* 35, no. 3 (July 2014). doi:10.4103/0971-5851.142040.

³⁵⁰Ibid.

³⁵¹Call for Action: Expanding cancer care in India, Ernst & Young, 2015.

³⁵²"National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)." Directorate General of Health Services. http://dghs.gov.in/content/1363_3_NationalProgrammePreventionControl.aspx.

³⁵³Yadavar, Swagata. "27 Regional Hubs, 300 Hospitals, Yet Patients Journey To 1 Mumbai Cancer Centre." IndiaSpend. September 6, 2017. <http://www.indiaspend.com/cover-story/27-regional-hubs-300-hospitals-yet-patients-journey-to-1-mumbai-cancer-centre-36149>.

³⁵⁴Rajaraman, Preetha et al. "Recommendations for Screening and Early Detection of Common Cancers in India." *The Lancet Oncology* 16, no. 7 (July 2015). doi:[https://doi.org/10.1016/S1470-2045\(15\)00078-9](https://doi.org/10.1016/S1470-2045(15)00078-9).

Case Study of Tamil Nadu (TN): In terms of early detection, attempts have been made at the state level to initiate cost-effective screenings since these increase the chances of successful treatment. For instance, the state government of Tamil Nadu launched the Tamil Nadu Health Systems Project (TNHSP) to create an accessible, equitable, and effective health care system in Tamil Nadu, which integrated efforts to tackle the four major NCDs: hypertension, diabetes, cervical cancer, and breast cancer. Women coming for consultation or treatment to government hospitals, primary health centers, or government medical colleges were encouraged to undergo screening. It is till date one of the most successful early interventions in the country, as it has raised awareness about cervical and breast cancers through strategic communication interventions focused on communities, workplaces, and schools and through media campaigns.³⁵⁵ However, the project currently lacks well-established treatment follow-up procedures. It does not effectively address issues of social determinants such as depression and lack of family support among women whose screening results indicate that they need further medical attention. Also, standardised treatment protocols for cervical and breast cancers need to be put in place to ensure that women whose screening results indicate the need for further diagnostic and treatment services are not lost to follow-up and are able to take up the required treatment.³⁵⁶

Treatment out of reach

Manpreet (name changed), a 50 year old Dalit woman from Punjab, was diagnosed with breast cancer in 2017. Hailing from a family which has no land and where her son was only working member, earning a wage of Rs 200 per day, the cost of her treatment had a significant impact on her family's financial condition. During the time of diagnosis, the biopsy at private centre cost her Rs 5300. Following the diagnosis, Manpreet received 4 rounds of chemotherapy, followed by a surgery to remove one of her breasts. Two more chemotherapies were to be followed after the surgery. Though Manpreet's family did not have to pay for the surgery or chemotherapy as after the diagnosis they had applied for financial assistance under the Chief Minister's Cancer Relief Fund, other expenditures such as medicines and travel had amounted to almost Rs 22000 during the time of surgery alone. Unable to pay for such a huge amount by themselves, Manpreet's family took a loan of about Rs 30000 against interest from a local lender, while also selling her gold earrings to meet the required cost of treatment.

Manpreet's story clearly illustrates, the urgent need address the requirements so as to enable the recovery of patients during the duration of their treatment, without further depleting their financial capacity and resources following their diagnosis and treatment. The treatment costs for cancer continue to remain high because of the high cost of drugs. With drugs being increasingly patented, resulting in escalating costs, inaccessibility to essential drugs for cancer treatment is exacerbated. This is seen, for

³⁵⁵Scaling Up Cancer Prevention in Tamil Nadu. *ET Healthworld*. April 20, 2015.

<https://health.economictimes.indiatimes.com/news/policy/scaling-up-cancer-prevention-in-tamil-nadu/46988484>

³⁵⁶Ibid.

instance, in the case of Trastuzumab, which is a life-saving drug for women with HER2+³⁵⁷ breast cancer and which is also listed in the WHO Model List of Essential Medicines (2015).³⁵⁸

An estimated 25,000 new cases of HER2+ breast cancer are recorded in India every year, with younger women constituting the majority of patients. In 2002, the Swiss pharmaceutical company Roche launched Trastuzumab (brand name Herceptin) and priced the medicine at Rs 120,000 for the 440 mg vial. At that time, India was importing the drug and it was priced at Rs 135,200 for the 450 mg vial. Depending on the status of the cancer (first stages or metastatic), the treatment using Trastuzumab would require anything from 2 mg to 8 mg every 90 minutes for the first 12 weeks of chemotherapy. Owing to the exorbitant price, it was out of reach for all but the most privileged of people with this type of breast cancer.³⁵⁹

In 2013, the MoHFW insisted on a compulsory licence (CL) for Trastuzumab. Roche's response was to merely offer a 30 per cent discount on its price, reducing the price to Rs. 75,000 for one vial.

However, in a much welcomed step in 2015, the GOI added Trastuzumab to the National List of Essential Medicines (NLEM), and in May 2017, it placed a price cap of Rs. 55,812 on it. However, the medicine still remains unaffordable for most women cancer patients in the country. Although the NLEM, 2015 lists this as an essential drug, state governments like Odisha, Rajasthan, and Tamil Nadu, which have a free drug policy in public health facilities within their states, have yet to list this drug in their respective state essential drug lists.

To address the existing situation, it is imperative that the government focus on increasing support to local cancer centers to provide affordable (and free for poor patients) cancer care and well-designed prevention services to reach out to underserved sections of the population.

The states also need to develop contextual public health care strategies to adapt to and address epidemiological migration by increasing the capacity and quality of cancer care, especially to serve marginalised and rural populations. Cancer needs to be seen and addressed as a public health priority, wherein improvements in outcomes are designed to result from early detection and presentation, primary prevention, better designed financial assistance schemes, and a greater emphasis on the social determinants of cancer.³⁶⁰

³⁵⁷HER2+ positive cancers are cancers that can be attributed to the gene mutation that produces an excess of the HER2+ protein and plays an important role in the development and progression of certain aggressive types of breast cancer.

³⁵⁸WHO Model List of Essential Medicines; 19th List. World Health Organization. April 2015.

³⁵⁹Rajagopal, Divya. "Roche vs Indian Pharma: The Battle for a Cheaper Cancer Drug." *The Economic Times*, May 14, 2017.

³⁶⁰Ibid

Gender Based Violence (GBV): A Reproductive, Sexual, and Public Health Issue

Gender-based violence violates a range of human rights of women and girls, including their rights to life, health, equality and non-discrimination, liberty and mobility, free speech and expression, social security, education, work and livelihood, shelter and adequate standard of living, and participation in social and political activities.³⁶¹

Sexual abuse, female genital mutilation, sexual harassment, domestic violence, and marital rape are all forms of gender-based violence. CEDAW has called attention to the increase in violent crimes against women in India, such as rape, abduction, caste-based sexual violence, dowry-related deaths, honour killings, acid attacks, and declining sex ratio. States have a responsibility to prevent, investigate, and punish acts of violence against women and girls, including those acts perpetrated by private actors.

The World Health Organisation (WHO) in its 2009 report, *Women and Health: Today's Evidence Tomorrow's Agenda*³⁶² states that “violence is an additional significant risk to women’s sexual and reproductive health and can also result in mental ill-health and other chronic health problems”. GBV results in physical, emotional, and/or sexual harm and injury, and it affects women’s right to health as well as their enjoyment of sexual and reproductive rights. GBV against women and girls is a significant public and reproductive health and rights issue. Several of the international conventions perceive GBV as a health issue.

In 1995, the Platform for Action of the UN Fourth World Conference on Women, Beijing, was the first to declare the need to strengthen health systems and to involve health care providers in provisioning services to address violence. The core document committed to by governments declared, “*violence against women constitutes a violation of basic human rights and is an obstacle to the achievement of the objectives of equality, development and peace*”. It also directed countries to

....integrate mental health services into primary health-care systems or other appropriate levels, develop supportive programmes and train primary health workers to recognise and care for girls and women of all ages who have experienced any form of violence, especially domestic violence, sexual abuse, or other abuse resulting from armed and non-armed conflict [Section 106(q)].

³⁶¹*Gender Based Violence and Health: Strengthening Linkages and Responses. An Information Booklet.* Sama. 2013.

³⁶²*Women and Health: Today's Evidence Tomorrow's Agenda.* World Health Organization. November 2009.

Thus, gender-based violence as a public health issue was recognised and articulated by the Beijing Platform, but this understanding and articulation became more nuanced through subsequent declarations and mandates.^{363,364}

The 57th Session of the Commission on the Status of Women (CSW) in 2013 adopted a set of conclusions on the elimination and prevention of all forms of violence against women and girls that also included recognition of the adverse consequences for health, the need to provide support to victims and survivors, the need to provide affordable and accessible health-care services, and the need to take necessary steps to sensitise and strengthen the capacity of public officials and professionals and hold them accountable, including in the health care sector (Agreed conclusions on the elimination and prevention of all forms of violence against women and girls, 2013).³⁶⁵

Combating gender-based violence is essential for promoting and protecting reproductive rights and for achieving the commitments as per the International Conference on Population and Development (ICPD), the Millennium Development Goals (MDGs), and the Sustainable Development Goals (SDGs). In addition, respecting and fulfilling reproductive rights is a necessary condition for preventing and mitigating gender-based violence and for ensuring gender equality.

Health impact of GBV

Domestic violence, rape, female genital mutilation, and early/forced marriage are forms of GBV, and impact the physical, mental, and emotional well-being and health of girls and women. GBV impedes the exercise of reproductive freedom by women and curtails their right to attain the highest standard of reproductive health. Sexual violence can lead to unwanted pregnancies and sexually transmitted diseases, and physical and emotional violence may limit a woman's choices regarding the use of contraceptives and family planning. Economic abuse affects a woman's ability to pay for and access health services. Laws and policies must address such violations and provide adequate redress to survivors, including access to health care that is responsive to their particular needs.

Women and girls facing gender-based violence experience a wide range of reproductive health consequences, including physical, psychosomatic, and psychological health consequences.

³⁶³ *15 Years of the United Nations Special Rapporteur on Violence against Women, Its Causes and Consequences (1994–2009): A Critical Review*. Report. Office of the United Nations High Commissioner for Human Rights. 2009.

³⁶⁴ *Breaking Free from Gender-based Violence. Global Health Watch 4*. Report. People's Health Movement. 2015

³⁶⁵ *Breaking Free from Gender-based Violence. Global Health Watch 4*. Report. People's Health Movement. 2015

Table 4 Health impacts of GBV

Health Impacts of Gender-Based Violence		
Non-Fatal Outcomes		Fatal Outcomes
Physical consequences - Injuries - Functional impairments - Permanent disabilities	Psychosomatic consequences - Chronic pain syndrome - Irritable bowel syndrome - Gastrointestinal disorders - Urinary tract infections - Respiratory disorders	- Fatal injuries - Killing - Homicide - Suicide
Psychological consequences/ Mental health - Post Traumatic Stress Disorder - Depression, fear, sleeping disorders - Panic disorders, eating disorders - Low self-esteem - Suicidal tendencies	Negative health behaviours - Alcohol and drug abuse - Smoking - Sexual risk-taking - Self-injurious behaviour	Consequences for reproductive and sexual health - Pelvic inflammatory diseases - Sexually transmitted diseases, HIV/AIDS - Unwanted pregnancy - Pregnancy complications - Miscarriage/low birth weight

While GBV affects the reproductive health and rights of women and girls, gendered social norms about girls' and women's reproductive health issues, such as infertility, HIV status, cancer, and covert contraceptive use, may also lead to gender-based violence.

Prevalence of GBV

Sexual violence and domestic violence are among the most prevalent forms of GBV throughout India, impacting women and girls from all regions, religions, and socio-economic backgrounds. NFHS-3 data show that one-third of women (in the age group 15–49 years) have ever experienced physical violence, and husbands were the most common perpetrators of physical violence, with 85.3 per cent of women reporting facing violence from their husbands.³⁶⁶ Husbands were also the most common perpetrators of sexual violence.³⁶⁷ Physical violence was the most common form of spousal violence (reported by 35.1 per cent of ever married women), followed by any form of emotional violence (15.8 per cent) and sexual violence (10 per cent).³⁶⁸ More than half of the women who have ever experienced physical and sexual violence from their husbands reported suffering cuts, bruises, or aches, and 20 per cent reported eye injuries, sprains, joint dislocations, or burns.³⁶⁹ In a study on the implementation of the PWDV Act, women who filed cases under the law were interviewed, and it was found that women suffered miscarriages and underwent abortions because of the severity of

³⁶⁶Report National Family Health Survey 3, *Domestic Violence*, Chapter 15, Table 15.2.

³⁶⁷National Family Health Survey 3, *Domestic Violence*, Chapter 15, Table 15.5.

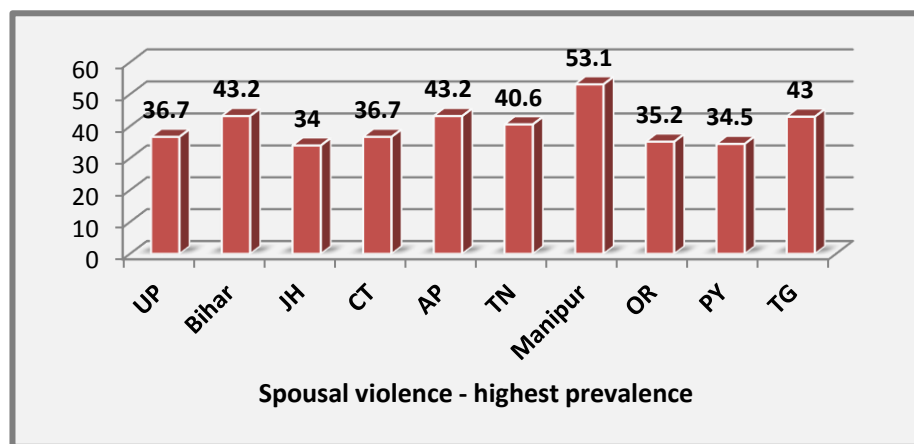
³⁶⁸National Family Health Survey 3, *Domestic Violence*, Chapter 15, Table 15.8.

³⁶⁹National Family Health Survey 3, *Domestic Violence*, Chapter 15, Table 15.13.

violence committed against them.³⁷⁰ Domestic violence erodes women's agency to control their fertility and affects their physical and mental health.

As per NFHS-4, 28.8 per cent of women in the age group of 15-49 years reported experiencing spousal violence. Violence during pregnancy, even though at 3.3 per cent, is a gross violation of the human rights of women. Spousal violence among women who are in the age group of 15-49 years (NFHS-4) was the highest in Manipur, followed closely by other states like Telangana, Andhra Pradesh, Bihar, Jharkhand, and Odisha (Figure 5).

Figure 5 States with highest prevalence of spousal violence



Despite the international mandates and the well-established health consequences of GBV, it has remained a marginalised issue within the public health system in India, being largely perceived as a law and order problem. The health care system and health care providers are often the first points of contact for survivors of violence. In addition, survivors come in contact with health facilities and health providers repeatedly, at several points in their lives. Studies have shown that women who have experienced violence are more likely to seek health care than those women who have not, even if they do not disclose having experienced violence.³⁷¹ Studies have also indicated that women who have ever experienced intimate-partner violence were significantly more likely to report poor or very poor health in comparison to women who have never experienced intimate-partner violence (WHO multi-country study on women's health and domestic violence against women, 2005). The discourse on GBV's linkages with SRHR is growing, albeit extremely slowly. However, the health-system response to GBV continues to be very limited.

³⁷⁰ *Quest for Justice: A Study of the Implementation of the Protection of Women from Domestic Violence Act, 2005*. Ministry of Women and Child Development and Tata Institute of Social Sciences. 2014.

³⁷¹ *Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines*. World Health Organization. 2013.

The following case study of a nine-year-old rape survivor from Jharkhand points to the absence of adequate health facilities and services, leading to difficulties for the survivor and her family in accessing healthcare.

A nine-year-old girl child from a village in East Singhum district in Jharkhand state was raped by a local driver near her home in June 2015. The child was lured with chocolates; she was sexually assaulted and abandoned by the riverside in the village. The girl was bleeding profusely and was unable to walk; she had to crawl back to her home where she told her parents about what had happened to her. The nearest government health centre was 4 kilometers away and in the absence of any public transport, the father had to carry the child in his arms, walking the entire distance to the health centre.

The staff at the health centre lacked the expertise to attend to the severe injuries sustained by the child, and she was rushed to the Jamshedpur district hospital for treatment. The doctors there could not stop the bleeding and referred the child to a hospital in Ranchi. She underwent a colectomy surgery in Ranchi to remove her damaged intestine and had to use a colostomy bag thereafter. After the surgery, the doctors managed to check the bleeding and discharged her, but her wounds had to be dressed regularly. The parents of the child continued carrying her in their arms for 4 kilometers to the nearest health centre each time her dressing had to be changed.

This was reported in the media two months after the assault. The article was accompanied by a blurred photo of the father carrying his daughter in his arms. Local organisations along with the media took up the issue, and the administration was forced to take cognisance of the matter and promised to provide some (monetary) relief to the family. The Jharkhand High Court took suo-moto cognisance of the case and ordered that compensation of one lakh rupees be paid to the family. The father who was a poor laborer in the village said, “I am unable to go to work as this is a priority. We have exhausted whatever we had in the name of savings. Rather, we are now deep in debt. God knows how many more days we will have to suffer like this. I wish a doctor could come to my home and dress the wounds of my daughter, but that’s a dream for us.”

(Source: ‘Jharkhand: Father carries raped minor daughter 4km daily for treatment’, 29 August 2015, <http://www.hindustantimes.com/india/jharkhand-father-carries-raped-minor-daughter-4km-daily-for-treatment/story-0X8bLwuXT0PikeSRPCXdzL.html>)

This report reveals the larger and more serious problems with the health care system in India, as well as lack of understanding and preparedness in providing treatment, including treatment for psychosocial problems and medico-legal care to survivors of GBV.

Laws and policies on the health system’s response to GBV

The two key laws pertaining to GBV, that is, the Protection of Women from Domestic Violence Act (PWDVA), 2005 and the Criminal Law (Amendment) Act, 2013 (Section 166B, 357C CrPC) have expanded the definitions and remedies for sexual assault.

Similarly, the Protection of Children from Sexual Offences (POCSO) Act, 2012 provides for crucial services for child survivors of sexual violence. Denial of care and treatment to a sexual assault survivor is deemed a punishable offence under the law. The PWDV Act, 2005 recognises the various forms of violence that women face in their homes, and provides for several civil remedies such as protection orders and compensation orders. Health providers are identified as stakeholders under the Act. Notified medical facilities are obligated to provide medical aid to aggrieved women.³⁷²

Marital rape, however, continues to remain outside the purview of criminal law, and is yet to be recognised as a criminal offence in India. PWDVA, however, recognises rape within marriage as a form of sexual violence, and empowers women to seek remedies for the same under this Act.

Recognizing the role of healthcare providers in responding to the survivors of sexual violence, MoHFW in 2014 released the 'Guidelines and Protocols: Medico-legal Care for Survivors/Victims of Sexual Violence'. The document sought to establish a standard healthcare response for survivors and victims of sexual violence.³⁷³ The guidelines including the proforma ensured the discontinuation of problematic practices like the two-finger test and the inclusion of comments on the laxity of the vagina in the medico-legal documentation of the survivor or victim of sexual assault, etc. It is therefore of critical importance that these guidelines be implemented across the country in a uniform and consistent manner.

However, since the release of the document, only eight states have given the necessary orders for the implementation of the guidelines and protocols. Moreover, evidence from these states indicates that mere orders for the implementation of the guidelines and protocols in the absence of systematic efforts to equip the healthcare system with quality infrastructure, and with suitably trained and qualified human resources to implement them in a manner that is meaningful to the affected individuals is grossly insufficient. Even when it is implemented, the focus has disproportionately been on forensics, that is, on examination and collection of evidence. Access to services for other health needs—both physical and psychological—continues to be inadequate or is completely absent. Despite the MoHFW protocols, the healthcare system routinely undermines the narratives of women survivors and victims of sexual violence and is preoccupied with the women's genital injuries; the absence of injuries is frequently equated with the absence of assault, resulting in the denial of the women's rights and autonomy.

The implementation of the MoHFW protocols, if it is to be true to their letter and spirit, thus requires an empathetic, efficient, and accountable healthcare system to prevent survivors being denied healthcare and justice.³⁷⁴ Further, the protocols

³⁷²Section 7, The Protection of Women from Domestic Violence Act, 2005.

³⁷³*Medico Legal Examination Report of Sexual Violence*. Government of India. Guidelines and Protocols: Medico-legal Care for Survivors/Victims of Sexual Violence, pp. 62–74.

³⁷⁴Fatima, Adsa, Aarthi Chandrasekhar, and Amita Pitre. "Need for Gender Sensitive Health System Responses to Violence against Women and Children." January 18, 2013.

clearly mandate the provision of care for survivors belonging to vulnerable groups like children, persons with disability, and LGBTQI persons. However, these aspects of the MoHFW protocols continue to be rarely understood and implemented.

There is also an urgent need for the health system to respond to survivors of domestic violence as well as survivors of other forms of gender-based violence alongside sexual assault. It is essential to develop and implement on an urgent basis a protocol for a health-system response to domestic violence. The comprehensive implementation of the MoHFW protocols requires building the capacities of all healthcare providers to recognise the impact of gendered violence on health and to provide the necessary care, support, and referrals to other requisite services.³⁷⁵

Another similar effort is the One Stop Centre (OSC) scheme, launched in 2015 by the Ministry of Women and Child Development (WCD), to provide support and assistance to “women affected by violence, both in public and private spheres”.³⁷⁶ The OSCs were envisaged as providing single-window access to a range of essential services for survivors of violence. They were proposed to provide medical assistance, to facilitate the lodging of First Information Reports (FIRs), and to extend psychosocial support, legal aid and counseling, shelter, etc. Currently, the OSCs are generally located in the premises of public hospitals. While such services need to be available and functional in every district for effective and comprehensive care and outreach, their functioning also needs to be better integrated and coordinated with the hospitals where they are located. Currently, this linkage remains weak in a large majority of the OSCs.

Despite the various laws, guidelines, and protocols related to gender-based violence, wherein health professionals are required to provide essential services and care to survivors, the reality presents a bleak picture. The implementation of the laws, guidelines, and protocols by the health system reveals serious deficiencies and shortcomings as presented in the table below.³⁷⁷

Table 5 GBV & Health: Gaps in implementation

Gaps in Status of existing response at the health system level towards GBV	
Ministry of Health and Family Welfare (MoHFW) Guidelines and Protocols for survivors	<ul style="list-style-type: none"> • Lack of awareness about the Guidelines and Protocols in the health care facilities across the states. • Barring about eight states most of the states have not passed orders directing the implementation of these protocols. • Therapeutic role of medical professionals remains minimal. • Sexual violence cases continue to be dealt only as a medico legal case and the health concerns of the woman, girl or child survivors gets

³⁷⁵Ibid.

³⁷⁶*One Stop Centre Scheme: Implementation Guidelines For State Governments / UT Administrations*. Ministry of Women and Child Development, Government of India. August 2016.

³⁷⁷Towards Change 2016, Sama; Advocacy initiatives by Sama to strengthen health system response to GBV (2012-2018)

<p>/ victims of sexual violence</p>	<p>grossly neglected and violated.</p> <ul style="list-style-type: none"> • Failure to implementation of use of new proformas as laid down by this guideline is leading to gross violation of rights of the women. • Healthcare providers conducting medico legal examination of the sexual violence survivors continue to comment on ‘hymen’ related findings and conducting two finger test, against the Honourable Supreme Court’s orders terming it as irrelevant and unscientific. • Copy of the documentation of the medical examination is to be provided to the survivor free of cost, but this is largely not being followed. This is important for medical follow up or even legal aid or consultation by the survivor. • Lack of financial, infrastructural and skilled human resources remains a major issue for the hospitals implementing the new guidelines. • With regard to child survivors and survivors with special needs, there is paucity of any human resources skilled in counselling for either child survivors or those with expertise in communicating or facilitating communication with survivors with disabilities. • Psychological care and long term follow up is completely lacking in the current scenario of the health system’s response.
<p>Criminal Law Amendments (CLA), and Protection of Children from Sexual Offences Act (POCSO)</p>	<p>There is lack of awareness and as well as lack of clarity amongst healthcare providers over the recent changes in law, and the role of healthcare. The conflict within two separate legal provisions further adds to the prevailing confusions; for example the law at one place says that any RMP (Registered Medical Practitioner) can conduct the medico legal examination of the survivors of sexual assault (Section 357C CrPC), while in POCSO it mandates that girl child be examined by female doctors only. Given the limited number of female doctors and staffs in our public health facilities, it creates a practical dilemma for the doctors and staffs to ascertain what is to be done.</p>
<p>Protection of Women from Domestic Violence Act</p>	<ul style="list-style-type: none"> • Awareness about this decade old law is very poor amongst the health facilities, and there exists a clear lack of recognition in the health system towards addressing domestic violence, or their accountability as per the PWDVA.
<p>Interlinkages with other agencies</p>	<ul style="list-style-type: none"> • In order to respond comprehensively to the survivors of GBV, it is essential that health system should develop and strengthen its existing inter-linkages with other agencies like Child Welfare Committee, Police, Judiciary, Protection Officers, Counselors/Counseling services, Shelter Homes etc. • Inter-linkages with police particularly remain a serious area of concern. It is often seen, that the healthcare providers remain disproportionately dependent on police personnel to carry out their duty in conducting medico legal examination of a sexual assault survivor. The guidelines however, clearly requires for non-interference of police in the role of the doctors, and that proper medical examination and healthcare services be provided to the survivor comprehensively as required in the given case. • The existing situation points towards poor inter-linkages of health system with these agencies requiring sufficient improvements in this aspect.

Regional gaps in existing health care services for GBV survivors	<ul style="list-style-type: none"> • Within the existing insufficient health system infrastructure and services to respond to the issue of GBV, there exists a further marginalisation of rural areas, especially the interior hamlets and villages. • While the services like one stop centre have been initiated, they largely remain restricted to the cities and tertiary level healthcare settings across the states. The primary and secondary level healthcare facilities reflect poor / limited preparedness in responding to the survivors. This jeopardises the health and rights of the women, girls and children survivors, especially from rural areas. • Although ASHAs have undergone trainings ³⁷⁸ to identify, refer survivors from the community, the lack of complementary services at the health facility creates barriers for a comprehensive response. Referrals are frequent due to unavailability of services and skilled human resources causing severe delays and denial in healthcare for survivors.
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The State needs to address these gaps at the earliest to meet its commitment to recognise GBV as a public health issue. Freedom from violence is a significant determinant of health and well-being. A public health approach implies multi-sectoral, coordinated efforts to address the impact of gender violence, as well as the prevention of violence. It calls for a collective and concerted effort from different spheres and by different stakeholders, including the health system, social services, the justice system, and policy-planning bodies, to ensure a comprehensive response to address the problem of GBV and to provide adequate care and support to GBV survivors.

Mental health and reproductive health rights

Mental health is inextricably linked to reproductive health and rights with considerable areas of intersections between them. Mental health issues with regard to menstruation and menopause, pregnancy and maternal outcomes, sexuality, gender violence, sexually transmitted infections including HIV and AIDS, family planning, uterine prolapse, obstetric fistula and infertility are widely known.³⁷⁹ Reproductive health issues contribute substantially to the global burden of disability, particularly for women.³⁸⁰ There is substantial evidence that stressful life events and reproductive health problems are closely associated with depression and anxiety disorders. These issues are often seen to get exacerbated in situations of conflict and other humanitarian crisis. Furthermore, girls and women disproportionately experience compromised mental health due to their subordinate gender roles and social positions. For example, mental health aspects of chronic health problems, such as fistula,

³⁷⁸ *Mobilising for Action on Violence against Women – A Handbook for ASHA. National Health Mission. National Health Mission. Ministry of Health and Family Welfare. Government of India. http://nhm.gov.in/images/pdf/communitisation/asha/ASHA_Handbook-Mobilizing_for_Action_on_Violence_against_Women_English.pdf*

³⁷⁹ *Mental Health Aspects Of Women's Reproductive Health: A Global Review Of The Literature. World Health Organization. 2009.*

³⁸⁰ *Ibid.*

perineal tears and utero-vaginal prolapse, are much more common among women living in resource poor settings.³⁸¹

However, epidemiological data on the interconnected mental and reproductive health issues is largely unavailable. Moreover, where such data is available, evidence is primarily in the context of married women of childbearing age, while the spectrum of reproductive and mental health issues of all others remains largely sidelined. The reproductive health and rights of persons with mental disabilities is also a critical component of mental health,³⁸² as is reiterated in the narratives below.

*Sheetal is 25 years and married for the last seven years. She has been trying to conceive for the last seven years but has been experiencing miscarriages and has not been able to conceive. She has been extremely stressed and fearful that her husband who has been supportive all these years is likely to come under pressure and ask her to leave. She is also depressed because of the stigma of infertility that excludes her from participating in social functions in the household and community. The family (natal and marital) is poor and hence she is unable to access treatment regularly for her problem.*³⁸³

Priti who was suffering from blood cancer had been suffering from immense mental distress and had even attempted suicide. Two years (prior to the interview with her) earlier she had been diagnosed with cancer. Immediately after her husband got to know about her condition he stopped talking to her, stopped caring for her, started abusing and beating her. She faced repeated episodes of verbal abuse and physical assault by her husband and threatened to marry again. The reason he gave for remarrying was that he may also get infected with the disease that she was suffering from. Depressed, without any support, she decided to consume phenyl and also fed it to her two children. Her husband took the children to hospital leaving her alone at home. The same evening he took her and the younger child to her natal home saying that he did not want to keep her. She continued to live in her natal home and has registered a case of domestic violence against him, with the support of a local organisation.

These narratives about women's experiences of infertility and cancer respectively draw attention to the inextricable linkages between these reproductive health issues, and the mental health and well being of the women. Both the narratives also foreground the issues of the lack of availability of care and treatment for the morbidities but also for the impact on mental health that the women were experiencing. The lack of affordability of care was also a common factor in both the narratives. The narratives reiterate the need for integrated understanding and care of

³⁸¹ *Mental Health Aspects Of Women's Reproductive Health: A Global Review Of The Literature.* World Health Organization. 2009.

³⁸² *UNFPA Emerging Issues: Mental, Sexual and Reproductive Health.* Report. UN Population Fund (UNFPA). 2008

³⁸³ *Interrogating Interruptions.* Sama. Research report on exploring mental health issues of young people. To be published 2018. Names and identifiers changed / removed to maintain confidentiality.

reproductive health rights that is encompassing of mental health and the requisite skills and services to provide them. The narratives also point to the absence of implementation of the District Mental Health Programme (DMHP) or any support at the community level for mental health issues.

According to the National Mental Health Survey 2015-16³⁸⁴, “An estimated 150 million persons are in need of mental health interventions and care (both short term and long term) and considering the far reaching impact of mental health (on all domains of life), in all populations (from children to elderly), in both genders, as well as in urban and rural populations, urgent actions are required”. Nearly 1 in 40 and 1 in 20, according to the survey, suffer from past and current depression, respectively.³⁸⁵

Most of the reproductive health issues mentioned previously, especially those that are chronic, especially in the absence of access to information, screening and treatment may lead to depression and other debilitating mental health issues both in the short and long term. However, neither the reproductive health policies and programmes nor public health initiatives include the requisite focus on mental health issues as integral to them.

Evidence also indicates that nearly 1% of the population reported high suicidal risk. The prevalence of high suicidal risk was highest in the 40-49 age group (1.19%) and among women (1.14%).³⁸⁶ According to the World Health Report, 2016, India has a suicide mortality rate of 20.9 per 100,000 populations.³⁸⁷ These extreme outcomes also point to the huge burden of mental health issues in the country. Further, that a majority of the nearly 11% of persons above 18 years who are suffering from mental health issues do not receive any care or treatment for a range of issues, points to the abysmal healthcare services available.³⁸⁸

Recognition of mental health as a critical part of public health and the integration of mental health care within the public health system is urgently required. While substantial care can be provided at primary levels, specialised care for mental health issues may also be necessary. However, in addition to the shortfalls in the public health system in general, there is a substantial deficit of mental health practitioners in the country—for example, the shortfall is of 8,500 psychiatrists, 6,750 psychologists, 22,600 psychiatric social workers and 2,100 psychiatric nurses.³⁸⁹

³⁸⁵ *National Mental Health Survey of India 2015-16 Summary*. Report. National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru. 2016. p. 16

³⁸⁶ *National Mental Health Survey of India 2015-16 Summary*. Report. National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru. 2016. p. 18

³⁸⁷ *National Mental Health Survey of India, 2015-16*. Report. National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru. 2016

³⁸⁸ *Ibid.*

³⁸⁹ *Situation Analyses: Backdrop to the National Health Policy 2017*. Report. Ministry of Health and Family Welfare, Government of India.

In all public health programmes, integration of screening for common mental health issues (depression, suicidal behaviors, substance use problems, etc.), health promotion and continuity of care and referral services, is extremely relevant. Strengthening community based models for care, peer and community support are also necessary to manage mental health issues and prevent any negative outcomes of the same. However, the poor status of implementation of the programmes for mental health, i.e. the National Mental Health Programme (NMHP) and the DMHP has been highlighted by recent government reviews. According to the 10th Common Review Mission Report of the Nation Health Mission (2016),³⁹⁰ the overall picture in terms of the NMHP and DMHP implementation has major gaps in the reviewed states. Some of the key concerns highlighted by the report included the lack of community awareness about the initiative, limited screening and referrals from peripheral health facilities, the shortage of trained human resources (including specialists) and the integration with other public health programmes. The report also suggests increased coverage through the NMHP by involving and ensuring services at primary and secondary health facilities (below the level of the district hospital). The shortage of human resources and funding has hampered the outreach activities envisaged under the NMHP/DMHP. The report recommends that the outreach activities at the district and block levels need to be implemented regularly along with their integration with programmes so as to reach out especially to vulnerable groups such as children and adolescents, both in schools and in the community.

Reproductive health rights of persons with disabilities

People with disability “have equal rights to sexual and reproductive desires and hopes as non-disabled people, society has disregarded their sexuality and reproductive concerns, aspirations and human rights”.³⁹¹ However, in most instances if at all, these rights are taken cognisance of in limited situations and largely in case of custodial violation. While this is extremely important, people particularly women with disabilities are infantilised, and are perceived as either asexual or even hypersexual beings.³⁹² Their reproductive and sexual health and rights are not affirmed and often overlooked and even contested. The experience of women with disability often implies exclusion from access to RHR information, care, and treatment; from sexual non hetero-normative partnerships; or denial of opportunities for motherhood, etc.³⁹³

Furthermore, services and care for persons with psychosocial disabilities in healthcare facilities as well as in other social welfare institutions indicate the violation of their reproductive rights through coercive measures such as the absence of informed consent, forced sterilisation, hysterectomy, and even forced medical examination following sexual assault. For example, despite existing protocols that clearly provide

³⁹⁰ 10th Common Review Mission. Report. Ministry of Health and Family Welfare, Government of India. 2016.

³⁹¹ Addlakha, Renu, Janet Price, and Shirin Heidari. "Disability and Sexuality: Claiming Sexual and Reproductive Rights." *Reproductive Health Matters* 25, no. 50, 4-9. July 5, 2017. doi:<https://doi.org/10.1080/09688080.2017.1336375>.

³⁹² Ibid

³⁹³ Ibid.

guidelines for examination of survivors of sexual assault who are persons with disabilities,³⁹⁴ health care providers and facilities flout informed consent processes in seeking consent for examination, evidence collection, treatment, etc. following sexual assault. Some health care providers have stated existing practices of giving general anesthesia to survivors with psychosocial disabilities with consent, to ensure that the medico-legal processes can be completed.

Provisioning of services must respect human autonomy and dignity and ensure that they are not violative of the human rights of persons with disabilities. Moreover, a range of interventions to address mental health issues must be provided through public health programmes so that they are accessible for all persons requiring them.

Egg Donation, Commercial Surrogacy and Assisted Reproductive Technologies (ARTs)

In January 2014, a young woman, Yuma Sherpa, died during the oocyte retrieval procedure at a fertility clinic in Delhi. She along with her husband and three year old daughter came to Delhi in search of better employment opportunities—a trend that has become more pronounced during the last two decades with the increasing globalisation of the Indian economy. The perpetual crisis in agriculture sector and consequent shrinking employment opportunities in rural areas are forcing people to migrate to big cities. However, the majority of migrant population in cities is employed in informal sector where they work in highly precarious conditions without any social security. Yuma Sherpa, who was working as a shop assistant, belonged to this vulnerable class of migrant population in Delhi. When she came to know from her neighbor that she could sell her eggs for 25,000 Rupees to fertility clinics, she might have gone through a difficult dilemma for egg retrieval procedure is not only highly invasive but also carries strong social stigma. Eventually, Yuma Sherpa decided to sell her oocytes and went through the oocyte retrieval procedure in which 24 follicles were extracted from her ovaries. When she was shifted to the recovery room after the egg retrieval procedure, she felt uneasy, drowsy and became unconscious and finally died after a few hours. The postmortem report of Yuma Sherpa suggested the presence of Ovarian Hyper Stimulation Syndrome (OHSS), which is generally caused by the high doses of hormones to stimulate ovaries.

(Source: Needed, an Assisted Reproduction Law that Doesn't Discriminate Against Single Women. *The Wire*, 2 December 2015³⁹⁵)

The case of Yuma Sherpa elaborates this with precision that the women and girls coming from poor economic backgrounds entering into the exploitative nature of this industry. While this case appeared to be a case of medical negligence where the concerned doctor at the clinic violated the Assisted Reproductive Technologies

³⁹⁴*Guidelines & Protocols; Medico-legal Care for Survivors/victims of Sexual Violence*. Ministry of Health and Family Welfare, Government of India. 2014.

³⁹⁵N., Sarojini, Priya Ranjan. "Needed, an Assisted Reproduction Law That Doesn't Discriminate Against Single Women." *The Wire*, December 2, 2015.

(ARTs) guidelines of the Indian Council of Medical Research (ICMR, 2005)³⁹⁶ and the Medical Council of India (MCI); the unfortunate and avoidable death of Yuma Sherpa raises many ethical issues related the ARTs³⁹⁷ including commercial surrogacy industry in India.

The lack of regulatory mechanism, cheap and affordable reproductive services and easy availability of women willing to offer their reproductive biological capacities to childless couples and individuals as a means to earn livelihood have significantly contributed to the recent growth in the ART industry in general and commercial surrogacy in particular. Since the ART industry in India is not regulated and there is no national registry, it is difficult to ascertain its size and growth pattern.

In addition to the clinics that are engaged in providing and promoting ARTs, including surrogacy, the industry in India includes several other players, a wide array of organisations and personnel catering to clientele, both national and international - health care consultants, various bodies associated with the hospitality industry, travel agencies, law firms, surrogacy agents, tourism departments, and surrogacy hostels.

Sama's studies^{398,399} found several discerning concerns related to the functioning of ARTs industry including commercial surrogacy from the ethical and individual rights perspective. Women who opt for surrogacy are often circumstantially coerced into choosing to do so because of the poverty and economic hardships being faced by their families.⁴⁰⁰ The socio-economic background of the surrogates who enter into surrogacy arrangements has a direct bearing upon their choice to enter as well as the terms of the arrangement.

In 2012, the Indian government instituted restrictions on foreigners commissioning commercial surrogacy in India. Currently, The ART Bill has been transformed into The Surrogacy (Regulation) Bill in 2016⁴⁰¹. It is separated from various versions of the Draft ART (Regulation) Bills 2008 till 2015 and the ICMR Guidelines (2005). The Surrogacy Regulation Bill 2016 prohibits commercial surrogacy and allows only "altruistic" surrogacy by a close relative for childless heterosexual Indian couples who have been married for five years. The Bill focuses only on the aspect of banning commercial arrangements. However, apart from the aspect of remuneration, there is

³⁹⁶*National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India*. Ministry of Health and Family Welfare, Government of India. New Delhi: Indian Council of Medical Research, National Academy of Medical Sciences (India), 2005.

³⁹⁷Assisted reproductive technologies (ARTs) encompass various procedures ranging from the relatively simple intra-uterine insemination (IUI) to variants of in-vitro fertilisation (IVF) and embryo transfer (ET), more commonly known as 'test-tube baby technology'.

³⁹⁸*Birthing a Market: A Study on Commercial Surrogacy*. New Delhi: Sama Resource Group for Women and Health, 2012.

³⁹⁹ *Constructing Conceptions: The Mapping of Assisted Reproductive Technologies in India*. Sama-Resource Group for Women and Health. 2010

⁴⁰⁰ Ibid.

⁴⁰¹ Bill No. 257 of 2016. As introduced in Lok Sabha

<http://164.100.47.4/BillsTexts/LSBillTexts/Asintroduced/257_LS_2016_Eng.pdf

no difference between a commercial or altruistic arrangement in terms of the medical procedures that are followed.

A priority that has been ignored by the Surrogacy (Regulation) Bill 2016, which is silent on the regulation the ART/Fertility clinics. The death of Yuma Sherpa clearly revealed the unethical manner in which the ART/Surrogacy clinics function without appropriate protocols, facilities and emergency medical care. It is also important to note the role of third party agents, surrogacy agents who play a key role in this industry but have never been under any kind of regulation.

PART III
CONSOLIDATED SUMMARY OF RECOMMENDATIONS

Law Reform

1. Indian Penal Code, 1860

- a. Repeal section 377 and make section 375 gender-neutral qua the victim but retain gender specific male perpetrator. Alternatively, amend section 377 to exclude consensual sexual intercourse from its ambit.
- b. Restore the age of sexual consent (including for statutory rape) to 16 years, taking into account the evolving capacities of children, as was the case in the IPC prior to the 2013 amendments. The only condition on which the age of sexual consent could be 18 years, is if it includes a proximity clause to de-criminalise consensual sexual contact between peers.
- c. Make sections 354A (sexual harassment), 354B (assault or use of criminal force with the intention to disrobe), 354D (stalking), 375 (rape), 376C (sexual intercourse by person in authority), and 376D (gang rape) gender neutral with respect to the victim, retaining the gender specific male perpetrator.
- d. Clarify that sexual violence within matrimonial home will be covered under section 498A IPC, and remove Exception 2 of Section 375 to criminalise marital rape.
- e. De-criminalise adultery by amending or repealing Sec. 497 of the Indian Penal Code.
- f. Remove the requirement of mandatory reporting of sexual offences from section 357C, for older adolescents, to ensure that they first avail counseling to prepare and equip them to participate in legal proceedings.

2. Protection of Children from Sexual Offences Act, 2012

- a. Restore the age of sexual consent (including for statutory rape) to 16 years, taking into account the evolving capacities of children. The only condition on which the age of sexual consent could be 18 years, is if it includes a proximity clause to de-criminalise consensual sexual contact between peers.
- b. Remove the requirement of mandatory reporting from POCSO (sections 19 and 21) in order to provide professional privilege of confidentiality to teachers, service providers and counselors. This is especially important for adolescents whose sexuality and sexual health needs should be handled with empathy and dignity.

3. Immoral Trafficking (Prevention) Act, 1956

- a. Decriminalise soliciting (section 8) and living off the income of sex work (section 4) by amending ITPA to categorically distinguish and separate sex work from trafficking.
- b. Remove references to consensual sex work from the ITPA.
- c. Amend section 15(5A) to remove the requirement of mandatory testing

of sex workers for HIV upon arrest.

4. Repeal section 6 of the Armed Forces Special Powers Act, 1958 that requires prior sanction to prosecute armed forces for sexual assault, to make it consistent with section 197 CrPC.
5. Enact a law for the protection of transgender persons with full community consultation and in compliance with the NALSA judgment and global best practices, and amend the existing legislations on criminal laws, marriage and divorce law, etc to recognise transgender identity.
6. Institute a comprehensive anti-discrimination law that tackles discrimination arising from sex, SC/ST status, religion, disability, sexual orientation, gender identity, HIV status, amongst others that is enforceable against private enterprises and transnational actors. The law must address single or intersecting discrimination including in relation to education, housing and employment.
7. Amend/ repeal the provisions enabling restitution of conjugal rights in the Hindu Marriage Act (section 9), the Special Marriage Act (section 22), the Parsi Marriage and Divorce Act (section 36), the Indian Divorce Act (sections 32 and 33), and in Muslim personal law.

Government Schemes and Programmes

8. Education and access to information

- a. Comprehensive Sexuality Education, that imparts information that is appropriate to the age and context of all population groups, is respectful of gender and sexual diversity, and facilitates access to services, needs to be implemented. This should be integrated with the life skills education programme and needs to be a part of the formal school curriculum. CSE should also be made available outside formal schooling, to adults and to vulnerable population groups through community health workers, local health centers and peer educators.

9. Legal protection from violence and victim-care

- a. Establish/ authorise an independent specialised agency to provide comprehensive support services to victims of sexual assault, including informing them of their right to avail reparations.
- b. Address patriarchal socio-cultural attitudes towards sexuality, dominant notions of masculinity and femininity all of which contribute towards domestic violence, sexual abuse within and outside marriage, and practices such as female genital mutilation, through public education, school curricula, community interventions and the media.
- c. Scale up one-stop crisis centres to one per district to deliver single window support to all victims of violence, as originally envisaged.
- d. Improve the quality of shelter homes, known for their poor conditions, substandard services, resource constraints including their paternalistic approaches. The MWCD's scheme Swadhar Greh must be expanded

beyond the existing 311 Swadhar Grehs in the country, with budgetary allocations to enable similar interventions by states.

- e. Constitute an empowered national task force on sexual violence in conflict regions.

10. Health

- a. Ensure central and state governments are providing free of cost Anti-Retroviral Therapy (ART) to all PLHIV.
- b. Formulate non-discrimination guidelines for hospitals to enable sexual health services to be responsive and respectful of diverse sexual orientations and practices, and gender identities.
- c. Implement the HIV and AIDS (Prevention and Control) Act, 2017 and ensure non-discrimination and equal participation of persons suffering from sexually transmitted diseases including HIV in all spheres of life.

11. Overall recommendations towards protecting, promoting, and fulfilling reproductive rights

- a. Strengthen compliance, in a time-bound manner, with international human rights standards that India has endorsed that protect, promote, and fulfil human rights and reproductive health rights in India.
- b. Review standards and conventions that India has had reservations about or those that have been poorly implemented in the country.
- c. Guarantee non-discrimination and access to comprehensive information on laws, policies, and programmes, as well as reproductive health care for ALL regardless of age, marital status, ethnicity, work status, caste, religion, disability, gender, etc.
- d. Review compliance to international human rights instruments, goals and standards; review and incorporate recommendations towards national indicators for the Sustainable Development Goals (SDGs) that are relevant to reproductive health rights.
- e. Amend all coercive, discriminatory, gender-biased, target based reproductive health related laws, policies and their implementation to ensure ethical, comprehensive and universal reproductive health care.
- f. Remove all conditionalities for accessing treatment from public or private health care facilities; curb the promotion of the Aadhar card as a condition to access care.
- g. Repeal Section 377 of the Indian Penal Code, as well as other laws, policies, and practices that penalize individuals on the basis of their sexuality or gender identity.

12. Improve Access to the Social Determinants of Reproductive Health

- a. Strengthen access to the social determinants of reproductive health such as nutrition, safe drinking water, safe and hygienic toilets, through convergence between different ministries and departments.
- b. Ensure access to nutritional services to prevent acute malnutrition, chronic infections such as TB, and provide special nutritional support for malnourished children and women through the promotion of food

security by the universalisation and expansion of the Public Distribution System (PDS).

- c. Improve the monitoring of malnutrition and undernutrition (including anaemia and other nutritional deficiencies).
- d. Ensure that procurement and distribution through the PDS is localised and decentralised and that no-cash transfers are part of the PDS and other food programmes.
- e. Policies and programmes must ensure that discrimination, which is one of the most important social determinants of health, is eliminated in health care settings. Special measures should be adopted to ensure equitable access to discriminated groups.
- f. Acknowledge the role of stigma (and the role of gender inequality) while planning and improving the design of the existing health system.
- g. Recognise gender-based violence as a key determinant of reproductive and public health and enable its prevention as well as a robust response to it through health policy and programmes.

13. Health System: Infrastructure, Human Resources, Guidelines

- a. Increase public expenditure on health; increase the budgetary allocation for health to a minimum of five per cent of the GDP.
- b. Ensure the commitment of requisite budgets by the Centre and the States towards the provisioning of free, high-quality, and comprehensive health care for all.
- c. Promote a universal rather than a targeted public health care system that moves away from the insurance model;
- d. This universal system should include a comprehensive system of health care protection for workers in the unorganised and organised sectors, linked with the expansion and rejuvenation of the Employees State Insurance (ESI) Act, 1948.
- e. Curtail the privatisation of health care or the promotion of public-private partnerships (PPP) in health care and ensure that PPPs are regulated effectively. Increase resource allocation from central funds to institute and capacitate mechanisms for implementing all laws relating to violence against women and children (without devolving the financial responsibility to the discretion of the states).
- f. Step up resource allocation towards support services for violence against women and children. Victim compensation schemes, although a laudable step, are not uniform across the states and victims rarely avail compensation, particularly at the interim stage. As compensation is conditional upon criminal prosecution, it excludes many victims. Substantial resource allocation for support services must be part of the public health response to violence against women and children regardless of criminal prosecution.
- g. Make substantial budgetary allocations as well as facilitate

international resources where necessary for HIV/ AIDS prevention work, especially community-based work with vulnerable groups given that some of these activities are still criminalised by the law.

- h. Ensure access to comprehensive health care (physical as well as psychosocial), screening, documentation, and referrals; facilitate coordinated ethical and medico-legal processes for survivors; and implement inter-sectoral campaigns on prevention of violence involving broad-based community participation.
- i. Ensure compliance with MoHFW's 'Guidelines and Protocols: Medico-legal Care for Survivors/Victims of Sexual Violence' as well as with other laws such as PWDVA, POCSO, etc. for survivors of domestic violence and child survivors of sexual offences. Ensure that these are implemented in all health facilities across all states and union territories in the country.
- j. Remove all targets based camp approach for sterilisation; the two-child norm policy must be urgently discontinued.
- k. Regulate the private health care sector including the ARTs and surrogacy industry. While the proposed legislation is for the regulation of the surrogacy arrangement, there is no law that currently regulates the vast ART industry.

14. Strengthen public health infrastructure

- a. Address the acute shortfall of public health care infrastructure in the primary, secondary-, and tertiary-level services, which includes access to free medicines, free diagnostics, and availability of skilled human resources.
- b. Guarantee a range of health care services, including those for mental health, that are free of user fees and that are provided directly by government-run facilities.
- c. Ensure quality of care in all health facilities; guarantee health care that is effective, safe, and non-exploitative, which is provided with due consideration and respect to the patient's rights and dignity, and which aims to secure the patient's comfort and satisfaction in both public and private health facilities.
- d. Ensure free access to drugs and diagnostics for all across all levels of the health system—from primary to tertiary care, from village-level health worker (VHW) to national-level institutions. Build provisions for integrated and comprehensive care in the health system.
- e. Ensure compliance with National Health Mission (NHM) 'Guidelines for Operationalizing First Referral Units (FRU)' to ensure the availability of standard care and services, including the availability of blood storage units, to be provided/delivered at the FRU level.
- f. Ensure continuity of care during the transit between facilities during referrals. Ensure that referral is not synonymous with denial of care.

- g. Ensure a conducive, safe, and healthy working environment for health workers, particularly frontline women health workers.

15. Undertake capacity building of human resources for improved health outcomes

- a. Establish a well-governed and adequate public health workforce by creating adequate numbers of posts and ensuring requisite training for the entire range of health personnel in the public health system.
- b. Regularise contractual employees and provide ASHAs, ANMs, and staff at all levels of the public health system with adequate skills, salaries, and decent working conditions.
- c. Address the acute shortfall of human resources in the public health system in primary-, secondary-, and tertiary-level services, including counselors to provide psychosocial support and care in varied cases, particularly in cases related to mental health and gender-based violence.
- d. Direct that updates and amendments to laws, policies, etc., be incorporated in medical curricula, textbooks, continuing medical education programmes, and other training programmes to ensure the provision of skill-based, unbiased, and ethical health care.
- e. Reorient medical, paramedical and affiliated curricula to equip health care providers to better understand and deal with reproductive health needs, including GBV, abortion, mental health in a sensitive manner
- f. Train forensic experts on the social aspects of sexual assault and rape, and the collection and retention of proof, in cases of individual or mass sexual violence such as during conflict.
- g. Ensure that health care providers are trained to be sensitive to the barriers to access to health care faced by sex workers, women with disabilities, women living with HIV and AIDS, and women with marginalised sexual orientation and gender identity; and to provide services in a non-discriminatory and responsive manner.

16. Strengthen reproductive health services

- a. Assure comprehensive maternal health services, including access to abortion services in the public health sector. Ensure safety of deliveries in both home delivery and institutional delivery.
- b. Appoint special cadres of health care workers, if needed, in underserved areas so as to assure that even home births are safe births. This would include the involvement of traditional birth attendants (*dais*).
- c. Develop special responses and policies to address malnutrition among women and girls during pregnancy. Ensure that pregnant women with low Body Mass Index (BMI) are identified during Ante Natal check-

ups (ANC) and that they are provided with food for daily intake in addition to Take Home Ration being given from the anganwadi centres.

- d. Ensure that outcome indicators go beyond JSY disbursements and that the numbers of institutional deliveries include indicators of safety like completeness of ANC, technical aspects of care like active management of the third stage of labour, and provision of postpartum care.
- e. Ensure availability of emergency transport for referrals is also an important issue.
- f. While the Janani Shishu Suraksha Karyakram (JSSK) is a step towards universal maternity care, this scheme should be monitored rigorously both from within the system and from outside the system through communities to ensure that no out-of-pocket expenditures are being incurred.
- g. Ensure availability of services including screening, follow-up, and treatment to address non-obstetric conditions and diseases such as tuberculosis, malaria, HIV/AIDs, reproductive and other cancers, NCDs, infertility, uterine prolapse, RTIs, STIs, menstrual disorders, etc.,
- h. Drugs available for Multi Drug Resistant-TB, which are exorbitant and unavailable due to intellectual property strangleholds. Ensure that the patients with TB will be provided along with free treatment and diagnosis.
- i. The full range of treatment options need to be provided free, including medicines to cope with side-effects, supplements for TB care, and nutrition requirements.
- j. Systemic change is also required - training of private and public healthcare workers on latest treatment, and greatly augment counseling within the TB response to ensure proper information is conveyed to people with TB, and adherence improves.
- k. Initiate and ensure that the scheme for food for patients will be implemented efficiently.
- l. Strengthen support to local cancer centres to provide affordable (and free for poor patients) cancer care and well-designed prevention services to reach out to underserved sections of the population.
- m. Develop contextual public health care strategies to adapt to and address epidemiological migration by increasing the capacity and quality of cancer care, especially to serve marginalised and rural populations.
- n. Address cancer as a public health priority, wherein improvements in outcomes are designed to result from early detection and presentation, primary prevention, better designed financial assistance schemes, and a greater emphasis on the social determinants of cancer.

17. Monitoring and Data for Accountability of Health Care Services

- a. Mechanisms to address grievances, particularly those related to abuse especially by health care providers, must be put in place in health systems.
- b. Verbal and physical abuse by health care providers of women undergoing labour in public health facilities must be stopped and action should be taken against health care providers who indulge in this misbehaviour.
- c. Strengthen the reporting and review of maternal deaths, including facilitating reporting by persons from outside the health system. Broaden the composition of district and state Maternal Death Review (MDR) committees by including civil society representatives, PRI representatives, and independent technical experts.
- d. Reports of MDR processes should be made transparent. Consolidated reports of MDR should be made public, along with details of actions recommended and actions taken.
- e. Schemes and campaigns for maternal health services like JSY, JSSK, and PMSMA should be monitored rigorously both from within the system and from outside the system through communities to ensure that no out-of-pocket expenditures are being incurred on seeking safe and quality maternal health.
- f. Maternity benefits and entitlements as provided for under the Maternity Benefits Act, 1961 and the Maternity Benefits (Amendment) Act, 2017 should be reviewed to include women working in the non-formal sector.

18. Services for young people and adolescents

- a. Implement a comprehensive sexuality education programme for adolescents so that adolescents regardless of caste, class, sex, or religion have access to correct and safe information regarding their sexual reproductive health and rights to promote informed choices regarding their SRHR.
- b. Guarantee robust implementation of relevant programmes so that young people have access to safe and youth-friendly reproductive health services in the public health sector.
- c. Remove barriers to access to services such as abortion and contraception to uphold young people's reproductive autonomy and agency.
- d. Enable the collection and dissemination of disaggregated data on current reproductive health indicators as well as reproductive morbidities.

19. Community Processes and Consultative Processes with Civil Society

- a. Encourage participatory planning, community participation, and community-based monitoring of health services to ensure accountability and responsiveness of services.
- b. Community-based monitoring and planning must ensure participation of women from diverse communities, particularly from marginalised groups, adolescents, and other underrepresented sections of society.
- c. Promote consultation with communities about appropriate and acceptable health care services to generate demand for health services. Make efforts to remove cultural and social barriers to access.
- d. Undertake and support regular interface and consultative and collaborative processes with civil society towards strengthening diverse aspects of RHR.

Convergence

20. The government, through its different ministries must adopt consistent approaches and converge their efforts towards providing scientific and quality information services on sexual health to all population groups.
21. Integrate family planning efforts along with HIV/ STI prevention work in order to address non-target groups as well as infection amongst heterosexual and married couples. Moreover, family planning and disease prevention programmes must be designed for the diverse sexual practices and not focus only on peno-vaginal sex.
22. Integrate services and programmes between the Ministry for Human Resource Development and Ministry of Health and Family Welfare to educate the general public about STIs and ways to prevent them. They should also be informed about the nearest available sexual health clinics where they can access services.

Trainings

23. Teacher training on Comprehensive Sexuality Education needs to focus not only on content of information but also capacitating teachers on the values that inform the content, the tactical ways to navigate cultural resistance to these topics and in doing so, help them overcome their own socialisation and biases.
24. CSE should also be made available outside formal schooling, to adults and to vulnerable population groups through community health workers, local health centers and peer educators.
25. Widespread public education and awareness on sexual health for marginalised and stigmatised populations like LGBTI, sex workers, adolescents and persons with disability, to dispel misconceptions and instill respect in human rights related to sexual health.
26. Sensitise healthcare service providers to the challenges faced by persons with disabilities, and their sexual health rights.
27. Medical textbooks that include information on trans bodies, with guidelines

for SRS in consonance with international guidelines must be formulated.

Monitoring and Data collection

28. Monitoring is the key tool for mapping the effect of interventions, enabling periodic reviews and planning course corrections. Age and sex disaggregated data collection must be emphasised, including in relation to the direct and indirect impact of the law, to be reviewed through periodic participatory processes to measure impact of implementation of laws and policies on sexual health.

Cooperation with civil society and stakeholders

29. Pro-actively involve and cooperate with civil society stakeholders, experts and the relevant population groups to design and implement programmes in a participatory manner, including for carrying out evaluations.

ANNEXURE

ANNEXURE A: RECOMMENDATIONS PERTAINING TO PART I OF THIS REPORT

Law Reform

Indian Penal Code, 1860

- a. Repeal section 377 of the IPC and make section 375 gender-neutral qua the victim but retain gender specific male perpetrator. Alternatively, amend section 377 to exclude consensual sexual intercourse from its ambit.
- b. Restore the age of sexual consent (including for statutory rape) to 16 years, taking into account the evolving capacities of children, as was the case in the IPC prior to the 2013 amendments. The only condition, on which the age of sexual consent could be 18 years, is if it includes a proximity clause to de-criminalise consensual sexual contact between peers.
- c. Make sections 354A (sexual harassment), 354B (assault or use of criminal force with the intention to disrobe), 354D (stalking), 375 (rape), 376C (sexual intercourse by person in authority), and 376D (gang rape) gender neutral with respect to the victim, retaining the gender specific male perpetrator.
- d. Clarify that sexual violence within matrimonial home will be covered under section 498A IPC, and remove Exception 2 of Section 375 to criminalise marital rape.
- e. De-criminalise adultery by amending or repealing Sec. 497 of the Indian Penal Code.
- f. Remove the requirement of mandatory reporting of sexual offences from section 357C.

Protection of Children from Sexual Offences Act, 2012

- a. Restore the age of sexual consent (including for statutory rape) to 16 years, taking into account the evolving capacities of children. The only condition on which the age of sexual consent could be 18 years, is if it includes a proximity clause to de-criminalise consensual sexual contact between peers.
- b. Remove the requirement of mandatory reporting from POCSO (sections 19 and 21) in order to provide professional privilege of confidentiality to teachers, service providers and counselors. This is especially important for adolescents whose sexuality and sexual health needs should be handled with empathy and dignity.

Immoral Trafficking (Prevention) Act, 1956

- a. Decriminalise soliciting (section 8) and living off the income of sex work (section 4) by amending ITPA to categorically distinguish and separate sex work from trafficking.

- b. Remove references to consensual sex work from the ITPA.
- c. Amend section 15(5A) to remove the requirement of mandatory testing of sex workers for HIV upon arrest.

Other recommendations for legal reforms

- a. Repeal section 6 of the Armed Forces Special Powers Act, 1958 that requires prior sanction to prosecute armed forces for sexual assault, to make it consistent with section 197 CrPC.
- b. Enact a law for the protection of transgender persons with full community consultation and in compliance with the NALSA judgment and global best practices.
- c. Institute a comprehensive anti-discrimination law that tackles discrimination arising from sex, SC/ST status, religion, disability, sexual orientation, gender identity, HIV status, amongst others that is enforceable against private enterprises and transnational actors. The law must address single or intersecting discrimination including in relation to education, housing and employment.
- d. Amend/ repeal the provisions enabling restitution of conjugal rights in the Hindu Marriage Act (section 9), the Special Marriage Act (section 22), the Parsi Marriage and Divorce Act (section 36), the Indian Divorce Act (sections 32 and 33), and in Muslim personal law.

Government Schemes and Programmes

Education

- a. Comprehensive Sexuality Education, that imparts information that is appropriate to the age and context of all population groups, is respectful of gender and sexual diversity, and facilitates access to services, needs to be implemented. This should be integrated with the life skills education programme and needs to be a part of the formal school curriculum. CSE should also be made available outside formal schooling, to adults and to vulnerable population groups through community health workers, local health centers and peer educators.

Legal protection from violence and victim-care

- a. Establish/ authorise an independent specialised agency to provide comprehensive support services to victims of sexual assault, including informing them of their right to avail reparations.
- b. Address patriarchal socio-cultural attitudes towards sexuality, dominant notions of masculinity and femininity all of which contribute towards domestic violence, sexual abuse within and outside marriage, and practices such as female genital mutilation, through public education, school curricula, community interventions and the media.
- c. Scale up one-stop crisis centres to one per district to deliver single window

support to all victims of violence, as originally envisaged.

- d. Improve the quality of shelter homes, known for their poor conditions, substandard services, resource constraints including their paternalistic approaches. The MWCD's scheme Swadhar Greh must be expanded beyond the existing 311 Swadhar Grehs in the country, with budgetary allocations to enable similar interventions by states.
- e. Constitute an empowered national task force on sexual violence in conflict regions.

Health

- a. Ensure central and state governments are providing free of cost Anti-Retroviral Therapy (ART) to all PLHIV.
- b. Formulate non-discrimination guidelines for hospitals to enable sexual health services to be responsive and respectful of diverse sexual orientations and practices, and gender identities.
- c. Implement the HIV and AIDS (Prevention and Control) Act, 2017 and ensure non-discrimination and equal participation of persons suffering from sexually transmitted diseases including HIV in all spheres of life.

Convergence

- a. The government, through its different ministries must adopt consistent approaches and converge their efforts towards providing scientific and quality information services on sexual health to all population groups.
- b. Integrate family planning efforts along with HIV/ STI prevention work in order to address non-target groups as well as infection amongst heterosexual and married couples. Moreover, family planning and disease prevention programmes must be designed for the diverse sexual practices and not focus only on peno-vaginal sex.
- c. Integrate services and programmes between the Ministry for Human Resource Development and Ministry of Health and Family Welfare to educate the general public about STIs and ways to prevent them. They should also be informed about the nearest available sexual health clinics where they can access services.

Training

- a. Teacher training on Comprehensive Sexuality Education needs to focus not only on content of information but also capacitating teachers on the values that inform the content, the tactical ways to navigate cultural resistance to these topics and in doing so, help them overcome their own socialisation and biases.
- b. CSE should also be made available outside formal schooling, to adults and to vulnerable population groups through community health workers, local health centers and peer educators.
- c. Widespread public education and awareness on sexual health for marginalised and stigmatised populations like LGBTI, sex workers, adolescents and persons

with disability, to dispel misconceptions and instill respect in human rights related to sexual health.

- d. Sensitise healthcare service providers to the challenges faced by persons with disabilities, and their sexual health rights.
- e. Medical textbooks that include information on trans bodies, with guidelines for SRS in consonance with international guidelines must be formulated.

Monitoring and Data collection

- a. Monitoring is the key tool for mapping the effect of interventions, enabling periodic reviews and planning course corrections. Age and sex disaggregated data collection must be emphasised, including in relation to the direct and indirect impact of the law, to be reviewed through periodic participatory processes to measure impact of implementation of laws and policies on sexual health.

Cooperation with civil society and stakeholders

- a. Pro-actively and regularly involve and cooperate with civil society stakeholders, experts and the relevant population groups to design and implement programmes in a participatory manner, including for carrying out evaluations.

Budgetary Allocation

- a. Increase India's budgetary allocation for health to at least 5% of the GDP, to ensure adequate resources for implementation of its mandate.
- b. Increase resource allocation from central funds to institute and capacitate mechanisms for implementing all laws relating to violence against women and children (without devolving the financial responsibility to the discretion of the states).
- c. Step up resource allocation towards support services for violence against women and children. Victim compensation schemes, although a laudable step, are not uniform across the states and victims rarely avail compensation, particularly at the interim stage. As compensation is conditional upon criminal prosecution, it excludes many victims. Substantial resource allocation for support services must be part of the public health response to violence against women and children regardless of criminal prosecution.
- d. Make substantial budgetary allocations as well as facilitate international resources where necessary for HIV/ AIDS prevention work, especially community-based work with vulnerable groups given that some of these activities are still criminalised by the law.

ANNEXURE B: RECOMMENDATIONS PERTAINING TO PART II OF THIS REPORT

The upholding of reproductive rights and the provision of sexual and reproductive health services are essential to supporting human rights. Addressing the various social determinants of health such as poverty, income inequality, and marginalisation of health care is necessary to ensure the right to reproductive health. However, violations of reproductive health rights are frequent and manifest in varied forms, including discriminatory national and international policies and laws, as well as denial of access to comprehensive and quality information and services.

It is also imperative that the government recognises and responds to discrimination arising from disability, sexuality, sexual orientation and gender identity, as well as on the basis of ethnicity, caste, religion, and on any other grounds mandated by the Constitution.

Policies and programmes must therefore take cognisance of and comprehensively fulfil to the reproductive rights beyond maternal health and contraception; they must encompass a gamut of imperatives such as nutrition, water, education, non-discrimination, freedom from violence; access to affordable, accessible and quality care for abortion, communicable and non communicable diseases; as well as access to information.

The following are our recommendations to NHRC emerging from the assessment towards directions to specific Ministries such as Health and Family Welfare, Women and Child, Finance, Home and relevant others at the centre and state levels.

Overall recommendations towards protecting, promoting, and fulfilling reproductive and sexual health and rights

- a. Strengthen compliance, in a time-bound manner, with international human rights standards that India has endorsed that protect, promote, and fulfil human rights and reproductive health rights in India.
- b. Review standards and conventions that India has had reservations about or those that have been poorly implemented in the country.
- c. Guarantee non-discrimination and access to comprehensive information on laws, policies, and programmes, as well as reproductive health care for ALL regardless of age, marital status, ethnicity, work status, caste, religion, disability, gender, etc.
- d. Review compliance to international human rights instruments, goals and standards; review and incorporate recommendations towards national indicators for the Sustainable Development Goals (SDGs) that are relevant to reproductive health rights.
- e. Amend all coercive, discriminatory, gender-biased, target based reproductive health related laws, policies and their implementation to ensure ethical, comprehensive and universal reproductive health care.

- f. Remove all conditionalities for accessing treatment from public or private health care facilities; curb the promotion of the Aadhar card as a condition to access care.
- g. Repeal Section 377 of the Indian Penal Code, as well as other laws, policies, and practices that penalise individuals on the basis of their sexuality or gender identity.
- h. Ensure central and state governments are providing free of cost Anti-Retroviral Therapy (ART) to all PLHIV.
- i. Formulate non-discrimination guidelines for hospitals to enable sexual health services to be responsive and respectful of diverse sexual orientations and practices, and gender identities.
- j. Implement the HIV and AIDS (Prevention and Control) Act, 2017 and ensure non-discrimination and equal participation of persons suffering from sexually transmitted diseases including HIV in all spheres of life

Improve Access to the Social Determinants of Reproductive Health

- a. Strengthen access to the social determinants of reproductive health such as nutrition, safe drinking water, safe and hygienic toilets, through convergence between different ministries and departments.
- b. Ensure access to nutritional services to prevent acute malnutrition, chronic infections such as TB, and provide special nutritional support for malnourished children and women through the promotion of food security by the universalisation and expansion of the Public Distribution System (PDS).
- c. Improve the monitoring of malnutrition and undernutrition (including anaemia and other nutritional deficiencies).
- d. Ensure that procurement and distribution through the PDS is localised and decentralised and that no-cash transfers are part of the PDS and other food programmes.
- e. Policies and programmes must ensure that discrimination, which is one of the most important social determinants of health, is eliminated in health care settings. Special measures should be adopted to ensure equitable access to discriminated groups.
- f. Acknowledge the role of stigma (and the role of gender inequality) while planning and improving the design of the existing health system.
- g. Recognise gender-based violence as a key determinant of reproductive and public health and enable its prevention as well as a robust response to it through health policy and programmes.

Health System: Infrastructure, Human Resources, Guidelines

- a. Increase public expenditure on health; increase the budgetary allocation for health to a minimum of five per cent of the GDP.
- b. Ensure the commitment of requisite budgets by the Centre and the States towards the provisioning of free, high-quality, and comprehensive health care

- for all.
- c. Promote a universal rather than a targeted public health care system that moves away from the insurance model;
 - d. This universal system should include a comprehensive system of health care protection for workers in the unorganised and organised sectors, linked with the expansion and rejuvenation of the Employees State Insurance (ESI) Act, 1948.
 - e. Curtail the privatisation of health care or the promotion of public–private partnerships (PPP) in health care and ensure that PPPs are regulated effectively.
 - f. Ensure access to comprehensive health care (physical as well as psychosocial), screening, documentation, and referrals; facilitate coordinated ethical and medico-legal processes for survivors; and implement inter-sectoral campaigns on prevention of violence involving broad-based community participation.
 - g. Ensure compliance with MoHFW’s ‘Guidelines and Protocols: Medico-legal Care for Survivors/Victims of Sexual Violence’ as well as with other laws such as PWDVA, POCSO, etc. for survivors of domestic violence and child survivors of sexual offences. Ensure that these are implemented in all health facilities across all states and union territories in the country.
 - h. Remove all targets based camp approach for sterilisation; the two-child norm policy must be urgently discontinued.
 - i. Regulate the private health care sector including the ARTs and surrogacy industry. While the proposed legislation is for the regulation of the surrogacy arrangement, there is no law that currently regulates the vast ART industry.

Strengthen public health infrastructure

- a. Address the acute shortfall of public health care infrastructure in the primary, secondary-, and tertiary-level services, which includes access to free medicines, free diagnostics, and availability of skilled human resources.
- b. Guarantee a range of health care services, including those for mental health, that are free of user fees and that are provided directly by government-run facilities.
- c. Ensure quality of care in all health facilities; guarantee health care that is effective, safe, and non-exploitative, which is provided with due consideration and respect to the patient’s rights and dignity, and which aims to secure the patient’s comfort and satisfaction in both public and private health facilities.
- d. Ensure free access to drugs and diagnostics for all across all levels of the health system—from primary to tertiary care, from village-level health worker (VHW) to national-level institutions. Build provisions for integrated and comprehensive care in the health system.
- e. Ensure compliance with National Health Mission (NHM) ‘Guidelines for Operationalizing First Referral Units (FRU)’ to ensure the availability of standard care and services, including the availability of blood storage units, to be provided/delivered at the FRU level.

- f. Ensure continuity of care during the transit between facilities during referrals. Ensure that referral is not synonymous with denial of care.
- g. Ensure a conducive, safe, and healthy working environment for health workers, particularly frontline women health workers.

Undertake capacity building of human resources for improved health outcomes

- a. Establish a well-governed and adequate public health workforce by creating adequate numbers of posts and ensuring requisite training for the entire range of health personnel in the public health system.
- b. Regularise contractual employees and provide ASHAs, ANMs, and staff at all levels of the public health system with adequate skills, salaries, and decent working conditions.
- c. Address the acute shortfall of human resources in the public health system in primary-, secondary-, and tertiary-level services, including counselors to provide psychosocial support and care in varied cases, particularly in cases related to mental health and gender-based violence.
- d. Direct that updates and amendments to laws, policies, etc., be incorporated in medical curricula, textbooks, continuing medical education programmes, and other training programmes to ensure the provision of skill-based, unbiased, and ethical health care.
- e. Reorient medical, paramedical and affiliated curricula to equip health care providers to better understand and deal with reproductive health needs, including GBV, abortion, mental health in a sensitive manner
- f. Train forensic experts on the social aspects of sexual assault and rape, and the collection and retention of proof, in cases of individual or mass sexual violence such as during conflict.
- g. Ensure that health care providers are trained to be sensitive to the barriers to access to health care faced by sex workers, women with disabilities, women living with HIV and AIDS, and women with marginalised sexual orientation and gender identity; and to provide services in a non-discriminatory and responsive manner.

Strengthen reproductive health services

- a. Assure comprehensive maternal health services, including access to abortion services in the public health sector. Ensure safety of deliveries in both home delivery and institutional delivery.
- b. Appoint special cadres of health care workers, if needed, in underserved areas so as to assure that even home births are safe births. This would include the involvement of traditional birth attendants (*dais*).
- c. Develop special responses and policies to address malnutrition among women and girls during pregnancy. Ensure that pregnant women with low Body Mass Index (BMI) are identified during Ante Natal check-ups (ANC) and that they are provided with food for daily intake in addition to Take Home Ration being given from the anganwadi centres.

- d. Ensure that outcome indicators go beyond JSY disbursements and that the numbers of institutional deliveries include indicators of safety like completeness of ANC, technical aspects of care like active management of the third stage of labour, and provision of postpartum care.
- e. Ensure availability of emergency transport for referrals is also an important issue.
- f. While the Janani Shishu Suraksha Karyakram (JSSK) is a step towards universal maternity care, this scheme should be monitored rigorously both from within the system and from outside the system through communities to ensure that no out-of-pocket expenditures are being incurred.
- g. Ensure availability of services including screening, follow-up, and treatment to address non-obstetric conditions and diseases such as tuberculosis, malaria, HIV/AIDs, reproductive and other cancers, NCDs, infertility, uterine prolapse, RTIs, STIs, menstrual disorders, etc.,
- h. Drugs available for Multi Drug Resistant-TB, which are exorbitant and unavailable due to intellectual property strangleholds. Ensure that the patients with TB will be provided along with free treatment and diagnosis.
- i. The full range of treatment options need to be provided free, including medicines to cope with side-effects, supplements for TB care, and nutrition requirements.
- j. Systemic change is also required - training of private and public healthcare workers on latest treatment, and greatly augment counseling within the TB response to ensure proper information is conveyed to people with TB, and adherence improves.
- k. Initiate and ensure that the scheme for food for patients will be implemented efficiently.
- l. Strengthen support to local cancer centres to provide affordable (and free for poor patients) cancer care and well-designed prevention services to reach out to underserved sections of the population.
- m. Develop contextual public health care strategies to adapt to and address epidemiological migration by increasing the capacity and quality of cancer care, especially to serve marginalised and rural populations.
- n. Address cancer as a public health priority, wherein improvements in outcomes are designed to result from early detection and presentation, primary prevention, better designed financial assistance schemes, and a greater emphasis on the social determinants of cancer.

Monitoring and Data for Accountability of Health Care Services

- a. Mechanisms to address grievances, particularly those related to abuse especially by health care providers, must be put in place in health systems.
- b. Verbal and physical abuse by health care providers of women undergoing labour in public health facilities must be stopped and action should be taken against health care providers who indulge in this misbehaviour.

- c. Strengthen the reporting and review of maternal deaths, including facilitating reporting by persons from outside the health system. Broaden the composition of district and state Maternal Death Review (MDR) committees by including civil society representatives, PRI representatives, and independent technical experts.
- d. Reports of MDR processes should be made transparent. Consolidated reports of MDR should be made public, along with details of actions recommended and actions taken.
- e. Schemes and campaigns for maternal health services like JSY, JSSK, and PMSMA should be monitored rigorously both from within the system and from outside the system through communities to ensure that no out-of-pocket expenditures are being incurred on seeking safe and quality maternal health.
- f. Maternity benefits and entitlements as provided for under the Maternity Benefits Act, 1961 and the Maternity Benefits (Amendment) Act, 2017 should be reviewed to include women working in the non-formal sector.

Services for young people and adolescents

- a. Implement a comprehensive sexuality education programme for adolescents so that adolescents regardless of caste, class, sex, or religion have access to correct and safe information regarding their sexual reproductive health and rights to promote informed choices regarding their SRHR.
- b. Guarantee robust implementation of relevant programmes so that young people have access to safe and youth-friendly reproductive health services in the public health sector.
- c. Remove barriers to access to services such as abortion and contraception to uphold young people's reproductive autonomy and agency.
- d. Enable the collection and dissemination of disaggregated data on current reproductive health indicators as well as reproductive morbidities.

Community Processes and Consultative Processes with Civil Society

- a. Encourage participatory planning, community participation, and community-based monitoring of health services to ensure accountability and responsiveness of services.
- b. Community-based monitoring and planning must ensure participation of women from diverse communities, particularly from marginalised groups, adolescents, and other underrepresented sections of society.
- c. Promote consultation with communities about appropriate and acceptable health care services to generate demand for health services. Make efforts to remove cultural and social barriers to access.
- d. Undertake and support regular interface and consultative and collaborative processes with civil society towards strengthening diverse aspects of RHR.

ANNEXURE C: LIST OF EXPERTS INTERVIEWED BY PLD

List of resource persons interviewed by PLD for the study:

S. No.	Name	Organisation
1.	Dipika Jain	Associate Professor, Jindal Global Law School, Sonapat, Haryana
2.	Kousalya Periasamy	Positive Women's Network, Chennai
3.	L. Ramakrishnan	Solidarity and Action against HIV infection in India (SAATHI), Chennai
4.	Shyamala Natraj	South India AIDS Action Programme (SIAAP), Chennai
5.	Simran Sheikh	India HIV/ AIDS Alliance, New Delhi
6.	Balaji Ubarhande	India HIV/ AIDS Alliance, New Delhi
7.	Ashok Row Kavi	Humsafar Trust, Mumbai
8.	Sangeeta Rege	Centre for Inquiry into Health and Allied Themes (CEHAT), Mumbai
9.	Shampa Sengupta	Sruti Disability Rights Centre, Kolkata
10.	Ratnaboli Ray	Anjali – Mental Health Rights Organisation, Kolkata
11.	Kuhu Das	Association for Women with Disabilities, Kolkata
12.	Meenakshi Sanyal,	Sappho for Equality, Kolkata
13.	Aparna Banerjee	Transgender Welfare Board, West Bengal
14.	Pawan Dhall	Varta Trust, Kolkata
15.	Pompi Banerjee	Sanjog, Kolkata
16.	Kaushik Gupta	Lawyer, Kolkata
17.	Rajesh Srinivas	Sangama: a resource centre on sexuality, Bangalore
18.	Paromita Chakraborty	Jadavpur University, Kolkata
19.	Bharati Dey	Durbar Mahila Samanway Committee (DMSC), Kolkata
20.	Smarit Jana	Durbar Mahila Samanway Committee (DMSC), Kolkata
21.	Amritananda Chakravorty	Human Rights Lawyer, New Delhi
22.	Prabha Nagaraj	Talking about Reproductive and Sexual Health Issues (TARSHI), New Delhi
23.	Anuradha Kapoor	Swayam, Kolkata
24.	Soma Sengupta	Sanhita, Kolkata
25.	Souvik Som	Activist, Kolkata

List of reviewers of relevant sections of the report:

S.No.	Name	Organisation
1.	Amritananda Chakravorty	Human Rights Lawyer, formerly Lawyers Collective.
2.	L. Ramakrishnan	Solidarity and Action against HIV infection in India
3.	Sonal Mehta	HIV AIDS Alliance
4.	Prabha Kotiswaran	King's College, London
5.	Samrajit Jana	Durbar Mahila Samanway Committee
6.	Jaya Sharma	United National Population Fund (UNFPA)