

Fulfilling Youth’s Right to nutrition, health including reproductive and sexual health, and development in India



Joint stakeholders’ report
United Nations’ Universal Periodic Review III

Submitted by :

CHETNA and FPAI



Introduction

A consultation was organised by CHETNA in partnership with 14 national and state alliances working on Health and Nutrition Rights in December 2015 with support from the Working Group on Human Rights, to orient them about the UPR process. A national round table was organised on 15th September 2016 to prepare for joint submission¹. Members also contributed in the regional and national consultation organised by WGHR and the Regional Consultation by National Human Rights Commission, India and contributed in the National CSO report on Right to Health. This is the first time the alliance has engaged with the Universal Periodic Review.

The alliance would like to report the following progress on

- The UPR-II Recommendations to India are to effectively balance the skewed sex-ratio among children; enhance access to information and counseling on SRHR as well as access to sexual and reproductive health services, including safe abortion and gender-sensitive comprehensive contraceptive services²
- The Sustainable Development Goal 3 target 3.7 is to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030.
- The Right to health has been firmly established in the ICESCR art.12 and other international human rights treaties and have recognized and referred to the right to health or its elements “Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health”³

¹ CHETNA since last 35 years is addressing issues of women, children and adolescents health and nutrition. CHETNA has contributed in the process of developing National Youth Policy and National Adolescent Health Strategy. Family Planning Association of India (FPA India)'s is a national level NGO. One of the focus of the Association is working with young people. It is an organization established in 1949 and provides sexual and reproductive health care information, education and services to young people in school and out of schools. It has been working in partnership with CHETNA on different project related integration of SRH and HIV

²(2) : Intensify efforts towards the MDG 5 by ensuring access to information and counseling on SRHR as set out in the National Population Policy. (Sweden) (152): Strengthen its efforts to improve maternal health and act to effectively balance the skewed sex-ratio among children, including by combating female foeticide. (Norway)

(153) : Take further measures to ensure that all women without any discrimination have access to adequate obstetric delivery services and sexual and reproductive health services, including safe abortion and gender-sensitive comprehensive contraceptive services. (Finland)

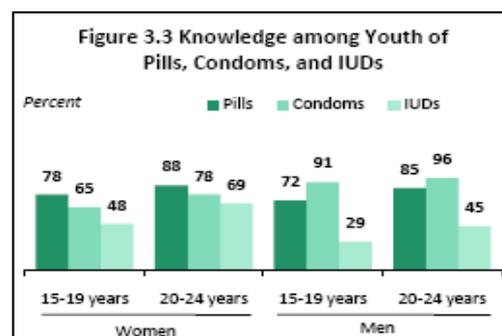
³ International Covenant on Economic, Social and Cultural Rights, art. 12 The 1965 International Convention on the Elimination of All Forms of Racial Discrimination: art. 5 (e) (iv) The 1966 International Covenant on Economic, Social and Cultural Rights: art. 12; The 1979 Convention on the Elimination of All Forms of Discrimination against Women: arts. 11 (1) (f), 12 and 14 (2) (b) The 1989 Convention on the Rights of the Child: art. 24 The 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families: arts. 28, 43 (e) and 45 (c) The 2006 Convention on the Rights of Persons with Disabilities: art. 25 key reports from the UN Office of the High Commissioner for Human Rights, the Human Rights Council and the UN Special Rapporteur on the Right to Health which have refined the definition of the right to the highest attainable standard of health.

- The Indian constitution articulates a duty of the state as follows: “The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties...” **Constitution of India (1950): Part IV, art. 47.a**
- The UN Convention on the Rights of the Child states that children and young people have the right to enjoy the highest attainable health, access to health facilities (Article 24), and access to information which will allow them to make decisions about their health (Article 17), including family planning (Article 24).
- Young people have the right to be heard, express opinions and be involved in decision-making (Article 12). They have the right to education, reach their potential and prepare them to be understanding and tolerant towards others (Article 29). They also have the right not to be discriminated against (Article 2).
- India is a young nation, comprise of young people with 253 million adolescents and 232 million youth population in 2011. (Census 2011)
- The skewed sex ratio among adolescents and youth is India’s failure to respect, promote and fulfill the right to life, survival and health. The adolescent and youth sex ratio in India is 898 and 908 respectively in 2011 (Census 2011). The youth sex ratio declined sharply from 990 in 1961 to 935 in 1971, and thereafter it fell in subsequent four decades, it fell continuously and during 2011 Census, it improved by only 13 points. The possible reasons for low sex ratio in this age group could be neglect of young girls in nutrition, timely access to health services, gender based violence, education, maternal deaths, unnatural deaths etc.
- Undernutrition and anaemia has remained common among children, youth and adults. Among children below the age of 5 years under nutrition and anaemia is common among both girls and boys. In youth fifty-six percent of women and 25 percent of men age 15-24 are anaemic, with rates of anaemia being higher in rural than in urban areas (NFHS-3 2005-06). The reasons could be neglect of girls resulting in insufficient intake of food accompany with early pregnancy.
- In India 43% of currently married women age 20-24 years were married before 18 years of age.⁵ Early marriage and early pregnancy contributes in maternal deaths. Also early sexual activities increase the chances of HIV/AIDS among adolescents and youth and cervical cancers among girls. DLHS 3 (2007-08)

⁴“Young people” are those people in the age group of 10-24 years. It is further divide in the sub group of adolescent (10-19 years) and youth (15-24 years). Keeping the needs of adolescents in view they can be further define as pre adolescent phase (10-14 years) and post adolescent phase (15-19 years).

⁵ National Family Health Survey (NFHS-3), India, 2005-06. Mumbai: International Institute for Population Sciences http://www.rchips.org/NFHS/nfhs3_national_report.shtml Youth Profile -2005-06

- Contraceptive use remains limited, just 28% of young women aged 15-24 years practiced contraception, 14-18% of births to adolescents and young women are unintended, 1-10% of abortion seekers in India are adolescents; young women who seek abortion often tend to delay seeking it into the second trimester which amounts to 25% of unmarried and 9% of married abortion seekers.



- There is an increase consumption of tobacco products among adolescents and youth. In the age group of 15-19. 29% young men and 3% young women had ever used tobacco, while 11% of young men and 1% of young women had ever consumed alcohol. Even among adolescents age 15 years, tobacco and alcohol use is quite high' 16% of males' aged 15 report use of tobacco in any form including smoking and 6% reported alcohol consumption.(NFHS-3)
- Suicides have been increasing at the rate of 5-10% every year across the country. Psychological disorders such as depression and anxiety occur more often in girls than boys⁶.
- The number of suicide death among female is highest among the age group between 18 to 30 years. Main causes of suicide among female were pertaining to issues related to marriage, dowry, non settlement of marriage, divorce etc. Other causes which are contributing substantially in male and female suicide were family problems, illness and prolonged illness, mental illness, love affairs etc. Causes of 33% suicide among female are not known. These data are from the cases which are reported there is all the possibility that considerable number of suicide death among girls are not reported.⁷
- Restriction on young people and gender inequality are still a reality –
 - 56% of young men and 27% of young women made decision about everyday life
 - 96% of unmarried young men, 73% of young women had freedom of movement inside their village.
 - 82% of young men and 24% of young women had freedom of movement to go to places outside their village. ⁸

⁶India is no exception as an epidemiological study by the National Institute of Mental Health and Neuro Sciences in Bangalore city reported that

⁷As per the 2014 data of national crime record bureau, Ministry of Home Affairs,

⁸Gender Discrimination (IIPS and Population Council 2010)

- Among female adolescents age 15-19, 23% reported having experience physical or sexual violence. Nearly one out of three (31%) ever-married female adolescents age 15-19 reported experiencing physical, sexual, or emotional violence perpetrated by their spouse. Of these 25% have experienced physical violence. 13% emotional violence. , NFHS-3.
- Despite government commitment to universalize secondary education, few young people transition to and successfully complete secondary education in India. Just 42% of young men and 32% of young women aged 18-24 had completed Class 10, the final year of (lower) secondary school, in 2005-06.
- Recently young people's health and nutrition has received greater attention the RCH programme broadened its scope by including issues related to newborn care and adolescent health. In January 2013 Ministry of Health and Family Welfare Government of India announced Strategic Approach document- Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A). Following this, in January 2014 the National Adolescent Health Strategy was launched which proposes to address the health and nutrition need of the adolescents beyond their reproductive role. The National Youth Policy was also declared in January 2014
- The National Adolescent Health strategy known as Rastiya Kishor Swasthya Karyakram, proposes to engage with adolescents and young people in implementation and review process of the programmes. It also moves away from a one size fit all approach to more customized programmes and services delivery, specific to needs of adolescents.
- It is important to be noted here that programmes related to adolescents and youth has remained on the pilot basis only. Also the strategy and plans to review the pilots and universalise it are not declared.
- There is no uniformity in implementation of sex/adolescent education programmes across states and Union territories.
- The Central Government has not taken any action in enforcing AEP in states that have opted out.
- Even though education is a state subject, the Centre should act to ensure that it meets its obligations under international laws.
- There is a massive gap in training under the ARSH programme– as per the latest report, only 15.63% of the target was achieved.
- Lack of rights-based approach to sex education.

- Lack on integration of Youth and Education Policies. Youth Policy is drafted by the Ministry of Youth Affairs & Sports while the AEP is implemented by the Ministry of Human Resources and Development.
- India is obligated under international laws to provide CSE⁹ in public and private schools.
- Develop an integrated Youth Policy and CSE programme. The AEP should be based on coordination between Ministries of Youth Affairs & Sports, Human Resources and Development, and Health & Family Welfare.
- Develop and implement a comprehensive Youth Policy, which covers youth in schools and well as out-of-schools
- Use rights-based language and approach for implementing CSE.
- Achieve targets set by the existing programmes and have systems to analyse missed targets.

[Please refer Annexure I for India's policy and programmatic environment.]

Recommendations:

Greater attention on Adolescents (age 10-19 yrs) and youth (15-24 yrs), who are a diverse group and fulfillment of sexual and reproductive health-care services, including for family planning, information and education is essential to ensure universal access. A comprehensive approach, within dynamic sociological, cultural and economic realities, is required to respond effectively to the health and development needs of adolescents and young people. The specific recommendations are-

1. The states' obligation to respect, protect and fulfill every young [persons' right to life and health, particularly with a focus on socio-economically marginalized sections needs to be recognized within the human rights framework¹⁰.

⁹ CSE is an important component of the Post 2015 Agenda. It ensures health and promotes well-being (SDG Goal 3: sub-target 3.7- by2030, ensure universal access to sexual and reproductive healthcare, family planning, information and education; integrate reproductive health with national strategies and programmes) and achieve gender equality and empower all women and girls (SDG 5: sub-target 5.6 - ensure universal access to sexual and reproductive health and rights as per the Programme of Action of ICPD and the Beijing

¹⁰ **Youth need accurate, comprehensive information on:**

- Human rights and values
- Gender norms
- Sexuality and sexual behaviour, consent, decision-making, sexual coercion and sexual diversity
- The body, puberty and reproduction
- Relationships - with family and peers, and romantic and long-term
- Communication, decision-making skills for refusing unwanted sex, negotiating, correct usage of condoms/contraception, seeking guidance and support from parents, and regarding substance abuse and sexual risk

2. Urgently look into the reasons of screwed sex ratio of adolescents and youth which can be by undertaking a research and develop an appropriate strategy to address the responsible reasons with appropriate budget. If adolescents and youth constitute more than 30% of the total population the budget allocation also need to be in the same proportion.
3. Appropriate budget/resource allocations need to be made for making information and services accessible to adolescents and young people. Develop a cadre of community-based trained individuals who can make access to information available to young people. Designated human resource and budget needs to be ensured in all the existing development programmes.
4. Gender inequality is the leading barrier to the realisation of human rights, it is vital for the state to take in consideration and address it fully through integration of life skills education and gender equality and empowerment of women and girls components in all the development programmes.
5. Plan and design customized interventions rather than “one size fits all”, based on evidences and disaggregated data by income, sex, age, caste, ethnicity, migration status, disability and geographic location etc.
 - Develop and mandate a rights-based CSE¹¹ programme aligned with ICPD and ICPD+5 principles and implement it uniformly across India. It should include school dropouts and other youth outside the formal education system. The Right to Education mandates free and compulsory education for children between 6 and 14 years of age; hence, AEP should be integrated with RTE.
 - Link CSE and other initiatives with overlapping goals like: Legal reforms and policies to provide universal access to SRHR, national programmes and campaigns to end child marriage, prevent transmission of HIV, promote girls’ education, and strengthen anti-rape laws¹².
6. Reproductive and sexual health education needs to be provided at all spaces and institutions where adolescents and young people are located such as: schools, colleges, orphanages, workplace etc. For this to happen convergence with other Government Departments- Education, Social security, Social justice, livelihoods etc. is critical.
7. There is a need for rights-based approach to Comprehensive Sexuality Education (CSE) equips young people with the knowledge, skills, attitudes and values to enjoy their sexuality – physically and emotionally, individually and in relationships. It views sexuality in the context of emotional and social development, recognising

• *Sexual health, especially STIs/HIV and AIDS, unintended pregnancy,*

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¹² Utilise FPA India’s and CHETNA’s expertise to present persuasive evidence based on international and national laws and policies, human rights principles, treaties and conventions.

that information alone is not enough. Youth need opportunities to acquire life skills and develop positive values¹³

8. Educate, train and empower youth to monitor the delivery of public services
9. Robust and accurate accountability framework needs to be in place with accurate, desegregated data according to location of vulnerable sections, young, migrants, wealth quintiles and caste at country and state level and ensure its availability in the public domain.
10. Strict enforcement of legislations to prevent early marriage and accessibility of contraceptives to young couple to delay pregnancy by provision of adequate resources for social change.

¹³ Have a budget allocation for an integrated CSE programme. Develop the Youth policy and programmes by involving young people – in setting the agenda, policy formulation, programme implementation, expert panels, and monitoring and evaluation

- Develop a multi-departmental coordination mechanism at the local, state, and national levels (personnel from Ministries of Youth & Sports, Human Resources and Development, and Health).
- Capacity building of Ministries involved in co-ordination; engage CSOs and youth.
- Partner with civil society organizations known for developing and implementing gender-transformative programmes and initiatives that engage males, reach out to youth out-of-school, and prioritise vulnerable girls, including those married.
- Identify Youth Advocates to interact with the community members and provide feedback to the government.
- Involve CSOs across policy formation: setting the agenda, formulating and implementing the policy, monitoring and evaluation, and feedback.

Annexure I

Policy and Programmatic Environment

Policy Environment

National Health Policy, National Population Policy, National AIDS Control Policy, National Policy on Education, National Nutrition Policy, and National Youth Policy are reviewed to learn how much importance is given on the issues related to adolescents and young people.

National Health Policy (2002)

The National Health Policy (2002) does not identify adolescents separately. Adolescents are grouped with children and pregnant women, which results in a misrepresentation of their concerns. The policy expresses concerns for the health care of special groups, under this it includes adolescent girls, however it is limited to nutritional needs. The age specific health needs of the adolescents and young people are not focussed upon. It touches upon the areas of awareness building among the school & college going children.

National Education Policy (1992)

The Education system plays a vital role in overall personality development of adolescent groups. The National Policy on Education does not target the specific educational needs of the adolescent population. Retaining children and adolescents in schools is not an area of concern, as only enrolment seems to be the focus in the policy, which reflects that it does not recognise education as a right. The National Education Policy reflects commitments to the eradication of illiteracy, particularly in the age group of 15-35 years. It has commitments of universalisation of the primary education; however it does not mention adolescents and young people as a separate category. It mentions need based vocational courses and non-formal education. The policy does not mention the explicit concerns of the 15-35 age group. It talks about population education as a means to motivate youth about family planning and responsible parenthood in the light of population stabilisation. The school curriculum has not yet included education on sexual health and HIV/AIDS.

National Nutrition Policy (1983)

The National Nutrition Policy recognises several aspects of gender discrimination. It identifies adolescent girls as a special vulnerable group. However the concern of vulnerability is articulated in terms of motherhood. It does not target adolescent boys and girls as individuals. In the strategies to implement the policy, importance is given to health and nutrition education to address the concerns of malnutrition and undernutrition.

National Policy for Empowerment (2001)

The policy clearly recognises the gender discrimination in different stages of women's life with a specific mention of adolescents. It also focuses on the nutritional needs of women at all stages of her life. Gender based violence is recognised as a problem requiring legal action. The issue of violence has been given its due recognition but it emphasises

violence against women and girls as a critical issue hindering their well-being. Specific concern of adolescents and violence is not clearly articulated; however early marriage in the light of maternal mortality has been given its due recognition.

National Population Policy (2000)

The National Population Policy (2000) has given importance to adolescents in terms of early marriage, teenage pregnancy and use of contraceptives for spacing. It strongly recommends action for enforcing the Child Marriage Restraint Act in the light of reducing teenage pregnancies.

Since the policy aims to reduce the fertility level to the replacement level by 2010, there is a recurring mention of adolescents in the light of population stabilisation. The policy further recommends a health package for adolescents which encompasses counselling, population education, contraceptive services etc. The policy recommends strengthening of Primary Health Centre and sub centres to provide contraceptive counselling to newly married young couples. It ignores the reproductive and sexual health service need of the unmarried adolescents to a great extent.

National Youth Policy (2013)

There is no government policy for adolescents. The National Youth Policy 2003 first time changed its definition of youth from 10-35 to 13-35 with specific importance to the adolescents between 13-19 years. Department of Youth Affairs declared the National Youth Policy 2013 in January 2014. The policy has explicitly mentioned different categories of the youth including sexual minority group. They are: Student youth, Urban youth in slums; migrant youth, Rural youth, Youth at risk – substance abuse, human trafficking, working in hazardous occupations, bonded labour, Youth in violent conflicts – participants or victims, Out-of-school or drop-outs from formal educational mainstream, Groups that suffer from social or moral stigma - transgender, gays and lesbians, those afflicted with HIV/AIDS, Youth in observation homes, orphanages or prisons, differently able.

The policy addresses the concerns of youth between the ages of 13-30 years. To give focus to all the age groups the policy has divided this broad age-bracket into three sub-groups: 13-18 years, 19-25 years, 26-30 years

Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A)

The RMNCH+A is a strategic approach which promotes ‘continuum of care’ to ensure equal focus on various life stages. Priority interventions for each thematic area have been address to ensure that the linkages between them are contextualised to the same and consecutive life stage. The key priority intervention areas are

1. Adolescent nutrition; iron and folic acid supplementation
2. Facility-based adolescent reproductive and sexual health services (Adolescent health clinics)

3. Information and counselling on adolescent sexual reproductive health and other health issues
4. Menstrual hygiene
5. Preventive health checkups

National Adolescent Health Strategy:

Following to the RMNCH+A strategic approach document the National Adolescent Health strategy is formally launched on 7th January 2014. The strategy emphasise on the comprehensive development of adolescents and not in context to maternal and child health. The strategy moves away from a ‘one-size-fits-all’ approach to more customised programmes and service delivery, addressing specific needs and aims at instituting effective, appropriate, acceptable and accessible service packages, addressing a range of health and development needs of adolescents. A combination of prevention, health promotion and healthy development strategies are proposed, offering continuum of care for our health and development needs. Interventions in the strategy are designed to provide information, commodities and services at the community level, and map referral linkages through the three-tier public health system. The strategy has a diversity of interventions that focus not only on adolescents but also on our social environment, including families, peers, schools and communities.

Objectives of the strategy

1. Increase availability and access to information about adolescent health.
2. Increase accessibility and utilisation of quality counselling and health services for adolescents.
3. Forge multi-sectoral partnerships to create safe and supportive environments for adolescents.

Strategic Priorities of the strategy

Improve nutrition

- Reduce the prevalence of malnutrition among adolescent girls and boys
- Reduce the prevalence of iron-deficiency anaemia (IDA) among adolescent girls and boys

Improve Sexual, Reproductive and Maternal health

- Improve knowledge, attitudes and behaviour, in relation to SRH
- Reduce teenage pregnancies
- Improve birth preparedness, complication readiness and provide early parenting support for adolescent parents

Enhance mental health

- Address mental health concerns of adolescents

Prevent injuries and violence

- Promote favourable attitudes for preventing injuries and violence (including Gender Based Violence) among adolescents

Prevent substance misuse

- Increase adolescents' awareness of the adverse effects and consequences of substance misuse

Address Non Communicable diseases

- Promote behaviour change in adolescents to prevent Non Communicable diseases (NCDs) such as hypertension, stroke, cardio-vascular diseases and diabetes

The adolescent health strategy promotes seven components

Coverage -The strategy brings in dedicated programming for 10 to 19-year-olds, with universal coverage, that is, urban and rural; in school and out of school; married and unmarried, including the vulnerable and under-served subgroups.

Content - The strategy incorporates content as listed under the head of strategic priorities, which will ensure comprehensive development of adolescents.

Communities -The adolescent health strategy envisages providing services to adolescents at community level. It encourages different approaches to make services such as nutrition and health information, Iron and Folic Acid (IFA) tablets and non-clinical contraception, nutrition supplements etc accessible to adolescents at schools, vocational education and training institutions, work places and recreation spaces. One of the core approaches to reach both adolescent girls and boys would be through peer educators/mentors.

Clinics (Health Facilities)-There will be dedicated weekly Adolescent Clinic at the Primary Health Centre (PHC), and the Community Health Centre (CHC), District Hospital (DH)/Sub District/Taluka Hospital and Medical College. Apart from this there will be designated Adolescent Friendly Health Centres.

Counselling-

The adolescent health strategy promotes adolescents' access to correct knowledge and information related to nutrition and health. At the community level through peers, nodal/school teachers, community based front line workers such as ASHA, Anganwadi workers, multipurpose health worker (male), Auxiliary Nurse Midwife etc. At the Adolescent Friendly Health Centre through staff nurses and Medical Officers (MOs) and dedicated professional counsellors.

Communication-It proposes interpersonal communication (IPC), mid-media and mass media to reach out adolescents and their family and community members.

Convergence—The Adolescent Health Strategy envisages intra-departmental convergence, with existing programmes of the department of health and Family Welfare like child health, Family Planning, Maternal Health, National AIDS Control Programme, National Tobacco Control Programme, National Mental Health Programme, and National Programme for Non-Communicable Diseases. The health ministry/department will also join hands and converge with other concerned ministry and departments like Ministry of Youth Affairs and Sports (MoYAS), Ministry of Human Resource Development (MHRD), Ministry of Women and Child Development (MWCD), Ministry of Labour and Employment (MoLE), Ministry of Social Justice and Empowerment (MSJE).

Programme Environment (Health and Nutrition)

The adolescents and young people receive services from different programmes and schemes from different Ministries/departments. A brief overview is given in Table 1.

At present the main programme addressing the needs of adolescents' health, nutrition and livelihood is 'Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG)–'Sabla' scheme. This scheme has been designed to ensure overall development of adolescent girls. It promotes awareness about health, hygiene, nutrition, adolescent reproductive and sexual health (ARSH) and family and child care and upgrade home-based skills, life skills and integrate with the National Skill Development Program (NSDP) for vocational skills. It also aims to mainstream out of school adolescent girls into formal/non formal education.

The scheme has yet to go through formal review to understand its status. The observations reported by the individuals and organisations who are actively involved in the implementation of the scheme indicate that there is a need to strengthen implementation and monitoring of all the component of the scheme. The livelihood component is the most poorly implemented. The scheme demands convergence especially in terms of planning and capacity building of the frontline workers of different departments and to evolve monitoring mechanism so as to take timely corrective actions.

Table 1: Overview of different programmes and schemes through which adolescent and young people get benefits

Ministry of Health and Family Welfare	Ministry of Women and Child Development	Ministry of Human Resource Development	Ministry of Youth Affairs and Sports
Youth Friendly Health Services	'Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG)-'Sabla'	Adolescent Education Programme	National Service Scheme- NSS
Menstrual Hygiene	Kishori Shakti Yojana (KSY)	MDM scheme	Nehru Yuva Kendra Sangathan NYKS
Family Planning	Balika Samridhi Yojana (BSY)	Rashtriya Madhyamik Siksha Abhijan -RMSA	National Programme for Youth and Adolescent Development -NPYAD
Maternal Health	Swadhar Scheme	Sakshar Bharat	
		National Population Education Project (NPEP)	



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