Analysis of the Situation of Children, Adolescents and Women in India 2016
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Acronyms and Abbreviations
ABL Activity Based Learning
AIDS Acquired Immune Deficiency Syndrome
AMRUT Atal Mission for Rejuvenation and Urban Transformation
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>BMI</td>
<td>Body Mass Index</td>
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<tr>
<td>BTAD</td>
<td>Bodoland Territorial Autonomous District</td>
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<td>CCA</td>
<td>Climate Change Adaptation</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination against Women</td>
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<td>CMAM</td>
<td>Community Management of Acute Malnutrition</td>
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<td>CPC</td>
<td>Child Protection Committee</td>
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<td>CPS</td>
<td>Child Protection Services</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>CRPD</td>
<td>Convention on the Rights of Persons with Disabilities</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>CSR</td>
<td>Child Sex Ratio</td>
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<td>DCPU</td>
<td>District Child Protection Unit</td>
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<td>DPMU</td>
<td>District Planning Monitoring Unit</td>
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<td>DRR</td>
<td>Disaster Risk Reduction</td>
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<tr>
<td>ECCE</td>
<td>Early Childhood Care and Education</td>
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<td>ECD</td>
<td>Early Childhood Development</td>
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<tr>
<td>EIU</td>
<td>Economist Intelligence Unit</td>
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<td>ELDS</td>
<td>Early Learning and Development Standards</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GER</td>
<td>Gross Enrolment Rate</td>
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<td>GNI</td>
<td>Gross National Income</td>
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<td>GPDP</td>
<td>Gram Panchayat Development Plan</td>
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<td>HDI</td>
<td>Human Development Index</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IAPPD</td>
<td>Integrated Action Plan for Prevention and Control of Pneumonia and Diarrhoea</td>
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<td>ICDS</td>
<td>India Child Development Scheme</td>
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<td>ICO</td>
<td>UNICEF India Country Office</td>
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<td>ICT</td>
<td>Information and Communication Technology</td>
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<td>IECEI</td>
<td>Indian Early Childhood Education Impact</td>
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<td>ISSNIP</td>
<td>ICDS Systems Strengthening and Nutrition Improvement Project</td>
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<tr>
<td>JSY</td>
<td>Janani Suaksha Yojana</td>
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<td>LWE</td>
<td>Left Wing Extremism</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MDM</td>
<td>Mid Day Meal</td>
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<td>MDR</td>
<td>Maternal Death Review</td>
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<td>MDWS</td>
<td>Ministry of Drinking Water and Sanitation</td>
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<td>MHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MHRD</td>
<td>Ministry of Human Resource Development</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
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<tr>
<td>MNREGA</td>
<td>Mahatma Gandhi Rural Employment Guarantee Act</td>
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<tr>
<td>MTR</td>
<td>Mid Term Review</td>
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<td>MWCD</td>
<td>Ministry of Women and Child Development</td>
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<td>NCD</td>
<td>Non-Communicable Disease</td>
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<td>NCERT</td>
<td>National Council for Education, Research and Training</td>
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<td>NCF</td>
<td>National Curriculum Framework</td>
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<td>New Education Policy</td>
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<td>NFHS</td>
<td>National Family Health Survey</td>
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<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NHM</td>
<td>National Health Mission</td>
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<td>NMR</td>
<td>Neonatal Mortality Rate</td>
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<tr>
<td>OBC</td>
<td>Other Backward Classes</td>
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<td>ODF</td>
<td>Open Defecation Free</td>
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<tr>
<td>OOSC</td>
<td>Out-of-School Children</td>
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<td>PDS</td>
<td>Public Distribution System</td>
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<td>POCOSO</td>
<td>Protection of Children against Sexual Offences Act</td>
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<td>PRI</td>
<td>Panchayati Raj Institution</td>
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<tr>
<td>PTCT</td>
<td>Parent to Child Transmission</td>
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<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
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<tr>
<td>RBSK</td>
<td>Rashtriya Bal Swasthya Karyakram</td>
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<tr>
<td>RIDP</td>
<td>Risk Informed Development Programming</td>
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Executive Summary

The Analysis of the Situation of Children, Adolescents and Women in India 2016 attempts to begin to answer the question: Where and how can UNICEF have the most impact on development progress and realisation of rights for children, adolescents and women in India during the UNICEF Country Programme 2018-2022? In so doing, it consolidates evidence on persistent inequities and makes the most disadvantaged and vulnerable young children more visible for the purposes of policy decision making, legislation, budgeting and national research. New
knowledge and information from more than 90 sources on the status of children and women in India, particularly from the Census 2011 and the Rapid Survey on children 2013-2014, have particularly enriched the process.

Thus, the Situation Analysis forms a basis for adjusting UNICEF programme interventions and strategies to ensure that programmes and policies remain relevant to the lives of girls and boys as well as women, and especially to the most vulnerable and disadvantaged among these groups. In turn, this will ensure that programmes and policies are likely to achieve the desired impact.

The Situation Analysis is influenced by a number of wider national and global factors, foremost among them India’s commitments under the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of Persons with Disabilities (CRPD). Likewise, it has been developed against the backdrop of the new global framework for development through the Sustainable Development Goals (SDGs) and the global Agenda 2030, as well as India’s ambitious transition toward becoming a high-income economy.

The Development Situation of India
As the SDG era opens, India is the fastest-growing large economy in the world and has made impressive strides in numerous social sectors, including halving the poverty head count ratio several years before the Millennium Development Goal (MDG) target of 2015. Likewise, under the MDGs it achieved gender parity in net enrolment in primary school; reversed the trend in HIV and AIDS;
achieved clean drinking water targets at community level; and significantly improved Internet and mobile phone access.

Nevertheless, the country’s progress toward achievement of the MDGs by 2015 was mixed, leaving a large unfinished development agenda to be carried over under the SDGs, compounded by still-low human development indicators. While hundreds of millions of Indians, including children and women, have exited extreme poverty, their lives still are marked by a continuous struggle to achieve dignity, comfort and security. A total of 1 in 5 of India’s people remains extremely poor, and 3 in 5 are poor. In particular, children from urban poor families, adolescent girls and tribal children suffer from multiple deprivations related to poverty, infant mortality, and early marriage, attendance rate in lower secondary and upper secondary education, open defecation, and access to drinking water. Just eight states (Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, and Uttar Pradesh) comprise a significant proportion of the national burden in relation to most core development indicators for children, adolescents and women.

Amid wide and often rising disparities on almost all social indicators – and at disaggregated levels, by gender, rural/urban location, geographic region and wealth, among others – the question remains key as to whether India is achieving progress with equity for its children and adolescents, who comprise the world’s largest such population, at more than 40 per cent of the country’s 1.2 billion people. Of these, about half belong to disadvantaged groups such as Scheduled Castes (SCs), Scheduled Tribes (STs) and other minorities. All this is particularly relevant given the CRC Committee’s broad concern over fragmentation and inconsistencies in the implementation of child rights across numerous areas, as well as what the CEDAW Committee has described as the persistence of patriarchal attitudes and deep-rooted stereotypes that discriminate against women. In all, the continuing strength of social norms, attitudes and practices in defining the status of children and women alike in India, by gender, age, social class, wealth, disability and other factors, cannot be overemphasised.

A brief synopsis indicates that the scale of continuing development challenges across sectors remains daunting:

- Some 3,600 children in India die every day, with most of these children dying from preventable causes and treatable diseases.
- An estimated 15 per cent of children younger than age 5 in India are wasted, 29 per cent are underweight and 39 per cent are stunted. In absolute numbers, this translates into 17 million wasted, 33 million underweight, and 44 million stunted children.
- While more than 9 in 10 households have access to an improved source of drinking water, only slightly more than 4 in 10 people use improved sanitation. About 564 million people continue to practice open defecation.
- India also lags in attempts to universalise primary education, as Gross and Net Enrolment Ratios show, with enrolment at secondary level rising more slowly. Indicating serious issues with quality of education, average achievement scores of Class V students have declined in all subjects between 2011 and 2014.
- Every fifth student drops out at primary level, rising to every third student at upper elementary and every second student at secondary level. Nearly 1 in 4 adult Indians (287 million) are still illiterate, and 50 per cent have not studied beyond middle school.
- Nearly 1 in 3 currently married women were married when younger than age 18.

Overall, effective governance will be central to development progress during the period 2018-2022, presenting a unique opportunity to take India to the next level, where no child is left behind, particularly the most disadvantaged and vulnerable. Specifically, this offers opportunities to further prioritise investment in rights-oriented interventions, and to deepen decentralised governance – attracting the right talent and streamlining processes – which can spur economic development and grassroots participatory planning. Strengthened social protection investments across the life cycle, which already have driven much of India’s progress to lift millions above the poverty line, will need to
support ongoing national structural reforms, and will better enable the country to positively impact human capital development and more rapidly progress.

Critically, many initiatives need to be implemented not only with equity but also with quality to assure adherence to the principles of the CRC. Despite India’s considerable advancements in governance, including e-governance, a continued need exists to execute well on service delivery and regulatory oversight alike, as also noted by the CRC Committee. For example, although Government spending on basic services increased rapidly between 2005 and 2012 – 11 per cent annually in real terms – how these resources are allocated at sub-national levels remains a major issue. One recent estimate, based on published Government data, found that 50 per cent of this spending did not reach the people. At the same time, India is mobilising less revenue at central and state levels, both tax and non-tax, than many comparable countries. In turn, this limits the public expenditure for provision of public goods, which can be seen, for example, in India’s chronic underfunding of health and other social services: Only around 1.2 per cent of the country’s Gross Domestic Product (GDP) is spent on health, far lower than the global average of 6 per cent and the middle-income country average of 3.1 per cent.

The most significant policy change relates to a new framework for financial devolution, recommended by India’s 14th Finance Commission. In essence, the new framework empowers states with greater expenditure discretion for funds not tied to centrally sponsored schemes or programmes. With the major re-casting of allocations from national social sector schemes, including deletion of a number of schemes, many state budgets have shown an overall decline. However, here too opportunities also exist: For example, “untied” funds to be transferred to local gram panchayats under the 14th Finance Commission – more than three times the previous amount – can allow these bodies to invest more in children. However, much will depend on ensuring child-focused priorities at sub-national levels.

Seven Key Crosscutting Priorities
In this context, seven key crosscutting and interlinked development themes that are emerging as necessary for the realisation of children’s, adolescents’ and women’s rights in India during 2018-2022. These are:
- Enhancing Early Childhood Development
- Empowering adolescents
- Strengthening tribal development
- Focusing on children in conflict-affected areas
- Prioritising climate change, to complement UNICEF’s longstanding engagement on Disaster Risk Reduction
- Improving services and opportunities for vulnerable children and women in urban settings, particularly urban slums
- Reducing gender-specific disparities and vulnerabilities across all areas of work

Greater attention is required for Early Childhood Development, a critical period of the life cycle. India’s 696,000 neonatal deaths annually are the highest in the world, and excess under-5 female mortality continues. A total of 39 per cent of children under 5 are stunted. Many children are born early, with India also having the world’s highest number of preterm babies (3.5 million). Although early initiation of breastfeeding nearly doubled in recent years, more than half of infants in 2014 still were not initiated to breastfeeding within 1 hour of birth.

Close to a third of children aged 3-6 years (20 million children) do not attend preschool, with children who are Muslim, poor, and from rural areas the most left behind. New research findings also indicate critical gaps in the quality of current Early Childhood Education programmes (basic infrastructure, appropriate learning materials, well-qualified teachers), both Government-run and private preschools, with low school readiness levels in children.
Moving forward, it will be necessary to ensure that ECD is central to the agenda for child rights in India, through promoting coordination among the many different actors in the field (health, nutrition, education, protection), including with respect to early detection and intervention of developmental delays, as well as for ensuring the rights of children with disabilities. For children aged 0-3, focusing more clearly on development, in addition to survival and growth, looking at promoting early stimulation, and providing a nurturing, safe and learning environment for children at home will be necessary. More effective monitoring of ECD outcomes likewise will be needed, as will capacity building of frontline workers, particularly with regard to early stimulation and Early Childhood Education.

For adolescents, some key indicators have strongly improved, such as literacy rates, although overall the development challenges specific to adolescents remain considerable. For example, the percentage of children of school-going age enrolled in school drops significantly between lower secondary and upper secondary levels. Many girls drop out of school before reaching Class X, often because they are married or are held responsible for care work in the household; nearly 1 in 3 adolescent girls aged 15-19 are currently married, especially girls from poorer families, SCs or STs, compared to 1 in 20 boys of the same age. Girls and boys also often drop out to be employed in labour, and many parents do not see the relevance of education for employment and employability. Significant proportions of adolescent girls and boys also suffer from undernutrition; as a result, adolescent mothers are especially vulnerable to disease and early death.

Critically, both sexes are widely excluded from decisions that affect them, have limited access to information on issues affecting their lives, and have limited spaces and opportunities to acquire and share knowledge and to participate actively in decision making processes. Thus, adolescents and their needs are largely invisible, although five states now have introduced government guidelines regarding adolescent participation in community platforms. The challenge is to translate adolescent participation and empowerment into an agenda that can be taken to scale programmatically and that has policy implications. Taking a prevention approach and prioritising the needs of young adolescents in particular (aged 10-14 years) will be critical. Likewise, ensuring accountability, influencing policies and public opinion in favour of adolescents, and generating data and evidence all will be necessary.

In terms of tribal development, evidence underscores that India’s tribal families and children are among the poorest and most vulnerable social groups in the country, with sub-optimal access to public goods and entitlements, and extensive exposure to drought, forced migration and subsequent displacement. Hence, from an equity perspective, they deserve the highest attention. The high vulnerability of this group is further aggravated by the fact that 9 out of the 10 tribal-dominated states have serious political challenges, and are influenced by left-wing extremism to varying degrees.

Five key opportunities exist: (1) Stepping up public advocacy to make tribal concerns a public and political priority, especially with Tribal Development Councils/Regional Councils and Missions; (2) Increasing allocation of funds to influence tribal budgeting; (3) Strengthening databases highlighting deprivations of tribal communities and children at sub-district level, using a comprehensive tribal deprivation index methodology; (4) Evaluating interventions and schemes, investing in evaluations and creating a body of literature of findings; and (5) Piloting area- and sector-specific activities while working with state governments to draw up integrated tribal plans of action for tribal areas and communities. In particular, up-to-date studies and evaluations, with effective follow-up plans, will be necessary to highlight gaps in resource allocations and human resource capacities in tribal areas.

At the same time, a total of 82 million children live in conflict-affected regions, including tribal areas, representing 17 per cent of the child population. In particular, three main sources of internal conflict are found, first, in separatist movements, ethnic conflicts and issues of identity and citizenship in the North East (Assam, Manipur, Nagaland, Tripura, Arunachal Pradesh and Meghalaya); second, in the so-called “Red Corridor” (Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh,
Maharashtra, Odisha, Telangana, Uttar Pradesh, West Bengal), dominated by left-wing extremism; and third, in Jammu & Kashmir, which encompasses separatist movements, territorial conflict and insurgency, compounded by terrorism.

Infants and young children are among the primary targets of violence, and adolescents continue to be used as combatants and trafficked into sex slavery. Indirectly, children in conflict areas also are negatively affected by undernutrition, disease outbreaks, poverty, the disruption of education, and internal displacement. They also face the risk of being tortured, arrested, sexually assaulted and raped, or killed in conflict zones. An acute need thus exists for long-term and longitudinal approaches – before, during and after conflict – to address the vulnerabilities of various populations, including a child rights approach to conflict. This will require improved understanding of governance in districts and states affected by conflict, along with linkages with other crosscutting issues such as tribal groups, adolescents, and climate change/Disaster Risk Reduction.

Overall, India ranks among the top 10 high-risk countries for disasters, which affects the lives of its children and adolescents in multidimensional ways. During 1986-2016, the country witnessed 1,107 major disasters affecting 1.68 billion people, with an estimated loss of US$10 billion. Climate-related stress increasingly exposes vulnerable people, especially girls, to violence, child trafficking, early marriage and child labour, as traditional sources of income no longer suffice to feed families and negative coping mechanisms are adopted.

The 2016 drought – affecting more than a quarter of the population of India – has proven particularly wide-ranging in its negative effects, with profound implications for children’s survival, education, nutrition, WASH, and protection, and an overall exacerbation of insecurities. A 60 per cent loss in subsistence farming has been noted, with “forest drought” leading to reduced timber and non-timber forest products and limited fodder for cattle, thereby compromising family livelihoods. Other negative effects in drought-affected states include decreased food and nutritional intake, with less quality and frequency; a high return to open defecation and unsafe hygiene practices; children suffering from exposure to extreme heat and sunstroke, including some who died while fetching water; a marked increase in the number of children dropping out of school, as they are required to spend hours collecting water and contributing to family income; and a compromised care and protective environment.

Bearing in mind the correlation between affected child growth patterns and exposure to natural disasters as well as growing menaces such as air pollution, a need exists for all development sectors to analyse how current and future disaster and climate risk affect their functioning, and to become more resilient. The element of migration also will need to be considered, since disasters and displacement of communities are closely linked.

Meanwhile, India will witness within 15 years an urban transformation of almost unprecedented scale and speed, and will possess two of the five largest cities in the world by 2030 (Mumbai, Delhi). Already, 377 million people live in urban areas, close to 31 per cent of total population. These cities face wide disparities and inequities among children, and evidence shows the poorest urban families are worse off than rural dwellers. Of the 65 million urban poor, 8 million are children younger than age 6. Services are available but largely out of reach for these children, in part because of complex – and often chaotic – urban governance. The agenda for urban programming will be to create an enabling environment for inclusive governance, and a resultant reduction in urban disparities. The prospect for children will largely depend on the capacity and capabilities of cities to govern themselves with an outcome orientation, which requires capacity and capability to anticipate needs, vulnerabilities and risks, to accord attention to finding sustainable solutions, and to allocate adequate planned resources, with a focus on equity. In addition, data and monitoring systems will particularly need to be strengthened to underscore evidence-based decision making.
Lastly, as a signatory to the CRC and CEDAW, India has a number of progressive laws and programmes that support gender equality, ending discrimination and preventing violence against women and girls. Yet India ranks low in the Gender Inequality Index, driven by a maternal mortality ratio, female labour force participation rate and percentage of girls with secondary education that are all lower than the average for middle-income countries. Gender-based discrimination and violence particularly continue to be defining issues, with the CEDAW Committee and CRC Committee both expressing serious concern.

Many women and girls, especially those belonging to the most marginalised groups, face overlapping social, emotional, physical, economic, cultural and caste-related deprivations. Challenges often stem from issues related to lack of personal choice or control, as well as the social norms highlighted above. As a result, many of India’s women lack skills, have poor employability, and have no control over their health and sexuality. Protecting children’s rights and enabling all children to survive and thrive thus requires interventions aimed specifically at addressing and mitigating the effects of gender discrimination on girls’ well-being, development and rights, while recognising and responding to the negative outcomes and vulnerabilities that boys face as a result of negative gender norms.

Rights-Based Thematic Analyses

The thematic analyses in this Situation Analysis focus on the right to adequate nutrition; the right to health; the right to water, sanitation and hygiene; the right to education; and the right to protection. Overall, the analysis particularly indicates a range of strengths and areas for improvement in all sectors with regard to institutions, systems and governance. Many of the areas for improvement relate to insufficient state- and district-level management and technical capacities, fragmentation of national-level responsibilities, low accountability/transparency, and weak coordination and monitoring.

The Right to Adequate Nutrition

Despite considerable progress, chronic undernutrition is likely to continue as India’s most urgent health crisis, particularly affecting poor children such as those in urban slums. Between 2006 and 2014, the level of stunting among children in India below 5 years has fallen from 48 per cent to 38.7 per cent. Even so, at this rate it would take around 40 years for India to achieve the SDG target of ending undernutrition by 2030 and the World Health Organization target of bringing down level of stunting to 23 per cent by 2025, indicating the scale of the challenges faced.

A further major cause of concern is the decline in the percentage of children aged 6-23 months receiving adequate feeding. Minimum diversity reduced from 35 per cent to 22 per cent between 2006 and 2014, and children receiving a minimum acceptable diet plunged by half, from 21 to 11 per cent. While there have been improvements in breastfeeding practices in the country, complementary feeding has shown negligible improvements. Among adolescents, undernutrition remains rampant, as highlighted above, with 53 per cent of adolescent girls aged 15-19 being anaemic, compared to 30 per cent of adolescent boys, and with 47 per cent of girls having a low Body Mass Index.

All nutrition-relevant sectors – health, education, WASH, child protection, agriculture, food, social protection et al. – will need to align around nutrition as a fundamental component of human and economic development. Recommendations include:

| Policy/Strategy | Support effective implementation and concrete Action Plans to complement policies in place Scale up nutrition-sensitive interventions, particularly in areas of WASH, reproductive health, adolescents, social protection, education and agriculture, to further address some of the underlying and structural causes of undernutrition |

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Ensure that a Multisectoral Nutrition Strategy is embedded in the larger National Nutrition Strategy being developed

**Institutions/Governance**

- Support institutional strengthening to effectively address undernutrition, including sustaining and adequately resourcing coordination institutions
- Adopt a convergence and equity approach for multisectoral and multi-stakeholder responses
- Document how well the establishment process for Nutrition Missions is taking place
- Identify what elements can ensure this sustainability and minimise political influence

**Programme, Including Crosscutting (Adolescents/Gender/ECD/Tribal/Conflict/Urban Slums/Climate Change&DRR)**

- Build a stronger focus on infant and young child feeding as a core nutrition component
- Support capacity development of human resources at national and sub-national levels, as well as sub-national-level technical assistance in planning, implementation and mainstreaming of issues such as gender and DRR
- Integrate issues of adolescent nutrition, especially adolescent girls’ nutrition, into existing platforms and programmes
- Give more attention to overlooked stages in the life cycle with regard to nutrition (e.g., secondary school level), to provide more seamless coverage
- Develop a more holistic view of nutrition within ECD, including breastfeeding and immunization, and focus on prevention of developmental delays
- Support the development of nutrition strategies, both nationally and in selected states, for urban slums

**M&E/Data/Knowledge Management/Innovation**

- Support the strengthening of the quality of the Management Information System (MIS), to inform policies and programmes
- Validate coverage estimates, supported by high-level advocacy with the Government on the importance of accurate validation
- Analyse disaggregated data for pockets of deprivation related to nutrition (e.g., rising food prices)
- Undertake technical support and advocacy to ensure that elements of programme evaluation are considered from the planning stage
- Support the Government to undertake more regular/periodic nutrition data surveys
- Examine how technology can be used more effectively for real-time monitoring or dissemination to the public domain
The Right to Health

India has made considerable strides in improving the health and well-being of its people, including meeting some of the key health-related MDGs on infant and maternal mortality. Despite this notable progress, however, India is still the world's most disease-burdened country. India's newborns and young children are especially vulnerable, not only because of the sheer size of India's population but also as a result of low levels of parental education, a weak public health system, and very low Government spending on health care. Some 9 million children remain unimmunised or partially immunised and continue to be at risk for vaccine-preventable diseases. Health outcomes vary dramatically across states, due to differences in rural accessibility, financial resources, administrative capacity, political priority and the quality of human capital, among other factors.

In addition to the world's highest rate of neonatal deaths highlighted above, the share of neonatal to under-5 deaths in India is higher than the global average of 45 per cent and has increased significantly, to 57 per cent. This likewise calls for increased investments and prioritisation of efforts toward reducing neonatal deaths. Critically, an adverse sex ratio for girls is widespread, though most acute in northwest India, as well as in families from the richest wealth quintile; in urban areas; and in families where the head of household has completed 12 or more years of education. Adverse CSR also is strongly present in the second wealth quintile, but less so in the poorer quintiles. About 1.2 million children younger than age 5 years died in India in 2015, also the highest in the world. Critically, India is the only country in the world where girls have a higher under-5 mortality rate than boys (13 per cent higher), compared to 7 per cent lower than boys globally. Pneumonia and diarrhoea were the main causes of young child deaths in the post-neonatal period.

In addition, every year about 45,000 women die from reasons related to pregnancy and childbirth, the second-highest number of maternal deaths in the world. Most of these deaths are preventable; alarmingly, nearly 9 in 10 of them occur in just nine states, for reasons including low coverage of quality antenatal care, persistent pockets of low institutional deliveries, limited number of facilities offering emergency obstetric care, and weak post-natal follow-up. SC/ST mothers, the poor, and Muslim mothers are particularly vulnerable. India also falls into the multi-burden category for the adolescent burden of disease, with mental and behavioural disorders, as well as injuries, forming emerging concerns for this age group.

Moreover, India's health issues are being made worse by air, water and other types of pollution, which are triggering an increase in respiratory ailments, waterborne diseases, and non-communicable diseases such as allergies and cancers. Experts studying the effects of climate change on India's disease profile believe that resistance to anti-malaria drugs and rising temperatures could challenge India's successful anti-malaria campaign and make the country the malaria capital of the world as soon as 2030.

Private health facilities are not accessible to large segments of the rural population and the urban poor, and only 5 per cent of Indians are covered by health insurance. The current per-capita public expenditure on health is US$75, placing India among the bottom 10 countries worldwide in terms of such Government spending. In addition, Government regulation of the private sector is weak, which has implications in the delivery of key quality maternal and newborn health services that may not necessarily be related to profit (breastfeeding, labour monitoring, “kangaroo” mother care).

The human right to health means that every child, every adolescent and every woman has the right to the highest attainable standard of physical and mental health, including access to all health services. To advance further toward this goal in India, recommendations include:
| **Policy/Strategy** | Advocacy for increase in the Government health budget to 2.5 per cent of GDP to reduce out-of-pocket expenditures  
Support to universal health coverage and financial risk protection through universal social health insurance  
Support to judicious use of low public health funding in districts and blocks where these resources are most required, thereby addressing significant intra-state as well as inter-state inequities  
Support to development of a policy framework to ensure standardization and regulation of private sector health services. Uniform minimum standards of care for the entire health system will be necessary, including both private and public service delivery |
| **Institutions/Governance** | Advocacy for improved regulation and enforcement of quality standards of private sector health facilities, to ensure quality of care and accountability  
Support to improved and revitalised national and state health partnership forums, inclusive of health professional associations; bilateral organisations; multilateral organisation; and private sector providers with government health management  
Support to district health management development and decentralisation  
Advocacy toward strengthening the pre-service and in-service health curriculum to accommodate public health issues, prioritising the needs of mothers and children in a holistic manner (preventive, promotive and treatment) |
| **Programme, Including Adolescents/Gender/ECD/Tribal/Conflict/Climate Change & DRR/Urban Slums** | Enhanced focus on equity, with particular attention to wide variations between and within states, rural and urban areas, across castes and wealth quintiles, and in tribal districts and districts affected by conflicts  
Greater attention to gender inequity, which remains a defining factor for neonatal and under-5 mortality in the country  
Support to improved health human resource management, with utilisation of private sector capacity to support the public sector  
Strengthen a multisectorial focus, including adolescent health, ECD, and the first 1,000 days of life for nutrition interventions  
Strengthened focus on the impact of urbanisation, climate change and outdoor air pollution on children’s and women’s health |
| **M&E/Data/Knowledge Management/Innovation** | Support uniform minimum standards of health management information systems (HMIS) and data collection for the public and private health systems  
Support desegregation of HMIS data by age, sex, geographic area, religion and ethnicity  
Conduct formative studies on the health status of children aged 6-9 years in India, who have not yet been the focus of major child health improvement efforts but are vital as they progress to adolescence |
Promote the use of technology for on-the-job trainings and decreasing workload on existing human resources, thereby mitigating the challenges that a lack of quality human resources poses

**The Right to Water, Sanitation and Hygiene**

Critically, nearly half of Indians continue to defecate in the open, with 564 million practitioners representing the highest number of people in the world. Stark disparities are seen in the practice of open defecation at the national level by residence, social groups, religion, and wealth quintile; for example, households belonging to the poorest wealth quintile are 40 times more likely to follow the practice than households belonging to the richest wealth quintile. Use of toilets in the poorest quintile of households is progressing particularly slowly; at the current rate, it is estimated that it would take some 180 years for the poorest people to reach the goal of being open defecation-free (ODF). Even among the middle wealth quintile, where improvement in toilet use has been most significant, the ODF goal is 20 years away.

In terms of use of improved sanitation facilities, overall access to improved sanitation has increased sharply during the last 25 years, to 42 per cent, but with continuing wide variations across states. Nevertheless, this was far below the MDG target, by some 19 percentage points. In contrast, almost 91 per cent of households have access to an improved source of drinking water. As in other countries, the burden of collecting waterfalls disproportionately on women and young girls; this situation can be made even worse by household adoption of toilet use, since water for sanitation and a reliance on water for cleansing demands greater and ready access to the resource. At the same time, however, water scarcity is increasingly affecting water quality, a worrying trend. Climate change and disaster also threaten important ODF gains. At institutional level, only 6 out of 10 schools have functioning toilet facilities. Even where toilets exist, only 1 in 2 is usable. Facilities at school often do not accommodate girls, particularly during menstruation, or children with disabilities. Although more than 4 out of every 5 households had an identified handwashing place, only 2 in 5 had water and soap at the site.

Moving forward, it will be necessary to focus on the emerging issues such as WASH compliance in health facilities, which is an SDG indicator, and strengthening linkages between the WASH and nutrition sectors, as well as to give new urgency to addressing the need for clean drinking water among other initiatives. In this context, recommendations include:

| Policy/Strategy | Advocacy for deeper understanding that ODF status is only a first milestone toward safely managed sanitation, and for funding for SBCC activities beyond the achievement of ODF status  
Advocacy for formulation of policies and management arrangements with regard to faecal sludge management in rural areas  
Support to strengthened policies for water quality, testing, monitoring and surveillance |
|---|---|
| Institutions/Governance | Advocacy for increased funding for operations and maintenance of WASH facilities in institutions, especially in schools  
Strengthening of PRI capacity to effectively demand services, implement community management of water sources, and implement the Swacch Bharat Mission  
Strengthening of district authorities’ capacity to accept the need for, and implement, an equity-based approach to service delivery |
| Programme, Including Adolescents/Gender/ECD/Tribal/Conflict/Urban Slums/Climate Change & DRR | Support to convergent programming to address stunting, for example, linking implementers of the Swacch Bharat Mission programme with Nutrition Missions and the National Health Mission, which can ensure messaging to new mothers around the need for handwashing and safe play environments for young children  
Promotion of integration of social and behavioural change communication activities into service delivery, rather than being seen as a stand-alone activity  
Support to empowerment of the middle class, and adolescents in particular, to become advocates for social change, including the right to water and sanitation, along with nurturing of broad-based partnerships in this regard  
Support to reducing the burden of water collection on women and girls  
Identification of alternative financing mechanisms for households in the bottom two wealth quintiles to enable them to acquire WASH technologies of their choice to accelerate coverage and use  
Support to addressing of resilience in infrastructure development, especially for water supply and toilet technologies  
Continued advocacy for equitable service delivery, complemented by work with partners to demand accountability from service providers |
| M&E/Data/Knowledge Management/Innovation | Support to agreement on SDG6 indicators. Further, agreement is needed on the data required to measure the indicators and the questions that need to be included in surveys to obtain the data, particularly for quality of services (e.g., water quality/availability, faecal sludge management, handwashing)  
Promotion of deeper understanding of what data are required, by stratifier, to allow for meaningful disaggregated data at state, district and block levels  
Support to studies on key questions affecting WASH programming – what works in India, and why?  
Strengthened partnerships with universities and think tanks for WASH evidence generation and the development of conceptual frameworks that are relevant to India |

**The Right to Education**

Significant achievements have been made in education across India, with near-universal enrolment in primary education. Disparities also have reduced over time with regard to the number of out-of-school children; gender and other social gaps; provisioning of schools, including separate toilets for girls and boys; and availability of drinking water. A strong legislative and policy framework for education exists.

Across the country, three challenges in education particularly stand out: (1) low attendance at preschool; (2) still-high numbers of children out of school; and (3) quality of learning outcomes. Access to quality ECE remains a central issue and an urgent deprivation, affecting other key education challenges such as school readiness, on-time enrolment in elementary school, retention, and learning ability. About 20 million of the country’s 3- to 6-year-olds are not in preschool, as noted above, heavily comprised of rural children and those from the most disadvantaged social groups; those who do attend are not necessarily receiving quality pre-primary education.
The number of out-of-school children has reduced to 6 million from 8 million since 2009, which represents a major achievement. Of these, however, 63 per cent have never attended school. This represents a key equity issue, since it is frequently the most deprived (tribal children, Muslim children) who are left behind. Data show that up to half of children leave school before completing Class V in eight states (Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan, Uttar Pradesh, West Bengal). Dropout rates are particularly high among SC/ST children and girls. While enrolment levels are generally high, regular attendance also must be considered, since this has significant implications for children’s learning outcomes. Children from SC, ST and Muslim communities missed nearly 30 per cent of school days at primary level, and attendance of rural children is lower than that of children in urban areas.

A shortage of qualified teachers and appropriate classrooms constitute key issues, and many schools, particularly in urban areas, are overcrowded and frequently unsafe, with rising levels of violence in school. Other main reasons for these shortfalls arise from inadequacies in implementation that have failed to benefit the deprived and marginalised children or to leverage available provisions. Multiple Ministries/departments that are involved in the delivery of education require further strengthening to work effectively in coordination, which has led to stand-alone interventions pursuing targets that do not always contribute to overall education goals and objectives. Yet as India’s economy grows further, it will need to create an adequate pool of highly skilled and literate workers, thereby securing their employability.

Even among those children retained in the education system, a high proportion completes primary education without grade-appropriate achievement levels/skills. Average achievement scores in the National Achievement Survey 2014 were found to have declined in all subjects compared to scores during the 2011 survey. Many of these challenges stem from low teacher quality and effectiveness; poor teaching quality in classrooms; and persistent issues of absenteeism, as well as sub-optimal home environments to support effective learning. Thus, millions of children, adolescents and women in India continue to be deprived of lifelong educational opportunities, many as a result of poverty. To move forward toward equitable education opportunities for all, recommendations include:

**Policy/Strategy**

- Support strengthened enforcement mechanisms for implementation of the RTE Act
- Advocate for extension of the RTE Act to include preschool education and secondary education
- Support the Integration of DRR strategies in the education policy framework

**Institutions/Governance**

- Strengthen inter-Ministerial and intersectoral coordination and convergence, with the effective use of data and evidence, for improved planning, monitoring and reporting on education programmes
- Support state education departments to establish systems and processes for timely recruitment, deployment and rationalisation of teachers
- Support strengthened and enforced regulatory mechanisms for teacher education institutions, including private teacher education institutions as well as private schools, and ensuring at least one woman teacher per school

**Programme, Including Adolescents/Gender/ECD/ Tribal/Conflict/Urban Slums/Climate Change & DRR**

- Support the expansion of preschool education to marginalised populations (e.g., tribal children and geographically remote areas)
- Generate evidence on DRR that demonstrates the social and economic cost of not prioritising this theme in education
Support education plans and budgets to accommodate different strategies that reflect the pluralism of India’s education situations

Support state governments to leverage corporate social responsibility/public-private partnerships with non-traditional partners as well as CSOs for the development of alternate education models and programmes in situations of armed conflict and DRR

Promote the development of flexible learning strategies for children who have never enrolled in school, children in labour, and migrant children

Support the establishment of coherent education-friendly social protection schemes to support marginalized households, including girls’ access to education

Support norm and behaviour change that prevents child marriage and child labour, including unpaid care work in the household, from becoming obstacles to school attendance and completion.

**M&E/Data/Knowledge Management/Innovation**

Strengthen the capacity of education functionaries in the effective use of data and monitoring mechanisms

Using innovative approaches, support the expansion of UDISE toward real-time monitoring of education officials from state down to school level

Support improved dissemination and feedback mechanisms of learning assessment data for improved learning and systemic change

Promote innovative models for scalability and sustainability of education interventions

Invest in a longitudinal study to follow a cohort of children from preschool to high school/university, to produce evidence on the benefits of preschool education for the individual and society alike

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**The Right to Protection**

Numerous issues of child protection, many of which often disproportionately affect adolescents, are found across the country. The focus on child protection is increasing from the MDG to the SDG era, with protection recognised as essential to child rights, social policy and social development. At the same time, child protection issues in India are becoming more complex due to evolving areas of equity, gender and risk alike (economic situation; by social groups, religion, urban-rural location, and age; urbanisation; conflict; climate change; migration; and globalisation).

Many of the country’s issues of child protection are manifested in the form of continued demand for child labour, prevailing practices of early marriage, widespread violence against children, sexual abuse, corporal punishment, institutional abuse, children affected in ethnic and civil strife conflicts, and human trafficking. A child in India goes missing every 8 minutes, and 40 per cent of these children – especially girls – are never found, with a link to trafficking.

Despite robust legislative framework for child protection and recent investments in the child protection system, much of the child protection infrastructure in India is still being built, and thus limited in its impact on children. In particular, a need exists to adapt and focus on the creation of safe communities or spaces for children in urban slums. Overall, effective child protection approaches face numerous challenges: a need for strengthened implementation of policies and legislation at the ground level; inadequate resources; insufficient convergence among sectors and capacities among

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core functionaries; and strengthened analysis and use of available data for evidence-based planning.

Data gaps at district and sub-district levels in particular need to be urgently addressed.

Low rates of birth registration make it difficult to protect children from early marriage and child labour. Violence against children (VAC), including corporal punishment as an “educational” and disciplinary measure, remains widespread despite legislation. Likewise, violence against women and girls (VAWG) remains the most visible and extreme form of the continuing need to strengthen the status of women and girls. Sexual abuse of both girls and boys represents a largely neglected issue, as in many countries. Commercial sexual exploitation of girls may start when they are only young adolescents aged 10 or 12. The number of suicides among adolescent boys and, especially, girls is steadily rising. Street children and other children, including orphans, lack critical parental guidance and are particularly vulnerable to abuse. At the same time, conflict or civil strife poses a grave protection issue. With this in mind, recommendations include:

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<tr>
<th>Policy/Strategy</th>
<th>Promote the development of a common vision and goals for the protection of children among key child protection actors, including Government, civil society, religious/community leaders and young people themselves. This vision should be accompanied by:</th>
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<td>- Adequate budget allocation and execution based on sound costing models and budget expenditure tracking systems</td>
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<td>- Specialisation and mobilisation of the child protection workforce.</td>
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<td>- Increased emphasis on prevention of violence, abuse and exploitation</td>
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<th>Institutions/Governance</th>
<th>Support the development of sound monitoring and evaluation systems with clear and measurable targets, and open to public scrutiny</th>
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<td>Support the empowerment of adolescents to participate in public fora and governance mechanisms</td>
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<td></td>
<td>Strengthen national and sub-national institutions in the promotion and protection of child rights (judicial bodies and independent monitoring agencies)</td>
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<tr>
<th>Programme, Including Adolescents/Gender/ECD/Tribal/Conflict/Urban Slums/Climate Change &amp; DRR</th>
<th>Advocate for the mainstreaming of prevention of child marriage, violence against children, and child labour into national-level delivery platforms to ensure large-scale interventions</th>
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<td>Invest in the second decade of life by investing in adolescent girls and boys, particularly young adolescents aged 10-14, empowering them to become agents of change through increased civic participation, improved life skills and promotion of positive social norms, especially gender norms.</td>
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<tr>
<th>M&amp;E/Data/Knowledge Management/Innovation</th>
<th>Invest in evidence generation to determine effective interventions in violence prevention and promotion of positive social norms and behaviours</th>
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<td>Support the development of systems to monitor the effective implementation of national laws, policies and programmes (i.e., scorecards, real-time monitoring, case management databases et al.)</td>
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The Way Forward
Despite numerous challenges and comparatively small budgets in the social sector, India has achieved major improvements in the lives of children, adolescents and women. India’s young girls and boys, adolescents and women thus are generally better off today than their peers from even recent years. India must be encouraged to foster an ever-stronger commitment to development of its children and adolescents. In so doing, the country can move a long way toward realising its ambitious hopes and vision. Even so, from the analysis above it is clear that many of the development challenges that continue to face India arise from the same or similar root causes, and that constraints to realisation of the full spectrum of rights among all of the country’s children, adolescents and women remain profound. Key root causes of major disparities include, among others:

- An acute need for systems/institutional strengthening, particularly at sub-national levels, to address insufficient capacities for equity-based planning, implementation, understanding of risk and change, coordination, and monitoring
- A strong need for a culturally sensitive transformation in social and behavioural development, including better definition of social norms to eliminate harmful practices, and promotion of social norms that enhance positive practices to ensure respect for and realisation of the rights of all women, adolescents and children
- The persistence of widespread poverty despite national economic progress, which continues to influence the life choices of many families
- A need to direct more substantive attention to quality services in disadvantaged and groups areas lagging in human development, including residents of urban slums, and tribal peoples, many of whom are conflict-affected
- Inadequate knowledge and awareness, particularly at family level, on good development practices and their benefits
- India’s heightened vulnerability to disaster, climate change and ensuing risks

At the same time, most of these challenges are complex, warranting comprehensive policies and robust, multisectoral implementation over a sustained period. This suggests that an integrated approach to India’s development needs among children, adolescents and women would best serve the country in many cases. Priority will need to be given to the seven themes highlighted across all sectors. In turn, these themes are drawn not only from this analysis but also are aligned with the Government’s overarching vision as well as the SDGs.

To address these broad areas, it will be critical to highlight the importance of context-responsive strategies tailored specifically to local and state realities as well as to disparities among and within India’s regions, socioeconomic groups, and others; this will require deepened strategic partnerships at different levels of governance. Priority will particularly continue to need to be given to the most crucial interventions related to reducing neonatal mortality, stunting and open defecation; all children in school and learning; and protection of children from violence and exploitation, with the introduction of further innovative, high-impact ideas in each area.

At the same time, new areas for focus can include knowledge generation and strengthened data analysis, including multidimensional child deprivation analysis; evidence-based social policy influencing and social protection; and effective communication for behavioural and social change. Use of “resource states” such as Kerala or Tamil Nadu may offer good practices for replication in more challenged states. In so doing, all this can help to ensure that the well-being of, and equitable outcomes for, all children, adolescents and women in India, particularly those from disadvantaged and vulnerable groups, is enhanced to the maximum.
Chapter 1: Introduction

1.1 Objectives and Conceptual Framework of the Situation Analysis
The UNICEF India Country Office (ICO) is undertaking to prepare its new Country Programme of Cooperation 2018-2022, with a view to inform and sharpen further key interventions on behalf of all girls, boys and adolescents in the country, especially the most vulnerable and disadvantaged. This Situation Analysis 2016 is intended as a critical contribution to the new Country Programme process, analysing the situation of children, adolescents and women with a rights-based, equity- and life cycle-focused, and gender-responsive approach.

In particular, the Situation Analysis builds on a series of analyses of vulnerable children and women in India, with a focus on key programming areas and on the results of the Census 2011, the Rapid Survey on Children (RSOC) 2013-2014, and the Mid Term Review (MTR) of the Country Programme 2013-2017. It also analyses priority crosscutting themes from an equity standpoint to highlight child- and adolescent-relevant dimensions of national development challenges and opportunities. Moreover, it synthesises new statistics, national policies, laws and trends, as well as new research since the previous UNICEF Situation Analysis in 2011, providing a disaggregated assessment that highlights patterns of inequality and key knowledge gaps related to child deprivation. In turn, it provides a comprehensive analysis of the policy and programme context that can develop an updated baseline of information for the realisation of the rights of children, adolescents and women in India, particularly the most vulnerable. Further, it also promotes the engagement of all stakeholders in shaping the child rights agenda at national and sub-national levels.

The Situation Analysis especially seeks to strengthen the knowledge of UNICEF and its partners on how India can translate continuing economic growth into improved and evidence-based outcomes for children, adolescents and women, and how it can effectively address remaining barriers and bottlenecks, as well as improve understanding of unattended risks for disaster mitigation and preparedness. In so doing, it particularly analyses the immediate, underlying and structural causes of shortfalls and disparities across various population groups and geographic regions of the country. It uses not only a broad equity “lens” but specific lenses on gender, conflict, and disaster risks and resilience building, including climate change and environmental sustainability, for a deeper understanding of these factors.

Thus, the Situation Analysis attempts to make the most vulnerable, disadvantaged and marginalised children, adolescents and women more visible for the purposes of policymaking, legislation, budgeting and national research. It also examines to what extent all children in India, including adolescents, are able to enjoy their rights under the Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Convention on the Rights of

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1 The MTR, conducted in 2015 through a consultative process involving a wide range of stakeholders, found that the Country Programme 2013-2017 has been aligned to UNICEF’s global Strategic Plan 2014-2017 and, increasingly, to a core set of national priorities under the Government’s 12th Five Year Plan, including key national flagship programmes and schemes. The MTR agreed that this focus should continue to evolve at national and state levels toward child-centred development in India, particularly the provision of high-quality strategic and technical support for policy formulation and systems enhancement. It urged a more focused, rigorously applied approach involving strategies related to integration/cross-sectoral synergy, innovation, and gender equality. More explicitly, the MTR recommended, among other initiatives: (1) promotion of country- and programme-wide convergent approaches to operationalise the National Policy for Children, involving all relevant sectoral Ministries; and (2) full integration of social and behavioural change communication and policy advocacy into programme planning, implementation and monitoring.
Persons with Disabilities (CRPD), Universal Periodic Review (UPR), and other major international standards, agreements and Conventions.

Critically, findings of the Situation Analysis are expected to contribute to accelerated progress toward achievement of the Sustainable Development Goals (SDGs) and the global Agenda 2030 for all children in India over the period 2018-2022 (see Section 2.1). It therefore is guided by basic rights principles of universality, equality, non-discrimination, accountability and participation. It also takes into consideration such global initiatives as the Global Plan for Women, Children and Adolescent Health 2016-2030, along with the UNICEF Regional Knowledge and Leadership Agenda, which focuses on reducing equity gaps across a wide range of issues in the areas of nutrition; health; water, sanitation and hygiene (WASH); education; and child protection. Hence, the Situation Analysis can further serve as a baseline for UNICEF as it proceeds to support the implementation of these and other initiatives in India.

In all, the Situation Analysis attempts to begin to answer the question: Where and how can UNICEF have the most impact on development progress for children, adolescents and women? In considering which deprivations should be further addressed by UNICEF in the next Country Programme, it applies five main filters: 1) criticality of national challenges and inequities; 2) mandate to act on a particular issue, drawing from priorities such as the SDGs; 3) other actors working in the same field; 4) capacity and position to act; and 5) lessons learned. It thus forms a basis for adjusting UNICEF programme interventions and strategies to ensure that programmes and policies remain relevant, especially for the most vulnerable and disadvantaged. To this end, it offers programming and policy recommendations to guide UNICEF programmes to address shortfalls and disparities, thereby accelerating progress toward the SDGs and the fulfilment of child rights.

1.2 Methodology and Structure of the Situation Analysis

To carry out the Situation Analysis, more than 90 primary and secondary data sources were used to better understand the state of children’s and women’s rights in the country. The Situation Analysis has further supplemented this review by engaging more than two dozen UNICEF staff in October 2016 to elicit their perspective on specific issues facing children, adolescents and women. These views are used particularly to contextualise secondary data, and to contribute to analysis of common capacity gaps among duty bearers. Nonetheless, some limitations to development of the Situation Analysis must be noted: First, not all data sources were consistent, up to date or sufficiently disaggregated, especially by gender, caste, religion and tribe, reflecting a continuing need for strengthened data collection with regard to children and adolescents. Second, although it was not possible for children and adolescents themselves to contribute substantively to the Situation Analysis, their views will continue to be sought throughout the new Country Programme cycle.

Chapter 1 has introduced the purpose of the Situation Analysis and the methodology for preparing this document. Chapter 2 comprises a synopsis of the programmatic context in India; this includes a closer look at the country’s international commitments on child rights and gender equality, as well as the overall national and sub-national policy and governance context of children’s lives, which underlies so many of the development opportunities and challenges in the years ahead. Further, the chapter presents an overview of child and family needs, relevant trends, and status of children and adolescents, by region, rural/urban location, gender, wealth quintile, and other key dimensions to the extent possible. Demographic profiles and trends, along with brief overviews of the country’s economic and human development, are highlighted.

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2 Based on the new Results Based Management (RBM) training package on strategic planning, issued by UNICEF Headquarters, May 2016.
Critically, particular focus is given in Chapter 3 to seven key crosscutting and interlinked development themes that are emerging as necessary for the realisation of children’s and women’s rights in India during 2018-2022. These are:

- Enhancing Early Childhood Development
- Empowering adolescents
- Strengthening tribal development
- Focusing on children in conflict-affected areas
- Prioritising climate change, to complement UNICEF’s longstanding engagement on Disaster Risk Reduction
- Improving services and opportunities for vulnerable children and women in urban settings, particularly urban slums
- Reducing gender-specific disparities and vulnerabilities across all areas of work

This leads to sectoral analyses of the status of children, adolescents and their families, including causality analyses linked to overall structural causes and to recommendations based upon the analysis as a whole. Chapter 4 focuses on the right to food and adequate nutrition; Chapter 5 highlights the right to health and survival for children, while Chapter 6 does likewise for rights linked to water, sanitation and hygiene. In Chapter 7, the right to education takes centre stage with a look at pre-primary through elementary and secondary levels; Chapter 8 focuses on the right to be respected and protected, examining the many forms of protection issues for children, adolescents and women in the country. Lastly, Chapter 9 offers a short conclusion and analysis of the way forward.

Chapter 2: Programming Context of India

2.1 International Commitments on Child Rights and Gender Equality

India has made impressive strides in numerous social sectors, but its progress toward achievement of the global Millennium Development Goals (MDGs) by 2015 was mixed, leaving a large unfinished development agenda to be carried over under the SDGs and Agenda 2030. Wide disparities continue to be found across the country on almost all indicators, underscoring the importance of deepening the equity agenda for development (see Chapters 3-8 for details).

The country achieved the target of halving the poverty head count ratio several years early (from 47.8 per cent in 1990 to 21.9 per cent in 2011), and achieved gender parity in net enrolment in primary school; met the required trend reversal in the fight against HIV and AIDS; achieved clean drinking water targets at community level; and significantly improved Internet and mobile phone access. It was found to be moderately on track with regard to (1) achieving universal education; (2) reducing child mortality, with particular attention to a sharp decline in infant and under-5 mortality in recent years; (3) reducing malaria and tuberculosis, despite some fluctuations in trends; and (4) measures to reverse the loss of environmental resources (forest/protected areas, decline in chlorofluorocarbon emissions), although carbon dioxide emissions and energy intensity remain areas of concern.

India continues to have a deeply skewed sex selection ratio, with 918 girls born per 1,000 boys, against the global standard of 952 girls per 1,000 boys. The country also continues to have high under-5

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4 MDG monitoring was conducted at national and state levels only, given a lack of data at district level.

5 MDGR 2015, op.cit.
mortality, at 45 per 1,000 live births, and infant mortality, at 39 per 1000 live births, with a higher mortality for girls under 5. At the same time, undernutrition and hunger remain priority challenges, as Chapter 4 clearly illustrates. Critically, the World Health Assembly (WHA) has mandated a reduction in stunting and wasting by 2025, with a target for India of 23 per cent; however, the current level of stunting still stands at about 39 per cent and is declining only slowly. Likewise, reducing the Maternal Mortality Ratio by three-fourths and significantly raising the proportion of people using improved sanitation both lagged as MDGs, while no pattern was statistically discernible in whether significant improvement had been achieved in the lives of slum dwellers.

The essence of the SDGs, meanwhile, lies in acknowledging the complementary nature of Goals and targets, together with social, economic and environmental processes. This mandates an integrated development approach, based on the adoption of universal principles, standards and values – along with universal commitment to leave no one behind – which marks a distinct shift from the sectoral approach of the MDGs.

Among the SDGs, Goals 1, 2, 3, 4, 5 and 6 directly affect children; Goals 7, 8, 10, 11, 13, 16 and 17, while more indirect, also are relevant for children. Numerous national and UNICEF development priorities are embedded in the SDGs through specific indicators, including reducing neonatal mortality; reducing stunting; eliminating open defecation; eliminating child marriage, child labour, and violence against women and children; and having all children in school and learning, all of which have been a priority focus for UNICEF.

Through the endorsement of numerous additional international instruments, India has further demonstrated its commitment to promote a sound enabling environment for the realisation of the rights of every child. India became a State Party to the CRC in 1992 and ratified CEDAW in 1993, as well as CRPD in 2007. It likewise has endorsed the World Fit for Children document, an outcome of the 2002 United Nations General Assembly Special Session on Children, while also endorsing the Beijing Platform for Action in 1995 to attain the objectives of safeguarding gender equality, legal rights and empowerment of women.

India also is among governments that have adopted the Dakar Framework for Action for Attaining Education for All, which calls for expansion and improvement of comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children, as well as the Declaration of Commitment on HIV/AIDS, from the United Nations General Assembly Special Session on HIV/AIDS in 2001. In March 2015, India adopted the Sendai Framework for Disaster Risk Reduction (DRR) 2015-2030, which seeks to build resilience to disasters alongside seven targets, while referring to children as “agents of change” for DRR. Most recently, in October 2016, it ratified the Paris Agreement on Climate Change, committing itself to reduce greenhouse gas emissions and to increase the ability to adapt to the adverse impact of climate change.

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8 MDGR 2015, op.cit.
9 SDG1: End poverty in all its forms, everywhere; SDG2: End hunger, achieve food security and improved nutrition, and promote sustainable agriculture; SDG3: Ensure healthy lives and promote well-being for all, at all ages; SDG4: Ensure inclusive and quality education for all, and promote lifelong learning; SDG5: Achieve gender equality and empower all women and girls; SDG6: Ensure access to water and sanitation for all; SDG7: Ensure access to affordable, reliable, sustainable and modern energy for all; SDG8: Promote inclusive and sustainable economic growth, employment and decent work for all; SDG10: Reduce inequality within and among countries; SDG11: Make cities inclusive, safe, resilient and sustainable; SDG13: Take urgent action to combat climate change and its impacts; SDG16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels; SDG17: Revitalise the global partnership for sustainable development.
Regionally, India is a party to the SAARC Arrangements for the Promotion of Child Welfare in South Asia and SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution, both 2002; the SAARC Social Charter 2005; the Colombo Statement of Children of South Asia 2009; the Colombo Declaration 2011, which promotes child-sensitive social protection; and the SAARC Framework for Child-Centred DRR 2015.

The Committee on the Rights of the Child, in its most recent Concluding Observations of 2014, welcomed India’s adoption of a number of legislative measures and policies, as well as ratification of Optional Protocols to relevant Conventions. Nevertheless, it offered 84 recommendations in numerous areas, including (1) broad concern over fragmentation and inconsistencies in the implementation of child rights; (2) persisting inequality with regard to girls, children from Scheduled Castes and Scheduled Tribes (SCs/STs), children with disabilities, children with HIV/AIDS, and asylum-seeking and refugee children; (3) high levels of chronic child undernutrition and inadequate infant and young child feeding practices; (4) children participating in work; (5) violence against women and children; (6) maternal mortality; (7) forced displacement of children and their families because of business operations; (8) skewed child sex ratios that significantly disadvantage girls; (9) adolescents’ lack of access to services including education, health and protection; (10) budget allocations that do not adequately take into consideration child protection needs, with mismanagement of resources, a high level of corruption, and a lack of effective monitoring and evaluation; and (11) child marriage.10

Similarly, the CEDAW Committee11 lauded India’s efforts on a number of initiatives, including the Criminal Law Amendment Act 2013; the Sexual Harassment of Women in the Workplace Act 2013; the Protection of Children from Sexual Offences Act 2012; and ratification of the CRPD. However, the Committee offered an extensive set of concerns and recommendations linked to violence against women (see also Section 2.7 and Chapter 8), including rape and other forms of sexual violence, enforced disappearance, and killings, acts of torture and ill treatment against women in conflict-affected regions.

Another priority area related to the Committee’s concern at the “persistence of patriarchal attitudes and deep-rooted stereotypes entrenched in the social, cultural, economic and political institutions and structures of Indian society and in the media that discriminate against women. It is further concerned about the persistence of harmful traditional practices in the State Party, such as child marriage, the dowry system, so-called ‘honour killings,’ sex-selective abortion, sati, devadasi, and accusing women of witchcraft.” It stated that it was “particularly concerned that the State Party has not taken sufficient sustained and systematic action to modify or eliminate stereotypes and harmful practices.” In addition to numerous sector-specific concerns, the Committee also pointed out specific challenges facing rural women, those from SCs/STs, and women with disabilities. No State report has yet been submitted on the CRPD.

Likewise, in India’s Universal Periodic Review (UPR) in 2012,12 a number of recommendations also were made related to child rights and women’s rights. In particular, the UPR urged the expeditious improvement of disaggregated data collection to facilitate the analysis of the situation of all children, especially the vulnerable. It also raised issues of active coordination among line Ministries, reforms to

combat violence against women, children participating in work, overall child protection, maternal mortality, and skewed child sex ratio, among others.

2.2 Child Rights-Related Governance, Legislation, Policies and National Priorities
Effective governance will be the key to development progress during the period 2018-2022, presenting a unique opportunity to take India to the next level, where no child is left behind, particularly the most disadvantaged and vulnerable. Specifically, it offers opportunities to further prioritise investment in rights-oriented interventions, and to deepen decentralised governance, which can spur economic development and deepen grassroots participatory planning.13

Under the 12th Five Year Plan 2012-2016, the Government has aimed to reverse the recent economic slowdown that has occurred in India (see Section 2.3), and to return to higher growth, while also making this growth more inclusive and with multiple dimensions. This includes improving regional equity across and within states, combined with a pro-poor programme approach. The 12th Plan also sets ambitious targets for flagship programmes in the areas of health, education, rural infrastructure and livelihood development, among others. Implementation in the field is the responsibility of state governments, but programme guidelines are set by the central Government, with room for flexibility to meet requirements of individual states.

The coming into force of the Commissions for the Protection of Child Rights Act 2005 ushered in a new phase in the implementation of measures by the Government to promote and protect children’s rights (see also Chapter 8). This provided for the establishment of a National Commission for the Protection of Child Rights (NCPCR) and State Commissions for the Protection of Child Rights (SCPCRs), of which 33 have been established.14 These are complemented by the national human rights framework, originating within the Constitution of India, which expressly mandates certain provisions for guaranteeing the rights of children. Further, these constitutional provisions have been greatly influenced by the concept of human rights contained in the United Nations Declaration of Human Rights and other international instruments to which India is a party (see also Section 2.1).

An important milestone for child rights in India was achieved when the National Policy for Children was approved in 2013, laying out key priorities for children in the context of survival, health and development, nutrition, education and protection. The Policy also sets out the need to develop a National Plan of Action for Children, finalised in early 2016 by the Ministry of Women and Child Development, and State Plans of Action to implement the Policy’s identified priorities. These state plans are now being developed and introduced, for example, in West Bengal. Formation of an inter-Ministerial coordination mechanism for children, at national level, also is being discussed, and if instituted will overcome a major bottleneck to the finalisation, implementation and monitoring of the National Policy for Children and National Plan of Action for Children, as well as in responding to the CRC Concluding Observations (see Section 2.1).

In addition, numerous states have adopted broad-based multisectoral policies targeting girls, while others have increased their policy focus to address tribal development issues. The Mid Term Review of the Country Programme 2013-2017 also found that evidence exists of successful piloting to promote

13 The 73rd and 74th Amendments to the Constitution envisaged a major reform of governance by giving rights to Panchayati Raj Institutions/urban local bodies to plan for economic development and social justice at local levels. The 11th Five Year Plan moved further and suggested a practicable action programme for local-level planning; it also suggested in detail the manner in which programmes of national importance in education, health, employment, poverty alleviation, housing and rural infrastructure could achieve their objectives better if centrality is accorded to panchayats in working out implementation details.

convergence and decentralisation to improve sub-national governance for child rights, such as the District Planning Monitoring Units (DPMUs) piloted in one district of Odisha and later scaled up to cover all districts in the state. Likewise, the government of Maharashtra has decided to replicate DPMUs in 36 districts.

Meanwhile, numerous pieces of key national legislation and national policies have been passed or adopted in all sectors specifically to advance the rights of children, adolescents and women (see Chapters 3-8 for details). At the same time, the Companies Act was amended in 2013 to make financial space for companies to invest in corporate social responsibility activities; many of these activities are focused on children and women, and also help the achievement of national socioeconomic development priorities.

Nevertheless, key challenges remain: For example, risk-informed development planning and programming require further strengthening. Existing systems to absorb shocks from fast- and slow-onset natural and manmade disasters continue to be dominated by a response approach instead of a prevention approach. Despite a policy shift following the landmark Disaster Management Act 2005, practical implementation of DRR remains limited and is by no means systematic, in particular at state and local levels. This puts children, adolescents, women and other vulnerable groups at risk and affects their development through disaster impacts including droughts, floods and earthquakes. Response mechanisms also do not ensure that losses will be recovered, where possible, and exacerbate pre-existing vulnerabilities or create new ones.

**Tackling Poverty: An Increased Focus on Social Protection**

A total of 14 of the 17 SDGs include a social protection element, with SDGs 1, 2, and 6 having specific social protection targets. Thus, as India increasingly settles into Middle Income Country (MIC) status, social protection will need to become ever more key for growth and development. India’s economy is growing rapidly, contributing alongside important social policies to lift millions above the poverty line. The great strides that the country has achieved in recent years in building a more comprehensive and integrated social protection system have driven much of this progress. At the same time, further social protection investments across the life cycle will support ongoing national structural reforms, and will better enable India to positively impact human capital development and more rapidly progress to a high-income economy.

Both the Government of India and the global United Nations System, including UNICEF, have committed to the concept of a life cycle-based set of basic social security guarantees. This encompasses available, accessible and quality essential health care, including maternity care, as well as basic income security for children and adolescents to provide access to nutrition, education, safe water and improved sanitation, shelter, and other necessary public goods and services. Children and adolescents also are affected by basic income security for persons of working age who are unable to earn sufficient income, particularly in cases of illness, unemployment, maternity and disability, as well as for older persons.

Despite India’s considerable achievements in reducing poverty and improving development indicators such as life expectancy and educational attainment, persistently high levels of poverty exist, as noted in Section 2.1, along with low levels of education, skills and productivity for many workers; low

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15 Social protection comprises those measures that aim at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation, which if unaddressed represent tremendous squandered human and economic potential.

16 The vulnerabilities of an individual change throughout her or his lifetime, as s/he enters different life stages, with varying needs, risks and capacities. Life cycle change can result from sudden shocks (e.g., death in the household, loss of income), or change in social or economic status (adulthood, career change, marriage, old age).
nutritional status, particularly of children, adolescents, and women; inter-group and inter-caste inequalities; and overall vulnerabilities arising from a largely informal workforce, the vast majority of whom are without any type of social security or social assistance (see also Chapters 3-8).

States alone, or the states and centre together, are responsible for social protection schemes, of which India has a large number, covering, among others, basic education and health; food and nutrition security; employment creation and promotion; workers’ social security; and social pensions, which have expanded significantly to cover divorced/separated/single women.

By working toward adopting an integrated, rights-based social protection system, India’s policymakers thus are aiming to transform the country’s economic growth into a development factor that is inclusive, sustainable, and allowing for continued progress for all vulnerable households, their children, and their communities. In addition to the socioeconomic benefits noted above, this is expected to:

- Reduce inequality and vulnerability
- Increase resilience to shocks, which reduces households’ vulnerability to falling back into poverty
- Improve equitable financial inclusion that expands livelihoods and capabilities
- Protect against demographic challenges resulting from rising dependency rates

Increasingly, the so-called “J.A.M. trinity” is seen as the linchpin of the Government’s social development agenda, and is aimed at building large-scale, technology-enabled and real-time direct benefit transfers systems to provide financial inclusion for India’s poor, including women and children. In the first of three core elements, the Jan Dhan Yojana scheme (the “J”) is opening bank accounts for millions of the poor and vulnerable so that they can save, invest, insure and borrow; around 217 million bank accounts have been opened since the scheme’s August 2014 launch, although many have no balance and remain inactive. The Aadhar scheme (“A”) is allotting a unique biometric identification number to every citizen, linked to the bank account, which from a service delivery perspective can be made sensitive to equity issues and vulnerable groups. Both are linked to mobile payment (“M”), which allows funds from different Government schemes to be directly deposited into the individual’s account. This in turn creates a “trinity” of enabled fund access, financial participation, and inclusion capacity that provides a more efficient and accessible environment for implementation of social protection schemes, particularly with regard to cash transfer programmes.

Nonetheless, challenges exist in establishing integrated social protection, especially for women and girls, who lag far behind men and boys in uptake of financial services, for example. There exists a need for additional fiscal resources to be mobilised, potentially from increasing the tax/GDP ratio; strengthened implementation capacities and accountability of implementers; and proactive measures to reach the most vulnerable segments of society, particularly in terms of Early Childhood Development among the youngest children, aged 0-3 years, as well as among pregnant women. If implemented well, however, these will offer extraordinary investment returns that can ultimately strengthen economic impacts and support the financing of a sustainable system.

Challenges of Reaching the Most Disadvantaged: Implementation, Quality and Budgets

Despite India’s considerable advancements in governance, including e-governance, a continued need exists to execute well on service delivery and regulatory oversight alike, as also noted in the CRC Concluding Observations. For example, although Government spending on basic services increased

rapidly between 2005 and 2012 – 11 per cent annually in real terms – how these resources are allocated at sub-national levels remains a major issue. One recent estimate, based on published Government data, found that 50 per cent of this spending did not reach the people. In one case, that of food subsidies, 35 per cent did not reach consumers, and the poorest people received less than 40 per cent of the subsidies intended for them, although they account for 80 per cent of the hunger gap.\(^\text{18}\)

As this Situation Analysis amply illustrates, equity issues continue to require urgent attention across sectors, including at state and district levels, to ensure equitable benefits for all children, adolescents and women benefit. While children have equal rights, their needs and entitlements are specific to their age and sex, the area they reside in, the cultural and social groups to which they belong, and the governance of environmental assets and ecosystems, among other factors. This demands a variety and mix of interventions, particularly with regard to extending the reach of services to the most underserved and marginalised communities.

Critically, many initiatives need to be implemented not only with equity but also with quality to assure adherence to the principles of the CRC. In addition, the push to streamline bureaucratic processes, and to strengthen anti-corruption efforts, has not yet been as wide-ranging, or as successful, as originally envisaged.

At the same time, exclusion often results from poor implementation of laws, policies and programmes.\(^\text{19}\) Evidence shows that among the most affected, including by deeply entrenched social norms (see Section 2.3), are women, especially poor women; ethnic or religious minorities, such as SCs, STs and Muslims; children and their families who survive ethnic or religious violence; members of isolated tribal communities; and urban slum dwellers, the urban homeless, or those in unsafe or underpaid urban occupations.\(^\text{20}\) Persons with disabilities continue to face particular obstacles.\(^\text{21}\)

At district level, development inequities can be particularly pronounced, with caste and religious affiliation, gender, education levels and other dimensions exacerbating insufficient financial allocations. Even the leading district in the country, out of 599 surveyed on indicators of education, maternal health, economy and overall well-being, has considerable scope to develop, with a rank of only 0.70, illustrating the depth of disparities; however, the least developed district achieved a rating of only one-fifth that, at 0.14.\(^\text{22}\) Because of tax exemptions and concessions, as well as low rates of compliance with tax payment laws, India is mobilising less revenue at central and state levels, both tax and non-tax, than many comparable countries.\(^\text{23}\) In turn, this limits the public expenditure for provision of public goods, which can be seen, for example, in India’s chronic underfunding of health and other social services: Only around 1.2 per cent of the country’s Gross Domestic Product (GDP) is spent on health (see Chapter 5), far lower than the global average of 6 per cent and the middle-income country average of 3.1 per cent.

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\(^\text{18}\) Ibid.
\(^\text{20}\) Ibid.
\(^\text{21}\) While a national policy and four national laws are in place with regard to persons with disabilities, a rights-based approach rather than an overall overall medicalised and/or welfare approach remains to be achieved. In some states, even minimum services for persons with disabilities (provision of disability certificates, basic rehabilitation services) are lacking or difficult to access.
\(^\text{22}\) US-India Policy Institute and Centre for Research and Debates in Development Policy. District Development and Diversity Index: Report for India and Major States. Washington, D.C., January 2015. North Delhi was ranked first, compared to Sheohar (Bihar), ranked last. Out of the 599 districts surveys, 107 were rated as most developed, 131 as developed, 112 as developing, 149 as underdeveloped, and 100 as least developed.
\(^\text{23}\) Exclusion Report, op.cit.
This also is lower than levels found in other BRICS countries (Brazil, Russia, China, South Africa), as well as in other South Asian countries (Sri Lanka, Bangladesh).24

All this calls for the building of institutional capacities and strengthening of systems to ensure accountability throughout the public sector that will subsequently bridge gaps in access to basic services for children, adolescents and women across the country. Without this, even the estimated necessary doubling of total public spending for basic services to address key deprivations during this decade – from US$118 billion in 2012 to US$226 billion by 202225 – will fall short.

The Deep Complexity of Governance in India’s States

The governance situation is particularly complex because of the many types of governance arrangements that exist in India, which strongly necessitate location-specific strategies. For example, in Assam two hill districts with mostly tribal populations are governed by Autonomous District Councils formed under the Constitution’s Sixth Schedule, which prescribes separate institutional arrangements for tribal areas in the country; these councils have extensive legal and executive powers over the use of land and resources, social customs, inheritance, and other areas of governance. Four other districts in the state have been declared as Bodoland Territorial Autonomous Districts (BTAD) and brought under the Bodoland Territorial Council created through an amendment to the Sixth Schedule, thereby fulfilling Bodoland aspirations for autonomy.

The rest of Assam’s districts fall under Part IX of the Constitution, and comprise governance bodies of Panchayati Raj Institutions (PRIs, for rural areas) and urban local bodies. However, six more autonomous councils related to six ethnic communities have been formed through state legislation. In addition, several dozen community-specific development councils also have been created by the state government and primarily mandated to bring about development for their specific communities, including for children and women. Such very diverse institutional arrangements present unique challenges to the overall processes of governance in general, and to the related processes of participation, planning and programme implementation in particular.

At the same time, a state like Nagaland has received United Nations recognition for its award-winning “communitisation” of village-level institutions, which are uniquely endowed with statutory powers and resources. However, because of some 70 years of political conflict over Naga autonomy, its people, including children, adolescents and women, also are covered by the Armed Forces Special Powers Act, enforced in the state for the last five decades and extended to 2017, giving the armed forces the power to search, raid and arrest without a warrant.

This is very different from the situation in a state like Odisha, which has sustained one-party political dominance for more than 15 years and takes a welfare populist approach, or from the equality-based programming found in West Bengal, which does not envision the formulation of separate strategies and budget allocations for the most deprived. Again, this underscores the complexity of governance issues across India, and the challenges in ensuring equitable approaches and solutions for the most vulnerable, disadvantaged and marginalised children, adolescents and women.

Sources: UNICEF India. Programme Context Analyses of (1) Assam, (2) Nagaland, (3) Odisha and (4) West Bengal. All New Delhi, 2016.

A New Framework for Financial Devolution, and Other Recent Measures

To move toward an overall vision of enhanced governance, the central Government, elected in 2014, has taken a number of steps to strengthen its commitment toward economic and social development.

and disparity reduction. This encompasses, among others, ambitious goals by 2022 of elimination of absolute poverty; housing for all, with every house having electricity, road access, safe water, and sanitation; access to livelihoods, employment or economic opportunities for at least one member of every family; provision of medical services in each village and city; ensuring a senior secondary school within 5km of every child’s residence; and improved education quality and learning outcomes.

To bring in more streamlined and convergent policy action, the Government has moved to planning for a 15-year time span, factoring in the SDGs. Starting from 2017, India will follow seven-year development plans toward this longer-term vision and eliminate the previous Five Year Plans. As part of the transformation agenda, the Government also has abolished the Planning Commission and replaced it with the NITI Aayog, which is intended to move India from “one size fits all” schemes toward more context-specific approaches aligned with individual states’ needs. In particular, the NITI Aayog, headed by the Prime Minister, is working to foster better inter-Ministry coordination as well as better centre-state collaboration, with special attention to vulnerable, disadvantaged and marginalised groups.

Yet perhaps the most significant policy change relates to a new framework for financial devolution, recommended by India’s 14th Finance Commission. In essence, the new framework empowers states with greater expenditure discretion for funds not tied to centrally sponsored schemes or programmes (“untied funds”), while suggesting removal of the distinction between general- and special-category states. Critically, the Finance Commission recommended that states’ share in net proceeds of tax revenues be raised to 42 per cent from 32 per cent.

This builds on the principle of decentralisation already in place in India, which is intended to give PRIs and local bureaucracies substantial independence in revenue and expenditure, greater autonomy over how to implement programmes, and more training to strengthen their capacities. Even so, it will mean that states still urgently need to to address systemic implementation gaps, with a special focus on the social sectors; this is a key challenge in many states (e.g., Uttar Pradesh, West Bengal, Tamil Nadu), where the overall administrative culture remains centralised and top-down. Maharashtra represents a notable exception, having introduced a comprehensive decentralised planning system for all 51 of its districts that projects local priorities for consolidation at higher levels; segregates district/sub-district resource envelopes and aligns activity planning with available resources; and uses customised ICT applications to improve efficiency and accountability.26

At the same time, following the Finance Commission recommendations, a major re-casting of allocations to national social sector schemes has occurred. In turn, this has included deletion of a number of schemes, reduction in total allocation of select schemes, as well as the re-formulation of state and central share requirements, noted above, in a number of schemes. Many state budgets have shown an overall decline.27 Regardless, a budgetary analysis in several states indicates that states’ public expenditures on children have increased gradually in absolute terms, although they fell in percentage terms before rising slightly in 2016-2017. Nonetheless, allocations remain low for the age group 0-6 years in particular.28 Untied funds to be transferred to local gram panchayats under the 14th Finance Commission – more than three times the previous amount – provide a special opportunity for these bodies to invest more in children, through such actions as preparing participatory Gram Panchayat Development Plans (GPDPs); Maharashtra is helping pilot such plans, which are being rolled out in more states.

27 Nonetheless, some states have benefited: For example, already the 2015-2016 social sector expenditures increased in states such as Chhatisgarh, where social sector spending rose by around 25 per cent.
28 UNICEF India, Socioeconomic Context of India (PowerPoint). New Delhi, August 2016.
An Opportunity to Enhance Budgeting for Children

With children featuring prominently across the SDG agenda, India, like other governments, will need to be increasingly concerned about the size and performance of its child-focused expenditures. However, thus far it appears that the 14th Financial Commission’s transfer of a number of major social sector programmes from national to state level is not going to be matched by an adequate increase in states’ spending capacity. This could make ongoing interventions in these sectors even more resource-constrained than what has been the case until now: The share of the child budget in the national budget has never been more than 5 per cent, and even this allocation has always been strongly tilted in favour of education schemes for children. Unless states significantly step up the priority for social sector programmes in their budgets, the total resource envelope for social sectors – and hence, for children and women – could decline.

India has had a child-focused budget analysis, called Expenditure Statement No. 22 for Children, which has been presented as part of the annual finance bill since 2008 and includes relevant spending at central and state levels. However, the criteria for including a particular programme in Expenditure Statement No. 22 is not publicly known, and no state has attempted to replicate the national-level methodology. Further, it is unclear how this information has been used and what results for children have been achieved. The budget share for children declined between 2008-2009 and 2014-2015, even though the number of Ministries included in the methodology nearly doubled. Moreover, looking at the distribution of the budget across the four main sectors in 2013-2014, child protection (0.04 per cent) and child health (0.58 per cent) received the lowest priority, a concern raised by the Committee on the Rights of the Child.

Now, however, new opportunities exist in light of the 14th Financial Commission’s decentralisation moves to better invest in children. By applying a child focus to budget processes at the state level, and asking what and how each budget scheme contributes to child-specific objectives, child focused expenditure and budget analysis can ensure due priority to existing policies for children, thus laying the foundation for ensuring that resources are adequate, well-spent and accountable.

Building on the growing body of experiences and good practices around child focused budget and expenditure analysis, proposed enhancements include (1) validating relevant schemes and estimating relevant portions; (2) mapping identified budget provisions to outcome areas (e.g., education, health, protection) or child rights themes (e.g., development, participation, survival); (3) tracking identified budget provisions throughout the budget cycle; and (4) routine analysis. This will help to apply a child-focused lens across sector and administrative boundaries to identify areas that may be “falling between the cracks,” as well as to apply a “whole child” approach, which can improve the composition of expenditures across sectors and enhance the value for money of overall public spending. Lastly, it will complement sector-based efforts by strengthening inter-sectoral allocation efficiency and coordination of public budget management. UNICEF is ready to use its convening power, deliver technical assistance, provide quality assurance, advocate around new information, and provide forums for discussing, benchmarking and motivating as Enhanced 22 is applied at national level and in different states.

Other policy changes have included the introduction of a number of initiatives, policies and schemes by the Government that are driving growth and poverty reduction, and that have strong potential to rapidly affect child well-being. They may lend increasing dynamism to positive governance trends for children and women, if they are implemented with greater urgency and supported by appropriate levels of human and financial resources.

Recent Government measures include: Swacch Bharat Abhiyan, which gives high priority to sanitation and building of toilets, for schools and households; Beti Bachao Beti Padhao, aimed at reducing gender-biased sex selection; National Health Mission and a new National Health Policy; Skills India Mission, which is working to equip 500 million less privileged youth with modern economy skills; Make in India; Mission Indrahanush, focused on reaching non-immunised/partially immunised children; and Smart Cities Mission. These are complemented by a focus on development in the seven states of the North East, most of which are conflict-affected (see also Chapter 3.4); the Digital India campaign, which aims to make Government services available to all citizens online, and to make at least one person in every family digitally literate within five years; and many more.

These initiatives are over and above existing flagship schemes such as the Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA); Integrated Child Development Scheme (ICDS), for nutrition and child development; the newly renamed Child Protection Services (CPS), focused on strengthening the system for children in need of care and protection and children in conflict or contact with the law; Sarva Shiksha Abhiyan (SSA), to achieve universal elementary education (Grades 1-8); Janani Suaksha Yojana (JSY), for safe motherhood; Mid Day Meal (MDM); and National Rural Drinking Water Programme, among others.

From Highly Challenged to “Learning Labs” for Child Rights
Policy changes and new initiatives notwithstanding, states still find themselves at different levels of effective governance for child rights. For example, Kerala – a potential “learning lab” for other states – has devolved powers to its local self-governments and shows very high utilisation of central Government funds, while also ranking high in social sector expenditures. Notably, it has made significant progress in implementation of CRC, CEDAW and CRPD, through the setting up of relevant apex institutions and a Child Rights Observatory. Tamil Nadu, meanwhile, has active civil society networks and hundreds of civil society organisations (CSOs) that monitor, promote and advocate child rights as mandated under the CRC; the state’s child participation forum prepared a “child election manifesto” for all political parties before state assembly elections in 2016, while the state child protection forum presented a “charter of demands” to the new state government.

Yet some of India’s most challenged states (e.g., Bihar) have been hard-pressed to close the equity gap, lacking basic infrastructure; expanded non-agricultural livelihoods; improved educational, health and social protection achievements; sufficient trained human resources; strong public service delivery mechanisms; and enhanced resilience to recurrent disasters. In West Bengal, schemes under national flagship programmes are not always linked to deprivations faced by vulnerable children and women, particularly in areas such as tea gardens, riverine islands, mining regions or enclave areas, as well as in districts with high concentrations of tribal populations or Muslims. Similarly, in Nagaland, the state has initiated few interventions to address child rights; the State Commission for Protection of Child Rights faces acute challenges in terms of resources, even for basic administrative purposes.

Different states also manifest different development priorities, again highlighting the need for a contextualised approach to issues regarding children and women. More developed states such as Kerala and Tamil Nadu are focusing on “second-generation” child rights issues (e.g., child drug abuse/alcoholism; an increasing share of the private sector in education and health, with resultant quality issues; very high proportion of deliveries by cesarean section, which has important health implications for women; increasing number of crimes against children, including cybercrime and
Moving Forward
Moving forward, to ensure more effective governance for the most vulnerable and disadvantaged children, adolescents and women, it will be critical to see that institutional capacities are improved by creating appropriate organisational structures, attracting the right talent, and streamlining processes. In so doing, priority will need to be given to:

- Supporting a framework that clearly configures institutional performance, including roles and responsibilities, and that ensures performance management
- Empowering institutions for high-profile initiatives, giving them operational flexibility but holding them accountable for outcomes, and prioritising policy alignment
- Advocating for full recognition and inclusion of children and adolescents in the policy discourse
- Mainstreaming gender equality, environmental sustainability and DRR, among other crosscutting issues
- Implementing a robust anti-corruption framework and enhancing public transparency
- Simplifying laws while also building legal/judicial capacity to ensure that citizens can more fully claim their rights

Special attention will need to be given to furthering decentralisation and devolution of power, particularly to capacity building of PRI members, strengthening of district planning/monitoring systems, building of evidence on social exclusion, and strengthening of investments in the most marginalised groups/areas. This will need to be complemented by adoption of a risk-informed approach, whereby the adverse effects of natural and manmade hazards – both current and expected due to climate change – are systematically assessed, monitored and addressed through DRR approaches to minimise their impact on children, adolescents, women, and the social infrastructure catering for them.

Other promising strategies include forming partnerships with the private and social sectors (see also Chapter 9), mobilising community participation, and using technology to streamline and monitor operations. In so doing, India can begin to provide the astute responses to power, autonomy, relationships and associated sensitivities that are necessary to make Government decisions more rights-based and equity-driven on behalf of children, adolescents and women.

2.3 Key Socioeconomic Development Trends and Demographic Profiles
India has been classified as a lower-middle-income country for nearly a decade, and may become among the world’s largest economies by 2050. Its real GDP grew by 7.6 per cent in 2015, slightly less

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29 McKinsey, Job and Growth, op.cit.
than the annual average of 7.7 per cent recorded in the previous decade. National GDP has grown from US$0.9 trillion in 2006 to US$2.1 trillion in 2014, and Gross National Income (GNI) per capita has doubled, from US$810 in 2006 to US$1,570 in 2014.

Although India is the fastest-growing large economy in the world, human development remains low, with the country ranked 130th out of 188 countries in the UNDP Human Development Index (HDI) 2015 and a score of 0.609. This categorises it as a medium human development country, but India’s score was lower than the average for this category (0.63), and lower than scores for countries with less developed economies and smaller GNI per capita, including Uzbekistan and Viet Nam. Moreover, improvement in India’s human development score appears to have stalled since 2010. The World Bank declares that India has not reduced poverty as quickly as other middle-income economies, even though the country’s pace of poverty reduction between 2005 and 2012 was three times higher than between 1994 and 2005. India also ranks 130th out of 188 countries in the Gender Inequality Index, driven by a Maternal Mortality Ratio, female labour force participation rate, and percentage of girls with secondary education that are all lower than average for middle-income countries.

India’s total population now stands at about 1.2 billion, according to the 2011 Census, with 37 per cent (444 million) younger than age 18 and another 48 million aged 18-19 years. Notably, around a quarter (21%) of the country’s people are adolescents aged 10-19 years. India is thus home to the largest number of children and adolescents in the world, with about half of these belonging to disadvantaged groups such as Scheduled Castes (SCs), Scheduled Tribes (STs) and other minorities. About two-thirds of people live in rural areas, and nearly half still make a living from low-productivity agriculture.

In all, the population is going through fundamental demographic changes: Over the coming decades, birth rates are expected to continue to drop and young people aged 10-24 will constitute the largest section of the population. In addition, over the coming 10 years, the working-age population (aged 15-65) is expected to rise by 125 million, giving India the biggest potential workforce in the world; already, this workforce is the youngest globally. To capitalise fully on the demographic dividend, focused investments will urgently be needed for the country’s youthful age groups, particularly adolescents (see also Section 3.2).

Persistence of Poverty and Inequality

However, while hundreds of millions of Indians, including children and women, have exited extreme poverty, their lives still are marked by a continuous struggle to achieve dignity, comfort and security. India remains home to a significant number of poor people, including 30 per cent (179.6 million) of the world’s extremely poor, who live on US$1.90 a day or less. This reflects the fact that 21 per cent of India’s own population is extremely poor and 58 per cent are poor (living on US$3.10 a day or less). According to World Bank global estimates, 1 in 3 of these poor or extremely poor people are likely to be children, many of whom may be locked into an inter-generational poverty trap if not proper

33 World Bank, Rural Population (% of Total Population), n.d.
educated, physically cared for and, ultimately, employed in the workforce. In contrast, just 1 in 5 of the global non-poor are children, based on the same calculations.

In particular, children from urban poor families, adolescent girls and tribal children suffer from multiple deprivations related to poverty, infant mortality, early marriage, attendance rate in lower secondary and upper secondary education, open defecation, and access to drinking water. Just eight states (Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh) comprise a significant proportion of the national burden in relation to most core development indicators for children, adolescents and women; they also represent 48 per cent of the total population, about 11 per cent of the tribal population, 63 per cent of children younger than age 5, 55 per cent of children younger than 18, and 43 per cent of women aged 15-49.

India’s overall Gini coefficient, at 0.36, remains significantly below that of the world’s most economically unequal countries, according to World Bank estimates. Yet critically, India’s combination of high growth and low human development has triggered a rise in inequality, which has widened faster in India’s cities, where the richest and best-educated tend to live side by side with some of India’s poorest and most vulnerable people. The wealth share of India’s richest 10 per cent is now 370 times that of the poorest 10 per cent, according to one 2014 report. Indicating the criticality of the social protection system and its capacity to provide needs-based responses, very large numbers of children, adolescents and women in marginalised communities are vulnerable to adverse impacts of disasters: About 215 million Indians (43 million households) have no assets; of these, 80 million (16 million households) are tribal households.

In terms of gender, in spite of powerful Indian women voices across the world in diverse fields of work, women and girls in India do not enjoy many of their rights and continue to labour under deeply held notions of (lesser) female value and power. Key manifestations of this include:

- The number of girls per 1,000 boys in the 0-6 age group has declined from 927 in 2001 to 919 in 2011.
- 75 per cent of rural women are engaged in agricultural production, but only 9 per cent own land.
- 39 per cent of men and women think that it is sometimes or always justifiable for a man to beat his wife.
- 56 per cent of 15- to 19-year-old girls are anaemic (compared to 30 per cent of boys), contributing significantly to low Body Mass Index and higher-risk pregnancies and childbirth.
- In 2014, 30 per cent of 20- to 24-year-old women were married before age 18 (down from 47 per cent in 2006).

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38 Census 2011.
India is one of only seven “middle development” countries in the world – and the only one in Asia – that has a rate of more than 20 per cent of women giving birth before age 18 (22 per cent). Chapters 4-8 provide a more detailed picture of sectoral progress and challenges with regard to the status of children and women. While significant progress has occurred in nearly all development areas and will be examined in these chapters, a brief synopsis indicates that the scale of the continuing challenges remains daunting:

- Some 3,600 children in India die every day, with most of these children dying from preventable causes and treatable diseases.
- An estimated 15 per cent of children younger than age 5 in India are wasted, 29 per cent are underweight and 39 per cent are stunted, as noted above, according to the RSOC 2013-14. In absolute numbers, this translates into 17 million wasted, 33 million underweight, and 44 million stunted children, as per the Census 2011.
- While about 91 per cent of households have access to an improved source of drinking water, only slightly more than 40 per cent of people use improved sanitation. About 564 million people in the country (59 per cent) continue to practice open defecation.
- India also lags in attempts to universalise primary education, as Gross and Net Enrolment Ratios show, with enrolment at secondary level rising more slowly. Indicating serious issues with quality of education, average achievement scores of Class V students have declined in all subjects between Cycle 3 of the National Assessment Survey, in 2011, and Cycle 4 in 2014. Further, average achievement scores of Scheduled Caste and Scheduled Tribe students in 2015 were below that of students from other social categories.
- Every fifth student drops out at primary level, rising to every third student at upper elementary level and every second student at secondary level. An estimated 6.1 million children aged 6-13 are out of school. Nearly 1 in 4 adult Indians (287 million) are still illiterate, and 50 per cent have not studied beyond middle school.
- Nearly 1 in 3 currently married women were married when they were younger than age 18, according to the Census 2011.

Patterns of Deprivation and Labour Informality

Many of these challenges stem from structural characteristics of India’s society and economy. Leading among these are deeply entrenched caste and social hierarchies and gender disparities, combined with India’s continued struggle to provide essential public services to all (see below as well as Section 2.2); geographical inequalities; agriculture’s continued dominance in employment; and high levels of illiteracy, among others. For example, 43 per cent of the ST population is poor, compared to one-fifth of other rural communities. Even in comparatively richer states, some districts may have high concentrations of the poor: For example, Dangs, India’s poorest district – with 88.4 per cent of its population below the poverty line – is in economically vibrant Gujarat. Moreover, in school only 68 per cent of SC children successfully complete Class X, compared to the national average of 87 per cent.

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50 Social and Rural Research Institute and EdCIL India Ltd. *All India Survey of Out of School Children of Age 6-13 Years and Age 5*. New Delhi, 2010.
51 Census 2011, op.cit.
At the same time, a major challenge is to bring at least some of the 93 per cent of the workforce that works in small, informal-sector enterprises into the formal sector; this comprises 475 million people, particularly women, including 250 million people in the low-productivity agricultural sector. Just 57 per cent of India’s working-age population participates in the labour force, well below the norm of 65 to 70 per cent in other developing countries. A key issue for Indian growth is the low rate of female labour force participation, which at about 22 per cent is significantly lower than the global average of about 50 per cent. Even among those who have joined the workforce, however, skilling requires significant strengthening; more than 3 in 4 of India’s workers have received no formal skills training, compared to 96 per cent of workers in the Republic of Korea, 80 per cent in Japan, 75 per cent in Germany, 68 per cent in the United Kingdom and 52 per cent in the United States who have benefited from such training.53

In particular, today there are too few decent work opportunities outside the agricultural sector, a factor that limits the economic opportunities available, especially for women. Poorly educated or illiterate, many of these agricultural workers do not have the skills to find jobs in India’s more lucrative sectors. It will be critical to equip India’s children and adolescents with a basic high school education in the future, as well as marketable modern-economy skills, given that young workers unable to meet the more demanding standards of tomorrow, particularly rural adolescents, are likely to be economically marginalised.

In all, the overwhelming informality of India’s labour force is a disadvantage for most of its children and adolescents: First, their lives are more financially precarious by their parents’ inability to draw on the health and insurance benefits of formal-sector employment. Second, informality tends to encourage children participating in work, resulting in children working alongside their parents, sometimes in very harsh conditions; according to the 2011 Census, 4.35 million of India’s children aged 5-14 worked as child labourers.

Overall, 56 per cent of India’s population still lacks the means to meet their essential needs.54 By this measure, some 680 million Indians are deprived – more than 2.5 times the population of 270 million below the official poverty line.55 A total of 171 million urban residents (44 per cent of the urban population) are below this “empowerment line,” compared with 509 million rural residents (61 per cent of the rural population). The “empowerment gap,” or the difference between each person’s current consumption and the levels called for in the empowerment line, amounts to about US$69 billion per year, or 4 per cent of GDP, seven times larger than the US$10 billion poverty gap.56

Yet patterns of deprivation are more complex and multidimensional than what is implied by income or consumption measures alone. About 46 per cent of basic services are not within reach for the average household, it has been found. People living in the most deprived districts may lack access to almost 60 per cent of basic services, while even in the least deprived districts, residents lack access to

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54 The costs of eight basic household needs (food, energy, housing, drinking water, sanitation, health care, education and social security), estimated at a level sufficient to achieve a decent, if modest, standard of living rather than just bare subsistence.
55 McKinsey, Jobs and Growth, op.cit. Some 57 million Indians are classified as excluded (poorest of the poor), unable to afford minimal food, shelter and fuel. An additional 210 million are impoverished, with consumption above bare subsistence levels but still below the official poverty line. Just above the official poverty line, some 413 million Indians are vulnerable, with only a tenuous grip on a better standard of living; shocks such as a lost job or a bout of illness can easily push them back into extreme poverty. The needs of all three segments are critical to address.
56 Ibid.
about 34 per cent of services. Even for households of similar income levels, the actual experience of poverty varies dramatically based on where they live. The availability of well-run social infrastructure and free or low-cost services in the vicinity of the poor is thus a crucial determinant of quality of life.57

The Central Role of Social Norms, and a Look Ahead
Critically, in India there exist many contrasting norms about what is socially acceptable and what is not. Perhaps the most prevalent norms are those associated with caste. Caste-based discrimination and associated prejudices represent a major underlying cause for inequity; in several states, caste and caste-based feelings have re-emerged recently, with early marriage to prevent inter-caste consensual marriage, wearing of caste bands, “honour killings,” and suicides on the rise, particularly in SC and Other Backward Caste (OBC) areas.

Another of the most pervasive norms slowing human development in the country continues to be found in widespread gender discrimination (see also Section 3.7). Just 66 per cent of Indian women are literate, and Indian girls are sent to school for just 3.6 years on average, half that for boys. More than 2 in 3 rural girls and nearly 1 in 3 urban girls are married by age 18, and the median age at first pregnancy is 20.8.58 In addition to the strong patriarchal attitudes that persist, matriarchal dynamics also may reinforce these attitudes, with the strong role of respect for mothers and mothers-in-law often perpetuating social norms such as preference to boys, and with harmful gender norms imposed on all household members. In particular, this relationship bears further examination to be leveraged as an entry point to address positive social change.

Several different rules may exist even within a community or a region to deal with norms of marriage, education, business dealings and other social factors. What one community considers a sign of strength and health, another may view as a mark of weakness and indulgence: For example, the social practice of valakappu, which signifies care and nutritious food for pregnant women in Tamil Nadu, is observed in some communities/regions but not in others.

Skills, knowledge and attitudes of parents are critical in perpetuating positive or negative social norms among children and adolescents. More broadly, across the country challenges particularly exist to convert negative social norms, like marrying a girl before she is 18 years old, into a positive norm of educating girls and boys equally for productive careers.

Yet despite all these challenges, India is projected to grow robustly in the coming decade, lifting more children and their families – up to 148 million households59 – into the middle class. Three-fourths of the potential impact of empowerment will come from non-farm job creation, particularly in manufacturing, construction and labour-intensive services (tourism/hospitality, retail trade, transportation), as well as from more innovative delivery of social programmes at both central and state levels. Notably, about 50 per cent of public social spending will be needed for health care, water and sanitation alone, up from 20 per cent currently.60

Also in barely a decade, 475 million Indians should have a daily earning of between US$10 and US$100, up from some 100 million currently; this should significantly raising expenditures on education, health care and food. Further, hundreds of millions of workers could receive formal skills training, even as

57 Ibid.
58 RSOC, op.cit.
60 McKinsey, Jobs and Growth, op.cit.
low learning outcomes could persist, slowing the move to higher-paying, more productive occupations.\textsuperscript{61}

Thus, by 2030, most of India’s children and adolescents should be economically much better off than they are today, as a result of rising per-capita incomes, expanded school and university education, continued progress in battling childhood diseases, and still-growing maternal literacy. In fact, India’s growing cohort of educated women represents perhaps the country’s most potent force for radically enhancing child well-being by 2030, with decades of research reporting that the children of better-educated parents do significantly better in school. Nonetheless, despite an expected steady decline in extreme poverty, vulnerability to poverty will remain high, and the challenges considerable.

Chapter 3: Key Crosscutting Development Issues Affecting Children, Adolescents and Women in India

3.1 Early Childhood Development
The SDGs strongly reflect Early Childhood Development (ECD)\textsuperscript{62} within their framework, marking a critical step forward from the MDGs, and pointing to the recognition of the vital importance of ECD in driving the new global development agenda. In addition, many of the 54 Articles of the CRC are as relevant to young children aged 0-8 as they are to older children. Evidence shows that brain development is most rapid and sensitive in these early years, affecting children’s physical and emotional well-being and learning, as well as success in their later lives, in school, in work, and in their communities. One SDG target specifically focuses on ECD (Target 4.2), although ECD connects with several other Goals as well.

Interventions in the early years for optimal ECD requires that children have access to: (1) appropriate, affordable, diverse and nutrient-rich food; (2) appropriate maternal and child care; (3) a safe, stable, nurturing, gender-responsive environment and opportunities to learn\textsuperscript{63} and play; and (4) adequate health services and a healthy environment, including safe water, sanitation and good hygiene. Thus, dietary deficiencies, inadequate feeding practices, chronic infections, exposure to violence, and low levels of stimulation during this period all jeopardise a child’s chance to reach her or his full potential (see also Chapters 4-8).

New research indicates that a child’s social environment is as important as genetics in influencing how s/he develops into an adult. Therefore, good parenting, strong families, and enriching, nurturing environments with positive social norms are critical to a child’s early development. Interventions in the early years compensate for early disadvantage, and are therefore critical from an equity perspective.\textsuperscript{64} Available cost-benefit ratios indicate that for every dollar spent on improving ECD,

\textsuperscript{61} EY. Hitting the Sweet Spot: The Growth of the Middle Class in Emerging Markets, n.d.

\textsuperscript{62} Early Childhood Development (ECD) refers both to (1) an outcome defining a child’s status – being physically healthy, mentally alert, emotionally sound, socially competent and ready to learn; and (2) a process – comprehensive and intertwined interventions achieving the outcome. (From UNICEF Policy and Programming Approach to ECD, UNICEF Headquarters, New York, January 2012.) The term Early Childhood Care and Education (ECCE), used in India, is equivalent to international terms such as ECD or Early Childhood Care and Development (ECCD).

\textsuperscript{63} Emerging findings from the five-year Indian Early Childhood Education Impact study, tracking 12,000 students and set for completion in 2016, clearly show a link between quality preschool education and learning in the early primary school years.

\textsuperscript{64} UNICEF India. ECD Roundtable Discussion Paper. New Delhi, June 2016.
returns can be on average 4 to 5 times the amount invested, and in some cases much higher. Much depends on the care and stimulation children receive in their earliest years (ages 0-3 years) and, subsequently, how well they start their education, along with how prepared they are for school.

In India, the population of children younger than 6 years is 139 million, according to the Census 2011, of which 74 million are aged 3-6 years, down from 77 million in 2001. Those in the 0-8 age group comprise close to 18 per cent of the population (113 million boys, 104 million girls). Overall, families have a huge unmet need for daycare/crèche facilities for their young children, both in urban and rural areas. This unmet need results in inadequate care of children and curtailed productive work opportunities for women, who continue to be almost exclusively responsible for caregiving. In recognition of this, the restructured ICDS includes a provision for expanding Anganwadi Centres into crèches.

**Development Constraints for Children Aged 0-3 Years, and 20 Million Not in Preschool**

Nonetheless, in India greater attention is still required for this critical period of the life cycle. Numerous health indicators remain sobering for children younger than age 3 years. India’s 696,000 neonatal deaths annually are the highest in the world and excess under-5 female mortality continues. A total of 39 per cent of children under 5 are stunted (see also Chapter 4). Many children are born early, with India having the highest number of preterm babies (3.5 million). Babies born preterm have the highest risk of birth defects, which exacerbate developmental delays, many of which lead to highly debilitating and incurable disabilities; the incidence of overt developmental delays in the country is 1.5 to 2 per cent of children younger than age 2 years, increasing to 10 per cent in the early childhood years. Other trends among young children are equally worrisome. Although early initiation of breastfeeding improved from 24.5 to 44.6 per cent between 2006 and 2014, more than half of infants in 2014 still were not initiated to breastfeeding within 1 hour of birth (see also Chapter 5).

Close to a third of children aged 3-6 years (20 million children) were not attending preschool education in 2014, with children who are Muslim, who are from the poorest families, and who live in rural areas the most left behind (see also Chapter 7). In addition to these disparities, geography matters in terms of ECE. In some states, more than 40 per cent of children were not attending preschool in 2014: Nagaland (80 per cent), Meghalaya (57 per cent), Uttar Pradesh (56 per cent), Rajasthan (46 per cent) and Bihar (40 per cent).

New research findings also indicate critical gaps in the quality of current ECE programmes, both with respect to Government-run Anganwadi Centres and private preschools, with low school readiness levels in children, particularly cognitive and language skills required for school. Evidence further points to gender differences in preschool/primary school participation trends among children aged 4-7, with a higher proportion of boys in private institutions and a higher proportion of girls in Government institutions.

Key factors that contribute to good-quality ECE that are lacking in most cases include basic infrastructure, appropriate learning materials and, critically, well-qualified teachers provided with continuous training and supportive supervision. In addition, no accreditation or regulatory framework is in place for the enforcement of quality standards in preschool institutions. This is an issue of particular concern given that private provision of preschool education is on the rise; data from the

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65 In the context of India’s National ECCE Policy 2013, the period of early childhood covers ages 0-6. In the context of the Situation Analysis, however, ECD is looked at as the period covering ages 0-8, as defined by the CRC and its General Comment 7, and organisationally by UNICEF.


68 ECD Roundtable Discussion Paper, op.cit.
landmark Indian Early Childhood Education Impact (IECEI) study 2011-2016 also indicate that these institutions in many cases are teaching developmentally inappropriate content to young children, with underqualified/untrained teachers.

Lastly, for children, exposure to violence in the early years of their lives leads to long-term impacts on behaviour and learning outcomes. Many women experience domestic and intimate partner violence from their husbands, but also from the family of their husband. Caregiving and household work are seen as women’s work, perpetuating unequal decision making, resource allocation and income earning, and setting negative gender-norm examples for children. (see also Section 3.7 and Chapter 8). A need exists to involve fathers in positive interventions for young children and emphasise their caregiving functions.

In 2013, the Government of India adopted the National Early Childhood Care and Education (ECCE) Policy, a significant achievement recognising the importance of investing in ECD and its impact on both lifelong development as well as on breaking the inter-generational cycle of inequity and disadvantage. It calls for a comprehensive approach for the survival, growth and development of the child, with a focus on care and early learning.69

The Policy also stipulates that a National ECCE Council be formed, with corresponding state councils to be established as well. The Council has been notified but not yet met, although some state councils (Bihar, Gujarat, Jammu and Kashmir, Madhya Pradesh, West Bengal) have been established and are functional. A National ECCE Curriculum Framework and Quality Standards accompany the Policy, and stakeholders from different sectors have initiated the development of Early Learning and Development Standards (ELDS) for children aged 0-8; the standards have been drafted and are in the process of being piloted and validated. While the National ECCE Policy calls for mother tongue-based instruction with exposure to other languages, no specific national policy exists on language-related issues in pre-primary and the early primary grades. Therefore, children may be taught in a different language than their home language, which can affect their learning (see also Chapter 7).

The main delivery platform for ECD services is the Government’s ICDS programme and the National Health Mission (NHM). However, past evaluations of ICDS, which covers around 36.5 million children through a network of almost 1.3 million Anganwadi Centres, have indicated that the ECE component is the programme’s weakest, such that strengthening of this aspect remains crucial (see also Chapter 7). In addition, various schemes and programmes exist such as the Rajiv Gandhi National Crèche Scheme for the young children of working mothers.

At the same time, the diverse group of children aged 0-8 years falls under different Ministries and departments. Lines of accountability are not entirely clear and still need to be addressed by policymakers. While pre-primary education generally falls under MWCD, for example, the Ministry of Human Resources Development is responsible for education from Class I,70 and the Ministry of Health and Family Welfare is responsible for maternal and child health, as well as aspects of nutrition and the Rashtriya Bal Swasthya Karyakram (RBSK) programme, conceived as a systematic approach to child health screening and early intervention. ICDS has traditionally focused on nutrition and, as noted above, requires strengthened capacities for preparing children for school.

Moving Forward

69 An August 2015 report by the Law Commission of India notes, however, that the legal and constitutional rights framework in the country does not sufficiently prioritise the rights of young children and ECD. The Commission recommends that legal entitlements be created for children aged 0-6.
70 MWCD up to age 6 and MHRD from 6+ years. However, since education is a concurrent subject, states like Assam and Jammu and Kashmir have opted to provide one year of preschool in primary schools.
Moving forward, it will be useful to focus on the following key areas to ensure that ECD is central to the agenda for child rights in India (see also Chapters 5 and 7):

- Promoting coordination among the many different actors in the field of ECD. This is important in supporting children’s holistic development, with respect to their health, nutrition, education and protection. For education, inter-Ministerial and -departmental coordination is critical to ensure the smooth transition of children from preschool to primary school, with curricula and pedagogy that are continuous and seamless between the two levels of education. Coordination also is important with respect to early detection and intervention, as well as for ensuring the rights of children with disabilities.

- For children aged 0-3, focusing more clearly on development, in addition to survival and growth, looking at promoting early stimulation, and providing a nurturing, safe and learning environment for children at home. Till now, programmes and initiatives have been focused primarily on survival and growth in relation to children under 3, although more needs to be done to address the lower survival of girls under 5) while there has been with less emphasis on care and development despite growing evidence showing that stimulation and care at this stage of life is critical. This is also a window in which to address gender socialisation and to work with parents in this regard, including on better parenting techniques such as early stimulation, positive interactions, and facilitating security and learning for young children. Following early detection of developmental delays or disabilities, children need the appropriate interventions, services and care during their early years through the RBSK programme and on into inclusive preschool programmes and primary schools. This will require strengthened collaboration and coordination among the health, nutrition and education sectors.

- Likewise, more effective monitoring of outcomes with regard to ECD is needed. The ICDS Management Information System (MIS) requires strengthening, as well as linkages with data systems in the health and education sectors, to obtain data on key indicators covering children aged 0-8. This also is necessary to ensure that ECD-related SDG commitments are fulfilled.

- Lastly, building capacity of ICDS officials, supervisors and Anganwadi workers on ECD, particularly with regard to early stimulation and Early Childhood Education. Capacity building efforts can focus on parental education with regard to caring practices, early stimulation and providing a learning environment for children. With regard to ECE programmes, the focus could be on strengthening curricula and training in line with the ELDS, building in supportive supervision and ensuring the quality of training as it cascades down to Anganwadi workers. Lessons learned from initiatives to strengthen the capacity of mid-level managers in ICDS can also be built upon to ensure the capacity needed at that level to support Anganwadi workers in their roles.

### 3.2 Adolescent Empowerment and Participation

From a development perspective, the second decade of life is a critical opportunity to break the inter-generational cycle of multiple deprivations in a much shorter time frame than that required for the first decade, which entails a much longer perspective. Adolescents have the potential to become change makers, not just passive beneficiaries. They can contribute to eliminating society’s greatest challenges: explosive urbanisation and migration, continued gender-based discrimination and violence, HIV and AIDS, economic turmoil, climate change and disaster, and humanitarian crises of increasing frequency and severity.

The Mid Term Review of the Country Programme of Cooperation recommended increasing engagement of adolescent girls and boys alike, in terms of empowerment and quality education/life skills, to ensure their full participation in social transformation. This also was particularly aimed at capitalising on the central Government’s large-scale initiatives to address gender inequalities (see also Section 3.7). In turn, this age group is expected to contribute to sustainable impacts on children’s and women’s health, nutrition and overall well-being as rights holders.
A Critical Population Group for India

India now has the largest adolescent population in the world, with this age group (10-19 years) constituting about one-fifth (253 million) of the Indian population. Of these, 120 million are girls; however, the sex ratio at adolescence stands at only 858 girls per 1,000 boys, according to an analysis of Census 2011 data, down from 918 at birth and indicating a substantial number of “missing girls.” Among states, Uttar Pradesh has the largest population of adolescents, accounting for 19.3 per cent of total adolescents (48.9 million). Along with Bihar (9.2 percent), Maharashtra (8.4 per cent), West Bengal (7.2 per cent) and Andhra Pradesh (6.4 per cent), these states account for nearly half of the total adolescents in India. By location and social groups, 181 million (72 per cent) of adolescents live in rural areas. About 17 per cent (44 million) belong to Scheduled Castes, while 9 per cent (23 million) belong to Scheduled Tribes.

Some key indicators for adolescents have strongly improved, such as literacy rates, which rose from 76.2 per cent to 91.7 per cent among males between 1991 and 2011, and from 57.6 per cent to 88.2 per cent among females over the same period. Worryingly, however, the school dropout rate among adolescents is as high as 53 per cent; it is highest among STs, at 75.2 per cent (see also Section 3.3). Moreover, data show that boys, especially Muslim boys, are dropping out more than girls in states such as West Bengal and Assam; this trend can be attributed in part to higher overall net attendance for boys than girls in rural and urban areas among children aged 6-10 years, and in rural areas for children aged 11-13. In turn, enormous gaps exist in education, skills and job opportunities, and the most deprived young people continue to work in exploitative and poorly paid jobs.

Despite representing a large proportion of the population, adolescent girls and boys are widely excluded from decisions that affect them, have limited access to information on issues affecting their lives, and have limited spaces and opportunities to acquire and share knowledge and to participate actively in decision making processes. Thus, adolescents and their needs are largely invisible, although five states now have introduced government guidelines regarding adolescent participation in community platforms. State consultations have been complemented at district level by coordination and convergence on adolescents, and at village/block level by the formation of adolescent groups, parent groups and community mobilisation.

Special Focus Needed on Young Adolescents Aged 10-14 Years

Investing in adolescents is crucial to build upon the historic gains achieved for children in early (0-4 years) and middle (5-9 years) childhood and to ensure a prosperous, more equitable future for them as individuals. At the same time, adolescents are a very diverse group, so effective development responses need to be contextualised. Critically, young adolescents aged 10-14 are especially invisible in discourse and data, falling between policies and programmes focused on children and on youth.

In India, few or no data are available on the current status or levels of information or knowledge on different issues among 10- to 14-year-olds. Yet for some young people, this may be the last chance to protect them from dangers in their environment, and to address issues that are developing that will affect their whole lives, particularly in the case of young adolescents who are out of school and

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71 UNICEF India. Adolescent Equity Profile. New Delhi, 2016.
73 Ibid.
74 Adolescent Roundtable Discussion Paper, op.cit.
75 Census 2011, op.cit.
77 UNICEF MTR, op.cit.
who lack the support of two parents at home. They may feel impelled to test limits and to take risks, without understanding the possible effects; the frontal lobe of the brain that governs reasoning is not fully developed in young adolescents, particularly in boys, resulting in marked impulsivity. Early matures of either sex are at extra risk.

Because many 10- to 14-year-olds still aspire to the values of parents and caregivers as role models, the best protection from risk is provided by parents who are closely involved with their children’s lives, who set expectations and limits, and who encourage their children to think for themselves. Other adults, relatives, teachers, religious teachers and club leaders can help by monitoring and supervising the activities of young people.

Ensuring an environment of support and protection for young adolescents is vital. Taking a prevention approach, and developing skills and competencies at this age, potentially reduces the need to focus on issues and harm reduction among older adolescents, whose attitudes and belief patterns are more firmly set. For example, a programme for 10- to 14-year-olds that could influence depression and poor mental health, help young people to become more aware of significant health risks, and to acquire the life skills to avoid them, would address a significant proportion of the top 10 causes of death and disability-adjusted lost years in the 15- to 19-year-old range. Programmes also are needed to ensure that 10- to 14-year-olds have access to adequate sport and leisure facilities, which again strengthens the community environment in which young adolescents grow.


Facing a Plethora of Challenges

Overall, the development challenges specific to adolescents remain considerable (see Chapters 4-8 for further details). For example, the percentage of children of school-going age enrolled in school drops significantly between lower secondary and upper secondary levels. Many girls drop out of school before reaching Class X, often because they are married or are held responsible for care work in the household (sibling care, cooking, cleaning, fetching water, household farming), as well as because of distance from school and lack of adequate sanitation facilities at school. Girls and boys often drop out to be employed in labour (family and external), and many parents do not see the relevance of education for employment and employability. Opportunities for non-formal education and vocational training are limited.

In particular, in India girls and boys also experience adolescence differently. While boys tend to experience greater freedom, girls face extensive limitations on their ability to move freely and to make decisions affecting their work, education, marriage and social relationships. In addition, adolescent girls are much less likely to be engaged in economic activities than adolescent boys, although even so, by ages 15-19, 25 per cent of girls are measured to be economically active, but this does not include the unpaid care work noted above. Girls are also at high risk of early marriage; trafficking, including sex trafficking; sexual and other abuse within the natal home and the home of the husband; and gender-based violence, further reducing their mobility.

Nearly 1 in 3 adolescent girls aged 15-19 are currently married, compared to 1 in 20 boys of the same age, according to the Census 2011. Girls from poorer families, from Scheduled Castes and Scheduled Tribes, and with lower education are more likely to be married at a younger age. Married girls are not only at risk of school dropout, as noted above, but also repeated childbearing with its inherent health

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78 UNICEF India. Adolescent Roundtable Discussion Paper. New Delhi, June 2016. Just 16 per cent of 15- to 19-year-old girls are able to move outside their community. Millions of adolescents, particularly girls, also do not have access to ICTs, which further marginalises them.
risks, HIV, and domestic violence. As many as 1 in 5 girls aged 15-19 years experiences physical violence, and 5 per cent are victims of sexual violence.

Early marriage and pregnancy is not only a rights issue for girls, preventing them from having agency over their lives, it is also a health issue. Further, these are major factors contributing to India’s continued high Maternal Mortality Ratio of some 200 deaths per 100,000 live births. Almost half of all maternal deaths are reported among 15- to 24-year-olds. The proportion of women aged 15-19 who have begun childbearing is more than twice as high in rural as in urban areas (19 per cent and 9 per cent respectively). Data also shows that 12 per cent of all women aged 15-19 have already had a child, and 4 per cent were pregnant; in other words, 1 in 6 women aged 15-19 had begun childbearing.\(^{79}\)

Early, unsafe and forced initiation into sexual activities, limited knowledge about and access to contraception, lack of access to safe abortion services and exposure to sexually transmitted infections lead to and exacerbate the vulnerabilities associated with early marriage and pregnancy. Barriers at household level include lack of family support, harmful gender norms, and limited communication between parents and adolescents on sexual- and reproductive health-related matters. The health system often does not recognise the diverse needs of youth, particularly unmarried youth. Laws that aim to protect the young – including the prevention of early marriage, sexual harassment, rape, sex selection, and prohibition of dowry – frequently are not implemented to their fullest extent.\(^{80}\) In all, sexual and reproductive health rights among adolescents are rarely promoted or protected, as noted in the CRC Concluding Observations.

In terms of adolescent nutrition, close to 56 per cent of adolescent girls and 30 per cent of boys aged 15-19 years are anaemic. Moreover, 63 per cent of girls aged 10-18 years have a low Body Mass Index (BMI), at less than 18.5 kg/m\(^2\), and 44 per cent are severely thin.\(^{81}\) Such undernutrition makes adolescents vulnerable to disease and early death and contributes to low birth weight of babies born to adolescent mothers, while also increasing maternal risk of haemorrhage and sepsis during childbirth. Babies born from an adolescent mother also have a heightened risk of stunting. The impact of malnourishment on the cognitive development and academic performance of adolescents also needs more research, as does, the emerging health issue of obesity among adolescents.

A comparison of the data from the National Family Health Survey (NFHS-4) 2015-2016 and NFHS-3 in 2005-2006 shows a considerable decline in the comprehensive knowledge of HIV among young women and men in many states. Adolescent girls who are sexually active are particularly vulnerable to HIV. It is estimated that more than 35 per cent of all reported HIV incidences in India occur among young people aged 15-24, with the current prevalence among this age group estimated at 0.47 per cent,\(^{82}\) nearly twice the adult HIV prevalence in 2015.

The lives of girls and young women are considerably affected by poor access to improved sanitation, as well as by low levels of knowledge to safely manage menstruation. Nearly 55 per cent of adolescents live in households without a toilet, with health and security consequences. The vast majority of young women (85 per cent) do not use sanitary napkins during menstruation, leading to missed school days and 11 per cent suffer from sexually transmitted infections. Unhygienic practices, including poor personal hygiene and use of unsanitary menstrual absorbents, lead to increased risk of infection and chronic reproductive health problems.

Substance misuse also is an area of growing concern. Tobacco consumption is widely prevalent among young people in India, particularly boys, with a direct impact on their health. Adolescence and early


\(^{81}\) RSOC, op.cit.

\(^{82}\) [www.unaids.org.in](http://www.unaids.org.in)
adulthood are the most susceptible periods for initiation of tobacco use, and a majority of tobacco users’ start before they are 18, with some starting as young as 10 years of age. Tobacco use also appears to be the first step in the path to other addictions. Several studies document use of other addictive substances among adolescents in school, out of school and those living on the streets. Substances used range from inhalants (petrol, glue, correction fluids) to oral ingestion or injection of non-prescription drugs (painkillers, cough syrups).

Few studies examine alcohol use among Indian adolescents, while cocaine use appears limited to higher socioeconomic groups.\(^{83}\) The projected number of drug abusers in India is about 3 million, with most in the age group 16-35, although data are very old.\(^{84}\) Nearly 11 percent were introduced to cannabis before age 15, and about 26 per cent between ages 16-20. However, there exist no sensitisation programmes about drug abuse in schools or for children out of school. India also does not have a substance abuse policy, with very few or no health centres that deal with child substance abuse issues, especially in rural areas.

In addition, about 37 per cent of adolescents in India live in high climate and hazard risk zones. Recurrent floods in several states – Assam, Bihar and others – often limit access to schools and health facilities for extended periods (e.g., several weeks) every year. Adolescents may also be forced to miss or drop out of school as a result of destruction of schools or due to the need to help their families recover from extreme events (see also Section 3.6). Resource scarcity also increases the possibility of internal and regional conflicts. Some 14 million adolescents live in civil strife-affected areas, not including Jammu and Kashmir (see also Section 3.4); in such areas, facilities may be damaged or co-opted by armed groups or the Government.

A Wide Range of Programmes Available, but Weak Budgeting
A roundtable on adolescents in June 2016 found that the Government, non-Government organisations (NGOs) and international agencies support a wide range of programmes for adolescent girls and, to a far lesser extent, adolescent boys. Government programmes, systems and services for adolescents also include scholarships, apprenticeships, cash transfers and the national skills development programme. Most important, India has a rather comprehensive legal framework addressing rights and protection for adolescents, including the Juvenile Justice Act, Prohibition of Child Marriage Act, Protection of Children from Sexual Offences Act, Child Labour Act, National Youth Policy, and National Adolescent Health Policy. Should we mention the Child Labour Act?

The legal and policy frameworks provide a strong opportunity to ensure that all adolescents have access to quality services, which is crucial for their empowerment and decision making. To implement the policies, the Government has launched several schemes to support adolescents, especially girls. For example, adolescent health is addressed by Rashtriya Kishor Swasth Karyakram (RKSX); nutrition and life skills through the Weekly Iron Folic Acid Supplementation (WIFS) programme and SABLA (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls); social protection through cash transfers such as Kanyashree in West Bengal; elementary (up to lower secondary) education through SSA and upper secondary education through Rashtriya Madhyamik Shiksha Abhiyan (RMSA); and protection through CPS.

Despite the Government’s overall frameworks, however, budgets for these schemes remain inadequate, and the reach, access and coverage of adolescent health, nutrition and non-formal education programmes in particular are poor at block level. In some cases, the schemes are not

\(^{83}\) Adolescents in India, op.cit.

gender-responsive and do not address the negative gender norms that underpin the behaviour that is being targeted, such as early marriage and child labour. In addition, no mechanisms exist to facilitate convergence between different schemes for adolescents.\textsuperscript{85} Thus, as in other development areas noted throughout this Situation Analysis, strong policies are hindered by weak implementation and limited accountability.

**Moving Forward**
Moving forward, significant opportunities exist to collaborate with the Government and others working not only on adolescent issues. Given the context in India, the challenge is to translate adolescent participation and empowerment into an agenda that can be taken to scale programmatically and that has policy implications.\textsuperscript{86} In particular, taking a prevention approach and prioritising the needs of 10- to 14-year-olds as young adolescents will be critical. Likewise, ensuring accountability, influencing policies and public opinion in favour of adolescents, and generating data and evidence all will be necessary.

To achieve larger-scale impact and address the bottlenecks related to issues of adolescents, it also will be necessary to move beyond earlier district-level and community-based work, but without abandoning child-centredness and understanding of grassroots realities. Several overarching strategies have been proposed to bring about social, system and policy changes to strengthen adolescent programming.\textsuperscript{87}

- Innovatively giving greater visibility and voice to adolescents to ensure their participation and empowerment. This includes a gender-responsive engagement with adolescents at community level, as well as engaging with parents in strategic and positive inter-generational dialogue. Further, this can include the expanded use of mass media, social media, ICT and mobile technologies to reach, influence and engage large numbers of adolescents, with concerted efforts to reach out to girls where they participate less and boys where they participate less.
- Broadening partnerships and mobilising new influencers can enhance the numbers of people who take action (parents, communities, parliamentarians, PRIs, the corporate sector), and can help to build the momentum for change.
- Strengthening systems and services, at national, state and district levels, through strategic capacity building and underscoring of accountability of service providers and structures.
- Convergence among sectors and scaling up of successful models on issues of adolescent programming
- Strengthening disaggregated data and monitoring/evaluation, for more evidence-based adolescent programming

Overall, challenging and innovative experiences for adolescents will need to be facilitated that are appropriate especially in being gender-responsive, diverse and sufficiently intense. All young people, in or out of school, whether low-income or affluent, need a mix of services, support and opportunities to stay engaged productively in their communities. They need relevant and reliable information to make informed decisions and to understand how the choices they make will affect their lives. In particular, adolescents need to participate in mainstream decision-making platforms/spaces alongside adults, such that advocacy for such policies and practices will need to be further stressed.

Positive adolescent outcomes can be brought about by understanding adolescents’ contexts, including their social environment, relationships, opportunities and challenges. The greater attention given to the care, empowerment and protection of adolescents — particularly girls, who continue to experience

\textsuperscript{85} Adolescent Roundtable Discussion Paper, op.cit.
\textsuperscript{86} Adolescent Roundtable Discussion Paper, op.cit.
\textsuperscript{87} Ibid.
greater rights deprivation, and young adolescents aged 10-14 years – the more likely the intergenerational transmission of poverty and risk will be broken.

3.3 Tribal Development
Evidence underscores that India’s tribal peoples are among the poorest and most vulnerable social groups in the country, with sub-optimal access to public goods and entitlements, and extensive exposure to drought, forced migration and subsequent displacement. Hence, from an equity perspective, they deserve the highest attention.

India’s 705 Scheduled Tribes constitute 8.6 per cent (104.3 million) of the total population and 9.8 per cent of the child population (44 million), with an overwhelming majority (90 per cent) living in rural areas, according to the Census 2011. About 3 in 4 STs live in West and Central India, concentrated in nine states. Key features of tribal areas include extensive forest area, with limited industrialisation or scope for ecotourism/heritage tourism, and remote location, with poor connectivity (especially rural all-season roads, telephones), and dispersed, very small habitations. Madhya Pradesh has the highest number of tribal people (15 million), followed closely by Maharashtra and Odisha. In 110 out of 640 districts, more than half of the population is tribal. Even within STs, 75 tribes are classified as Particularly Vulnerable Tribal Groups (PVTGs), with populations of fewer than 500, critically, for some of these groups, what is conventionally described as “inclusion” – access to certain public goods and involvement in mainstream society – is what some scholars have described as “adverse inclusion,” marked by exposure to disease, sexual exploitation and economic exploitation, and even precarious survival of the tribe itself.89

The poverty level of the ST population remains extremely high overall. More than 3 in 5 tribal households are in the poorest wealth quintile, the RSOC 2013-14 found, compared to only 28 per cent of non-tribal households. At the national level, 45.3 per cent of STs in rural areas remained below the national poverty line, compared with 25.4 per cent for all groups. Two states, Maharashtra and Odisha, exhibited ST poverty rates exceeding 60 per cent, while another four states (Chhattisgarh, Jharkhand, Madhya Pradesh, West Bengal) have ST poverty levels higher than 50 per cent.90 In contrast, only 1.6 per cent of tribal households were in the top wealth quintile in 2014, although this represents a substantial increase from a decade earlier.

Challenges of Survival, Conflict, Developmental Deficits and Aspirations
Key challenges tribal peoples face related to survival include (1) limited livelihood opportunities, chronic health issues, and overexploitation of natural resources, with the latter often leading to the forced migration noted above; (2) conflicts, issues of identity and governance; (3) developmental deficits, human resources, infrastructure and institutions; and (4) constrained aspirations and preservation of cultural heritage, participation in all walks of life, and inadequate alternative vocational skills.

A total of 3.3 per cent of ST households have at least 3 deprivations.91 The high vulnerability of this group is further aggravated by the fact that 9 out of the 10 tribal-dominated states have serious

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88 PVTGs are characterised by pre-agricultural systems of existence (hunting/gathering); zero or negative population growth; extremely low levels of literacy; and absence of a written language.
89 Exclusion Report, op.cit.
90 UNICEF India. Tribal Equity Profile. New Delhi, 2016.
91 Socio-Economic Caste Census Multiple Deprivation Analysis. Deprivations include (1) Households with only one room, kuccha walls and kuccha roof; (2) No adult member in household aged 18-59; (3) Female-headed household with no adult male member aged 16-59; (4) Households with differently abled member and no other able-bodied adult member; (5) SC/ST household; (6) Household with no literate adult above age 25; (7) Landless household deriving a major part of income from manual labour.
political challenges, and are influenced by left-wing extremism (LWE), although to varying degrees (see also Section 3.4).

In most tribal states, traditional practices such as early and exclusive breastfeeding are more prevalent than in non-tribal communities; however, infrastructure and service provisioning are both weak, as the RSOC 2013-2014 and other surveys have found. For example, only 56 per cent of STs have three or more prenatal visits, compared to 73 per cent nationally. Institutional delivery also is lower, at 70 per cent vs. 84 per cent nationally, with only 56 per cent of children aged 12-23 months fully immunised (72 per cent in non-marginalised populations).

Nearly half (49 per cent) of adolescent tribal girls aged 15-18 have a Body Mass Index (BMI) of less than 18.5, compared to 41 per cent for girls from categories other than SC/ST or OBC. Disparities in the proportion of households practicing open defecation are particularly wide, at 69 per cent (ST) vs. 28 per cent (in households other than SC/ST or OBC). Moreover, literacy stands at 59 per cent among STs, the lowest among all social groups (male 64, female 49), compared to 73 per cent (male 81, female 65) among others. Dropout rates of ST children at all levels of education are significantly higher than the national average, with the disparity at different levels varying between 12 and 15 percentage points. Overall, more than 3 out of every 5 tribal children drop out by secondary level (see also Chapter 7).

Other key challenges for tribal children include:

- **Ashramshalas** (residential schools) managed by the Tribal Welfare Department offer opportunities for protection and education of children in tribal areas. However, these are constrained by insufficient budgets, staff shortages, poor monitoring and issues of violence, including sexual harassment, assault and rape. Inter-departmental coordination with schools under the Education Department requires further strengthening.
- According to Ministry of Human Resource Development (MHRD) data, about 1 million tribal children aged 6-13 were out of school in 2013 (out of the 6 million in the country). In addition, a total of 1.7 million child workers are tribals (17 per cent of total child workers), based on the Census 2011. The language issue is one that has hindered the education of children of tribal communities (see also Chapter 7). Improved coordination between the Tribal and Education Departments in the states, and with Ministries in the states, has the potential to improve education provisioning and achievements of tribal children through rationalising allocation of resources and building on each others’ resources. In addition, a severe shortage of trained teachers in science and math results in a lack of these classes in tribal areas. Levels of undernutrition for under-5 children are worst among STs, compared to other children, according to the RSOC 2013-2014. In 2014, tribal children were more likely to be stunted than non-tribal children (42 vs 32 per cent respectively); severely stunted, 20 vs 14 per cent; wasted, 19 vs 14 per cent; underweight, 37 vs 24 per cent; and severely underweight, 13 vs 7 per cent. Among the states, stunting levels of tribal children vary from 53 per cent in Jharkhand to 20 per cent in Kerala.
- In tribal areas the burden of adult and child hunger is compounded by high rates of tuberculosis, malaria, sickle cell anaemia, snakebite, burns and scorpion stings. Tobacco use and alcoholism are common.

<table>
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<tr>
<th>Key Governance Issues for Tribal Families and Their Children</th>
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<td>In terms of governance mechanisms, the nine states where STs are highly concentrated are administered by the Fifth Schedule of the Constitution, which gives extensive powers to the Governors to oversee development of tribal areas and people. Tribal Advisory Councils in these states advise the</td>
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92 Based on Unified District Information System for Education (UDISE) 2013-2014.
93 Ibid.
Government on welfare and advancement of the Scheduled Tribes, but have no lawmaking powers. The Sixth Schedule covers the seven states in the North East (see also Section 2.2), which are administered by the autonomous regional and district councils; unlike in Schedule V, legislative, educational and judicial powers are devolved to Schedule VI local bodies.

However, the failure of state governments to protect tribal rights to their land and resources, despite legislation, is a major contributor to increasing civil strife in these areas. Experts envisage marginalisation deepening in the coming years, in part because the federation of organisations working for tribals has not been as strong as federations for other social groups. Most efforts in tribal areas are led by non-tribal leaders, underscoring a lack of tribal leadership. Schemes, programmes and forums where SCs and STs are represented together also often favour SCs, given their collective numbers and voice in political spaces. Investing in tribal leadership and empowerment thus will be critical to ensure improved outcomes for tribal people. Other governance issues to be addressed include:

Focus blocks/districts for intensive campaigns/schemes of different Ministries are different; for example, open defecation-free focus blocks/districts are not the same as those for intensification of routine immunisation. Moreover, schemes may not be culturally sensitive: Food grains (normally cereals), stocked in the Public Distribution System (PDS), and are often not a part of tribal peoples’ diet. The forest is not recognised as a food-producing habitat, and if trees are planted, they are usually not fruit-/food-producing.

With poor housing and recreational facilities, endemic road, power and electricity issues, centralised human resource policies that rarely specify the duration of such postings, and inadequate hardship allowances for serving in difficult conditions, few professionals want to work in tribal areas, all negatively affecting development outcomes. While tribal candidates are preferred for selection, it is difficult to find ones who meet the qualification criteria.

In some tribal villages, no Government officer may have ever visited, even in non-civil strife-affected areas. Strategies are weak for provision of food and services to the internally displaced and those affected by civil strife, as well as by food scarcity and drought as well as other natural hazards and disasters. Because both parents generally work outside the home, crèches in tribal areas are a must. However, this is only beginning to be piloted.

Tribal Welfare Department/Ministry roles for convening and coordinating access to entitlements/services require strengthening, as does the capacity of Tribal Research Institutes (TRI) in many states.


Moving Forward

Moving forward, RSOC 2013-2014 data show that in states where there has been an annual rate of overall improvement in select development indicators over the last eight years, such improvement has been maximised among tribal children, who are generally starting from a very low base. This means, however, that pathways to improved outcomes can be achieved through an intensive focus on tribal children and their families.

Five key opportunities exist: 94 (1) Stepping up public advocacy to make tribal concerns a public and political priority, especially with Tribal Development Councils/Regional Councils and Missions; (2) Increasing allocation of funds to influence tribal budgeting; (3) Strengthening databases highlighting deprivations of tribal communities and children at sub-district level, using a comprehensive tribal deprivation index methodology; (4) Evaluating interventions and schemes, investing in evaluations and creating a body of literature of findings; and (5) Piloting area- and sector-specific activities while

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working with state governments to draw up integrated tribal plans of action for tribal areas and communities. In particular, up-to-date studies and evaluations, with effective follow-up plans, will be necessary to highlight gaps in resource allocations and human resource capacities in tribal areas.

Further, despite the recognition that preserving the unique customs and traditions of STs is necessary, they have not been made partners with regard to what is their vision of development. A need exists to link overall planning to the process of micro-planning involving stakeholders, including tribal women. Moreover, expanding partnerships beyond traditional Ministries also may be considered, with untapped funds channelled into social sector schemes. Lastly, expanded partnerships with religious groups, tribal groups and NGOs also will help tap into local culture and beliefs.

3.4 Children in Conflict-Affected Areas

India has experienced a number of conflicts, both prolonged and short-term, with ethnic, religious and political groups of varied social identities clashing over poverty, inequality, autonomy and access to natural resources. The types and magnitudes of conflicts also have been different. Civilians, especially women and children, have suffered disproportionately in these conflicts. In 2015, 15 out of 29 states were embroiled in armed conflict, and conflicts over land rights and mineral resource distribution affected some 200 of India’s districts (30 per cent) in these states. A total of 82 million children live in conflict-affected regions, representing 17 per cent of the child population.\(^{95}\) Infants and young children are among the primary targets of violence, and adolescents continue to be used as combatants and trafficked into sex slavery. Indirectly, children in conflict areas also are negatively affected by undernutrition, disease outbreaks, poverty, the disruption of education, and internal displacement. They also face the risk of being tortured, arrested, sexually assaulted and raped, or killed in conflict zones. An acute need thus exists for long-term and longitudinal approaches – before, during and after conflict – to address the vulnerabilities of various populations, including a child rights approach to conflict.

The three main sources of internal conflict in India are found, firstly, in separatist movements, ethnic conflicts and issues of identity and citizenship in the North East (Assam, Manipur, Nagaland, Tripura, Arunachal Pradesh and Meghalaya), which are quite distinct from the country’s other conflicts. Second, substantial internal violence has been perpetrated by left-wing Maoist groups in the so-called “Red Corridor” (Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Maharashtra, Odisha, Telangana, Uttar Pradesh, West Bengal). Although Jharkhand has the highest percentage (90 per cent) of population affected by LWE, in terms of population, Bihar (59 million) and Andhra Pradesh, plus Telangana (57 million), taken together, comprise more than half of the LWE-affected population in the country, according to the Census 2011.\(^{96}\) While there has been an overall decrease in LWE activities, according to the Annual Report of the Ministry of Home Affairs 2015-16, the number of incidents has risen by 42 per cent in Chhattisgarh and 94 per cent in Andhra Pradesh, largely because of a spate of violent activities during panchayat elections and resistance to bauxite mining respectively. In both the above cases, considerable proportions of the population in these conflict areas are tribal groups, indicating the close linkage with issues discussed in Section 3.3.

Third, separatist movements, territorial conflict and insurgency, compounded by terrorism, also exist in Jammu & Kashmir.\(^{97}\) Importantly, the provisions of the Constitution of India, as well as central laws,


\(^{96}\) UNICEF India. *Left Wing Extremism (LWE) Equity Profile.* New Delhi, 2016.

\(^{97}\) According to the Ministry of Home Affairs, 2,162 civilians and 802 security force personnel have been killed by Maoists in different parts of India between 2010 and 2015. Most of the civilians killed are said to be tribals. In Kashmir, nearly 40,000 people, including 13,226 civilians and 5,369 security force personnel, died in violence between 1991 and 2011, according to the Government. North East India, in 2015 alone, witnessed 574 incidents of extremist violence in which 46 civilians were killed. Among the states in the North East, Manipur witnessed
policies and schemes, are not automatically applicable to the state; the state thus enacts its own laws and formulates its own policies under its own Constitution. Although the Prime Minister declared a special INR 80,000 crore (US$17.15 billion) development package for the state in November 2015, over and above amounts already committed toward infrastructure, health and other development work, implementation of policies and programmes has often been constrained when conflict flares. For example, the state has experienced significant unrest again since July 2016, which has hampered access to basic services, including the closure of schools.

Key Factors Driving Conflict

Key factors that drive change in the nature and scale of conflict include:

- A need for strengthened implementation of policies to overcome rising economic and social inequalities in all three conflict zones. At district level in particular, decision making for social sector priorities may be driven by a security agenda.
- A need to combat perceived high levels of corruption and cronyism in many conflict areas, which in turn affected government capacity, transparency and efficiency. This also has hindered investment in and development of infrastructure and financial institutions, along with civil society participation.
- Advanced weapons technology and the Internet may allow armed groups to leverage new tools such as electronic and online payments, which are hard to trace, and which could be used to purchase weapons. Increased smartphone penetration and the growing popularity of social networking websites also are likely to cause substantial changes in the nature and scale of armed conflicts.
- Although civil society organisations (CSOs) operate in all three conflict-affected regions, diminishing civil society and humanitarian space has had serious consequences for the safety and security of women and children.

Few interventions are focusing on direct peacebuilding or support for violence reduction programmes, which is a key determinant for child welfare. Critically, because of the obvious challenges encountered in conflict settings, other long-term challenges (e.g., related to endangered livelihoods due to climate change) also are not sufficiently considered and may lead to additional hardship.

At the same time, the politics of polarisation has added to fragility of the situation. A range of stakeholders (CSOs, non-State combatants, private sector corporations) will need to be brought together to craft long-lasting solutions, and national legislation for protecting children in conflict zones is necessary.

Moving Forward

Moving forward, the overall strategic focus on improving the delivery of central-, state- and district-level schemes for realising child rights in conflict-affected areas will need to be a key area of engagement, emphasising a conflict-sensitive approach. Issues related to restoring the primacy of civil administration and child rights, gaining space for local participation in decision making, and gaining wider leadership for results for children in these districts are key issues that also will need to be discussed. Overall, this will require improved understanding of governance in districts and states affected by conflict, along with linkages with other crosscutting issues such as tribal groups, adolescents, and climate change/DRR.

Specifically, opportunities particularly exist to promote public discourse on children affected by conflict, supported with study findings, thus promoting greater awareness and highlighting of issues. Mobilisation of more resources for conflict-affected areas through budget and human resource...
analysis also offers a key opportunity, as does creation of an information base for conflict-affected children. Piloting and replication of good practices, particularly working with district administrations to create models of excellence, will be critical.

3.5 Climate Change and Disaster Risk Reduction

Development is never disaster-neutral: it creates, exacerbates or reduces risk. Climate change has added a new dimension to disaster risk, through mostly adverse effects on communities, whose extent is still being investigated. Both geo-physical and hydro-meteorological (climate-related) hazards are likely to reduce, and at times halt, development gains, unless action to build resilience and stop the spiral of global warming is taken. In turn, this can endanger achievement of the ambitious SDGs; thus, this gives increased need to address the challenges of climate change and other disasters through risk reduction and resilience approaches. Resilient development incorporates both climate change adaptation (CCA) and DRR, as well as risk-informed development programming (RIDP), and combines humanitarian and development work. It also has a close link with social protection, which is designed to absorb shocks related to the impact of natural hazards. In turn, reduced risk makes overall development results sustainable.

India ranks among the top 10 high-risk countries for disasters, which affects the lives of its children and adolescents in multidimensional ways. A total of India 58 per cent of its landmass lies in high-risk earthquake zones, 68 per cent is susceptible to drought, and an increasing 12 per cent to floods. On average, between 2000 and 2009 some 8.5 million children younger than age 5 and 3.25 million pregnant and lactating mothers were affected each year. Altogether, during 1986-2016 India witnessed 1,107 major disasters affecting 1.68 billion people, with an estimated loss of US$10 billion. Five major disasters from 2000-2016 alone destroyed 19,466 schools, killed 17,671 children, and resulted in nearly an equal number of children being injured.

As these data reveal, India has been harshly affected by hazardous events, both of climatic and geo-physical nature. Reflecting global trends, hydro-meteorological events are also increasingly unpredictable and more difficult to manage. These weather patterns are more and more referred to as climate change, and find their expression in repetitive drought spells and heat waves, which are often followed by floods and untimely hailstorms.

### Extreme Weather on the Rise

Events are also becoming more extreme. The 2016 drought in India affected at least 330 million people from 255,923 villages, across 254 districts in 10 states. At the same time, the December 2015 floods in Tamil Nadu were the most severe in 100 years and affected an estimated 1 million children in six districts. In 2016 in Assam – which faces one or two major flood spells annually – 3.5 million people, of which 40 per cent are children, were affected by the most severe flooding in a decade. This caused the evacuations of 242,000 people and damaged more than 215,910 hectares of crops, as well as basic health, education and child protection services. Bihar also saw the massive evacuation of more than 1 million people in 2016, along with more than 8 million people affected by floods. Extreme rainfall events display a significant increasing trend of 6 per cent per decade over central India.

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98 As per India’s National Disaster Management Plan 2016.
100 This information is drawn from the International Disaster Database EM-DAT’s country profile for India (http://www.emdat.be/). EM-DAT references only major events which affects at least 100 people, cause the death of 10 persons, or lead to declaration of natural catastrophe. More frequent minor disasters are not covered by the analysis; in India, no official and comprehensive public loss accounting is available.
Yet at the same time, as a UNICEF 2016 drought impact assessment reveals, water insecurity shows a compounded deficit for consecutive years in several states. An increased “dry period” for groundwater sources has been compounded by extraction for irrigation, leaving shallow handpumps dysfunctional. Time for fetching water, usually by women and girls, has increased by up to five hours in Bihar, Madhya Pradesh and Telangana, with a need to cover more distance. Lastly, inequitable distribution has been reported; underserviced communities either purchase water from the market or resort to unimproved sources.

In turn, climate-related stress increasingly exposes vulnerable people, especially girls, to violence, child trafficking, early marriage and child labour as traditional sources of income no longer suffice to feed families and negative coping mechanisms are adopted. Comprehensive school safety, including pillars of safe learning facilities, school disaster management, and risk reduction and resilience education, is particularly crucial, and must be aligned to national, sub-national and local disaster management plans.

The 2016 drought – affecting more than a quarter of the population of India – has proven particularly wide-ranging in its negative effects, with profound implications for children’s survival, education, nutrition, WASH, and protection, and an overall exacerbation of insecurities. In all, a significant reduction (60 per cent loss) in subsistence farming has been noted, with “forest drought” leading to reduced timber and non-timber forest products and limited fodder for cattle, thereby compromising family livelihoods. Other negative effects include:

- Decreased food and nutritional intake, with less quality and frequency, was reported from 11 states, with a reduction of up to 58 per cent in food crops. Acute malnutrition was reported at a “critical” level, with a very high prevalence of stunted and underweight children, and of undernutrition among pregnant women. In Bundelkhand district in Uttar Pradesh, 17 per cent of all households replaced regular meals with rotis made of grass, and half of all households had eaten no vegetables in more than 10 days prior to the survey; 60 per cent had not been able to offer milk to their children for 30 days. Similar patterns were reported in other states, where vegetables, pulses and milk temporarily disappeared from the diet. While the Public Distribution System was mostly functional and the sole source of staple food in many villages, it faced issues of being unable to address the drought-specific requirements of the most vulnerable.

- Open defecation and unsafe hygiene practices were spreading, with previously open defecation-free districts witnessing 50 to 70 per cent of their populations practicing open defecation again.

- Children suffered from exposure to extreme heat and sunstroke, and several were injured, including at least four children who died while fetching water.

- School attendance has decreased as children are required to spend hours collecting water and contributing to family income. A 22 per cent increase has been reported in the number of children dropping out of school in drought-affected states.

- A compromised care and protective environment was revealed, encompassing not only child marriage and child labour, but also physical hardship, orphanhood from farmer suicides, and other trauma.

Bearing in mind the correlation between exposure to natural disasters and the likelihood to suffer from acute illnesses, as well as affected child growth patterns, a need exists for all development

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101 According to a Government response filed in the Supreme Court in April 2016.

102 UNICEF India. Presentation on Disaster Risk Reduction to the Country Programme Document Workshop (PowerPoint). New Delhi, August 2016.

103 A study covering 80,000 children from three sets of India’s National Family and Health Surveys (1992-93, 1998-99, 2005-06) revealed that (1) Exposure to a natural disaster in the past month increases the likelihood of acute illnesses such as diarrhoea, fever, and acute respiratory illness in children less than 5 years by 9-18 per
sectors to analyse how current and future disaster and climate risk affect their functioning, and to become more resilient.

**Future Climate Change Predictions for India**

All the above aspects are critical given that the International Panel on Climate Change has made the following broad projections for India:

- A further increase in both mean and extreme precipitation in the summer monsoon
- Likely increase in floods and droughts, with a decline in seasonal rainfall but a rise in extreme precipitation during the monsoon
- Changes in more than a third of the country’s forest area by 2100 in response to increasing rainfall
- In the Indo-Gangetic Plain, a changing climate that is expected to reduce monsoon sorghum grain yield by 2 to 14 per cent by 2020, with worsening yields by 2050
- Large reductions in both rice and wheat production
- Temperature variations also are likely to lead to increased outbreaks of disease

Already, distress migration is occurring as a coping strategy to supplement shattered incomes, as highlighted above. Adolescents are migrating to cities, entire families are migrating in place of male members only, and marginal farmers are leaving their lands, in addition to landless labourers. The period for which migrants are staying away has increased by 3-6 months. Thus far, no registration is being conducted either at source or destination to understand the changing migration pattern.

Beyond these challenges from adversely changing climate patterns, unplanned urbanisation presents other disaster risks. Unplanned settlements with slum-like conditions in Delhi – among the most densely populated in India, with 37,346 persons per sq.km. – and in other mega-cities also are highly prone to multi-hazard disasters like earthquakes, floods and waterlogging, frequent epidemics, fire accidents, and building collapses.

**The Growing Menace of Air Pollution**

Notably, indoor and outdoor air pollution are increasingly affecting urban Indians, particularly children and women, and are linked to acute respiratory infections. Such pollution, ranked by the Indian Council of Medical Research as one of the three top national health priorities, was the leading cause of disease outbreaks in 2015.

As far as outdoor air quality is concerned, India is home to 10 of the top 20 most polluted cities globally (Gwalior, Allahabad, Patna, Raipur, Delhi, Ludhiana, Kanpur, Khanna, Firozabad, Lucknow), according to the World Health Organization. With regard to indoor pollution, which has an even more immediate negative effect on children and women, accelerated efforts are being undertaken to address air pollution-linked issues, including a study to understand the perceptions of mothers, children and health care providers on the link between indoor air pollution and under-5 childhood pneumonia. Measurements of breathing capacity of children and air quality monitoring via mobile application also are being considered. Opportunities also exist to establish “champions of change” to drive advocacy around air pollution issues linked to child rights.

Despite the fact that children are among the most vulnerable to disasters and comprise roughly 70 per cent of disaster victims, this impact is rarely systematically assessed, much less addressed. This

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reflects a wider need in India, where no comprehensive disaster impact reports are made publicly available. Similarly, risk assessments are yet to be conducted systematically, and most publicly shared data refer to exposure to natural hazards, whereas more accurate disaster risk data are required to monitor related vulnerability, exposure and capacities of populations, disaggregated by age, gender and other social determinants.

As highlighted above, India’s governance structures for disaster risk management continue to remain primarily response-focused; these are scattered among Ministries and services that have yet to be effectively coordinated. A large number of sectoral guidance notes and trainings have been promoted by the National Disaster Management Authority and National Disaster Management Institute. Civil society, academia, the media, professional associations and the private sector, as well as international and bilateral organisations, also are not yet systematically involved. An exception is found in the state of Bihar, where a comprehensive Road Map for DRR 2015-2030 has been adopted and is being implemented with lead support from UNICEF.

Moving Forward
Moving forward, it is necessary to generate more evidence on the impact of both major/intensive as well as small-scale disasters on children and women, as well as on relevant state services catering to them. This would reveal the full extent of disaster impact/disaster risks and, combined with probabilistic risk assessments, would help to continue the necessary refocusing from a predominantly response-focused approach to a modern preventive and resilience-building approach. Existing disaster response systems also should also be optimised (e.g., through improvement of supply chain management and more effective and timely social sector recovery and social protection mechanisms). Evidence-based advocacy and engagement with Governments and CSOs on disaster risk and climate change can promote policies and programmes for child-focused DRR, CCA and mitigation actions. Mainstreaming the use of disaster- and climate risk-related information will be useful, including the expansion of risk-informed development programming approaches piloted in Bihar and Rajasthan, as well as sharing of good practices.

In addition, a need particularly exists for more convergence between sectors on disaster risk and climate change, especially – but not only – at local level. It will be important to consider the varying institutional hosting arrangements for climate resilience (Ministry of Environment, Pollution Control Board, Ministry for Agriculture and Animal Welfare for drought, Ministry of Home Affairs for flood, etc.). A multisectoral approach thus will need to be employed, including WASH, nutrition/food security, education, health and child protection. The element of migration also will need to be considered, since disasters and displacement of communities are closely linked, as noted above.

Governance systems will further need to be strengthened through smart DRR to anticipate, as well as absorb, shocks in the event of climate-related disasters and reduce the toll they take on communities. These systems need to become more inclusive and invite multiple stakeholders and sectors to contribute to what is fundamentally a multisectoral endeavour to reduce risks and build resilience. Disaster risk management approaches also will need to be adopted by various line Ministries, with support from disaster management authorities and through strengthened collaboration in multi-stakeholder coordination mechanisms.

In terms of climate change mitigation, the emission of greenhouse gases (GHGs) should be reduced or prevented through new technologies, renewable energies and smarter management practices, since these emissions have major implications both for today’s children and future generations. Moreover, it will be necessary to team up with other international partners to improve early warning and response systems for climate-induced shocks (droughts, floods), down to the community level, bearing in mind that improved early warning systems are a Government priority. Importantly, DRR and climate change efforts need to be integrated in GPDPS, and DRR can be included as a standing
agenda item in District Review Meetings. The resilience of critical infrastructure also needs to be assessed and retrofitted as necessary, to ensure structural and non-structural resilience of schools, health facilities and Anganwadi Centres at all times.

Specifically, comprehensive school safety and security programmes should be expanded, including pillars of safe learning facilities, school disaster management committees, and risk reduction and resilience education, and should be aligned to national, sub-national and local disaster management plans. Schools should be examples of functionality and adopt an approach whereby no deaths occur, and no days of schooling are lost, due to disasters. As laboratories for the new generation, they should promote “greening” and respect for the environment. Key initiatives can include the promotion of the use of solar-based energy in social infrastructure and for cold chain management, providing critical health services such as immunisation and obstetric/newborn care. This also can help in establishing and training a cadre of experts for public health in emergencies, through high-level advocacy, facilitation and pilot initiatives.

3.6 Improving Services and Opportunities for Vulnerable Children and Women in Urban Settings, Particularly Urban Slums

To fully capitalise on its potential demographic dividend, India needs thriving cities. Urban India’s population has grown by a factor of 5 since 1961, and the Census 2011 shows the urban population continues to increase exponentially. Thus, it is becoming difficult to address child rights without addressing urban governance; urban basic services; climate change and disaster risk; air pollution, particularly outdoor pollution in low-income urban environments; and children in difficult circumstances, among other key issues.

Moreover, these must be contextualised in terms of the stark economic, social and environmental divides that characterise Indian cities. As the UNICEF State of the World’s Children Report 2012 stated, “Many children enjoy the advantages of urban life, including access to educational, medical and recreational facilities. Too many, however, are denied such essentials as electricity, clean water and health care – even though they may live close to these services.” In addition to India’s tens of millions of slum dwellers, low-income settlements and notified slums, as well as peri-urban areas, also all present huge challenges.

Women are expected to benefit most from urbanisation and migration, particularly from better services and formal employment opportunities. At the same time, as urbanisation and inequality increase, and as family ties fray, millions of women, adolescents and children will become more vulnerable to issues such as trafficking and forced prostitution. Indicating the depth of protection issues and gender discrimination even in India’s richest locations overall, the child sex ratio in urban areas, at 905 girls per 1,000 boys, is far below the already-constrained child sex ratio of rural areas (923).

A total of 377 million people live in urban areas, according to the Census 2011, close to 31 per cent of total population. Of these, 32 per cent (120 million) are younger than 18, and around 36.5 million are children below 6. The largest share of the urban population (almost 40 per cent) is found in just four states (Maharashtra, Uttar Pradesh, Tamil Nadu, Gujarat). At the same time, new research estimates that 590 million people will live in Indian cities by 2030, nearly twice the population of the

107 Ibid.
United States today, and will comprise 40 per cent of India’s population. Cities could generate 70 per cent of net new jobs created by 2030, produce more than 70 per cent of Indian GDP, and drive a near-fourfold increase in per-capita incomes across the nation.

In short, India will witness within 15 years an urban transformation of almost unprecedented scale and speed. In a global context, the scope of India’s urbanisation will be immense: The country will have 68 cities with populations of more than 1 million people – up from 42 today – along with 13 cities with more than 4 million, and 6 mega-cities with populations of 10 million or more. At least two of the latter (Mumbai, Delhi) will be among the five largest cities in the world by 2030.109

As highlighted above, these cities face wide disparities and inequities: The average monthly per-capita expenditure in urban areas, estimated by the National Service Scheme in its 2011-2012 report, was INR 2,630, compared to INR 1,430 for rural areas, indicating the proportion of urban dwellers among the higher wealth quintiles. However, the figure for the bottom 30 per cent of the urban population varied between INR 701 and 1,363, also showing that the poorest urban families are worse off than the average rural dweller.

8 Million Young Children in Urban Slums
Most of the urban poor – 65 million people in 13.7 million households – live in the 49,000 slums found in India, and comprise nearly 1 in 3 urban residents. Of these, 8 million people are children younger than age 6. Half of these slums are located in the five states of Maharashtra, Andhra Pradesh, West Bengal, Tamil Nadu and Gujarat. Indeed, India alone accounts for 17 per cent of the world’s slum dwellers.110

People living in non-regularised slums – those not established before a certain cutoff date, and then declared as illegal by legislation – are ineligible for municipal services, and thus the most vulnerable group. Nearly half of slum in the country are non-notified, which means that more than 50 million urban dwellers are not recognised by the Government as official residents.111 Often these people are migrants, living in tenuous housing conditions, with limited access to services and amenities, such as sanitation, sewage, drainage and police protection, as well as schools and health clinics. Absence of security of tenure contributes greatly to their exclusion. Although the Government has taken steps to build up the slum notification process and recognize the residents of these areas, this still occurs in a piecemeal fashion.

Nearly 3 in 5 urban dwellers are from rural areas, according to the National Sample Survey Report 2012 report. As has been noted above (see Section 2.2), India has one of the world’s most mobile populations, with nearly 400 million internal migrants in the country, including more than 15 million children. Most of these migrants are relatively young, and the majority are women; many will end up living in slums or on the outskirts of major cities in peri-urban areas. Disasters and climate change (see Section 3.5) and potential conflicts (see Section 3.4) also are likely to increase migration rates, as well as cause an influx of potential cross-border refugees.

Acceptance of migrants also differs across the country, with some areas less welcoming of them. Even so, by 2030, more than 200 million more people are expected to move to India’s major cities in search of better job prospects, higher-quality education and a more stable environment. Yet children of undocumented migrants particularly often miss out on important services, including education and health care, as their parents avoid interacting with authorities who could question their living status.

109 Ibid.
111 Urban Roundtable Discussion Paper, op.cit.
In addition to migrant children, other groups of vulnerable children in difficult circumstances require particular attention for their care and protection, including so-called “nowhere children,” who are neither in the education system nor working. These boys and girls aged 12 to 18 years – comprising younger adolescents as well as older ones – are highly vulnerable to early marriage, trafficking and child labour. “Invisible” children also are particularly vulnerable, such as domestic workers, sex workers and their children, working children forced to live in bondage, and children who are on the move (street children, trafficked children). In Delhi alone, there are an estimated 51,000 street children, 20 per cent of them girls; most were aged 7-14 years, and 87 per cent earned a living. More than 50 per cent of them had suffered verbal, physical or sexual abuse. In particular, sexual abuse of these vulnerable children is extensive and not sufficiently addressed, especially sexual abuse of boys.

Meanwhile, unsustainable development decisions are being compounded by violation of ecosystems like wetlands and floodplains, with resultant loss of ecosystem services, open spaces, and urban resilience to disaster. For example, 128 million gallons per day of sewage is generated in the Trans-Yamuna region of Delhi and eventually discharged, untreated, into the River Yamuna. As highlighted in Section 3.5, half of the world’s most polluted cities also are found in India, which is an important health concern for children and women. Similarly, the burden and impact of indoor air pollution on health, particularly in rural areas, due to poor housing and use of unclean fuel is estimated to be considerably high. National and state disaster management plans and climate management plans do not mention children and adolescents nor address urban areas adequately. Vulnerability in urban areas is understood in times of disaster, but little has been done thus far to prevent and address causes.

A higher-than-average urban crime rate clearly means that children and adolescents in the cities are not only victims of such violence but are in danger of becoming part of an organised crime racket, especially when faced with circumstances such as disruption in/absence of schooling, dysfunctional family, lack of parental care and exposure to substance abuse. Juvenile delinquency (children in conflict with law) is fast becoming a dominant aspect of urban crime. Women and girls have been disproportionately affected by the sharp uptake in crime; e.g. in 2015, New Delhi saw 20 a per cent increase in crime against women and girls compared to 2014.

Services Available, but Out of Reach
For the urban poor, the relative abundance of services in urban areas does not necessarily translate into better health care. Infants born to urban poor families are at significantly higher risk of mortality (55 per 1,000 live births) than other urban children (42 per 1,000 live births), according to the NFHS-3 (2005-2006). Immunisation coverage of urban poor children also is at least 25 percentage points lower than that of the urban richest; in fact, coverage of urban poor children is lower than of rural children aged 12-23 months. The implementation framework for National Urban Health Mission indicates that nearly 60 per cent of children in urban poor settings miss out on total immunisation before reaching age 1 year. Many vulnerable groups, particularly the urban homeless – including street children – as a population sometimes are completely excluded from health care. Often homeless persons do not seek such care, while many suffer from multiple morbidities (e.g., injury and mental illness, or disability and chronic disease) that may beyond the capacities of primary health care facilities to handle.

112 UNICEF India, Urban Equity Profile. New Delhi, 2016.
113 Urban Roundtable Discussion Paper, op.cit.
115 Urban Equity Profile, op.cit.
116 Exclusion Report, op.cit.
Critically, alarming rates of undernutrition, stunting and obesity coexist in urban India. A child from the poorest families is at least 3 times more likely to be stunted by age 2 years as those from the richest urban families. In 2014, 3 in every 5 poorest urban children younger than age 3 years were stunted. Among adolescent girls aged 10-18, 59 per cent also suffered from undernutrition that year.

Key disparities also persist in examining access to drinking water and sanitation. Nearly 50 per cent of urban child mortality is the result of poor sanitation and lack of access to clean drinking water in urban slums; 46 per cent of urban poor families practice open defecation compared to just 0.5 per cent among the urban richest families. While poverty remains the strongest predictor of lack of access to safe drinking water and sanitation facilities, caste also plays a highly significant role: Only 57 per cent of urban Dalit and 55 per cent of urban Adivasi households have drinking water within their premises, compared to the national urban average of 71 per cent. Female-headed households have similarly poor access to a water source within the premises, and to exclusive use.

In particular, the access of homeless persons to water and sanitation services is hugely inadequate to ensure their human dignity and health; they are forced to access non-potable water, fetched over long distances, and often including significant costs. They also have to resort to open defecation, or use paid or unpaid public toilets, which are frequently poorly maintained and afford little safety and privacy, especially for women and children. Many women go to defecate early in the morning and then wait until nightfall, leading to several health issues such as urinary tract infections. Infections due to inadequate water and sanitation are responsible for 15 per cent of maternal deaths, and girls and women face additional problems during menstruation.

Despite enactment of the Right to Education Act and various policy measures for its implementation, addressing the needs of out-of-school children among urban poor households remain a huge challenge (see also Chapter 7). In urban areas, it is believed that out of 1,000 girls, only 14 reach Class XII. Even among those who get to go to school, their safety and security in schools and settlements alike is in urgent need of attention. A significant proportion of children also are either underage or overaged for their level/grade in school.

Urban Governance: Complex, and Often Chaotic
If India continues to invest in urban infrastructure at its current rate – very low by international comparison – in 20 years’ time the urban infrastructure will fall woefully short of what is necessary to sustain prosperous cities. In turn, life for the average city dweller in India would become a lot more difficult. Water supply for the average citizen could drop from an average of 105 liters to only 65 liters a day, with a large section of the population having no access to potable water at all. India’s cities could leave between 70 and 80 per cent of sewage untreated. Unless it dramatically steps up its construction of the urban infrastructure needed, India will not be able to bridge the gap between demand for services and their provision. Some 700 million to 900 million sq.m. of commercial and residential space will need to be built by 2030 – or a “new Chicago” every year. About 2.5 billion sq.m of roads will have to be paved, 20 times the capacity added in the past decade. And 7,400 km of metros and subways will need to be constructed, also 20 times the

118 Exclusion Report, op.cit.
119 Urban Equity Profile, op.cit.
120 Urban Roundtable Discussion Paper, op.cit.
capacity added in the past 10 years. In per-capita terms, India’s annual capital spending of US$17 is only 14 per cent of China’s (US$116) and 4 per cent of the United Kingdom’s US$391. India needs to invest an estimated US$1.2 trillion just in capital expenditure in its cities over the next 20 years, equivalent to US$134 per capita per year – almost eight times the level of current per-capita spending.122

On key dimensions of urban management, India’s record thus far also requires strengthening. As clearly illustrated above, many cities are facing a declining quality of life, exacerbated by numerous governance and basic service delivery issues despite numerous dedicated urban programmes.123 Governance systems of cities are hugely complex, with roles and responsibilities split among local, district and state-level agencies and lines of accountability highly unclear. This is a major reason why cities are unable to realize their potential on ensuring safety security and well-being of their citizens. Further disconnects exist between planning and execution bodies of municipalities.

The 74th Amendment in relation to local self-governance in urban areas has generally been constrained, except in a few states, so that institutional dimensions of social services are led by state governments. At the same time, Government programming in many sectors has been “urbanised” to some extent (e.g., health), but in many others, flagship schemes designed for a rural context do not fit well into the urban context (e.g. ICDS, CPS). Coordinated action with shared goals among a multitude of institutions and actors will be required to deliver urban resilience.

Moving Forward

Moving forward, and despite the abundance of programmes noted above, an urgent need exists to create child-centred Government programmes that address the urban reality. Hence, the agenda for urban programming will be to create an enabling environment for inclusive governance, and a resultant reduction in urban disparities. The prospect for children will largely depend on the capacity and capabilities of cities to govern themselves with an outcome orientation, which requires capacity and capability to anticipate needs/vulnerabilities/risks, to accord attention to finding sustainable solutions, and to allocate adequate planned resources, with a focus on equity. In addition, data and monitoring systems will particularly need to be strengthened to underscore evidence-based decision making.

In the coming years, urbanisation should bring some positives from the perspective of enhanced child health and education. Many mothers – and therefore children – are expected to be better fed and nourished in urban areas, and have access to better health care facilities. Children also are more likely to have better employment opportunities within urban areas than rural areas, given the expanded range of professional opportunities, as long as jobs grow fast enough to absorb them. However, there is likely to be less connectedness to an extended family and less adult supervision and protection, since both parents may work far from home. India’s urban children are thus becoming increasingly susceptible to human predators. Sexual violence against urban children has also soared, with UNICEF reporting that one-third of adolescent girls (aged 15-19) have experienced some sort of physical, sexual or emotional violence (see also Chapter 8). It also reports that 9,500 children and adolescents were killed in 2012, mostly in urban areas, representing 10 per cent of all children killed worldwide. This made India the third-largest contributor to child homicide globally.

122 Ibid.
123 Such programmes include Smart Cities, AMRUT, Pradhan Mantri Awas Yojna (Housing for All-Urban), National Urban Livelihoods Mission, National Urban Health Mission, complementing nationwide social sector programmes such as SSA, RMSA, ICDS and ICPS.
In all, the cities with populations of 1 million-plus, comprising nearly half of the urban population, represent probably the best place to invest. These cities are important from the point of view of child population too, since more than 1 in 4 children aged 0-6 years in these cities live in slums. Promising approaches include promoting innovations and mainstreaming successful initiatives, such as demonstrating models of special services and assistance for new migrants and their children, or piloting urban safe havens. Bearing in mind that most infrastructure needed to accompany urban growth in India is still to be constructed, it is critical that such infrastructure is resilient to both current and future challenges of unplanned migration, climate change and disaster, including health risks, and with communities capacitated to reduce risks. The urban context also offers possibilities of new partnerships with different actors (media, private sector, elected representatives, NGOs, academic institutions).

Overall, a core strategy should be found in building leadership for results, including capacity building of urban governance systems and local self-government bodies for efficient and effective responses to urban requirements. Having qualified human resources in municipal governance will be critical, and can promote convergence and multisectorality. In tandem, supportive strategies will need to focus on knowledge management, advocacy and capacity building to enable local systems to understand the bottlenecks and opportunities to effectively deliver and monitor urban child survival, growth and protection services. Documentation of best practices and remaining challenges will strengthen feedback loops and bring out the need for change or adaptation.

3.7 Mainstreaming Gender, Empowering Women, and Facilitating the Participation of Men and Boys in Promoting Gender Equality

Gender equality means that women and men, and girls and boys, enjoy the same rights, resources, opportunities and protections, and to that end, UNICEF’s programmatic efforts are directed at levelling the playing field. This requires working directly with girls and women, as well as with boys and men, parents, community leaders, and those with power and influence in the economic, political and social spheres. Gender is about the relationships between and among women and men, girls and boys; transforming these relationships requires the involvement of all the people, not just half of them.\textsuperscript{124}

As a signatory to the CRC and CEDAW, India has a number of progressive laws and programmes that support gender equality, ending discrimination and preventing violence against women and girls. These laws set 18 as the minimum age of marriage for girls, banning dowry, criminalizing prenatal sex selection, institutionalising the right to safe abortion, and providing free birth control mechanisms. Recently, Section 375 of the Indian Penal Code was reviewed and updated, following the gang-rape and death of a young woman in New Delhi in December 2012. The 1997 Visakha Guidelines set out protocol for workplaces to prevent and prosecute sexual harassment in the workplace. India is also home to robust social movements and organisations for gender equality and women’s rights. In fact, many national laws and policies, including the Right to Information Act, Rural Employment Guarantee Scheme and the Right to Education Act were developed and proposed by an active and organised civil society, including women’s rights organisations. In addition, the Government at federal and state levels has implemented innumerable schemes and programmes that provide everything from bicycles and hostels to life skills and stipends to girls. Most recently, Beti Bachao Beti Padhao directly tackles sex selection, while Janani Shishu Suraksha Karyakaram and Janani Suraksha Yojana seek to decrease the vulnerability of pregnant women and support new mothers and infants. Every state government in the country has schemes aimed specifically at girls from birth to adulthood. Social protection

schemes aimed at protection of the rights of the girl to survive and thrive likewise are present in every state.

Yet India ranks 130th out of 188 countries in the 2014 Gender Inequality Index, driven by a maternal mortality ratio, female labour force participation rate and percentage of girls with secondary education that are all lower than the average for middle-income countries. Traditional patriarchal norms and matriarchal dynamics, also highlighted in Section 2.3 and below, have relegated women and girls, including the unborn girl child, to secondary status within society. Gender-based discrimination and violence particularly continue to be defining issues (see also Chapter 2 and Chapters 4-8 for details), with the CEDAW Committee and CRC Committee both expressing serious concern in their 2014 reports on India over a wide range of gender-related issues.

Many women, especially those belonging to the most marginalised groups, face overlapping social, emotional, physical, economic, cultural and caste-related deprivations. Challenges often stem from issues related to lack of personal choice or control, as well as the social norms already noted. As a result, many of India’s women lack skills, have poor employability, and have no control over their health and sexuality. Protecting children’s rights and enabling all children to survive and thrive thus requires interventions aimed specifically at addressing and mitigating the effects of gender discrimination on girls’ well-being, development and rights, while recognising and responding to the negative outcomes and vulnerabilities that boys face as a result of negative gender norms.

At the same time, the engagement and support of men and boys in achieving gender equality is vital. Not only should men and boys take up the onus of preventing violence against women and girls, it is important to address the narrow and harmful notions of masculinity that lead to it, as well as to a restrictive focus on life and career options. The United Nations Commission on the Status of Women, in March 2004, agreed to an important set of conclusions on the role of men and boys in achieving gender equality and urged all key stakeholders, including governments, United Nations organisations and civil society, to promote action at all levels in fields such as education, health, media and the workplace to increase males’ contribution in this regard. Likewise, in the Beijing Declaration of 1995, governments expressed their determination to encourage men to participate fully in all actions toward gender equality.

Single women – understood as a wide category including widows, divorced women, abandoned or separated women, and unmarried women (by choice or circumstance) older than 35 – are particularly excluded from a range of public goods and services. Evidence indicates that single women have been traditionally excluded from the consideration of lawmakers and administrators, since marriage is considered the fundamental marker of social respect and “protection” for women. Even when mentioned in public policy, single women are largely constructed as “vulnerable” or “women in distress,” thereby casting them as passive recipients of State and societal charity. Recent recognition of widows’ economic vulnerability has led to pension schemes for them, but the amounts are typically small, and other categories of single women are excluded.

Gender Norms Critically Influence Gender Deprivations

Critically, gender norms are not static. Divergent normative practices between and within communities make it extremely challenging to devise standard interventions for behaviour and social

125 For example, in several states – particularly those with substantial tribal populations or poorer economic indicators (Jharkhand, Assam, Bihar) – “witch hunting,” often of widows, is very common.
126 UNICEF MTR, op.cit.
127 Exclusion Report, op.cit.
change that would successfully apply to all communities, as highlighted in Section 2.3. While some social norms might impede achievement of child rights, others may foster those rights; a community may have both. Having said that, however, some of the common female gender deprivations among young children that require highlighting include:

- Abortion of nearly a half-million female foetuses every year
- Higher neonatal mortality for girls (see also Chapter 5)
- Higher under-5 mortality for girls than boys (13 per cent), compared to 7 per cent lower globally
- Girls comprising only 40 per cent of Sick Newborn Care Unit admissions
- Girls being likelier to go to Government preschools than private preschools, reflecting higher parental investment in boys

Wide-ranging vulnerabilities for adolescent girls (see also Section 3.2) include poor nutritional status, early marriage and early childbearing; other adolescent issues particularly relate to reproductive health and a need for empowerment:

- 56 per cent of adolescent girls are anaemic, although 30 per cent of boys also face this nutrition issue
- India is sixth out of the 10 countries with the highest rate of child marriage (see also Chapter 8), with the second-largest number of child marriages in the world for girls, after Bangladesh
- A 16 per cent risk of teenage pregnancy exists
- Of missing children reports, 42 per cent more girls were missing than boys in 2014, and 31 per cent more girls than boys were missing in 2015; this frequently links to issues of trafficking
- 83 per cent of adolescent girls miss 12-24 days of school a year because of menstruation

Indian women too face multiple deprivations, as highlighted throughout this Situation Analysis:

- 74 per cent of rural women are agricultural workers, but only 9 per cent own land
- Female labour force participation stands at only 29 per cent, 11th-lowest globally. Women are heavily concentrated in unpaid work or the informal sector (see also Section 2.3). 39 per cent of men and women think that it is sometimes or always justifiable for a man to beat his wife; 47 per cent of girls and 47 per cent of boys justify wife beating
- Further, reported incidents of violence perpetuated by panchayats on women, involving public stripping and rape by community members and lynching, are particularly alarming signals of a deteriorating social fabric
- The threat of violence is as much of a disempowering factor as violence itself; for example, parents may cite violence against women and girls as a reason for their daughter’s early marriage – but violence in the home of the husband does not count; the threat of violence also is a reason for girls and young women being discounted from jobs with late shifts and travel
- Only 12 per cent of parliamentarians (lower house) are women, ranking India 141st out of 193 countries
- 54 per cent of rural women spend 35 minutes getting water every day, equivalent to the loss of 27 days’ wages over the course of a year
- Unfair time use also is a critical disempowering factor, with women spending only 19 hours per week on productive work (wage earning), compared to 42 hours for men, but another 19 hours on reproductive work, compared to 0.5 hours for men

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129 Ibid.
130 Ibid. and UN Women, World Bank, UNICEF, Inter-Parliamentary Union, and National Sample Survey Office.
At the same time, male gender deprivations exist as well, although usually among adolescent boys and men rather than young boys. For example, among adolescents, 25 per cent more boys than girls (aged 4-15) are engaged as main or marginal workers, according to the Census 2011. Boys also face a high risk of extremist recruitment and detention, often in adult jails, in conflict areas. Custodial rape is not considered a crime against juvenile boys. Men comprise 96 per cent of the prison population; two-thirds have not been convicted (e.g., are under trial), among whom Muslims are over-represented.  

### Men and Boys: Privileged, but Also Challenged

In all, views of what it means to be a man and a woman in India are rooted in children’s earliest experiences and memories, with cultural norms about gender roles imparted by families, peer groups, and communities. As also noted in Section 2.3, young boys generally are allowed more freedoms and have fewer restrictions placed on them as young girls. They are frequently taught to play rough, to stand up for themselves, and not to walk away from a fight. Often, they run out to play while their sisters are kept indoors to care for younger children and to help with domestic chores. The privileging of boys begins early, with different child-rearing strategies and parental expectations, often reinforced by the mother, who is largely more present in the child’s life. Women, therefore, are key contributors to the perpetuation of male behaviour and males’ sense of superiority.

Yet as also highlighted above, boys and men can suffer as a result of current male gender roles and gender inequality. They are under considerable pressure to stick to their gender roles and norms of masculinity, which make it difficult to be different: in India as elsewhere, political and economic power are valued and rewarded. Physically and financially powerful men are frequently viewed as enviable by other men and desirable by women. At times, men are also socialised to be sexually promiscuous, even sexually irresponsible, which may compromise their health and put their spouses, partners and children at risk. The male socialisation process and social expectations can thus lead to personal insecurities conferred by a perceived failure not to be “man enough,” and subsequently expressed through fear, isolation, anger, and aggression or violence, especially in adolescent boys and young men. Negative changes for men (unemployment, alcoholism, mental illness, suicide) also have a negative impact on women, and can create a growing number of female-headed households, increasing women’s economic burden and reducing their protection.

In India, including men and boys will require a focus on positive attributes and contributions as well as on what they desire for themselves and their children – improved relationships with their partners, more involvement in the rearing of their children, and more options and opportunities in the future for themselves and their children, for example. The needs of children, and for a father’s contribution in their lives, seem to be positive entry points for engaging men in broader issues of gender equity. In so doing, men have opportunities not only for richer personal lives, but also for sharing in the care and contributing to the growth of their children.

### Chapter 4: The Right to Adequate Nutrition

#### 4.1 Introduction

Undernutrition in India remains unacceptably high, with evidence indicating that all forms of undernutrition account for 46 per cent of child deaths. Therefore, if India is to dramatically reduce child mortality, it must break this cycle of chronic undernutrition and disease. This will involve tackling

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131 Based on National Crime Records Bureau statistics.

not only inadequate dietary intake and disease, but also food insecurity, inadequate feeding and care practices and, ultimately, inadequate access to services, inadequate human and financial resources, and the socio-cultural, economic and political context with regard to nutrition.

**Figure 1** depicts the prevalence of stunting among children of various age groups. While an overall decline is seen in the level of stunting during the years 2006-2014, yet more than 2 in 5 (46 per cent) of children were already stunted by age 2 years in 2013-14 (**Figure 2**). In all, according to RSOC 2013-2014 data, more than 44 million under-5 children are stunted, accounting for nearly one-third of the global burden of childhood stunting. At the same time, more than 17 million under-5 children are wasted and dangerously thin. **Figure 3** indicates trends in levels of stunting and wasting among under-5 children in India, most of whom are unlikely to survive, grow and develop to their full potential. Further, India is home to 5.6 million severely wasted children (4.6 per cent of children), representing half of the global severe wasting burden.

**Figure 2: Trend in Stunting Among Under-5 Children**

**Figure 3: Trend in Wasting Among Under-5 Children**

Children from the poorest families and marginal groups face more deprivation than those in wealthier families. Adolescent girls particularly face nutrition issues, including anaemia, although a significant proportion of boys also are anaemic, as highlighted in Sections 3.2 and 3.7. In all, poor nutrition is a
major cause of other health problems in the country, including high infant and maternal mortality (see also Chapter 5), as well as affecting school performance and economic growth.

All this is leading to growing recognition among policymakers that chronic undernutrition is India’s “silent emergency” and is likely to continue to 2030, across nearly all states (Figure 4). It also underscores the importance of focusing on the first 1,000 days of life as a crucial nutrition window of opportunity, with a multisectoral approach targeting the most affected areas and groups for maximum impact. For example, despite Kerala’s impressive HDI rank, high per-capita income and high female literacy rate, the state’s prevalence of stunting is comparatively high, at 19 per cent (more than 480,000 children below 5 years);¹³³ this is due in part to poor infant and young child nutrition practices, such as low levels of initial breastfeeding and exclusive breastfeeding.¹³⁴ In other states, disparities between districts are particularly pronounced, with five of 19 districts accounting for 42 per cent of the estimated numbers of stunted children in West Bengal. Similarly, in Andhra Pradesh, three of 13 districts account for 34 per cent of that state’s stunted children.¹³⁵

Figure 4: chronic undernutrition is India’s “silent emergency”

Tribal districts also have high proportions of stunted children; every second tribal person in rural India lives in food-insecure conditions, with caloric and protein consumption from 25 to 53 per cent below the recommended dietary allowance.¹³⁶ Rates of anaemia and micronutrient deficiencies are generally high. At the same time, diminished livelihoods, chronic poverty and poor access to resources, fuelling conflict, all make service delivery in these areas a challenge.

Major Gaps in Access to Essential Nutrition Interventions
RSOC 2013-2014 findings indicate that poor access to essential nutrition interventions result in a number of key risk factors, particularly linked to poor maternal status and caring practices for women and children, including low male involvement. All 25 key interventions* are poor in terms of national coverage – with none achieving more than 78.7 per cent – but particularly low proportions are reported minimum dietary diversity (6-23 months), at 19.9 per cent; de-worming, (27.2 per cent); consumption of 100+ iron folic acid tablets during pregnancy (23.6 per cent); proportion of children whose stools are disposed of safely (21.1 per cent); adolescent girls (aged 15-18) with low BMI (44.7

¹³³ RSOC 2013-2014, op.cit.
¹³⁵ NFHS-4 2015-2016 data.
per cent); proportion of women aged 15-49 consuming fruits (39.8 per cent), eggs (32.3 per cent) or fish/chicken/meat (35.45 per cent); and children with low birth weight (18.5 per cent).

*Covering infant and young child feeding, micronutrients, health/WASH, and adolescent and maternal nutrition.

Critically, nutrition-specific interventions alone cannot improve nutrition outcomes without due attention to multisectoral nutrition-sensitive interventions as well. While nutrition-specific interventions – e.g., to promote breastfeeding, improve the diets and nutrient intake of children and women, and improved coverage of health services – will address the immediate causes of undernutrition, for sustainable and accelerated improvements in nutrition outcomes, increased focus needs to be given to nutrition-sensitive interventions that address underlying causes of undernutrition (women’s education and decision making, delaying age at marriage and childbirth, poverty reduction, and social protection programmes for the most vulnerable).

In addition, a need exists to further investigate the link between undernutrition and emerging issues such as climate change, LWE and conflict, migration and rapid urbanisation, through collaboration with strategic research and knowledge institutions and partnering with knowledge forums such as the Scaling Up Nutrition (SUN) movement. There also exists a need to build an evidence base, including trend analysis on emerging nutritional risks such as overweight and obesity, which can lead to nutrition-related non-communicable diseases (NCDs), including high blood sugar levels and hypertension (see also Chapter 5). Lack of disaggregated data at the district and sub-district levels and by gender, wealth quintiles and other stratifiers represents a particular area of concern that will need to be addressed.

4.2 Nutrition Institutions, Systems and Governance
The Government has introduced numerous policy and legislative measures to improve the nutritional situation of children and women. These include the adoption of the National Policy for Children 2013 and the National Food Security Act 2013 (Right to Food Act). The National Policy for Children has nutrition as among the undeniable rights of every child. It reaffirms the Government’s commitment to securing this right for all children through access, provision and promotion of essential nutrition and care services to ensure that children attain their optimal potential for growth and development. The Policy also calls for purposeful convergence and coordination across different sectors and levels of governance toward overall child rights. Now, this favourable policy environment for nutrition in the country needs to translate into commensurate actions and budgets for achievement of the SDGs.

For its part, the National Food Security Act converts the existing food security programmes of Government into legal entitlements. It includes the supplementary feeding programme under the ICDS, the school Mid Day Meal programme, and the maternity entitlements programme, among others. A total of 32 states and Union Territories are implementing the Act, with some providing direct cash transfer of food subsidies to beneficiaries.

While the Act focuses on the right to food, adequate attention still needs to be given to nutrition security. The Act aims to achieve food security through the supply of required quantities of subsidised food grains, but quality nutrient foods such as pulses and milk/dairy products have been overlooked, although the consumption of these in the diets of children and mothers from poor households is severely limited. Therefore, the proposed food basket for the priority households needs to be expanded to include foods with high nutritive value. In addition, a 2015 study in six states revealed
gaps in the identification of priority households and leakage in the system.\textsuperscript{137} Meanwhile, a further key piece of legislation is the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992, as Amended in 2003 (IMS Act); this also is important given that the CRC identifies breastfeeding as a legal right of the child and calls for protection of the public from inappropriate and biased information that persuades mothers to give up this practice.

The Government is in the process of developing a National Nutrition Strategy, while the National Nutrition Mission is awaiting Cabinet approval. However, institutional capacity to plan and manage large-scale programmes for public health nutrition remains limited, particularly at district- or sub-district levels. A need further exists to enhance the knowledge and counseling skills of community- and facility-based functionaries on nutrition.

Meanwhile, despite national initiatives to improve infant and young child feeding, strengthened commitment to complementary feeding, in terms of policy and investment, has yet to receive its due share of attention. The Government has made provisions for 6 months’ paid maternity leave for central Government employees to promote exclusive breastfeeding; however, this benefit does not cover state government employees or women working in the private and informal sectors, thereby leaving out most working women. Similarly, India still requires the appropriate legislation to support expansion of food fortification programmes. In 2013 and 2014, a national food fortification coalition was formed, which is advocating with the central Government for stronger commitment to food fortification programmes.

Critically, the responsibility for the delivery of nutrition-specific services is shared by the Ministries of Women and Child Development (MWCD) and Health and Family Welfare (MHFW) and their state departments. MWCD is the nodal Ministry for the formulation and implementation of the National Nutrition Policy and the ICDS programme, whereas MHFW has prime responsibility for implementing micronutrient programmes and providing facility-based treatment for children with severe acute malnutrition (SAM). In the emerging scenario, initiatives such as MHFW taking up nutrition issues (e.g., exclusive breastfeeding) and ECD should be considered, along with ways to increase such positive approaches.

MHFW is completing the NFHS-4, which for the first time since 2002-2003 will generate estimates for key nutrition indicators at district level, while also allowing disaggregation by urban/rural, STs, SCs, wealth quintiles, and gender. In addition, MHFW and UNICEF are conducting the Comprehensive National Nutrition Survey, which for the first time will generate national data on the micronutrient status and worm infestation status of children and adolescents in the country. This initiative also will serve as the first national effort to document the extent and severity of overnutrition and nutritional risk factors for NCDs among school-age children and adolescents.

In 2013, MHFW universalised the adolescent girls’ anaemia control programme, renamed as the Weekly Iron Folic Acid Supplementation (WIFS) programme. The programme aims to cover 30 million adolescent girls in and out of school nationwide, as well as boys in school. Although WIFS coverage reporting and accurate reporting continue to be challenges, WIFS reporting formats have been simplified and are being pre-tested in four states. Another key scheme for adolescents is the Rashtriya Bal Swasthya Karyakram (RBSK), which screens children and adolescents for nutrition deficiencies as well as health developmental delays.

At the same time, the Ministry of Food and Civil Supplies and Ministry of Agriculture are involved in addressing nutrition-sensitive issues such as poor household food security, including food availability,

economic access and use of food, while the Ministry of Drinking Water and Sanitation is in charge of household access to safe drinking water and sanitation services, both of which affect nutrition. Lastly, the Ministry of Rural Development, Ministry of Land and Forests and Ministry of Tribal and Minority Affairs also are involved in nutrition-related policies and governance.

Efforts are under way to strengthen service delivery and convergence, such as through the ICDS Systems Strengthening and Nutrition Improvement Project (ISSNIP), which focuses on enhanced capacity building, advocacy and communication for behaviour change, and real-time monitoring. Priority also is being given to the strengthening of Village Health and Nutrition Days (VHNDs) as a delivery platform for delivery of health and nutrition services, using feeding schemes for pregnant women and children for delivery of an integrated package of interventions. Notably, however, many nutrition service delivery points are still not located in structurally and functionally resilient buildings for uninterrupted supply even during and after disasters; pre-positioning of emergency food stocks close to communities also has yet to be mainstreamed.

At the same time, collaboration between key Ministries remains a key challenge. Meanwhile, numerous states are setting up Nutrition Missions or an equivalent mechanism for improving governance, coordination and accountability for nutrition; the pilot Nutrition Mission approach in Maharashtra has produced encouraging results, with the NFHS-4 indicating that stunting has continued to steadily decline in the state. At least three states are making specific commitments for tribal children’s nutrition.

MHFW and several state governments also have indicated interest in introducing community-based management of children with severe acute malnutrition (CMAM), with Maharashtra and Odisha having initiated pilots; this approach need to be strengthened further. Other states, including Gujarat, Kerala, Madhya Pradesh, Rajasthan, and Haryana, are at different stages of planning integrated programmes in the management of children with SAM. National guidelines for CMAM have been drafted, along with development of a training package for frontline health and nutrition workers. The lack of national guidelines has been a major barrier to planning for CMAM, and once approved, should serve to accelerate action. At the same time, no clear Government policy exists on the use of ready-to-use therapeutic foods for CMAM.

In terms of partnerships, the Citizen Alliance against Malnutrition continues to play an important role in mobilising high-level political support for nutrition. The Coalition for Nutrition and Food Security in India works on advocacy and policy influencing, including building consensus on the essential nutrition interventions. Further, a growing number of private institutions and agencies have the capacity to undertake large-scale surveys on nutrition.

Meanwhile, major barriers and bottlenecks remain in terms of nutrition knowledge generation and management. The accuracy of coverage data has been questioned, and systems are not in place for validating reported data. No composite MIS is available to capture all essential nutrition interventions and real-time progress, disaggregated by block/district; however, the MIS of flagship programmes/schemes under MWCD and MHFW have been strengthened, and some states are rolling out a revised ICDS MIS. With UNICEF support, MHFW is pioneering the establishment of NutritionInfo, a responsive and web-based dashboard envisaged to meet the critical need of having timely and effective access to a core set of integrated nutrition data on maternal, infant and young child nutrition plus adolescents, all in one platform.

As this chapter amply illustrates, it will be increasingly necessary to see nutrition not as a sectoral issue, but rather, a complex, multisectoral development challenge, with many underlying determinants. This requires coordinated and comprehensive multisectoral interventions within the Government, with leadership from the highest level. It also requires multi-stakeholder solutions,
including expanded partnerships with civil society, the private sector, and academia and development partners.

A strong need exists (1) to formulate viable social protection measures (e.g., direct transfers of inputs, food and/or cash to properly targeted households/communities); (2) to formulate natural resource management policies encouraging best practices in land and water use regimes, which nonetheless take into account locally sustainable practices; (3) to provide and disseminate high-quality information on various nutrition-related risks that communities face, and response options to these (e.g., timely and accurate climate forecasts, market dynamics); and (4) to invest in more ex ante risk management strategies (e.g., increasing livelihood diversification options). All this can strengthen governance for better nutrition outcomes for children and women.

4.3 Key Deprivations Affecting Children’s, Adolescents’ and Women’s Nutritional Status

Undernutrition is a critical form of deprivation that has profound effects on the child’s right to survival, growth and development (for analysis of key nutrition deprivations applying the five filters, see Annex 1). Between 2006 and 2014, the level of stunting among children below 5 years has fallen from 48 per cent to 38.7 per cent. However, the decline in the national level of stunting over these 8 years has been slow, at close to one percentage point per year; at sub-national level, Delhi, Tamil Nadu, Maharashtra, Uttarakhand and West Bengal registered impressive drops in stunted children, along with some of the states of the North East. Even so, at this rate it would take around 40 years for India to achieve the SDG target of ending undernutrition by 2030 and the World Health Organization target of bringing down level of stunting to 23 per cent by 2025 (for full causality analysis of undernutrition, including stunting, see Annex 2).

Stunting, Underweight and Wasting

In global terms, India contributes to 36 per cent of under-5 children who are underweight, 35 per cent of under-5 children who are wasted and 29 per cent of under-5 children who are stunted. Disparities in these indicators by residence, gender, social groups and wealth quintiles have narrowed over the years, and the proportion of girls is lower than boys across all three. However, children belonging to SC and ST families continue to be malnourished in higher proportion than those from other families (see Section 3.3).

In terms of the overall burden of children suffering from stunting in the country, 1 in 4 stunted children are in Uttar Pradesh, followed by 15 per cent in Bihar, as Figure 5 below illustrates.

Figure 5: overall burden of children suffering from stunting in the country

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138 Stunting Equity Profile, op.cit.
139 Ibid.
Stunting prevalence continues to vary widely among states, ranging from 50.4 per cent in Uttar Pradesh to 19.4 per cent in Kerala. Most stunted children in the country in 2014 were in the central and western states. Out of 44 million stunted children, 11.1 million alone were in Uttar Pradesh (23.7 per cent) and 6.9 million in Bihar (14.8 per cent), as indicated above. A total of three-fourths of the stunting burden (35 million) is concentrated in just eight states: Uttar Pradesh, Bihar, Maharashtra, Madhya Pradesh, Rajasthan, West Bengal, Gujarat and Andhra Pradesh. At the underlying level, poor hygiene and sanitation practices remain a major driver of stunting, with nearly half of households defecating in the open and only 1 in 5 disposing of child stools safely (see also Chapter 6). In three states – Bihar, Jharkhand and Odisha – more than 75 per cent of households practice open defecation, and are more likely to have very low rates of safe disposal of child stools (less than 10 per cent).

Figure 6: level of stunting among children below five by residence

More children in rural areas (42 per cent) are stunted than those in urban areas (32 per cent) (see Figures 6 above), although stunting is expected to be a major issue among the urban poor living in slums. As per an analysis of RSOC 2013-2014 data, 42 percent of urban poor children are stunted, while overall stunting among children from urban areas is 32 per cent. For example, there is a high risk of stunting among young mothers and infants living in non-notified slums, which lack access to proper sanitation, sewage and drainage. Stunting among children increased 6 per cent in the

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140 RSOC 2013-2014, op.cit.
141 Stunting Equity Profile, op.cit.
wealthiest quintile of the population, but overall stunting rates remain double among the poorest compared to the wealthiest, as highlighted above. The bottom wealth quintile still comprises more than half of stunted children. Nearly half of children from SC, ST and OBC families are stunted, while stunting among Muslim children is relatively more common than among children from other religious groups (see Figures 7 and 8 below). Children of mothers with no education are twice as likely to be stunted as children of mothers having completed at least 12 years of education.\footnote{Ibid.}

Critical indicators affecting stunting include low birth weight, institutional delivery, breastfeeding practices, minimum dietary diversity, frequent infections and, as noted above, open defecation. Longer-term conflicts (Maoist LWE, North East insurgency), sudden eruptions of conflict such as communal riots, and natural disasters (floods, drought) all make children even more vulnerable.

As the data above show, between 2006 and 2014, wasting in the country declined notably, by 23.7 per cent, but it continues to be a major risk for child survival and development, especially among lower wealth quintiles, SCs/STs, and the urban poor. It is affected by seasonality, including the rainy season and extreme weather conditions, as well as by short-term social conflict and migration.

Meanwhile, while the average annual rate of improvement for early initiation of breastfeeding and exclusive breastfeeding till age 6 months both showed strong improvement between 2006 and 2014, the initiation of complementary feeding remained more or less stagnant; half of children still are not initiated to complementary feeding at the appropriate time.\footnote{Nutrition Programme Context Synthesis Paper, op.cit.}

Inadequate Young Child Nutrition Practices
A major cause of concern is the decline in the percentage of children aged 6-23 months receiving adequate feeding. Minimum diversity has reduced from 35 per cent to 22 per cent, and children receiving a minimum acceptable diet plunged by half, from 21 to 11 per cent. While there have been improvements in breastfeeding practices in the country, complementary feeding has shown negligible improvements. Only half of children aged 0-6 months are introduced in a timely fashion to complementary foods (see Figure 9).
Adolescent Anaemia

With the world’s largest adolescent population, India faces an acute issue of adolescent and maternal undernutrition, particularly including anaemia among adolescents, as noted above (see also Sections 3.2 and 3.7). According to the NFHS-3, 53 per cent of adolescent girls aged 15-19 are anaemic, compared to 30 per cent of adolescent boys (for full causality analysis of adolescent anaemia, see Annex 3), 47 per cent had low BMI, and 16 per cent had a child or were pregnant. High rates were found among out-of-school girls, SCs/STs, the urban poor, and those from lower wealth quintiles.

This affects not only individual cognition, but also national economic productivity, which in turn can be constrained. All this also is worrisome in light of the fact that girls and women who enter pregnancy with poor nutrition status are more likely to face poor pregnancy outcomes, such as pre-term births and low-birth-weight babies. At the same time, little or no official information is available on the specific nutritional needs of adolescents, although upcoming NFHS-4 data are expected to address this issue.

Links to Disaster Risk

Lastly, natural and manmade disasters – floods, cyclones, drought, earthquakes, landslides, and conflicts/civil unrest – all affect nutrition outcomes, with India articularly prone to all of these (see also Sections 3.4 and 3.5). As noted above, it is forecast that in the short term (2-5 years), these are likely to contribute to disease outbreaks, lack of access to medical facilities, and a breakdown in food security, all affecting children.

Moving Forward

Moving forward (see also Section 4.5 for full recommendations), evidence can be generated based on cutting-edge analysis of existing and emerging data on nutrition inequities. Critically, actors are fragmented in this field, offering major opportunities for value-added investment. Stunting among the most disadvantaged children is influenced by multiple inter-related factors, including maternal undernutrition before and during pregnancy; non-optimal infant and young child feeding, especially inadequate complementary feeding practices in the first 2 years of life; poor access to improved water and sanitation services; and poor access to health care. Addressing all these factors can help to accelerate efforts to improve children’s nutrition through multisectoral approaches, and can be replicated among particularly vulnerable groups.
4.4 Structural and Underlying Causes of Key Nutrition Challenges

Based on the above analysis as well as that found in the relevant Annexes, a number of structural/root causes for nutrition-related challenges in India, at different levels of duty bearers, have been identified. While detailed causality analysis of specific issues are offered in the Annexes as noted above, very broadly, these structural causes can be summarised as stemming from:

- A need for strengthened governance, including leadership, capacities and financial resources
- Overall socio-cultural, economic and political contexts that disadvantage children, adolescents and women
- Lack of household access to land, employment, income and education

All this results in a variety of underlying challenges, again multisectoral and multi-level, encompassing:

- Poor household food security, including food availability, economic access and use of food
- Inadequate maternal and child care and feeding practices
- Household lack of access to health services, safe drinking water and sanitation services

4.5 Recommendations to Improve Children’s, Adolescents’ and Women’s Nutritional Status

All children, women and men in India should be able to enjoy optimum nutrition to lead healthy and productive lives. Overall, this can be achieved only by prioritising nutrition services and key target groups, scaling up nutrition-specific and nutrition-sensitive interventions, and strengthening the enabling environment for concerted, multisectoral action on nutrition. All nutrition-relevant sectors – health, education, WASH, child protection, agriculture, food, social protection et al. – will need to align around nutrition as a fundamental component of human and economic development. Recommendations include:

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<th>Policy/Strategy</th>
<th>Support effective implementation and concrete Action Plans to complement policies in place</th>
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<td>Scale up nutrition-sensitive interventions, particularly in areas of WASH, reproductive health, adolescents, social protection, education and agriculture, to further address some of the underlying and structural causes of undernutrition</td>
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<td>Ensure that a Multisectoral Nutrition Strategy is embedded in the larger National Nutrition Strategy being developed</td>
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<th>Institutions/Governance</th>
<th>Support institutional strengthening to effectively address undernutrition, including sustaining and adequately resourcing coordination institutions</th>
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<td>Adopt a convergence and equity approach for multisectoral and multi-stakeholder responses</td>
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<td>Document how well the establishment process for Nutrition Missions is taking place</td>
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<td>Identify what elements can ensure this sustainability and minimise political influence</td>
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## Programme, Including Crosscutting (Adolescents/Gender/ECD/Tribal/Conflict/Urban Slums/Climate Change&DRR)

- Build a stronger focus on infant and young child feeding as a core nutrition component
- Support capacity development of human resources at national and sub-national levels, as well as sub-national-level technical assistance in planning, implementation and mainstreaming of issues such as gender and DRR
- Integrate issues of adolescent nutrition, especially adolescent girls’ nutrition, into existing platforms and programmes
- Give more attention to overlooked stages in the life cycle with regard to nutrition (e.g., secondary school level), to provide more seamless coverage
- Develop a more holistic view of nutrition within ECD, including breastfeeding and immunization, and focus on prevention of developmental delays
- Support the development of nutrition strategies, both nationally and in selected states, for urban slums

## M&E/Data/Knowledge Management/Innovation

- Support the strengthening of the quality of the Management Information System (MIS), to inform policies and programmes
- Validate coverage estimates, supported by high-level advocacy with the Government on the importance of accurate validation
- Analyse disaggregated data for pockets of deprivation related to nutrition (e.g., rising food prices)
- Undertake technical support and advocacy to ensure that elements of programme evaluation are considered from the planning stage
- Support the Government to undertake more regular/periodic nutrition data surveys
- Examine how technology can be used more effectively for real-time monitoring or dissemination to the public domain

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### Chapter 5: The Right to Health

#### 5.1 Introduction

India has made considerable strides in improving the health and well-being of its people, including meeting some of the key health-related MDGs (see also Section 2.1): It has more than halved infant mortality, from 80 deaths in 1991 to 39 deaths per 1,000 live births in 2014, and cut maternal mortality from 437 deaths in 1991 to 167 deaths per 100,000 live births in 2013 ([see Figures 10 and 11 below]).
Critically, it also has eradicated smallpox and guinea worm, and in 2014 achieved polio-free status. The launch of Mission Indhrahanush, in 201 high-priority districts with the aim of increasing full immunisation to 90 per cent of children by 2020, resulted in 21 million children being immunised during special drives in 2015 and 2016.

Despite this notable progress, however, India is still the world’s most disease-burdened country, according to the World Health Organization, accounting for one-fifth of the global incidence of disease. More Indians suffer from or die of preventable diseases than any other nationality in the world. India’s newborns and young children are especially vulnerable, not only because of the sheer size of India’s population but also as a result of low levels of education, a weak public health system, and very low Government spending on health care. Health outcomes vary dramatically across states, due to differences in rural accessibility, financial resources, administrative capacity, political priority and the quality of human capital, among other factors.

At the same time, the private health care sector is responsible for most health care in India, with recent research indicating that up to 3 in 4 patients opt for private care. However, private-sector health provision is localised in urban areas, which currently comprise only 35 per cent of the population; moreover, even in urban settings, it can only be accessed by upper- or upper-middle-income individuals and families, indicating a significant gap to address health-seeking behaviours among poorer segments of the population. Most health care expenses are paid out of pocket by patients and their families rather than through insurance, although wide variations exist between states. This has led many households, particularly the poor, to incur catastrophic health expenditures.
In 2015, 1.2 million children younger than age 5 years died in India, the highest number in the world. Critically, India is the only country in the world where girls have a higher under-5 mortality rate than boys (13 per cent higher), compared to 7 per cent lower than boys globally, as noted above. India, home to 17.5 per cent of the global population, accounted for 21 per cent of the 5.9 million under-5 deaths in 2015, and 27 per cent of all newborn deaths. Pneumonia and diarrhoea were the main causes of young child deaths in the post-neonatal period, responsible for some 300,000 children dying. In addition, every year about 45,000 women die from reasons related to pregnancy and childbirth, during or around the time of delivery.

Overall, about 696,000 babies in India die in the first 4 weeks of life every year, again the highest of any country in the world. About 37 per cent of these newborn deaths occurred in the child’s first day of life and 75 per cent during the first week, due to complications from prematurity, neonatal infections or complications during delivery. Newborn health outcomes thus are strongly linked to maternal antepartum and intrapartum health, and thus cannot be rectified after delivery. Hence, integrated maternal and newborn health interventions are required to further reduce newborn mortality. To also address this acute issue, more than 650 Sick Newborn Care Units (SNCUs) have been established, with 750,000 newborns enrolled in their real-time online monitoring systems. Globally this is one of the biggest real-time newborn databases, with the potential to be adapted to other country contexts.

Although India has reduced neonatal mortality by 20 per cent overall between 2008 and 2013 alone, progress has not been uniform. Stark inequities are found between states and districts, as well as by gender, rural/urban location, among different population groups, and across wealth quintiles. For example, the state of Punjab recorded a 43 per cent decrease in neonatal mortality over the five-year period, while in Jharkhand newborn deaths increased, by 4 per cent.

India also falls into the multi-burden category for the adolescent burden of disease (see also Section 3.2 and sub-section below). Adolescent pregnancies, undernutrition, sexual and reproductive health issues, and cases of HIV continue to be key issues for adolescents’ health in India, while mental and behavioural disorders, injuries and NCDs are further emerging concerns for the age group 10-19 years.

Critically, the issue of gender equality, as in other areas, is an important concern with regard to health outcomes (see Section 3.7), with significant barriers around access to care for the girl child and for women. Cultural and social norms are prevalent in this regard; the draft National Health Policy, which is yet to be approved, has a strong equity focus. At the same time, health consequences also are severe for persons, many of them women, who are denied access to decent work and trapped in low-end, poorly paid jobs with unhealthy, unsafe and debilitating work conditions.

Persons with disabilities, including children with disabilities, often have distinct and multiple health care needs relating to their impairments, which compound the general health care needs resulting from poverty and from living in difficult environments such as urban slums. Major barriers to physical mobility exist, often leaving options such as a wheelchair totally unfeasible. Accessible public transport is rare. Persons with disabilities also may face abuse when seeking services and entitlements.

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149 Equity Report, op.cit.
In particular, the health consequences of denial of decent housing in urban slums are acute, especially for children, who may be forced to occupy places with poor infrastructure, lacking space and provisions, and thus with problematic access to drinking water and toilets (see also Chapter 6). Regional disparities in access to piped water supply also are evident. At the same time, rapid urbanisation and changing lifestyles are altering the disease profile of the average urban Indian, requiring changes to national health strategies and increased spending. Many of the 1 in 3 Indians who today live in urban areas are primarily engaged in activities that do not require, or leave little time for, regular physical exercise. Rising incomes and the emergence of India’s packaged food industry also have increased consumption of processed food, high in unhealthy fats and sugars. This combination of unhealthy food and a sedentary lifestyle is fuelling a rise in NCDs, including diabetes and obesity, which are even beginning to be found among adolescents and young people.\(^{150}\) A recent study by the World Economic Forum and Harvard University School of Public Health predicts that NCDs will cost India US$3.55 trillion in lost work days and health treatment between 2012 and 2030, with heart disease accounting for more than 60 per cent of this cost.\(^{151}\)

Moreover, India’s health issues are being made worse by air, water and other types of pollution (see also Section 3.5), which are triggering an increase in respiratory ailments, waterborne diseases, and NCDs such as allergies and cancers. Worryingly, experts studying the effects of climate change on India’s disease profile believe that resistance to anti-malaria drugs and rising temperatures could challenge India’s successful anti-malaria campaign, warning that the country could become the malaria capital of the world between 2030 and 2050. Women, adolescents and children living in India’s Himalayan states of Jammu & Kashmir, Uttarakhand and Himachal Pradesh – much of which are above 1,700 metres – also might become vulnerable to malaria for the first time. Hotter temperatures could fuel a rise in water-borne diseases, particularly in urban slums, in addition to triggering drought and heat waves affecting children in particular. In northern India, climate change is expected to raise the incidence of diarrhoea by 13 per cent by 2040 compared to current level. Studies also predict a growth in protein-energy malnutrition among under-5 children due to dehydration and drought-related food shortages (see also Chapter 4).\(^{152}\) Lastly, although India has achieved MDG6 related to halting and reversing the HIV epidemic, still 86,000 new cases occur each year, with children younger than age 15 accounting for 12 per cent of new infections.\(^{153}\)

In the years to 2030, current trends will have both positive and negative impacts on the health of India’s children. India is likely to make progress toward further reducing childhood illness and mortality from communicable diseases, birth-related problems and undernutrition, supported by (1) rising incomes, which should substantially reduce the number of children living in poverty (see also Section 2.3); (2) top Government priority being given to maternal and child health under the National Health Mission, combined with expanded essential primary health care services to universalise health care; and (3) more educated women, with fewer and healthier children, given that the proportion of children is expected to decline substantially with a drop in the country’s total fertility rate.

At the same time, and despite considerable progress, chronic undernutrition is likely to continue as India’s most urgent health crisis (see also Chapter 4), particularly affecting poor children such as those

\(^{150}\) The National Diabetes Foundation reports that nearly 1 in 3 adolescents aged 14-18 in Delhi’s private schools are already overweight.


\(^{153}\) Health Programme Context Analysis Synthesis Paper, op.cit.
Moreover, as the growing population intensifies competition for jobs, schoolchildren and adolescents are likely to increasingly feel pressure to study and outperform their peers, leading to continual feelings of anxiety and depression, fear of failure, isolation and rising rates of suicide (see also Section 3.2). This represents a huge issue, and one that is already manifesting, because India’s public health system is not adequately equipped to deal with mental health issues.

Lastly, shortages in public health infrastructure and personnel will most affect poor children. More than 83 per cent of India’s community health centres have no surgeons, 75 per cent have no obstetricians and gynaecologists, 83 per cent have no physicians and 82 per cent have no paediatricians – which means even rapid improvements will not have a significant effect in the short and medium term.

In all, key drivers of health issues in India include not only low public health spending, but also low levels of literacy and education, resulting in unsafe practices that cause and/or perpetuate widespread disease and death, especially among the poor. The logistical challenge of India’s huge, and largely rural, population also is key, with people spread across more than 640,000 villages, many of which are still inaccessible by road. It is difficult for medicines to reach residents of remote areas regularly, and doctors tend to shy away from such postings. For the poor, these shortages are exacerbated by the concentration of national health and infrastructure and resources in richer, more urbanised areas. Illustrating the stark disparities involved, Goa, one of India’s smaller, more developed and literate states, has 1 Government hospital bed per 614 people, while in Bihar, a large and poor state, the ratio is 1 to 8,789.

5.2 Health Institutions, Systems and Governance
Growing concerns regarding access, affordability and quality of care have led to substantial reforms in India’s health sector in recent years. Policymakers recognise that health is essential to economic Development, which has led the Government to introduce key policies and programmes. Under the Constitution, India’s states have primary responsibility for health service delivery, while the central Government owns the national health programmes.

The NHM is the flagship programme for health and is funded by both central and state Governments; while it started with predominantly a rural focus, it added an urban component in 2013 (National Urban Health Mission) with a pro-urban poor component, but one that requires further strengthening. In addition, the MWCD is an important stakeholder for immunisation, nutrition and adolescent-related health interventions. The Government also has its own internal technical support wing, the National Health System Resource Centre, which provides support for planning and monitoring. On the policy front and to bring various departments and line Ministries together on crosscutting issues, the new NITI Aayog plays a key role (see also Section 2.2).

The draft National Health Policy, released in January 2015, remains to be adopted, due to Government concerns regarding the fiscal space available and the requirements for the Policy’s implementation; this requires adoption of a time-bound plan for implementation to expedite the Policy. In all, the Policy looks at making health a fundamental right through parliamentary legislation, and gives more flexibility to states to design their own health programmes. It focuses on additional health system improvements.

154 Not only are levels of child undernutrition high among urban slum children, but slum children also are 1.3 times more likely to suffer diarrhea than non-slum children, primarily due to widespread open defecation in the absence of functional toilets.


156 Ibid.
reforms, including the strengthening of urban primary health care services, and strongly emphasises equity.

Critically, the Policy also proposes to increase Government spending on health from current levels of 1.4 per cent\textsuperscript{157} to 2.5 per cent of GDP, in a phased manner, to achieve universal health coverage, which in itself is an important target of SDG3. At the same time, the global average of national GDP spent on health care stands much higher, at 5.4 per cent.\textsuperscript{158} Meanwhile, a new health insurance scheme for families below the poverty line will be another critical step toward ensuring the right to health and addressing financial burdens on the poor due to illness. Both public and private-sector out-of-pocket payments for health care are forcing many families into debt and up to 55 million poorer Indians back into poverty.

**A Favourable Policy Environment for Health**

Overall, a favourable policy environment exists for a number of key health concerns, including:

- Launch of India’s Call to Action, which shifted the approach of the health system toward comprehensive reproductive, maternal, newborn and child health plus adolescents (RMNCH+A), promoting a life-cycle concept at all levels of delivery
  - Launch of India’s Newborn Action Plan in 2014 further fine-tuned national and sub-national efforts in RMNCH+A by providing clear guidance for planning, implementation, monitoring and evaluation of life-cycle approaches for maternal and child survival
  - Development and launch in 2014 of the first national adolescent health strategy (RKSK), which takes a multisectoral approach and has given adolescent health and well-being higher priority. This strategy represents a paradigm shift, with a focus on community-based health promotion and preventive care. Nevertheless, the programme has been slow to take off.
  - A number of other programmes/schemes available for adolescents across different Ministries (Health and Family Welfare, Women and Child Development, Youth Affairs and Sports, Human Resources Development), including SABLA, RKSK, and the Adolescent Education Programme (see also Section 3.1
  - Development and implementation of the Integrated Action Plan for Prevention and Control of Pneumonia and Diarrhoea (IAPPD) in four states, marking a major shift toward an integrated approach focused on protection, prevention and health. This initiative has the potential for nationwide scale-up.
  - A decision on universal screening of pregnant women for HIV, as well as its integration with maternal and child health services, are critical opportunities to achieve elimination of Parent to Child Transmission (PTCT). The Option B+ treatment regime is being implemented countrywide
  - Launch of national guidelines for WASH in health facilities in 2015, which reaffirmed the Government’s commitment in this regard; this is critical given the new emphasis on this indicator under the SDGs (see also Chapter 6).
  - Mission Indhranush, launched in 2015 to accelerate full immunisation, with a focus on unimmunised and partially immunised children. In another major policy decision, the Government announced the introduction of four new vaccines under the Universal Immunisation Programme, including pneumococcal, rubella containing MR vaccine, rotavirus vaccine and adult Japanese encephalitis vaccine.
  - Launch of the RBSK programme in 2014, targeting the long-neglected issue of early identification of birth defects and developmental delays, which offers critical linkages with work on ECD
  - Establishment of a maternal death review (MDR) process for all states, with the exception of those in the North East. This has enhanced health monitoring systems through processes such as state-level MDR task forces, district-level committees, and the use of both community- and facility-based review systems.

\textsuperscript{157} World Bank data.

As highlighted above, private facilities are not accessible to large segments of the rural population and the urban poor, and only 5 per cent of Indians are covered by health insurance. In 2014, private inpatient care cost four times more than public inpatient care.\textsuperscript{159} The current per-capita public expenditure on health is US$75, with India being among the bottom 10 countries worldwide in terms of such Government spending. Nearly two-thirds of total out-of-pocket expenditures goes to purchase prescription drugs. Existing financial protection schemes currently cover only 25 per cent of the population, with a low ceiling for protection and exclusion of expenses on outpatient care, investigative procedures and drugs.\textsuperscript{160}

Government regulation of the private sector is weak, with practice and quality of care largely left to the private practitioner. This has implications in the delivery of key quality maternal and newborn health services that may not necessarily be related to profit, such as breastfeeding, use of labor monitoring through partograph, and “kangaroo” mother care. Such services may not be provided much by the private sector, while some procedures that may not be necessary may be delivered more at private facilities (e.g., high rates of cesarean sections). With weak regulatory systems failing to set and subsequently re-enforce quality standards, some patients also receive inadequate or inappropriate medical care. Several reasons are cited for relying on the private rather than the public health sector, with nearly 3 in 5 households citing poor quality of care in the public sector as their main reason for preferring private health care.\textsuperscript{161}

Lastly, rarely are primary health centres located at manageable distances from where the poorest and most excluded families and children live; they also are open only during working hours so that seeking care at such a centre usually requires taking a day off from work, thus losing that day’s wages. Waiting hours are long, and referrals and diagnostics can be costly. Moreover, these centres are widely seen as a location only for the receipt of family planning and pregnancy-related care. In addition, a majority of patients, who belong to “lower” castes or socially marginalised groups, report that health care staff are not polite and respectful.\textsuperscript{162} All this indicates the scale of health governance challenges still faced.

5.3 Key Deprivations Affecting Children’s, Adolescents’ and Women’s Health Status

India has shown better progress than much of the world during the MDG era in tackling health deprivations among children and women, even though it did not achieve many of the MDG health targets (see also Section 2.1) (see Annex 4 for analysis of key health deprivations applying the five filters). The under-5 mortality rate (USMR) for the country during 1990-2015 fell by 62 per cent, higher than the global decline of 53 per cent during the same period. Similarly, the Maternal Mortality Ratio for India declined 68 per cent during the MDG era, compared to the global decrease of 44 per cent.\textsuperscript{163}

Maternal Mortality and Skilled Birth Attendance

India accounts for the second-highest number of maternal deaths in the world, with 17 per cent of the burden. Most of these deaths are preventable. More than 87 per cent of such deaths occur in just nine states (Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh, Uttarakhand), for reasons including low coverage of quality antenatal care, persistent pockets of low institutional deliveries, limited number of facilities offering emergency obstetric care, and weak post-

\textsuperscript{159} World Health Organization. \textit{Global Expenditure Database}, n.d.
\textsuperscript{160} Health Programme Context Analysis Synthesis Paper, op.cit.
\textsuperscript{161} Ibid.
\textsuperscript{162} Exclusion Report, op.cit.
natal follow-up. Close to half of women do not receive the requisite number of antenatal care visits, nor have been visited by a health care provider within one week of delivery or discharge from the hospital. SC/ST mothers, along with those from the poorest wealth quintile and Muslim mothers, are all particularly vulnerable despite improved rates of institutional delivery among these groups.

In terms of skilled birth attendance, India has made good progress in the last decade, with institutional delivery reaching 81.9 per cent nationally;\textsuperscript{164} however, this figure requires further strengthening. In 2013, 5.5 million women still delivered at home, without a skilled birth attendant; many of these women were from tribal groups, and particularly from the lowest wealth quintile. In addition to maternal mortality, poor-quality maternal antepartum and intrapartum care is directly responsible for most newborn mortality in India, as noted above. Quality of institutional delivery represents a significant challenge, reflected not only in the maternal death rate, but also in the large number of asphyxia admissions in SNCUs, as well as in India having the highest number of stillbirths in the world.\textsuperscript{165} In addition to asphyxia, two of the major newborn killers include prematurity and newborn sepsis, both of which are also highly linked to poor maternal antepartum and intrapartum care. Thus, such care needs to be rectified if newborn mortality is to be significantly reduced.

**Neonatal Mortality**

At the same time, the country accounts for the highest number of neonatal deaths in the world, contributing to more than a quarter of the global burden. Its total is more than that of the other top four countries put together (See Figure 12 below).\textsuperscript{166} While the Neonatal Mortality Rate (NMR) per 1,000 live births has declined from 52 in 1990 to 28 in 2013, the rate of decline has been slow and lags behind in the decline of infant and under-5 mortality rates. Moreover, the decline has not been uniform across states. The goal for the 12th Five Year Plan is to reduce NMR to less than 24 deaths per 1,000 live births by 2017.

**Figure – 12 Neonatal Mortality Rate**

![Figure 12 Neonatal Mortality Rate](source)

Moreover, the share of neonatal to under-5 deaths in India is higher than the global average of 45 per cent and has increased from 46 per cent in 2000 to 57 per cent in 2015.\textsuperscript{167} This calls for increased investments and prioritisation of efforts toward reducing neonatal deaths.

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\textsuperscript{164} RSOC 2013-2014, op.cit.

\textsuperscript{165} Health Programme Context Analysis Synthesis Paper, op.cit.

\textsuperscript{166} Ibid.

\textsuperscript{167} Ibid.
In 2013, the Neonatal Mortality Rate (NMR) stood at 28 per 1,000 live births, but with wide variations among states (Kerala, 6; Odisha, 37) (see Figure 13 Below) as well as between rural and urban areas, urban and urban poor, and across castes/social groups and wealth quintiles, with particular effects on girls.168 Addressing these inequities will be critical to achieve the next level of gains under the SDGs. In terms of the absolute number of newborn deaths, the highest number of deaths occurs in Uttar Pradesh, with that state, along with Bihar, Rajasthan and Madhya Pradesh, accounting for more than half of newborn deaths in the country.

Gender inequity remains a defining factor for neonatal and under-5 mortality alike, with India being the only large country in the world to have a higher under-5 mortality rate for girls than boys (see also

Annex 5 for a causality analysis of key health deprivations, with a focus on girls). Within states, the variation in under-5 mortality between girls and boys is significant, ranging from 40 percentage points in Jharkhand to almost zero in Jammu & Kashmir; Chhattisgarh, Punjab, Haryana and Rajasthan also record a difference of more than 30 percentage points.169

Figure 15: Proportion of Excess U5 Mortality among Girls vs. Boys (%)

![Graph showing proportion of excess U5 mortality among girls vs. boys in different states.]

Source: SRS 2013

Gender iniquity between male and female newborn admissions in SNCUs also is a major concern, as noted above, with only 41 per cent of admissions being girls.

Critically, an adverse sex ratio for girls is widespread, and is worst in rural areas and higher wealth quintiles, as well as among the urban poor (see also Sections 2.3 and 3.7). Overall, the child sex ratio has declined from 927 to 919 girls per 1,000 boys, with some states reporting fewer than 900 girls per 1,000 boys.

Adolescent Health Issues
As highlighted throughout this Situation Analysis, issues of poor adolescent nutrition, child marriage and adolescent pregnancy all have major implications for preterm births, low birth weight, and neonatal and maternal mortality (see also Section 3.2 and Chapters 4 and 8). For example, there exists a 50 per cent increased risk of stillbirth and neonatal death if the mother is younger than age 18.

Adolescent health profiles differ greatly between and within states, between urban and rural areas, and among boys and girls. These differences reflect epidemiological transitions, where reductions in mortality and fertility patterns shift both population structures and disease patterns. In some states, adolescents have a higher prevalence of HIV and other infectious diseases, undernutrition, adolescent fertility and poor sexual and reproductive health. These states continue to have high adolescent fertility and high unmet need for contraception, particularly among unmarried, sexually active adolescents. Meanwhile, adolescents from the most marginalised groups, including STs, migrants and

transgenders, are some of the most unreached and underserved in India (see also Sections 3.3 and 3.6).

Breastfeeding

Figure 16: Early/Exclusive Breastfeeding among SC/ST/OBC Women

The persistent gap between institutional delivery and early initiation of breastfeeding also constitutes a matter of concern (see also Chapter 4). Only around 65 per cent of households across social groups have practiced exclusive breastfeeding (for children aged 0-6 months). More than half of newborns are deprived of mothers’ milk in the first hour of life. Among different social groups, more babies from Scheduled Tribes were breastfed early. On the more positive note, newborn babies initiated to breastfeeding immediately after birth has nearly doubled between 2006 and 2014. Addressing these, along with issues of low breastfeeding rates in urban settings, as well as declining urban immunisation coverage in some states and high rates of cesarean sections, are other areas for action, with particular attention to urban slums.

Immunisation
Some 9 million children remain unimmunised or partially immunised (see Figures 17 and 18 below) and continue to be at risk for vaccine-preventable diseases. The increase in full immunisation coverage in the last five years has been modest, according to the RSOC 2013-14, while ST/SC children have even lower rates of immunisation, of up to 16 per cent less; the rural-urban divide also remains significant.

**Figure 17: Children Partially Immunised (6.1 million/28 per cent)**

![Pie chart showing children partially immunised by caste]

**Figure 18: Children Never Immunised (1.5 million/7 per cent)**

![Pie chart showing children never immunised by caste]

Pneumonia and Diarrhoea
In the postnatal period, as noted above, childhood illnesses, especially pneumonia and diarrhoea, remain the major killers, with 179,000 and 118,000 deaths each year respectively, particularly in socioeconomically deprived populations (see also Figure 19 below). About 1 in 5 children suffering from diarrhoea did not seek treatment in 2014.  

**Figure 19: Causes of death**

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170 RSOC 2013-2014, op.cit.
171 Ibid.
Data from the Institute of Health Metrics and Evaluation raise the alarm on four strong trends, all of which have already begun to affect India’s children and adolescents, as indicated above:

- **Diabetes and obesity.** Since 1990, diabetes has grown by 54 per cent to become the eighth leading cause of morbidity in India. The International Diabetes Federation reports that the incidence of diabetes in the country is likely to surge by 2030 and to affect more than 100 million people.

- **Heart disease.** In tandem, heart disease has emerged as the principal cause of premature death. Since 2000, there has been a steady increase in blocked arteries and heart attacks among India’s younger citizens, particularly in urban areas.

- **Self-harm, depression, anxiety and suicide.** A 44 per cent increase has occurred in self-harm or suicide, which has climbed from the 20th to the ninth leading cause of premature death. India’s suicide rate is now among the highest in the world, driven primarily by increases in suicide among adolescents and young people aged 15-29. Depression also has climbed from fourth place to second as a leading cause of morbidity, and anxiety continues to rank in ninth place, having increased by 5 percentage points since 1990. Overall, suicide has emerged as the second-leading cause of death in the age group 15-29. Young women are more prone to suicide than young men, with some relying on it to escape patriarchal oppression in arranged marriages. About two-thirds of youth suicides occur among better-educated high school or university graduates in more developed parts of the country, related to perceived unsatisfactory performance in India’s highly competitive school-leaving examinations. An increase also has occurred in suicides among...
housewives and indebted farmers (estimated at 20,000 and 5,000 respectively in 2014), with subsequent impact on their families (see also Section 2.5).

- **Respiratory tract infections and pulmonary diseases.** Lower respiratory tract infections and chronic obstructive pulmonary diseases rank among India’s top 10 killers, with the 26 per cent rise in cases of the latter reflecting the leading role smoking and air pollution now play in causing morbidity in India (see also Section 2.5), particularly in urban slums and rural areas.

**Moving Forward**

Moving forward (see Section 5.5 for full recommendations), emerging health issues that require special focus in the period 2018-2022 include long-term survival, growth and development of the large number of babies discharged from SNCUs. By 2017, it is expected, 1 million newborns will be discharged each year from the 750 SNCUs in the country. These newborn continue to remain at high risk of death, stunting and developmental delay later in life, as well as NCDs. In the absence of appropriate follow-up, nearly 10 per cent are likely to die.

Ensuring such follow-up, both in the community and in the facility, will be key to enhanced long-term outcomes for these children, marking the next significant gain in reducing neonatal mortality and addressing disability. Strong linkages also exist with (1) early identification of developmental delays and (2) addressing of gaps in institutional delivery and early initiation of breastfeeding under an ECD focus.

A second major emerging issue arises from needed improvements in quality of care in delivery rooms and SNCUs, as noted above, thereby reducing maternal deaths, stillbirths and asphyxia deaths among newborns. It is estimated that by the end of 2017, nearly 100,000 neonatal deaths will occur in SNCUs themselves. Fewer female admissions in SNCUs likewise will need to be addressed, as will a need to better monitor deprivations in relation to maternal and newborn health. Other key crosscutting issues will be related to adolescent nutrition and low birth weight; linkages of air pollution, particularly indoor air pollution from use of solid and unclean fuel, with child deaths from pneumonia; ensuring health services in drought-affected districts, especially services for delivery and newborn care, are not affected by water scarcity; and strengthening WASH in health facilities (see also Chapter 6).

Overall, the equity focus will differ by intervention, state and geographies. For example, institutional delivery has maximum inequity across caste and wealth quintile, while early initiation of breastfeeding has the least inequity on this account. Similarly, immunisation and early initiation of breastfeeding display no gender inequity, while gender is a defining factor for child survival as evidenced in neonatal care in SNCUs. Further, the urban advantage for immunisation is compromised in states such as West Bengal, Andhra, Pradesh, Telangana, Karnataka and Sikkim, with higher coverage in rural areas. Thus, each state and intervention will have its own equity dimension that will need prioritisation. Lastly, partnerships will need to be strengthened with the private sector, especially the corporate sector, which can be useful for expertise and funding for infrastructure development, capacity building and innovative use of ICTs.

Additional issues in health care programming that will require priority focus in the near term include:

- **Moving toward universal health coverage and financial risk protection,** which will require engagement in policy advocacy and programme support toward expansion of social health insurance from the current very low level, so that equity gaps in health care do not expand further.

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172 According to BBC reports.
173 Ibid.
174 Ibid.
Focusing on quality of maternal and child health care throughout the continuum of care

Improving partnerships and coordination of efforts with the private sector and health professional associations for better maternal and newborn health

Mainstreaming maternal and newborn health within not only health programmes but also in other sectors

5.4 Structural and Underlying Causes of Key Health Challenges

Based on the above analysis as well as specific causality analyses in the relevant Annexes, a number of structural/root causes for health-related challenges in India, at different levels of duty bearers, have been identified:

A need for strengthened Government stewardship, including in policy implementation, strategic planning and effective coordination, and particularly in light of a potential shift toward universal health coverage

The engagement of most of the trained human resources in health in the private sector. For example, 28,000 of the total of 32,000 obstetricians in India are in the private sector; the situation is the same for all other specialty medical categories. Critically, therefore, the challenge is the inability to attract and retain qualified human resources for health in the public sector

Weak institutionalisation of key maternal and newborn health human resources, with particular emphasis on the midwifery profession. India adopts the nurse-midwifery model of midwifery health human resources; this has been shown to be a weak model in terms of quality human resource development, retention and regulation as compared to a generic, stand-alone midwifery profession. The latter is the globally accepted model of midwifery care

Limited numbers of adequately trained health management human resources at lower levels of the health system in particular

A need for improved access to and strengthened quality of services and infrastructure, especially in hard-to-reach areas, including urban slums

Low status of women and adolescents, including the autonomy to take decisions for antenatal care, safe birth, and family planning, as well as persistent son preference and low value for girls

Extremely low public health allocations, along with high out-of-pocket health expenditures for seeking skilled care

Low levels of financial risk protection, including extremely low levels of social health insurance coverage

Poor engagement with and regulation of the private health sector

Emerging effects of climate change and recurrent natural disaster

All this results in a variety of underlying challenges, including:

Inefficient and inequitable allocation/utilisation of resources (human resources, finance, supplies), especially in hard-to-reach areas

Poor health care seeking, especially on behalf of the girl child

Lack of awareness among health workers on critical issues, particularly with regard to effective newborn care and quality health services, including reproductive health services, for adolescents

Inadequate knowledge on and attitudinal barriers to good health and caregiving practices and their benefits among family members

Lack of evidence and real-time monitoring data for planning, particularly demand-side disaggregated data and disaggregated data between urban and urban slum areas

Vacant posts and absenteeism, especially in hard-to-reach areas

5.5 Recommendations to Improve Children’s, Adolescents’ and Women’s Health Status

The human right to health means that every child, every adolescent and every woman has the right to the highest attainable standard of physical and mental health, including access to all health services. It means that hospitals, clinics, medicines and doctors’ services must be accessible, available, and of
good quality for everyone, on an equitable basis, where and when needed. To advance further toward this goal in India, recommendations include:

<table>
<thead>
<tr>
<th>Policy/Strategy</th>
<th>Advocacy for increase in the Government health budget to 2.5 per cent of GDP to reduce out-of-pocket expenditures</th>
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<tbody>
<tr>
<td></td>
<td>Support to universal health coverage and financial risk protection through universal social health insurance</td>
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<tr>
<td></td>
<td>Support to judicious use of low public health funding in districts and blocks where these resources are most required, thereby addressing significant intra-state as well as inter-state inequities</td>
</tr>
<tr>
<td></td>
<td>Support to development of a policy framework to ensure standardization and regulation of private sector health services. Uniform minimum standards of care for the entire health system will be necessary, including both private and public service delivery</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Institutions/Governance</th>
<th>Advocacy for improved regulation and enforcement of quality standards of private sector health facilities, to ensure quality of care and accountability</th>
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<tbody>
<tr>
<td></td>
<td>Support to improved and revitalised national and state health partnership forums, inclusive of health professional associations; bilateral organisations; multilateral organisation; and private sector providers with government health management</td>
</tr>
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<td></td>
<td>Support to district health management development and decentralisation</td>
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<td></td>
<td>Advocacy toward strengthening the pre-service and in-service health curriculum to accommodate public health issues, prioritising the needs of mothers and children in a holistic manner (preventive, promotive and treatment)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Programme, Including Adolescents/Gender/ECD/Tribal/Conflict/Climate Change &amp; DRR/Urban Slums</th>
<th>Enhanced focus on equity, with particular attention to wide variations between and within states, rural and urban areas, across castes and wealth quintiles, and in tribal districts and districts affected by conflicts</th>
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<tr>
<td></td>
<td>Greater attention to gender inequity, which remains a defining factor for neonatal and under-5 mortality in the country</td>
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<td></td>
<td>Support to improved health human resource management, with utilisation of private sector capacity to support the public sector</td>
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<td></td>
<td>Strengthen a multisectorial focus, including adolescent health, ECD, and the first 1,000 days of life for nutrition interventions</td>
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<tr>
<td></td>
<td>Strengthened focus on the impact of urbanisation, climate change and outdoor air pollution on children’s and women’s health</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>M&amp;E/Data/Knowledge Management/Innovation</th>
<th>Support uniform minimum standards of health management information systems (HMIS) and data collection for the public and private health systems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Support desegregation of HMIS data by age, sex, geographic area, religion and ethnicity</td>
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</table>
Chapter 6: The Right to Water, Sanitation, and Hygiene (WASH)

6.1 Introduction

Access to water and sanitation are explicitly recognised as essential human rights in a United Nations General Assembly resolution from July 2010. Later in 2010, a Human Rights Council resolution also was passed by consensus, confirming that the rights to water and sanitation already exist in international law. In 2013, the General Assembly Resolution and Human Rights Council both reaffirmed their recognition of these rights. However, while India is a signatory to these resolutions, it is yet to provide the right to water and sanitation as legal and justiciable, with direct legal recourse unavailable for citizens to access such services.

Although India met the MDG target for water (see also Section 2.1), the SDG for water is far more ambitious. For example, although the coverage of rural water supply in India stands at 93 per cent, the overlay of parameters as per SDG requirements sees a reduction to just 27 per cent; this takes into account definitions of improved water supply facilities, facilities located on premises, and those “available when needed.” Moreover, the unavailability of reliable data on water quality in India further risks reducing coverage levels to align with SDG indicators. All this disproportionately impacts women and girls, who are almost exclusively those engaged in water collection.

Similarly, rural sanitation coverage is estimated at 28 per cent, but falls to 19 per cent when SDG indicators are taken into account (e.g., population using an improved sanitation facility that is not shared with other households; and where excreta is safely disposed in situ or transported and treated off-site). The unavailability of data for handwashing at household level also poses challenges to meet the relevant SDG indicator (see Annex 6 for analysis of key deprivations in WASH using the five filters). In all, the impact of water, sanitation and hygiene interventions can vary widely depending on environmental context. Thus, it may be only some of these interventions are absent in a given setting, and it is these that should be focused upon. For example, in states where sanitation coverage and toilet use is high, a strong argument exists for addressing issues of water quality to increase the impact of WASH interventions.

Critically, India has 564 million people practicing open defecation, of which 524 million live in rural areas. Further, 75 per cent of STs and 63 per cent of SCs have no access to household sanitation, according to the Census 2011. Given the widespread incidence of open defecation in the country, it is clear that the issue needs to remain a priority in many areas, not least because of high-level Government commitment. The Prime Minister re-launched the Government sanitation programme as the Swachh Bharat Mission (SBM/Clean India Mission) in October 2014 with the aim of making India open defecation-free (ODF) by October 2019. Subsequently the Ministry of Drinking Water and


176 Ibid.
Sanitation (MDWS) released SBM guidelines that provide broad strategies to create an improved enabling environment for the acceleration of sanitation and hygiene services.

In all, access to WASH services has strong linkages to prevailing cultural and social norms in India that negatively impact marginalised populations and women. While open defecation is a socially accepted behaviour, gender norms adversely affect women and girls, who are faced with issues of privacy, dignity, health and safety (see also Section 2.3). Without access to toilets, women may only relieve themselves at dawn or dusk to mitigate the risks of physical harm and sexual assault. This leads to multiple health risks (see also Section 3.7 and Chapter 5). In all, women’s WASH concerns have rarely been addressed. They are not involved in decision making and are rarely in control of household finances, further impacting their abilities to access basic WASH services. Further, women’s responsibility for collecting water for many households, especially in rural areas, implies not only an additional physical and health burden, but also significantly lessens the time available for education or economic and other activities.

In 2014, the Government directed that every school should have separate toilets for girls and boys. MHRD also released the Swachh Bharat Swachh Vidyalaya guidelines in 2014, which provides a framework for the implementation of WASH in schools. Further, in 2015, the MDWS released menstrual hygiene guidelines. Although these are welcome steps, a major gap is found in effective operation and maintenance of WASH in schools. Taboos and a culture of silence around menstruation add to the WASH challenge. The overwhelming majority of girls miss school days during menstruation, and some girls drop out of school because of restrictive mobility norms as they gain puberty, or because of a lack of WASH facilities in schools.

At the same time, the Government’s preference for improved toilets means that Indians may build comparatively expensive pour-flush toilets instead of cheaper twin-pit or septic tanks. Consequently, understanding of the concept of a “sanitation ladder” is limited, which is a major barrier in persuading poor families to abandon open defecation and invest in the use of lower-cost alternative sanitary latrines.

### A Need to Remember Water Issues

The strong support at the highest levels for the Swacch Bharat initiative is now reflected in a race by states to attain ODF status by 2019. However, this has meant there is less attention to activities to sustain ODF status, a longer-term gain that risks being overlooked.

Critically, the push for ODF also has meant that water has been given less priority by Government, development partners and the private sector alike. The implications of this are potentially catastrophic: Such comparative neglect has contributed to insufficient emphasis on water safety and security planning; bacteriological and chemical contamination; and water for sanitation, among others.

The country suffers from groundwater overextraction in addition to the deteriorating drinking water quality, with poor agricultural and industrial practices arising from inadequate regulation and lack of routine water quality testing. Excess fluoride in India may be affecting tens of millions of people across 19 states, while equally worryingly, excess arsenic may affect up to 15 million people in West Bengal, according to the World Health Organization, and is being increasingly discovered in Uttar Pradesh.
Bihar, Chhattisgarh, Jharkhand and Assam. Combined water and sanitation related diseases are responsible for at least 60 per cent of the environmental health burden in India.  

In addition, four main bottlenecks exist, including capacity limitations within the Government to plan at scale for quality implementation; lack of a systematic approach to create demand for and use of quality water supply; limitations in water safety planning, testing and reporting; and constraints in generation, analysis and use of data and information to improve policy and implementation.

In all, while coverage is being accelerated and India has shown remarkable success already in issues such as ODF, sustainable change in WASH practices at societal level remains slow. Prioritising issues of infrastructure construction may come at the cost of quality and genuine behaviour change, a situation the country must avoid.

6.2 WASH Institutions, Systems and Governance

In India the delivery of water, sanitation and hygiene services is a state responsibility, as with health and education. However, the enabling environment in both the urban and rural sectors has systemic challenges as well as emerging opportunities. A vision and flexible policy guidelines are in place and, as noted above, the elimination of open defecation and achievement of a “clean India” represents a top Government priority.

With inconsistent implementation of flagship programmes, a major gap relates to the lack of an equity-driven approach in service delivery. State governments and others specifically need to do more to understand who the deprived are, and where they live, and then ensure that they are served first in a way that responds to their particular needs.

Critically, although the budget for sanitation is increasing, a huge gap remains in the funds required for making India ODF. Since its launch, the rural SBM programme has received only about 22 per cent of its 2019 target for total coverage. As a result, most districts receive insufficient funding to enable the entire district to be made ODF. Faced with a choice, district authorities may prioritise communities that are easier to reach rather than those that are more remote. Another critical bottleneck in SBM implementation in most states is the lack of human resources deployed within the SBM framework, resulting in sub-optimal service delivery, with women and children most affected.

Under the rural Swachh Bharat programme, a significant change in policy involves the recognition of the need for contextually appropriate state SBM strategies and initiatives. In turn, this has introduced greater degrees of programme decentralisation to states. The overall enabling environment for sanitation has been improved with four major strategic changes: (1) Flexibility to design a customised programme implementation approach; (2) A focus on districts as units of implementation; previously it was gram panchayats, which limited the ability to plan for service delivery at scale; (3) Responsibility for the programme under the District Magistrate, which enables convergence because the District Magistrate is the coordinator of all Government business in a district and thus is able to pull in the support of relevant agencies and programmes; and (4) States now have unprecedented leeway to use the SBM incentive in a more creative way than in the past, for example, paying a lump sum amount to an ODF community rather than to individual households, which facilitates more participatory approaches.

The other flagship WASH programme is the National Rural Drinking Water Programme (NRDWP), revised in 2013, which aims to provide a piped water supply to all gram panchayats by 2022, and to

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179 Ibid.
increase the water supply norm for at least 50 per cent of gram panchayats by 2017. Under a strategic plan developed to help operationalise the National Rural Drinking Water Programme, every rural person is intended to have enough safe water for drinking, cooking and other domestic needs, as well as for livestock throughout the year, including during natural disasters.

However, in addition to the key challenges related to water quality noted above, inter-sectoral coordination, continuous professional support to gram panchayats and communities, and emerging issues linked to climate change all require additional attention. Likewise, so do specific elements of bacteriological contamination and mitigation of arsenic and fluoride contamination; differentiated service levels between rural and urban areas; strengths and weaknesses of the water quality testing lab system; and a move from groundwater-based supply to surface water supply.

At the same time, a key breakthrough has been to align the Government’s successful Mid Day Meal programme in primary schools with the WASH in schools initiative. Mobilisation of the Mid Day Meal platform has enabled rapid scaling up of WASH in schools, particularly through the core element of handwashing with soap before meals, potentially reaching 110 million children in 1.4 million schools.\(^{180}\) At the same time, however, notable issues exist with regard to management of WASH facilities in schools, including funding of operations and management.

To address the considerable WASH issues found in urban areas, particularly urban slums (see also Section 3.6), the Ministry of Urban Development has initiated a number of programmes for urban water supply and sanitation. In addition to the urban SBM programme, these include the Accelerated Urban Water Supply Programme; the Atal Mission for Rejuvenation and Urban Transformation (AMRUT), which covers all states and Union territories and focuses on water; Smart Cities, covering 100 cities in five years; the Jawaharlal Nehru Urban Renewal Mission, for 60 cities; and the Urban Infrastructure Development Scheme for Small and Medium Towns, again focused on water supply.

Nevertheless, while urban areas are characterised by high levels of coverage overall, levels of service are relatively low; no cities have 24/7 WASH supply. Significant regulatory gaps exist for treatment of faecal sludge and waste management, an increasingly serious issue in urban areas with significant public health implications for the poor. For instance, various Municipalities Acts, echoing the 74th Amendment to the Constitution, do not explicitly mandate the treatment of wastewater, or even regular cleaning and de-sludging of on-site installations, particularly found in urban slums. Regulatory frameworks are also missing for private water supply tanker operators and de-sludging truck operators.

Absence of an independent regulator in the WASH sector represents a major issue: The Government is the producer, service provider and regulator, all in one, particularly in rural areas. In addition, urban assets are constructed without subsequent professional management, while persistent issues exist around a need for strengthened governance (mandates of water and sanitation service providers; financing for the poor; cost recovery and tariffs). Further issues arise from a lack of private sector engagement; poor slum management; environmental degradation; and sub-optimal community participation. Consequently, the urban WASH sector is highly fragmented, with a need for strengthened customer services.\(^{181}\)

Meanwhile, the responsibility of implementing WASH in public facilities lies with the respective line departments under the coordinating umbrella of the rural SBM programme. Therefore, core components of the rural sanitation programme are now supported through a cross-sectoral approach, integrating national flagships such as WASH in schools and SSA, as well as WASH in public health

\(^{180}\) UNICEF MTR, op.cit.

\(^{181}\) WASH Synthesis Paper, op.cit.
facilities, the national Newborn Care Action Plan, the clean hospital initiative and ICDS. However, important policy changes have occurred in the overall policy framework for WASH: Guidelines have been recently introduced for WASH in schools and for clean hospitals, along with National Guidelines on Menstrual Hygiene Management, to be implemented through coordinated actions by different Ministries dealing with adolescent health, education and sanitation (see also Section 3.2).

Lastly, evidence on key aspects of sanitation and water safety planning in India remain weak. This calls for strong partnerships with think tanks, academia and management agencies to undertake studies that can help to address gaps on issues of sustainability, embedding behaviour change, and working at scale. Mapping of stakeholders as part of district-wide interventions will be useful to identify the range and typology of influencers in states, who they influence, and their reach.

6.3 Key Deprivations Affecting Children’s, Adolescents’ and Women’s WASH Status

Critically, nearly half of Indians continue to defecate in the open, according to the RSOC 2013-2014 (see Annex 7 for full causality analysis of open defecation), with its 564 million practitioners representing the highest number of people in the world, as highlighted above.\textsuperscript{182}

Open Defecation

Stark disparities are seen in the practice of open defecation at the national level by residence, social groups, religion, and wealth quintile; for example, rural households are five times more likely to defecate in the open compared to urban households (rural 62 per cent, urban 13 percent). ST/SC households are 2 to 3 times more likely to practice open defecation in comparison to other households.

Similarly, households belonging to the poorest wealth quintile are 40 times more likely to follow the practice of open defecation than households belonging to the richest wealth quintile (see Figure 20 below). Use of toilets in the poorest quintile of households is progressing particularly slowly, with 91 per cent of people still practicing open defecation; at this rate, it is estimated that it would take some 180 years for the poorest people to reach the ODF goal.\textsuperscript{183} Even among the middle wealth quintile, where improvement in toilet use was most significant, the ODF goal is 20 years away.

**Figure 20: Open Defecation Progress, by Wealth Quintile, 2006-2014**

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<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>WQ1</td>
<td>95</td>
<td>91</td>
<td>4%</td>
</tr>
<tr>
<td>WQ2</td>
<td>83</td>
<td>71</td>
<td>14%</td>
</tr>
<tr>
<td>WQ3</td>
<td>64</td>
<td>46</td>
<td>28%</td>
</tr>
<tr>
<td>WQ4</td>
<td>20</td>
<td>17</td>
<td>15%</td>
</tr>
<tr>
<td>WQ5</td>
<td>2</td>
<td>2</td>
<td>0%</td>
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</tbody>
</table>

\textsuperscript{182} WHO and UNICEF, op.cit.

\textsuperscript{183} UNICEF India. *WASH Equity Profile*. New Delhi, 2016.
Although the practice of ODF is declining across nearly all categories of social group, it rose by 15 percentage points among ST households between 2008 and 2014.\(^{184}\) Moreover, three states with open defecation rates of more than 70 per cent in 2006 (Bihar, Jharkhand, Odisha) continued to be in the same situation in 2014, with negligible or no improvement. Thus ODF status, while being intensely pursued, remains a huge challenge.

**Improved Sanitation and Hygiene**

In terms of use of improved sanitation facilities, overall access to improved sanitation has increased sharply during the last 25 years, from 17 per cent in 1990 to 42 per cent in 2013-2014, according to the RSOC. In absolute numbers, 365 million more people have started using improved toilet facilities. Nevertheless, this was far below the MDG target, by some 19 percentage points (see also Section 2.1). Wide variations exist across states in the use of improved sanitation, from 15.0 per cent in Jharkhand to 92.9 per cent in Mizoram. However, just a third of the urban poor were using improved toilet facilities in 2014. Lastly, usage of improved sanitation in rural areas, at 30 per cent, is less than half that in urban areas overall (66 per cent) (see also Figure 21 below).

**Figure 21: Improved Sanitation Usage by Different Stratifiers**

<table>
<thead>
<tr>
<th>Improved Sanitation (%)</th>
<th>NE</th>
<th>CHSA</th>
<th>UP</th>
</tr>
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<tbody>
<tr>
<td>41.8</td>
<td>29.9</td>
<td>29.8</td>
<td>22.2</td>
</tr>
<tr>
<td>66.0</td>
<td>22.2</td>
<td>4.5</td>
<td>26.4</td>
</tr>
<tr>
<td>84.5</td>
<td>67.7</td>
<td>30.4</td>
<td></td>
</tr>
</tbody>
</table>

Source: RSOC 2014  
Note: NE: Head of household (HoH) with no education; CHSA: HoH completed higher secondary or more education; UP: Urban poor

Hygiene is a new indicator in the SDG framework, and its inclusion will require the development of effective approaches to address this crucial issue. In September 2016, the Government issued an order to all states to ensure that hygiene is addressed during implementation of the Swachh Bharat Mission; it already had increased the incentive payment to households in 2014 to allow for the installation of handwashing facilities outside household toilets, but behaviour change communication is critical for not only issues of handwashing, but also of menstrual hygiene management and good food hygiene practices.

**Clean Drinking Water**

Almost 91 per cent of households in India had access to an improved source of drinking water in 2013-2014 (see Annex 8 for full causality analysis of issues of lack of safe drinking water). The proportion of such households exceeded 90 per cent across residence, social groups and wealth quintiles, except for ST households (85 per cent) and households belonging to the poorest quintile (89 per cent). The 2011

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\(^{184}\) WASH Synthesis Paper, op.cit.
Census showed that 46.6 percent of households had access to drinking water within the premises, and another 35.8 percent had drinking water near the premises. As in other countries, the burden of collecting water falls disproportionately on women and young girls (see also Section 2.7); ironically, this situation can be made even worse by household adoption of toilet use, since water for sanitation and a reliance on water for cleansing demands greater and ready access to the resource. Meanwhile, after piped water supply, groundwater is the second major source of drinking water in India, for about 1 in 3 people. Nonetheless, groundwater use for drinking water is not sustainable because of the very high extraction of groundwater for agricultural irrigation and other purposes.

Yet at the same time, water scarcity is increasingly affecting water quality. Because of climate change, malaria and other vector-borne diseases, along with the diarrhoeal infections that remain a major cause of child mortality, are likely to spread into areas where colder temperatures had previously limited transmission (see also Section 2.5 and Chapter 5). Climate change and disaster also threaten important ODF gains: Worryingly, a rapid assessment of the 2016 drought in Maharashtra in 2016 revealed that use of toilets, wherever available, was drastically reduced, with 80 per cent of families in affected areas practicing open defecation because of water scarcity; toilets were being used only by women and girls “in case of emergency.”

Solid and Liquid Waste Management
Critically, 63 per cent of rural households lack proper drainage, which is important to address solid and liquid waste management once villages have become ODF. In several states (Gujarat, Jharkhand, Tripura, West Bengal, Assam, Odisha, Chhattisgarh), according to the Census 2011, more than 80 per cent of rural households do not have proper drainage. Yet solid and liquid waste, left unattended, provides a conducive environment for harmful microorganisms to thrive, and also attracts flies and mosquitoes, increasing the probability of vector-borne disease. Rodents such as rats and mice are also attracted by unmanaged solid wastes.

Related to this is the further challenge of ensuring proper management of bio-medical waste in clinical settings. Out of 38,000 million litres of sewage generated daily, treatment capacity exists for only 12,000 million litres per day (32 per cent), combined for metropolitan, Class I cities and Class II towns; moreover, sewage treatment plants often work at well below maximum efficiency. All major rivers of India are polluted, with potentially harmful effects on children and women.

WASH in Schools
At the same time, only 6 out of 10 schools have functioning toilet facilities. Even where toilets exist, only 1 in 2 is usable.\textsuperscript{185} Facilities at school often do not accommodate girls, particularly during menstruation (see also Section 3.7), or children with disabilities. It should be noted that to be declared ODF, districts need to also focus on ensuring access to WASH in institutions (schools, Anganwadi Centres, health facilities).

Handwashing

(See Figure 22 below), it is clear that although more than 4 out of every 5 households had an identified handwashing place, only 2 in 5 had water and soap at the site. In rural areas, nearly half of households did not have water and soap at the handwashing place.

Figure 22: Percentage of Households with Handwashing Facilities, Including Availability of Water\textsuperscript{186} and Soap

\textsuperscript{185} UNICEF India. \textit{WASH in Schools Report}. New Delhi, 2012.
\textsuperscript{186} As observed by the enumerator
Emerging Issues

In terms of emerging issues, new emphasis is required for WASH compliance in health facilities, an issue incorporated into SDG6 as an indicator. Many health facilities in India, particularly pre- and post-natal wards as well as labour/delivery rooms, have poor WASH facilities (see also Chapter 5). This heightens the risk of infection and contributes to neonatal deaths. Lack of WASH facilities also can discourage expectant mothers from having institutional deliveries. The governments of Rajasthan, Gujarat, and Tamil Nadu have made positive strides in this area, but more needs to be done across the country to make health facilities WASH-compliant.

While no baseline for WASH compliance in health facilities exists, anecdotal evidence points to it being lowest in facilities serving hard-to-reach populations.

A second important emerging issue involves strengthening of linkages between the WASH and nutrition sectors (see also Chapter 4). It is becoming widely accepted that even with sound implementation of the entire suite of 10 essential nutrition interventions, undernutrition in India’s children – particularly stunting – will continue to present with all its negative consequences. Nutrition-sensitive interventions, such as the provision of household sanitation and a clean and healthy household environment for children younger than 2 years, are essential to reduce stunting. With nearly 40 per cent of Indian children stunted, this implies that convergence among Nutrition Missions, NHM and WASH programmes (SBM, National Rural Drinking Water Programme) requires strengthening. Convergence between WASH and ICDS in Anganwadi Centres also is particularly essential for effective services for under-5 children, pregnant women, and new mothers alike.

Third, safe disposal of child faeces represents a particularly neglected WASH area, and one of the highest importance. Child faeces are frequently disposed of in the open, directly outside dwellings or into drainage systems. This practice is influenced by a well-established belief that children’s faeces is harmless. In fact, children’s faeces are known to have a higher pathogen load than that of adults and therefore pose a real risk to health. Acute emphasis is necessary to ensure that households adopt the safe disposal of child faeces as well as maintain clean and hygienic environments free of faecal matter.

Moving Forward

Moving forward (see Section 6.5 for full recommendations), it will be necessary to focus on the emerging issues highlighted above, as well as to give new urgency to addressing the need for clean drinking water. Further, it will be useful to seek ways to support health practitioners to understand where to invest in WASH so as to reduce neonatal and maternal deaths, while also reducing
pneumonia and diarrhoea in newborns and under-5 children. From a health sector perspective (see also Chapter 5), this requires further investment in interventions at the time of birth; care of small and sick newborns; and community- and home-based care.

Additional attention also is required to social and behavioural change communication, which is often excluded from WASH service delivery models, to ensure ODF sustainability, so that communities do not revert to open defecation. Moreover, further attention is needed both with respect to water and sanitation usage (all times, all situations), and to operations and maintenance practices in households as well as in public/institutional facilities. In this regard, the lack of inclusion of adolescents and children from decision making risks forgoing a significant opportunity to influence their WASH practices and behaviour (see also Section 3.2). This is especially relevant because much of the behaviour change required to improve WASH practices (prioritising toilet use, menstrual health management, handwashing at critical times, using only safe drinking water) relates to norms that are easiest to establish in children and young people. WASH socialisation also will need to include preschool children on toilet use and good hygiene practices.

It also will be crucial to consider the WASH stresses imposed by disaster (floods, drought) or conflict when development deficits are already so high (see also Section 2.5). Climate change will continue to exacerbate this situation, where already millions of households and communities are living with water stress. Systems to provide services to children, adolescents and women in conditions of mass displacement will require particular attention.

6.4 Structural and Underlying Causes of Key WASH Challenges

Based on the above analysis as well as that found in the relevant Annexes, a number of structural/root causes for WASH-related challenges in India, at different levels of duty bearers, have been identified:

- Low capacity of public institutions, including local Government institutions, and need for strengthened monitoring mechanisms as well as effective messaging
- Decreasing political will and financing for Government water quality programmes
- Lack of knowledge about WASH impact, particularly water quality, poor sanitation and poor hygiene, on health, nutrition and overall behaviour change
- Rapid urbanisation and issues of access in hard-to-reach areas
- Acute vulnerability to climate change and natural disasters
- Poverty
- Social norms and cultural beliefs that influence WASH practices (e.g., permissibility of open defecation, low value on handwashing with soap at critical times)
- Prevailing patriarchal norms throughout society that limit participation of women and girls and hold them and girls responsible for household and care work, including water collection

All this results in a variety of underlying challenges, including:

- Need for strengthened coordination, capacities and monitoring among sectoral stakeholders
- Need to ensure ODF sustainability
- Competing use of water resources (agriculture, drinking water, land tenure issues in urban slums)
- High levels of WASH-related health issues among children and women
- Inability to translate hygiene knowledge into practice, in part because of the need for strengthened messaging
- Accelerating issues of faecal sludge management in urban and rural areas alike, along with lack of technology and systems/poor understanding of technology options for solid waste management
- Lack of climate-resilient technologies and frequent destruction of WASH infrastructure from natural disasters
- Inability to upgrade or have toilets, with inconsistency of use among all members of households
Lack of low-cost water quality testing facilities
Need for more gender-sensitive and disability-focused sanitation

6.5 Recommendations to Improve Children's, Adolescents' and Women's WASH Status

Access to safe water and access to decent sanitation are human rights, as noted above, and are both included within the human right to an adequate standard of living. These human rights are in themselves essential for life and dignity, but are also the foundation for achieving a wealth of other human rights, including the right to health and the right to development. Around the world, the real challenge now is to translate these human rights obligations into meaningful action on the ground.

For India to further achieve this, recommendations include:

<table>
<thead>
<tr>
<th>Policy/Strategy</th>
<th>Advocacy for deeper understanding that ODF status is only a first milestone toward safely managed sanitation, and for funding for SBCC activities beyond the achievement of ODF status</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Advocacy for formulation of policies and management arrangements with regard to faecal sludge management in rural areas</td>
</tr>
<tr>
<td></td>
<td>Support to strengthened policies for water quality, testing, monitoring and surveillance</td>
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<tr>
<th>Institutions/Governance</th>
<th>Advocacy for increased funding for operations and maintenance of WASH facilities in institutions, especially in schools</th>
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<td></td>
<td>Strengthening of PRI capacity to effectively demand services, implement community management of water sources, and implement the Swacch Bharat Mission</td>
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<td>Strengthening of district authorities’ capacity to accept the need for, and implement, an equity-based approach to service delivery</td>
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<tr>
<th>Programme, Including Adolescents/Gender/ECD/Tribal/Conflict/Urban Slums/Climate Change &amp; DRR</th>
<th>Support to convergent programming to address stunting, for example, linking implementers of the Swacch Bharat Mission programme with Nutrition Missions and the National Health Mission, which can ensure messaging to new mothers around the need for handwashing and safe play environments for young children</th>
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<td>Promotion of integration of social and behavioural change communication activities into service delivery, rather than being seen as a stand-alone activity</td>
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<td>Support to empowerment of the middle class, and adolescents in particular, to become advocates for social change, including the right to water and sanitation, along with nurturing of broad-based partnerships in this regard</td>
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<td>Support to reducing the burden of water collection on women and girls</td>
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<td>Identification of alternative financing mechanisms for households in the bottom two wealth quintiles to enable them to acquire WASH technologies of their choice to accelerate coverage and use</td>
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<td>Support to addressing of resilience in infrastructure development, especially for water supply and toilet technologies</td>
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<td>Continued advocacy for equitable service delivery, complemented by work with partners to demand accountability from service providers</td>
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Support to agreement on SDG6 indicators. Further, agreement is needed on the data required to measure the indicators and the questions that need to be included in surveys to obtain the data, particularly for quality of services (e.g., water quality/availability, faecal sludge management, handwashing).

Promotion of deeper understanding of what data are required, by stratifier, to allow for meaningful disaggregated data at state, district and block levels.

Support to studies on key questions affecting WASH programming – what works in India, and why?

Strengthened partnerships with universities and think tanks for WASH evidence generation and the development of conceptual frameworks that are relevant to India.

Chapter 7: The Right to Education

7.1 Introduction

Significant achievements have been made in education across India, with near-universal enrolment in primary education. Disparities also have reduced over time with regard to the number of out-of-school children; gender and other social gaps; provisioning of schools, including separate toilets for girls and boys; and availability of drinking water. A strong legislative and policy framework for education exists (see also Section 7.2); in addition, progress has been made on the increased allocation of resources; recruitment of qualified teachers; use of child-friendly/child-centred learning practices; and formation of School Management Committees. Across the country, learner-centred methods under Activity Based Learning (ABL) have demonstrated impact on learning achievement, equity, inclusiveness, and strong engagement between student and teacher, and have provided ample scope for community participation and all-round development of children, based on evidence from more than 30 evaluation studies.

At the same time, the major concern in India’s education system is the low learning levels of children. In addition, not all children are in school and learning: Children 3 to 5 years are not necessarily receiving quality pre-primary education, while 6 million children aged 6-14 remain out of elementary and lower secondary school.187 Yet as India’s economy grows further, it will need to create an adequate pool of highly skilled and literate workers, thereby securing their employability.

The main reason for these shortfalls arises from inadequacies in implementation that have failed to benefit the deprived and marginalised children or to leverage available provisions. Multiple Ministries/departments that are involved in the delivery of education require further strengthening to work effectively in coordination, which has led to stand-alone interventions pursuing targets that do not always contribute to overall education goals and objectives.

The Government is expected to soon issue a New Education Policy (NEP), updating the existing National Policy on Education in 1986 and its subsequent modification in 1992, to meet the changing dynamics of the population’s requirements with regard to quality education, innovation and research. In turn, this is expected to help make India a knowledge superpower by equipping its students with

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187 According to 2014 education data.
the necessary skills and knowledge to eliminate the shortage of human resources in science, technology, academia and industry, among others. Led by the Ministry of Human Resource Development, consultations for this Policy were held at national and state levels in 2015 and 2016; the final Policy has not yet been shared publicly.

India’s education system thus is ripe for such initiatives as the use of vouchers to encourage schools to improve performance and gain enrolment share, or hiring teachers from the local community, which enables them to better connect with students and puts reputational pressure on the teacher to deliver. Again, such approaches can produce better learning outcomes (see also Section 7.3), whose criticality is demonstrated by evidence from several states. Moreover, the 2014 National Achievement Survey (NAS) for Class V found that only about 30 per cent of children could identify the main theme of a short, simple text and use information from a notice board. Slightly less than half of Class V children could identify the highest three-digit number from a given set of numbers.\textsuperscript{188}

At the same time, at state level the survey for Class III students found, for example, that 35 per cent of students in this grade in Maharashtra could not read with understanding, and 40 per cent could not do basic arithmetic; a 2015 Government Resolution passed by the state calls for a statewide mandate for improving learning outcomes for all children in Classes I-VIII. In Madhya Pradesh, meanwhile, a recent study revealed that 65 per cent of children in Class V could not read at a Class II level. Budget availability is erratic, and only 51 per cent of the allocated budget was released by the state government for 2015-2016. To combat falling standards at its Government schools, Rajasthan is pursuing a unique initiative to establish 10,000 model schools with Classes I to XII in each gram panchayat, with a sufficient number of teachers, adequate infrastructure, and essential supplies as well as close monitoring of functions.\textsuperscript{189}

In its 2014 Concluding Observations, the CRC Committee noted the following issues for education in the country: high dropout rates, particularly among SC/ST children and girls and upon completion of lower primary grades; large numbers of out-of-school children; low quality of education, resulting in low numeracy and literacy skills; and a shortage of qualified teachers and appropriate classrooms.

Specifically, the Committee highlights the following actions to be taken by the State: (1) strengthen efforts to fully implement the Right to Education (RTE) Act (see also Section 2.2), including by developing RTE-compliant school development plans; (2) improve the quality of education and provide adequate training for teachers; (3) address various discriminatory practices in education settings; (4) introduce child rights education in the school curricula; (5) improve preparedness for schooling and expansion of programmes on ECE; (6) ensure that out-of-school children (OOSC), child labourers, children in disadvantaged/marginalised situations, and girls are supported and assisted to exercise their right to education; (7) improve data and information systems to track OOSC; (8) measure quality and learning outcomes; and (9) take measures to increase access of adolescents to secondary education, and develop/promote quality vocational training for children who have dropped out of school to enhance the skills of all children. The Committee further recommended that ECD be incorporated into the RTE Act as part of the education system and sufficient resources be allocated for implementation at all levels, with the aim to ensure universal, high-quality education and care services to all children aged 0-8 years.

With regard to CEDAW, the Concluding Observations note that only 4 per cent of the GDP is spent on education, that girls with disability and minorities still register low enrolment rates, and that the dropout rate among adolescent girls is as high as 64 per cent, making them particularly vulnerable to early marriage. The Observations also note concern about girls’ low retention and completion rates at

\begin{enumerate}
\item \textsuperscript{188} \url{http://www.ncert.nic.in/departments/nie/esd/pdf/NationalReport_subjectwise.pdf}
\item \textsuperscript{189} Maharashtra, Madhya Pradesh and Rajasthan Programme Context Analyses, all op.cit.
\end{enumerate}
secondary level due to early marriage, harmful social norms and practices, and poverty, especially in rural areas, while also offering numerous specific recommendations for action.

7.2 Educational Institutions, Systems and Governance
The National Curriculum Framework (NCF) 2005 remains an important reference document that articulates the principles and philosophy of Indian education, underpinned by the constitutional vision of India as a secular, egalitarian and pluralistic society founded on values of social justice and equality. States are expected to adopt and include contextual specificities.

More recently, in addition to the expected NEP highlighted above, a number of major national policies and legislation related to education have been adopted, most notably the RTE Act, which came into effect in 2010 (see Section 2.2). The Act, founded on the constitutional provision of free and compulsory education for all children, guarantees every child aged 6–14 years the fundamental right to education – one that helps them to acquire basic literacy and numeracy, enjoy learning without fear, and feel welcome and included irrespective of their background. The RTE Act is the only legal provision for ensuring quality elementary education for children in the country; the 2014 CRC and CEDAW Concluding Observations both recommend full implementation of the Act.

However, six years after the RTE Act came into force, some of the commitments made by the Act still require further strengthening to be fulfilled, particularly with regard to teacher training (see also Section 7.3). A clear road map needs to be developed for realisation of RTE provisions, with a focus on the “right to learn,” and with enhanced budget allocations (see also below). In addition, the legal framework of the Act needs to be extended to cover pre-primary education and secondary education. Lastly, monitoring mechanisms for RTE implementation require further strengthening, including of the NCPCR and SCPCRs (see also Section 2.1 and Chapter 8).

The Government also approved the first National Early Childhood Care and Education Policy in 2013, which reiterates the commitment to promote inclusive, equitable and contextualised opportunities for optimal development and active learning capacity of all children younger than age 6 years. Although the compliance rate with this Policy has been on the rise, some states are yet to comply with it or its quality standards and national curriculum. Effective implementation of the Policy also requires coordination between the MWCD, responsible for ECE, and the MHRD, responsible for education from Class I, as well as other key actors; but this has yet to be achieved. Meanwhile, Odisha in 2014 became the first state to approve a Multilingual Education Policy, an important step for ensuring that young children receive instruction in their mother tongue, and thereby enhancing the potential for higher learning outcomes later on (see also Section 7.3).

All these policies are being delivered through several flagship education programmes. These include SSA, for universal elementary education, and the main vehicle to implementation of the RTE Act; RMSA, which aims to make quality secondary education available, accessible and affordable to all adolescents; and ICDS, the national ECE programme. Several other new initiatives and programmes also have been introduced to enhance the quality of education. These include Padhe Bharat Badhe Bharat, to enhance reading, writing and numeracy skills in the early grades, and Rashtriya Avishkar Yojana, for improving science and mathematics learning. Data collection for tracking individual students and census-based student assessments also have been initiated.

Budget allocations for education, while considerably higher than those for health, nonetheless remain low. Government estimates for 2014-2015 showed that about 4.14 per cent of GDP was provided in the budget for education; the 2014 CEDAW Concluding Observations also noted that only 4 per cent of GDP is spent on education in India. Notably, budgets for the flagship schemes have gone both up and down between 2012-2013 and 2016-2017. The budgets for SSA and ICDS have decreased overall, while RMSA budgets have steadily increased, although at rates of less than what was estimated, and
not enough for full RTE implementation. A key issue also exists regarding absorption of funds by the states, as well as the timeliness of funds released by the central Government to states, and by states to districts.

Other line Ministries also have programmes and schemes in support of equity in access to, and quality of, education, including scholarships and conditional cash transfers. These are provided by Ministries such as Tribal Welfare, Social Justice and Empowerment, and Minority Affairs to children from marginalised communities. A consistent lack of coordination and convergence to pool resources from all sources to fill gaps and increase efficiency of service delivery again has been noted.

Numerous partners are available for education policy planning, monitoring and service delivery. Relevant Ministries include not only MWCD and MHRD, but also Ministry of Rural Development, Ministry of Tribal Affairs, Ministry of Social Justice and Empowerment, and Ministry of Labour and Employment. National institutes and monitoring bodies such as the National/State Councils for Education, Research and Training (NCERT/SCERTs), National Institute of Public Cooperation and Child Development, National University of Educational Planning and Administration, National Council of Teacher Education and National Commission for Protection of Child Rights also are mandated to work on children’s education. Critically, many education development partners have not worked in situations of humanitarian crisis to reach the most marginalised or at-risk children. With an increasing need for resilience building and responding to the impact of climate change, this represents a serious capacity gap.

7.3 Key Deprivations Affecting Children’s, Adolescents’ and Women’s Educational Status

Despite considerable progress, education deprivations remain acute and multifaceted, resulting in not all children in school and learning (see Annex 9 for analysis of key deprivations in education using the five filters). Many schools, particularly in urban areas, are overcrowded and frequently unsafe, with rising levels of violence in school. Across the country, however, three challenges in education particularly stand out: (1) low attendance at preschool, (2) still-high numbers of children out of school, and (3) quality of learning outcomes, as highlighted below.

Low Attendance at Preschool

Access to quality ECE remains a central issue and an urgent deprivation, affecting other key education challenges such as school readiness, on-time enrolment in elementary school, retention, and learning ability (see Annex 10 for full causality analysis of ECE issues). The ICDS scheme reaches 36.5 million children through a network of almost 1.3 million Government-run Anganwadi Centres, but these children account for only 38.7 per cent of those eligible for ECE, with another 30.7 per cent of children attending private preschool facilities.

Overall, therefore, 20 million of the country’s 3- to 6-year-olds are not in preschool (see also Section 3.1 for details), with 3 in 4 of these from rural areas. These children also are primarily from the least advantaged social groups; for example, more than 1 in 3 children from the poorest families, 1 in 3 from Muslim families, and more than 1 in 4 from SC and OBC families did not attend preschool in 2014. Research shows that boys are more likely to be sent to private ECE providers, while girls are more likely to be sent to free Government-run centres like Anganwadis. The present 30-percentage-point gap between existing levels of enrolment in preschool and the target of 100 per cent set under SDG4 thus denies many children their right to development.

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190 Early Childhood Development Equity Profile, op.cit.
In all, a lack of functional ECE centres is compounded by a preponderant view of Anganwadi Centres in particular as “feeding centres,” reflecting the low awareness of the importance of preschool education and families’ need for strengthened knowledge and skills on parenting. This is compounded by low capacities among Anganwadi workers to ensure quality early childhood learning, in part stemming from limited understanding of school readiness, as well as insufficient pay and motivation. Critically, no regulatory mechanism exists for private preschools; moreover, the National ECCE Policy mentions drawing up an urban preschool strategy, but this strategy has yet to been developed. In addition, a need exists for strengthened attention to the safety and protection of children.

In turn, all this results in a transition from preschool to elementary education that is less than seamless: Emerging evidence from the Indian Early Childhood Education Impact Study (IECEI) shows low school readiness levels in children from Anganwadi Centres and private preschools alike. This also is reflected in the large proportions of children who drop out in the early grades.

**Out-of-School Children**
The number of OOSC has reduced to 6 million from 8 million since 2009, which represents a major achievement. Of these 6 million OOSC, however, 63 per cent have never attended school and 37 per cent dropped out. Overall, about 20\(^{191}\) per cent of children leave school during the first five years of schooling and 36 per cent leave during the first eight years, although data show that up to half of children leave school before completing Class V in eight states (Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan, Uttar Pradesh, West Bengal). By the time they reach secondary school, only 52 to 61 out of 100 children may be retained in the system.\(^{192}\) Moreover, in four states (Bihar, Odisha, Rajasthan and Uttarakhand), more than 4 per cent of children aged 6-13 years overall are out of school (see Annex 11 for full causality analysis of out-of-school children).\(^{193}\)

This still-high proportion of out-of-school children represents a major equity issue; although trends indicate a significant lessening of disparities across social groups, it is frequently the most deprived who are left behind. These include tribal children and Muslim children in particular, with about 4 per cent of each group out of school.\(^{194}\) Gender-disaggregated data show that 2.77 per cent of males and 3.23 per cent of females are out of school.

It is clear from **Figure 23 below** that there are more OOSC in rural areas (3.13 per cent) compared to urban areas (2.54 per cent). In addition, more young adolescents aged 11 to 13 years are out of school than children aged 6-10 years. Notably, as high a proportion of 28 per cent of children with special needs are not in schools, although special provisions have been made under the SSA and RMSA to support inclusive education for children with disabilities. At the same time, The Rights of Persons with Disabilities Bill 2014, which still awaits approval, gives children aged 6-18 years with at least 40 per cent of the disabilities specified in the Bill the right to free education in a neighbourhood school or special school, if required.\(^{195}\) In August 2016, meanwhile, the Government launched an online platform (Sugamaya Pustakalaya) that makes accessible content to print-disabled persons. Even so, inclusive education and teaching/learning practices remain to be integrated into both pre- and in-service teacher training. Clear guidelines and monitoring mechanisms also are required to ensure schools are accessible to children with disabilities, along with strengthened measurement instruments to identify children with disabilities and inter-Ministerial/inter-departmental coordination on their behalf.


\(^{192}\)Education Programme Context Synthesis Paper, op.cit.

\(^{193}\)UNICEF India. *Education Equity Profile*. New Delhi, 2016.

\(^{194}\)Ibid.

\(^{195}\)The Bill also calls for all public buildings, hospitals and modes of transportation to be accessible to persons with disabilities.
Figure 23: Proportion of Children Aged 6-13 Years Out of School (it would be good to see this disaggregated by gender across age and social groups. But at the very least by age – so male female for 6-10 and then 11 to 14)

Source: IMRB, 2014

Enrolment levels are generally high, but regular attendance also must be considered, since this has significant implications for children’s learning outcomes (see also sub-section below). Children from SC, ST and Muslim communities missed nearly 30 per cent of school days at primary level, and attendance of rural children is lower than that of children in urban areas. Efforts are under way to improve regular attendance by emphasising its importance, with campaigns launched in low-performing areas across states. Formative studies indicate that while parents would like to have their child attend school regularly and obtain the benefit of education, they do not prioritise school attendance over other issues and events (e.g., festivals, family functions, visits to relatives, marriage in the family). This indicates the need to create social norms around regular attendance so that social pressure to send children to school regularly exists (see also Section 2.3).

Figure 24: Proportion of Children Transitioning from Elementary to Secondary Level, by Social Groups and Gender

The retention rate at elementary level is the most crucial indicator deciding the fate of schooling at subsequent stages. At national level, this has been increasing gradually over the years and stood at 83.74 per cent in 2014-2015, according to “flash statistics” from the education management information system (UDISE). Retention varies substantially by social group, religion and gender, however (see Figure 24 above). For example, the retention rate at primary level for ST children is just 68.64 per cent. Meanwhile, significant numbers of children, especially girls and Muslim children, also drop out as they move from elementary to secondary level; in 2013-14, dropout in Classes I-IX was more than twice that of Classes I-V.\(^{197}\) Although overall transition rates are high, 26 per cent of children of secondary school-age are not in school,\(^{198}\) and thus vulnerable to early marriage and child labour (see also Sections 3.2 and 3.7, and Chapter 8). In particular, social beliefs that girls will “go into another family” after marriage, that they will not support parents in their old age, and that they will not get a good match in marriage if they get “too” educated continue to deter parents from investing in girls’ education, especially for adolescent girls.

At the same time, the critical issue of transition of girls from upper primary to secondary education, an issue also noted in the CEDAW Concluding Observations, has been acknowledged, and systematic actions undertaken in several states (Gujarat, Rajasthan, Uttar Pradesh), with some success. In 2015, 83 per cent of eligible girls from Class VIII in Rajasthan transitioned to Class IX in the new 2015-2016 academic session. While the national enrolment ratio of girls to boys at the secondary level is 0.90, it is less than 0.85 for Delhi, Gujarat, Maharashtra, Punjab and Rajasthan. However, the district-level scenario for girls’ transition changes dramatically, with 75 districts having a ratio of <0.75. It also must be noted that more girls are enrolled than boys in secondary classes in four states (Assam, Meghalaya, Sikkim, West Bengal). Adolescent boys in these states may be leaving the school system for child labour, although further research is needed.

Meanwhile, close to 20 per cent of Muslim students are left behind while moving from elementary to secondary level.\(^{199}\) In general, more children from urban than from rural areas also attend secondary and higher secondary levels; at higher secondary level, the difference is close to 10 percentage points.\(^{200}\)

All this arises from diverse factors, including lack of household/parental support; poor school infrastructure, including inadequate sanitation facilities, particularly for adolescent girls (see also Section 3.2 and Chapter 6); poor school readiness; and, critically, issues of early marriage, child labour, 

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197 Ibid.
198 Ibid.
199 Education Equity Profile, op.cit.
200 Ibid.
and trafficking (see also Chapter 8), as well as differential treatment or attitude to caste, religion and disability. Violence in schools and a lack of female teachers also are key factors, as are constraints to inclusive programmes that respond to diverse needs. Schools also may be inaccessible or not available: For example, they may be closed because of conflict (see Section 3.4) or because they are used for relief services after natural disaster (see Section 3.5).

In turn, this results from the lack of understanding by parents and communities of the importance of regular school attendance, noted above, along with opportunity costs of sending a child to school. Compliance with RTE norms for school construction may be poor, while a need for strengthened teacher preparation in teacher education institutions, in terms of pedagogy/curriculum, as well as inclusivity and gender, results in weak teacher capacities and poor-quality teaching. This too is compounded by a need for strengthened teacher monitoring and supervision, as well as greater engagement with parents, to ensure all children and adolescents are in school.

Challenges of Quality Education and Learning Outcomes
As noted above, even among those children retained in the education system, a high proportion completes primary education without grade-appropriate achievement levels/skills (see Annex 12 for full causality analysis of issues of education quality). Many of these challenges stem from low teacher quality and effectiveness; poor teaching quality in classrooms; and persistent issues of absenteeism, as well as sub-optimal home environments to support effective learning. Inadequate monitoring of teachers and teaching, as well as inadequate education budgets, low levels of parental education, inability to provide additional educational materials at home, and a need for strengthened measures to prevent and address violence in schools also contribute to low quality of learning outcomes.

Average achievement scores in the National Achievement Survey 2014 were found to have declined in all subjects compared to scores during the 2011 survey. In addition to the poor results noted in Section 7.1, about 2 in 3 children in Class V correctly responded to fewer than half of reading and mathematics questions in the National Achievement Survey 2014. Overall, Class V students were able to correctly answer 45 per cent of reading comprehension items, 46 per cent of mathematics items, and 50 per cent of environmental studies items. Given that reading is a fundamental skill for learning, weak reading skills impede students’ abilities to deal with other subjects. Meanwhile, no significant differences were found between boys and girls in terms of the average achievement score in mathematics, while no significant differences were found between average achievement scores of rural and urban children.

SC/ST children comprise 60 per cent of low achievers, which directly correlates to low attendance and high dropout rates. Further, the National Achievement Survey 2014 shows a large variation in quality of learning outcomes between states; for example, on average a student from Bihar is nearly two school years behind a student from Kerala in reading. Similarly, on average a student from Chhattisgarh is more than two school years behind a student from Tamil Nadu. Research conducted as part of past National Achievement Surveys indicates that effective school governance and parental involvement, lower teacher/pupil ratios, and teacher professionalism and peer reviews, along with sufficient learning aids and other school equipment, all can positively influence learning outcomes.

Data also reveal that children perform significantly better when the language of teaching at school is the same as their home language. An analysis of data from 22 developing countries and 160 language groups revealed that children who had access to instruction in their mother tongue were significantly

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201 Ibid.
202 Ibid.
more likely to be enrolled and attending school, while a lack of education in a first language was a significant reason for children dropping out. In India, mother-tongue education that helps to keep children in school and learn productively in the classroom has yet to receive due attention (see also Section 3.3).

Children from disadvantaged rural and predominantly tribal locations are particularly deprived of quality teachers and resources that contribute to widening the inequities in learning outcomes. The proportion of professionally trained teachers in Classes I-V increased by 9.3 percentage points from 2005-06 to 2013-14, but even so, overall nearly 1 in 5 teachers are not professionally qualified. Among those teachers who are not professionally qualified, more than 3 in 4 are located in just four states (West Bengal, Bihar, Uttar Pradesh and Jammu & Kashmir). At the same time, the gap in availability of teachers as per RTE norms totals 6,36,115 (13.5 per cent), of which an overwhelming 6,22,856 is found in rural schools. Nearly 57 per cent of primary schools have only one or two teachers; similarly, despite a significant decrease overall in pupil-teacher ratios in recent years, more than 1 in 4 primary schools still have a ratio above 1:30, and 1 in 7 upper primary schools have a ratio above 1:35. This multi-grade situation poses a challenge, and again may affect students’ ability to attain grade-appropriate learning levels.

Meanwhile, privatisation of education services for children has grown, but the sector is largely unregulated. Data indicate that a shift of students from Government-run institutions to privately run institutions, at all levels, has occurred between 2007-2008 and 2013-2014.

Moving Forward
Moving forward (see Section 7.5 for full recommendations), the issues of pre-primary education, out-of-school children and quality learning outcomes will need to be prioritised, as the above analysis clearly indicates. In addition, evidence building for education will particularly be an area that requires further strengthening. Planning for children is presently based on data from micro-studies or programmes such as SABLA. The emerging issue of education provisioning for older children, especially for those who have never been to school, also needs to be addressed by data and evidence. While this calls for exploring flexible learning options and building necessary partnerships, a significant gap is found in formulating flexible strategies for these OOSC to acquire livelihood skills.

7.4 Structural and Underlying Causes of Key Educational Challenges
Based on the above analysis, as well as the analysis found in relevant Annexes, a number of structural/root causes for education-related challenges in India, at different levels of duty bearers, have been identified:

- Need for strengthened governance and enhanced education system coordination and convergence in all sub-sectors
- Inadequate understanding of positive parenting and child development, especially the importance of early stimulation and learning, and insufficient development of ECD services
- Deeply rooted social beliefs, norms and practices with regard to gender, caste and religion that lead to gendered reasons for children dropping out of school or never enrolling, and to discrimination against SC and ST children
- Continuing low rates of literacy among parents, especially among women
- Poverty and lack of parental/community resources to support children’s education

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204 Education Programme Context Synthesis Paper, op.cit.

205 UDISE 2014-2015, computed figures, found in Education Equity Profile, op.cit.

206 Ibid.
Inadequate strategic directions and institutional arrangements for provision of alternative education services, particularly in urban slums and hard-to-reach areas, to serve large populations of out-of-school children
- Inadequate budget allocations to education
- Widespread vulnerability to disasters and hazards

All this results in a variety of underlying challenges, including:
- Poor compliance with or inadequate enforcement of RTE norms
- Persistent pockets of deprivation in terms of economic stress faced by the community and poor access to quality services. These pockets often have a preponderance of marginalised populations and are in difficult terrain
- High proportion of out-of-school children and significant numbers of adolescent boys and girls, particularly from among the poorest families, still being withdrawn from school, largely for child labour or early marriage respectively
- Lack of understanding of the importance of regular attendance at school
- Need for strengthened numbers of qualified human resources, particularly at ECE and primary levels
- Need for improved assessment of child learning achievements
- Poor school infrastructure, especially in hard-to-reach areas, including frequent lack of functional WASH facilities or any WASH facilities for girls
- Ineffective system of teacher management and deployment
- Need for additional attention to multilingual education
- Low priority for DRR and climate change in education policies and subsequent lack of preparedness

### 7.5 Recommendations to Improve Children’s, Adolescents’ and Women’s Educational Status

Access to quality education is a fundamental human right and remains essential for the exercise of all other rights. It promotes individual freedom and empowerment and yields important development benefits; moreover, it is a powerful tool by which economically and socially marginalised people can participate fully as citizens. Yet millions of children, adolescents and women in India continue to be deprived of lifelong educational opportunities, many as a result of poverty. To move forward toward equitable education opportunities for all, recommendations include:

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<th>Policy/Strategy</th>
<th>Support strengthened enforcement mechanisms for implementation of the RTE Act</th>
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<td></td>
<td>Advocate for extension of the RTE Act to include preschool education and secondary education</td>
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<td>Support the Integration of DRR strategies in the education policy framework</td>
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<tr>
<th>Institutions/Governance</th>
<th>Strengthen inter-Ministerial and intersectoral coordination and convergence, with the effective use of data and evidence, for improved planning, monitoring and reporting on education programmes</th>
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<td>Support state education departments to establish systems and processes for timely recruitment, deployment and rationalisation of teachers</td>
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<td>Support strengthened and enforced regulatory mechanisms for teacher education institutions, including private teacher education institutions as well as private schools, and ensuring at least one woman teacher per school</td>
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| Programme, Including Adolescents/Gender/ECD/Tribal/Conflict/Urban Slums/Climate Change & DRR | Support the expansion of preschool education to marginalised populations (e.g., tribal children and geographically remote areas)  
Generate evidence on DRR that demonstrates the social and economic cost of not prioritising this theme in education  
Support education plans and budgets to accommodate different strategies that reflect the pluralism of India’s education situations  
Support state governments to leverage corporate social responsibility/public-private partnerships with non-traditional partners as well as CSOs for the development of alternate education models and programmes in situations of armed conflict and DRR  
Promote the development of flexible learning strategies for children who have never enrolled in school, children in labour, and migrant children  
Support the establishment of coherent education-friendly social protection schemes to support marginalized households, including girls’ access to education  
Support norm and behaviour change that prevents child marriage and child labour, including unpaid care work in the household, from becoming obstacles to school attendance and completion. |
| --- | --- |
| M&E/Data/Knowledge Management/Innovation | Strengthen the capacity of education functionaries in the effective use of data and monitoring mechanisms  
Using innovative approaches, support the expansion of UDISE toward real-time monitoring of education officials from state down to school level  
Support improved dissemination and feedback mechanisms of learning assessment data for improved learning and systemic change  
Promote innovative models for scalability and sustainability of education interventions  
Invest in a longitudinal study to follow a cohort of children from preschool to high school/university, to produce evidence on the benefits of preschool education for the individual and society alike |

**Chapter 8: The Right to Protection**

**8.1 Introduction**

The focus on child protection is increasing from the MDG to the SDG era, with protection recognised as essential to child rights, social policy and social development. At the same time, child protection issues in India are becoming more complex due to evolving areas of equity, gender and risk alike (economic situation; by social groups, religion, urban-rural location, and age; urbanisation; conflict; climate change; migration; and globalisation).

Many of the country’s issues of child protection are manifested in the form of continued demand for child labour, prevailing practices of early marriage, widespread violence against children, sexual abuse, corporal punishment, institutional abuse, children affected in ethnic and civil strife conflicts,
and human trafficking. A child in India goes missing every 8 minutes, and 40 per cent of these children – especially girls – are never found, with a link to trafficking.\footnote{According to the National Human Rights Commission.}

Isolating social changes driven by urbanisation can have a particular impact on children who lose the extended family and support networks of rural lives (see also Section 2.6); the overall lack of safety nets means that urban children, especially those in slums and streets, are a growing, vulnerable group, more likely to be abused or forced into labour and prone to be affected by natural disasters. A report of the Sub-Group on Child Rights for 12\textsuperscript{th} Five Year Plan 2012-2016 estimated that 40 per cent (172 million) of India’s children are vulnerable to, or experiencing, difficult circumstances.\footnote{Ministry of Women and Child Development. \textit{Report of the Working Group on Child Rights for the 12\textsuperscript{th} Five Year Plan (2012-2016)}. New Delhi, 2012.} Thus, it is critical that policies, laws and programmes all address protection deprivations and inequalities, including those of adolescents and women.

Some important successes have been achieved, including the establishment of District Child Protection Units (DCPUs) in 14 states and of more than 12,000 Child Protection Committees (CPCs) at village level. In at least four states, block-level CPCs also are being established. TrackChild, a national child protection online data system, is being rolled out across most of the country. At the same time, the formation of adolescent girls’ groups, safe spaces and life skills programmes for 230,000 girls across 10 states has occurred (see also Section 3.2). As a result, adolescent girls are better protected and can receive more support from their families, community groups and community leaders, along with enhanced access to basic social services from community-level service providers.

Yet despite robust legislative framework for child protection and recent investments in the child protection system, much of the child protection infrastructure in India is still being built, and thus limited in its impact on children. In particular, a need exists to adapt and focus on protection system strengthening for urban areas, given the programme’s generally rural focus, and on the creation of safe communities or spaces for children in urban slums. In addition, while national response mechanisms are generally receiving the required support, most community-based or -led initiatives on child protection – particularly the formation of CPCs – need further attention despite the progress noted above.

Overall, effective child protection approaches face numerous challenges: a need for strengthened implementation of policies and legislation at the ground level; inadequate resources; insufficient convergence among sectors and capacities among core functionaries; and strengthened analysis and use of available data for evidence-based planning. Data gaps at district and sub-district levels in particular need to be urgently addressed.

In its 2014 Concluding Observations, the CRC Committee emphasised urgent actions needed on issues of non-discrimination, harmful practices, sexual exploitation, child labour, adoption and the administration of juvenile justice. In particular, child labour and early marriage (see also Sections 2.3, 3.2 and 3.7) are priority issues for strengthening preventive services in education, social protection and health. Critically, addressing of multiple vulnerabilities will be necessary: For example, a child victim of trafficking may manifest issues of child labour, migration, abuse and exploitation.

Deprivations and vulnerabilities for children, adolescents and women in India also increase if they live in tribal or conflict-affected areas, or those affected by climate change. Further, gender inequalities represent an added source of marginalisation and disempowerment, which may lead to extreme forms of violence against women and adolescent girls, particularly among those from poorer or socially marginalised groups. Such violence is often exacerbated by gender norms, inequality and a
prevailing “culture of silence” (see also Section 2.3) Thus, placing the issue of violence against children, adolescents and women high on the agenda of different constituencies at both national and state levels requires special intensification.

8.2 Protection Institutions, Systems and Governance

Many legal and policy frameworks are available in India concerning the protection of children, adolescents and women. This provides a major opportunity to ensure that all these groups have access to quality services, which is critical for their empowerment and decision making, especially for girls.

In addition to the CRC, these include the National Policy for Children 2013; National Youth Policy and National Adolescent Health Policy; Juvenile Justice (Care and Protection of Children) Act 2015; Protection of Children from Sexual Offences Act 2012; and Child Labour Prevention and Regulation Amendment 2016. Earlier important legislative achievements include the Child Marriage Act 2006 and Right to Education Act 2009. National flagship schemes include the CPS, with an emphasis on creating child protection systems and structures, and allied schemes like RSK and SSA. The recently launched national-level Beti Bachao Beti Padhao also has highlighted the focus on the girl child, in terms of prevention of gender-biased sex-selective elimination; ensuring survival and protection of the girl child; and ensuring education and participation of the girl child. In addition, states have their own specific schemes on various child protection issues.

However, the challenges remain daunting: gaps in implementation, weak enforcement of these Acts and schemes, a need for strengthened capacities, low accountability and declining social sector budgetary allocations have all resulted in the most deprived and excluded communities being unable to access these services and benefits. As noted above, this is particularly evident for children among ST/SC families and children living in the most remote areas or in urban slums, migrant and trafficked children, children in institutions and children in areas affected by armed conflict.

Despite Government investments in CPS, funding for child protection falls far short of existing needs; the decline in budget outlay by the central Government to strengthen child protection systems and structures continues to be a serious concern. Of all sectors, the budget for child protection has been the lowest, and in 2015-16 stood at only 0.04 per cent of the total budget. This amount is intended to cover the juvenile justice system, child labour, and provisions for orphan and street children. Moreover, many states fail to allocate their share of the CPS budget, and actual expenditures are often significantly below the annual plan. Poor budget execution also has hampered the implementation of the CPS, with some states being unable to spend available funds.209

In recent years the Government also has taken a number of actions that threaten to roll back public policies that strengthen child protection, including:

- Lowering of the age of trial as an adult to 16 years for certain categories of offences
- Efforts to partly legalise child labour for 6- to 14-year-olds
- A continued need for finalisation of the draft Child Marriage National Plan of Action 2013
- Continuing erosion of investments in public education
- Absence of a comprehensive, effective and efficient social protection system

Critically, the Juvenile Justice (Care and Protection of Children) Act 2015 has introduced a transfer clause for children aged 16-18 committing “heinous” offences, as noted above. They can now be tried as adults outside the juvenile justice system, in violation of the CRC and despite strong protests from child rights advocates. Although the new law aims to make substantive changes in the administration of juvenile justice, the level of investments it will require in terms of human resources and skills has yet to be achieved. At the same time, the Act has made corporal punishment in all institutional setting

a cognisable offence. However, the issue of violent discipline in the home or other non-institutional settings is still outside any legislative provision.

In July 2016, meanwhile, the Rajya Sabha amended the Child Labour Bill, prohibiting any employment of children younger than age 14. However, a provision in the Bill allows children to help their family or family enterprises after school hours or during vacations. Children from poorer families are likely to be most affected by the legitimisation of family work. Moreover, much of the family- and home-based work in India may be hazardous in nature.

Considerable focus has been given to the Protection of Children against Sexual Offences Act 2012 (POCSO), with nearly 18,000 cases registered under the Act thus far. However, implementation and support for child victims requires strengthening, as is also found for child victims of human trafficking. Although no comprehensive programmes exist to address child trafficking specifically, the issue of trafficking appears to be garnering more attention, with the recent presentation of a draft Bill on trafficking by the Ministry of Women and Child Development. However, the legislation’s objective and its alignment with existing legislation require more clarity.

Meanwhile, foster care guidelines have been finalised, as have new guidelines on the adoption of children, an issue that has been made a statutory provision under the new Juvenile Justice Act. Nonetheless, alternative care is still understood in a limited sense, and a high rate of institutionalisation in several states is a remaining key area of concern. Little progress also has been made to protect children in street situations.

Opportunities exist to expand traditional partnerships with Government, child rights/child protection NGOs, and police into strategic partnerships with newer constituencies. Working with PRLs, for example, can result in larger engagement and greater reach at community level on child protection issues. Already, partnerships are being strengthened with the judiciary. At the same time, other opportunities remain to be identified and mobilised in the area of violence against children and women, adolescent empowerment (e.g., early marriage), and child labour.

8.3 Key Deprivations Affecting Children’s and Women’s Protection Status

As the previous chapters and the Introduction to this chapter have amply illustrated, child deprivation and vulnerability represent serious concerns in India (see Annex 13 for an analysis of key child protection deprivations using the five filters). Numerous issues of child protection, many of which often disproportionately affect adolescents (see also Section 3.2), are found across the country: Low rates of birth registration make it difficult to protect children from early marriage and child labour. Issues of rapidly accelerating urbanisation (see also Section 3.6) also give rise to numerous child protection challenges, as highlighted above.

Violence against children (VAC), including corporal punishment as an “educational” and disciplinary measure, remains widespread despite legislation. Likewise, violence against women and girls (VAWG) remains the most visible and extreme form of the continuing need to strengthen the status of women and girls. Sexual abuse of both girls and boys represents a largely neglected issue, as in many countries. Commercial sexual exploitation of girls may start when they are only young adolescents aged 10 or 12, and human trafficking is believed to be extensive both within the country and to other countries, including for sex work. The number of suicides among adolescent boys and, especially, girls is steadily rising. Street children and other children, including orphans, lack critical parental guidance and are particularly vulnerable to abuse. At the same time, conflict or civil strife affects nearly 1 in 5 of India’s children (see also Section 3.4) and poses a grave protection issue.
Birth Registration
The RSOC 2013-14 shows a significant improvement in the level of birth registration of under-5 children, from 41 per cent in 2006 (NFHS-3) to 72 per cent (see Figure 25 below). Significant barriers and bottlenecks to achieving universal birth registration still exist, including a lack of awareness among parents and community about the need for and procedures involved in birth and death registration; knowledge and capacity of staff doing registration; a shortage of stationery and communication facilities; lack of easy access to registration units, particularly in conflict-affected areas or due to internal migration; and socio-cultural barriers to the reporting of such events.

Figure 25: Children less than 5 yrs with no birth registration

The Government plans to universalise birth registration by 2020, with development of a strategic plan under way. Nonetheless, only 3 in 5 children under 5 years had a birth certificate in 2014, including 1 in 4 whose parents/guardians could not show the certificate at the time of the survey.

Figure 26: Women age 20-24 married before 18 years

In all, around 31 million young children were not registered. Children who are not registered are largely in the bottom two wealth quintiles (lowest quintile, 43 per cent not registered; second-lowest quintile, 35 per cent not registered). Among social groups, around 1 in 3 children from SC/ST or OBC families were not registered. At state level, eight states have levels of birth registration above 90 per cent, 16 states have levels between 60 and 90 per cent, and 5 states have fewer than 60 per cent of children registered. Those with a level less than the national average include Jammu & Kashmir, Uttar Pradesh, Chhattisgarh, Bihar, Jharkhand, Manipur, Rajasthan and Andhra Pradesh (undivided).

Early Marriage
Early marriage, although declining, remains one of the most pressing issues for India’s large adolescent population (see Annex 14 for full causality analysis of child marriage); the negative effects of early
marriage, including on girls’ education and health, have been highlighted extensively throughout this Situation Analysis (see also Section 3.2 and Chapters 5 and 7). The Census 2011 showed that almost 1 in 3 married women were married when still younger than age 18, down from 44.7 per cent in 2001 but still high. Among women aged 20-24 years, 1 in every 5 has been married before age 18, according to the RSOC 2013-2014. The practice is more common in rural (25.1 per cent) than urban areas, although the urban poor also display a strong trend toward child marriage (30 per cent). It also is strongly correlated with low levels of education. Girls with a secondary school education or higher are 7 times less likely to marry early than those with primary education or less (5 per cent vs. 35 per cent respectively).\footnote{RSOC 2031-2014, op.cit.}

A strong correlation between poverty and early marriage also exists. Across India, girls from the poorest households are more than four times more likely to marry early than those from the richest quintiles (37 per cent vs. 8 per cent).\footnote{Ibid.} However, in areas with child marriage rates of 50 per cent and higher, girls marry early regardless of wealth. The east-west corridor spanning six states (Rajasthan, Madhya Pradesh, Uttar Pradesh, Bihar, Jharkhand, West Bengal) accounts for two-thirds of the child marriages in India; mean age at marriage for women is still below the legal age in at least four of these states, and ranges as low as 16.3 years.\footnote{Ibid.} Moreover, in some parts of India, such as Rajasthan and Gujarat, early marriage is strongly associated with caste membership and, in some districts, child marriage rates are highest among richer, high-caste girls.

Meanwhile, adolescents in rural areas are more likely to initiate childbearing in their teens compared to their urban counterparts (see also Section 3.2). The proportion of women aged 15-19 who have begun childbearing is higher among girls from SC families (7 per cent) than from other social groups (5 per cent). The level of adolescent pregnancy and motherhood also decreases with an increase in the wealth index (6 percent in the lowest quintile vs. 2 percent in the highest quintile)

Overall, drivers of high prevalence of early marriage include: widely accepted and sanctioned social norms; poverty, high wedding costs and other economic considerations; lack of easy access to schooling, especially at secondary level; political patronage, which weakens law enforcement agencies; vested interest groups and networks; gender norms and prescriptions; and shocks and stresses resulting from disaster, climate change and/or protracted emergencies. Together, these drivers have ensured that child marriage continues to persist in India and has resisted Government efforts to ban the practice.

At the same time, five drivers of change exist and must be further leveraged: (1) access to safe, affordable and good-quality secondary education; (2) empowerment of women and girls, along with engagement with men and boys (see also Section 3.7); (3) incentivising the change through social protection; (4) agenda building and influencing public opinion to promote behaviour change; and (5) consistent laws and stricter enforcement. By amplifying these drivers of change, it is considered possible to accelerate the decline in early marriage.\footnote{UNICEF India. Reducing Child Marriage in India: A Model to Scale Up Results. New Delhi, 2016.}

**Child Labour**

Data from the Census 2011 also show that India has 10.1 million child workers aged 5-14 years, down from 12.7 million in 2001 (see Figure 27 and Annex 15) for full causality analysis of issues of child labour). An overall decline has occurred in the magnitude of child labour, to 3.9 per cent in 2011 from 5.0 per cent in 2001. However, the decline has not been uniform across rural and urban areas; indeed,
the number of children working in urban areas has increased, indicating the growing demand there for child workers in new urban areas, where more small-scale industries are being established or more construction is taking place. Nonetheless, overall most children (3 in 5 in 2011) were engaged in cultivation and agricultural labour.

A large number of states still have a high incidence of the practice – more than half of child workers are concentrated in 15 states and Union territories – and district-level disparities within states also are found. About 1.7 million SC/ST children (3.4 per cent of the total tribal population) are working, comprising around 1 in 6 total child workers in the country in 2011.\(^{214}\)

**Figure 27: Child workers in India 2001-2011**

Critically, India has yet to ratify ILO Conventions Nos. 138, concerning the minimum age of admission to employment, and 182, concerning the prohibition and immediate action for the elimination of the worst forms of child labour. This has been cited repeatedly in the UPR review, among other international human rights instruments, and requires urgent attention.

**Children Deprived of Care and Protection**

No precise figures are available for children deprived of care and protection in India (see Annex 16 for full causality analysis of children deprived of adequate family care and protection). However, numerous such children exist: on the streets, in institutions, and in boarding schools, among others. A mapping exercise is under way to determine how many children are housed in institutions across the country. In particular, education policies in tribal areas are aimed at placing children in residential schools (see also Section 3.3). However, this has the effect that children are alienated from their own culture and often end up providing low-paid labour in society. Tribal children also are extremely vulnerable to labour and trafficking.

Meanwhile, the number of children in conflict with the law has risen marginally, from 1.0 per cent to 1.2 per cent between 2003 and 2013. At the same time, issues of accelerating migration, urbanisation, lack of skills education and growing substance abuse all point toward an increasing magnitude of the issue in the coming years.

**VAC/VAWG**

Violence against children (VAC) and adolescents, including sexual violence, corporal punishment, bullying, stalking and sexual harassment, is widespread (see Annex 17 for full causality analysis of child

\(^{214}\) Tribal Equity Profile, op.cit.
victims of sexual and physical violence). It is also structurally embedded in age, gender, caste, religious and other social divisions, as well as in poverty. Similarly, violence against women and girls (VAWG) pervades Indian society, with 34 per cent of all women aged 15-49 having experienced it at any time since the age of 15 (see also Sections 3.2 and 3.7).\(^{215}\)

Violence in all its forms is used by those in power to enforce these social and economic divisions and their perceived entitlements. It occurs in schools, child care institutions, homes, workplaces, rural and urban communities, online, on the street, on public transport, at police stations, and even while women and girls go to the toilet. Moreover, the silence surrounding violence often assures impunity and acts as a block to perpetrators being held accountable for their violent actions.

The most horrific crimes against children, adolescents and women are sensationalised in the media and by politicians, but there is little or no coverage of the normalised everyday violence at home, in schools and institutions, or the workplace. An effective strategy for prevention of violence against children and adolescents has to go beyond child protection, however, and requires a multisectoral approach of working closely with other sectors, including education for school safety, behavioural change communication, and public health response mechanisms (see also Chapters 5 and 7).

Numerous data gaps exist related to VAC in India. However, a total of 89,423 cases of crimes against children were reported in the country during 2014, compared to 58,224 cases during 2013, showing an increase of 53.6 per cent in just one year. In particular, crimes against children are on the rise in cities; Maharashtra and New Delhi, two of the most urbanised areas in India, record nearly 1 in 4 total crimes against children in the country. Also in 2014, 13,766 cases of child rape were reported in the country, compared to 12,363 in 2013, an increase of 11.3 per cent. Married girls aged 15-19 are 10 times more likely to experience sexual violence than unmarried girls; critically, marital rape is still not classified as a crime. In addition, nearly half of both boys and girls justify wife beating.\(^{216}\)

At the same time, surveys of schools show a changing pattern of violence experienced by adolescents overall, including rising levels of mental violence, stress and bullying, leading to increasing numbers of suicides among adolescents (see also Section 3.2 and Chapter 5).

Violence also is finding new forms and channels through mobile and digital technologies, although online risks for children have received relatively less attention. Serious gaps exist in protection services for children who are victims of online abuse (cyberbullying, harassment, sexual abuse/child pornography). In fact, a widespread lack of awareness is found among parents, teachers, police and policymakers of the growing and ever-changing risks of child online abuse and exploitation. Legislation, mechanisms and services are inadequate to respond to these threats and will need to be updated and strengthened.

Among women, differentials in prevalence of violence are substantially based on the woman’s level of education. A total of 44 per cent of women with no education have experienced violence at some time since age 15, higher than the 34 per cent of women found overall, as highlighted above. The prevalence of violence also is much higher among SC women (42 per cent) and ST women (40 per cent) than among women who do not belong to these categories (27 per cent). Differentials across wealth quintiles also are large, from 45 per cent among the poorest women to 19 per cent among the richest.

\(^{215}\) NFHS-3.

\(^{216}\) Many data gaps exist related to violence against children in India. For more information, refer to UNICEF, *Hidden in Plain Sight*, 2014.
Tripura is second only to Assam in the rate of incidents of crime against women and is sixth in the rate of incidents of crime against children; issues of crimes against women have garnered national attention for the state since 2013, when Tripura recorded 1,628 cases, with the National Human Rights Commission directing the state government to investigate the issue. Domestic violence against women in Tripura is very high (38.3 per cent), the highest among all states. Further, the rate of reported crimes against children has soared between 2012 and 2014.\textsuperscript{217}

Missing or Trafficked Children
The issue of trafficking in children continues to be a complex one and appears to be increasing in scale, although full data are not available. A staggering 45,000 children – one from every 4,200 households – are reported to go missing in India every year, with many of them trafficked. Non-Government organisations working in the field estimate only 10 per cent of all cases are registered with police; hence, the actual numbers could be much higher. As noted above, nearly half of these children are never found.\textsuperscript{218} In 2014, 42 per cent more girls were reported missing than boys, and in 2015, 31 per cent more girls were reported missing. Girls are also less likely to be found, with 52 per cent more girls represented among untracked children in 2014 and 31 per cent more reported in 2015.\textsuperscript{219} At the same time, women and children in conflict-affected districts face a high risk and rising incidence of trafficking, with some also forced into armed conflict.

Adverse Child Sex Ratio
Declining child sex ratio (CSR) is testimony to the fact that girl child faces severe discrimination even before taking birth (see also Section 3.7 and Chapter 5). Preferences for a son and patriarchal mindsets result in illegal sex determination tests and high levels of female foeticide. According to the Census 2011, the child sex ratio (0-6 years) has fallen from 927 females per 1,000 males in 2001 to 919 females per 1,000 males in 2011, as highlighted above. This is alarming, and the lowest child sex ratio since India’s independence more than 70 years ago.

UNFPA states that an estimated 456,000 girls were “missing” at birth every year from 2001 to 2012. The excess female U5MR also can be estimated to be 134,000 deaths per year over the same period – thus, around 600,000 girls are missing annually in this way. The issue is most acute in northwest India, as well as in families from the richest wealth quintile; in urban areas; and in families where the head of household has completed 12 or more years of education. Adverse CSR also is strongly present in the second wealth quintile, but less so in the poorer quintiles. A CSR of below 950 is prevalent among all social groups, although among STs less so than others.

Moving Forward
Moving forward (see Section 8.5 for full recommendations), it will be important to advocate for child protection and give child protection issues greater visibility, prioritising the use of a multisectoral approach and community-based approaches. This may also include expanded use of mass media, social media, ICT and mobile technologies to reach and influence much larger numbers of people. Partnerships will need to be broadened, including with new constituencies such as parliamentarians, adolescents and children themselves, and urban middle-class professionals.

In terms of capacity building, more strategic strengthening of child protection service providers and structures can be provided, by targeting mid-level child protection cadres and by collaborating with leading academic and training institutions in the country. Lastly, it will be necessary to strengthen data

\textsuperscript{217} Tripura Programme Context Report, op.cit.
\textsuperscript{218} National Human Rights Commission data.
\textsuperscript{219} Ministry of Home Affairs, Rajya Sabha, Special Cell to Find Out Cause of Missing Children. “Unstarred Question 1324.” 2016,
and data systems, along with monitoring, research and evaluation for evidence-based decision making and greater accountability.

8.4 Structural and Underlying Causes of Key Protection Challenges

Based on the above analysis, as well as the analyses in the relevant Annexes, a number of structural/root causes for child protection-related challenges in India, at different levels of duty bearers, have been identified:

- Shortcomings in enforcement of legal/policy frameworks, linked to inadequate allocation and utilisation of financial resources
- Acute institutional capacity issues, including in monitoring and accountability, and gaps in qualified human resources
- Harmful cultural, religious and other social norms that perpetuate son preference and a low value and status of women and girls, including practices like dowry and women living in the home of the husband with the husband’s family after marriage.
- Marginalisation of tribal groups, including as a result of armed conflict
- Social norms and traditional/cultural beliefs accepting violent discipline as a legitimate disciplinary measure
- Social norms and traditional/cultural beliefs resulting in denial of sexual and other abuse of boys
- Wide social disparities and poverty
- Overall lack of awareness of importance of child protection issues; for example, many parents do not see the importance and benefit of registering the birth of their children until school enrolment age
- Weak child protection in situations of mass displacement and need for strengthened capacity of mandated systems (education, Anganwadi Centres, CPS) to service the need

All this results in a variety of underlying challenges, including:

- Emphasis on “purity” and “honour” for girls, where the bodies of women and girls are held responsible for the “honour” of the family and community
- Stigmatisation of sex outside marriage, where rape and sexual assault of women and girls are seen to be their “fault”
- Stigmatisation of victims of sexual abuse, especially boys, with lack of available support and inequitable power forces in society
- Slow movement from responsive to right-oriented protection system
- Need for enhanced coordination among child protection stakeholders
- Need for extension of and strengthened child-sensitive social protection, including in remote and hard-to-reach areas and populations (urban slums et al.)
- Children, particularly adolescent girls, often are unaware of their legal rights or are made to feel they cannot exercise those rights
- Need for strengthened targeting of social protection programmes

8.5 Recommendations to Improve Children’s, Adolescents’ and Women’s Protection Status

All children, adolescents and women have the right to be protected from violence, abuse and exploitation. While the direct impact of a society’s failure to adequately protect its children and adolescents is difficult to quantify, and the impact on poverty is not directly documented, it is recognised that abuse, violence and exploitation of these groups are fundamental social problems, as is violence against women. Moreover, these issues have implications not only for the well-being and rights of children, adolescents and women, but also for the long-term well-being and stability of
Creating a truly protective system is a highly complex undertaking. With that in mind, recommendations include:

| Policy/Strategy | Promote the development of a common vision and goals for the protection of children among key child protection actors, including Government, civil society, religious/community leaders and young people themselves. This vision should be accompanied by:
|                 | - Adequate budget allocation and execution based on sound costing models and budget expenditure tracking systems
|                 | - Specialisation and mobilisation of the child protection workforce.
|                 | - Increased emphasis on prevention of violence, abuse and exploitation |

| Institutions/Governance | Support the development of sound monitoring and evaluation systems with clear and measurable targets, and open to public scrutiny
|                         | Support the empowerment of adolescents to participate in public fora and governance mechanisms
|                         | Strengthen national and sub-national institutions in the promotion and protection of child rights (judicial bodies and independent monitoring agencies) |

| Programme, Including Adolescents/Gender/ECD/Tribal/Conflict/Urban Slums/Climate Change & DRR | Advocate for the mainstreaming of prevention of child marriage, violence against children, and child labour into national-level delivery platforms to ensure large-scale interventions
|                                                                                         | Invest in the second decade of life by investing in adolescent girls and boys, particularly young adolescents aged 10-14, empowering them to become agents of change through increased civic participation, improved life skills and promotion of positive social norms, especially gender norms. |

| M&E/Data/Knowledge Management/Innovation | Invest in evidence generation to determine effective interventions in violence prevention and promotion of positive social norms and behaviours
|                                         | Support the development of systems to monitor the effective implementation of national laws, policies and programmes (i.e., scorecards, real-time monitoring, case management databases et al.) |

Chapter 9: Conclusion: The Way Forward

Despite numerous challenges and comparatively small budgets in the social sector, India has achieved major improvements in the lives of children, adolescents and women. India’s young girls and boys, adolescents and women thus are generally better off today than their peers from even recent years. While considerable challenges remain, these are being increasingly recognised and addressed by the Government, communities, parents, families, the international community, and children themselves. India must be encouraged to foster an ever-stronger commitment to development of its children and
adolescents. In so doing, the country can move a long way toward realising its ambitious hopes and vision.

Even so, from the analysis above it is clear that many of the development challenges that continue to face India arise from the same or similar root causes, and that constraints to realisation of the full spectrum of rights among all of the country’s children, adolescents and women remain profound.

Key root causes of major disparities include, among others:
- An acute need for systems/institutional strengthening, particularly at sub-national levels, to address insufficient capacities for equity-based planning, implementation, understanding of risk and change, coordination, and monitoring
- A strong need for a culturally sensitive transformation in social and behavioural development, including better definition of social norms to eliminate harmful practices, and promotion of social norms that enhance positive practices to ensure respect for and realisation of the rights of all women, adolescents and children
- The persistence of widespread poverty despite national economic progress, which continues to influence the life choices of many families
- A need to direct more substantive attention to quality services in disadvantaged and groups areas lagging in human development, including residents of urban slums, and tribal peoples, many of whom are conflict-affected
- Inadequate knowledge and awareness, particularly at family level, on good development practices and their benefits
- India’s heightened vulnerability to disaster, climate change and ensuing risks

At the same time, most of these challenges are complex, warranting comprehensive policies and robust, multisectoral implementation over a sustained period. This suggests that an integrated approach to India’s development needs among children, adolescents and women would best serve the country in many cases. Priority will need to be given to the seven themes highlighted across all sectors. In turn, these themes are drawn not only from this analysis but also are aligned with the Government’s overarching Vision 2030 as well as the post-2015 global development agenda.

In all, these priority areas are intended to capture key development issues as well as broad and important structural causes – socio-cultural, economic, and institutional and those related to governance, and environmental – that form the basis of deeper themes of vulnerability. At the same time, it is also important to note that it is not that the structure, systems or legal provisions of India not changing; they are, sometimes even quite dramatically. What is at issue, however, is the very embeddedness of the analysed structural causes in everyday life, which still constricts social, economic, cultural and governance opportunities for significant numbers of children, adolescents and women in the country.

To address these broad areas, it will be critical to highlight the importance of context-responsive strategies that are tailored specifically to local and state realities as well as to disparities among and within India’s regions, socioeconomic groups, and others; this will require deepened strategic partnerships at different levels of governance. Priority will particularly continue to need to be given to the most crucial interventions related to reducing neonatal mortality, stunting and open defecation; all children in school and learning; and protection of children from violence and exploitation, with the introduction of further innovative, high-impact ideas in each area.

At the same time, new areas for focus can include ECD, especially early intervention and stimulation, as well as good parenting skills, involving children aged 0-3 years; knowledge generation and strengthened data analysis, including multidimensional child deprivation analysis; evidence-based social policy influencing and social protection; and effective communication for behavioural and social
change. Use of “resource states” such as Kerala or Tamil Nadu may offer good practices for replication in more challenged states. As recommended by the MTR of the Country Programme of Cooperation, new partnerships for “thinking out of the box” will be necessary, including with youth, faith-based leaders, corporate, media, academia, and others. In so doing, all this can help to ensure that the well-being of, and equitable outcomes for, all children, adolescents and women in India, particularly those from disadvantaged and vulnerable groups, is enhanced to the maximum.
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Economist Intelligence Unit. *The Impact of Technology on India’s Workforce and Education*. New Delhi, 2016.


Annexes
Annex 1: Key Deprivations in Nutrition

Table 1. Analysis of deprivations applying the five filters

<table>
<thead>
<tr>
<th>Deprivations</th>
<th>Stunting</th>
<th>Adolescent/Maternal Undernutrition</th>
<th>Anemia</th>
<th>Wasting</th>
<th>Overnutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criticality of national challenge</td>
<td>▪ Trend declining (48% in 2006 to 39% in 2014), but slow progress (annual reduction rate of 2.4%, lower than the WHA(^\text{220}) target of 3.9%)</td>
<td>▪ India has the highest number of adolescents globally</td>
<td>▪ More than half the adolescent girls (56%) and women of reproductive age are anemic</td>
<td>▪ Increasing trend in wasting</td>
<td>▪ Increasing trend in overweight &amp; obesity</td>
</tr>
<tr>
<td></td>
<td>▪ High burden: still affects 46.8 million children under-five (39%), accounting for ~ one third of global burden of childhood stunting</td>
<td>▪ Nearly half (44.7%) of adolescent girls have low BMI</td>
<td>▪ There has been limited improvement on anemia prevalence across the life cycle</td>
<td>▪ Very high burden both in India and globally</td>
<td>▪ Increasing recognition by the Government</td>
</tr>
<tr>
<td></td>
<td>▪ Serious short-term &amp; long term consequences, especially in relation to economic development of the country</td>
<td>▪ About one third (33.7%) of women of reproductive age have low BMI</td>
<td>▪ Has intergenerational effect – adolescent &amp; maternal anemia is a strong risk factor for low birth weight, stunting</td>
<td>▪ Links to child survival</td>
<td>▪ However, more evidence needs to be generate, and more work needed in knowledge management</td>
</tr>
<tr>
<td></td>
<td>▪ Impacts progress of other sectors (school performance, health, economic growth etc)</td>
<td>▪ There has been limited improvement on relevant indicators – low BMI of adolescents &amp; adult women</td>
<td>▪ Ranked #2</td>
<td>▪ Ranked #3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Gaining momentum &amp; receiving more attention in India</td>
<td>▪ Has intergenerational effect, and an importance cause of the perpetuation of vicious cycle of undernutrition</td>
<td>▪ Ranked #2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^{220}\) World Health Assembly
<table>
<thead>
<tr>
<th>Mandate</th>
<th>Core corporate mandate at national, regional and global levels</th>
<th>Core UNICEF corporate mandate</th>
<th>While these issues are part of core UNICEF mandate, more work needs to be done</th>
<th>Ranked #1</th>
<th>Ranked #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core mandate not only for UNICEF, but also for UN (i.e., SDGs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ranked #1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actors in the same field</th>
<th>There are growing number of actors working on stunting</th>
<th>Not many actors working in this field</th>
<th>There are growing number of actors working on wasting</th>
<th>Ranked #1</th>
<th>Ranked #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actors are multisectoral in nature (e.g., Govt, development partners, media etc)</td>
<td></td>
<td>Actors are fragmented</td>
<td>Actors are fragmented</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ranked #2</strong></td>
<td></td>
<td></td>
<td><strong>Ranked #1</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capacities &amp; position to act</th>
<th>UNICEF has the internal capacity</th>
<th>UNICEF has the internal capacity</th>
<th>UNICEF needs to strengthen capacity in terms of community care for SAM</th>
<th>Ranked #1</th>
<th>Ranked #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF is well positioned to act</td>
<td></td>
<td>UNICEF is well positioned to act</td>
<td>UNICEF needs to strengthen capacity in terms of community care for SAM</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ranked #1</strong></td>
<td></td>
<td></td>
<td><strong>Ranked #1</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lessons learned</th>
<th>Strong evidence exists on what works</th>
<th>Stronger links with nutrition sensitive sectors are important (e.g., education, CP, agriculture etc)</th>
<th>Strong leadership and governance is missing (e.g., supply chain, M&amp;E etc)</th>
<th>Community based approach needs to be strengthened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience with Nutrition Mission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience with tribal nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ranked #2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Increased investment by state
- Increased CSR investment

| Table 2. Defining the focus for each deprivation |
|---|---|---|
| **Who** | **When** | **Where** |
| **Stunting** | Less than two years | Social Conflicts include long term conflicts like the Maoist movement, north-eats insurgency as well as sudden eruptions of conflict like the Dalit Movement, communal riots |
| | SC&ST Lowe wealth quintiles Born to undernourished mothers Urban poor | Natural disasters like floods, droughts |
| | | There are 4 states (UP, Bihar, MP and Maharashtra) with high absolute numbers which means high burden states. |
| | | The high prevalence 7 states are UP, Bihar, MP and Maharashtra, Rajasthan, Chhattisgarh, Jharkhand, Gujarat and Andhra Pradesh. |
| **Adolescent and maternal undernutrition** | Adolescent girls and boys | Social Conflicts include long term conflicts like the Maoist movement, north-eats insurgency as well as sudden eruptions of conflict like the Dalit Movement, communal riots |
| | SC/ST Urban poor Lowe wealth quintile | Natural disasters like floods, droughts |
| | | There are 4 states (UP, Bihar, MP and Maharashtra) with high absolute numbers which means high burden states. |
| | | The high prevalence 7 states are UP, Bihar, MP and Maharashtra, Rajasthan, Chhattisgarh, Jharkhand, Gujarat and Andhra Pradesh. |
| **Anaemia among adolescents** | Adolescent girls and boys | Social Conflicts include long term conflicts like the Maoist movement, north-eats insurgency as well as sudden eruptions of conflict like the Dalit Movement, communal riots |
| | Women of reproductive age Out of schools and girls SC/ST Urban poor Lowe wealth quintile | Natural disasters like floods, droughts |
| | | There are 4 states (UP, Bihar, MP and Maharashtra) with high absolute numbers which means high burden states. |
| | | The high prevalence 7 states are UP, Bihar, MP and Maharashtra, Rajasthan, Chhattisgarh, Jharkhand, Gujarat and Andhra Pradesh. |
| **Wasting** | Under five boys and girls | Seasonality : non-harvesting period, rainy season, extreme weather conditions |
| | SC/ST Lowe wealth quintile | High ODF states (>70%) – 3 |
Urban poor & Social conflict of short term (in terms of time period) nature & Migration & High Burden States (>50%) – 6 (UP, Maharashtra, Bihar, MP, AP, West Bengal) 
High prevalence states – 13 (UP, Maharashtra, Bihar, MP, AP, West Bengal, Tamil Nadu, Gujarat, Karnataka, Rajasthan, Odisha, Jharkhand, Kerela) 

<table>
<thead>
<tr>
<th>Filters</th>
<th>Stunting</th>
<th>Adolescent and maternal undernutrition</th>
<th>Anaemia</th>
<th>Wasting</th>
<th>Over nutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criticality of national challenges</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Mandate</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Actors in the same field</td>
<td>4221</td>
<td>5</td>
<td>5</td>
<td>42</td>
<td>1</td>
</tr>
<tr>
<td>Capacities and position to act</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4222</td>
<td>1</td>
</tr>
<tr>
<td>Lessons learned</td>
<td>5</td>
<td>2 or 3223</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>22</td>
<td>23</td>
<td>18</td>
<td>5</td>
</tr>
</tbody>
</table>

221 Numbers of actors working on these issues are growing. However, UNICEF has important role to play as a convener and coordinate efforts of various actors  
222 Scoring is less compared to stunting, adolescent/maternal undernutrition and anaemia, because UNICEF needs to strengthen capacity in community-based management of wasting  
223 Scoring can be 2 taking account the limited amount of knowledge available globally on what works to improve adolescent / maternal nutrition; scoring can be 3 taking into account some evidence created at state level in some states
Annex 2: Causality Analysis of Child Undernutrition

**Immediate Causes**
- Inadequate maternal nutrient intake
  - Inadequate maternal dietary diversity
  - Low compliance to IFA & calcium supplements and deworming
- Inadequate Infant and Young Child (IYC) growth
- Maternal infections, Poor access to maternal health & pregnancies – too early, too many and too soon
- Low education, nutrition knowledge of caretakers
- Inadequate decision making power of mothers
- Inadequate HH WASH & food safety

**Underlying Causes**
- HH Food Insecurity
- Inadequate food allocation for mothers Young Children
- Poor maternal and IYC care practices
- Inadequate Infant and Young Child (IYC) growth
- Inadequate IYC Dietary Intake
  - Inadequate BF Practices
  - Inadequate CF Practices
- Frequent IYC Diseases

**Basic Causes:**
- Poor Health & Nutrition Care Seeking Behavior
- Agriculture & Food Systems
- Political Economy & Governance
- Social norms on gender & Caste
- Education
- Water, Sanitation & Environment
- Health & Nutrition Care
- Poverty, Inequality & Discrimination
- Political Economy & Governance

**Immediate Causes:**
- Inadequate maternal nutrient intake
  - Inadequate maternal dietary diversity
  - Low compliance to IFA & calcium supplements and deworming
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- Political Economy & Governance
Annex 3: Causality Analysis of Adolescent Anaemia

*Girls are more affected by anaemia than boys
## Annex 4: Key Deprivations in Health

### Table 1 - Health Analysis of deprivations applying the five filters

<table>
<thead>
<tr>
<th>Deprivations - Unfinished agenda of MDGs</th>
<th>NMR/MMR</th>
<th>US Mortality</th>
<th>Immunization</th>
<th>Adolescent pregnancies</th>
<th>Adverse sex ratio</th>
<th>HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criticality of national challenge</td>
<td>• Large number of Maternal (45,000) and Neonatal deaths (696,000) More than half of Newborn deprived of mothers milk in 1st hour of life</td>
<td>• 300,000 child deaths due to pneumonia and diarrhea</td>
<td>• 9 million children deprived of full immunization</td>
<td>• Nearly 30% of women in India in the age group of 20-24 are married before the age of 18 years, with rates as high as 47% in Rajasthan and Bihar and 45% in West Bengal.</td>
<td>• 456,000 girls aborted every year</td>
<td>• 86,000 new cases happen each year, with children (&lt;15 years) accounting for 12% of new infections.</td>
</tr>
</tbody>
</table>

### Mandate

Core mandate not only for UNICEF, but also for UN (i.e., SDGs)

### Actors in same field

UNICEF continues to remain the lead partner for newborn and child health with UNFPA being lead for maternal and adolescent health. For immunization and GAVI support, WHO and UNICEF along with UNDP are the major partners for the Ministry of Health. Other important development partners at national level are BMGF, Save the Children, USAID, JHPEIGO, PATH and Norway India Partnership Initiative (NIPI). A lead development partner has been identified for each state for Call to Action by Ministry of health.

### Capacities & position to act

- UNICEF has the internal capacity
- UNICEF is well positioned to act
- UNICEF needs to strengthen capacity
- UNICEF needs to strengthen capacity
- UNICEF has the internal capacity

### Lessons learnt

- Leveraging the opportunity of a strong government leadership and a positive policy environment to address long standing coverage, equity, and disparity gaps.
- Importance of following up on the unfinished agenda of MDGs, as aim to broaden our focus. This balance will be the key to achieve the next set of big results for maternal and child survival in India.
- A need to combine upstream policy/advocacy work at national and state level, with downstream work at district level.
<table>
<thead>
<tr>
<th>Table 2. Defining the focus for each deprivation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who</strong></td>
</tr>
<tr>
<td>NMR</td>
</tr>
<tr>
<td>- Max load</td>
</tr>
<tr>
<td>- Female new born</td>
</tr>
<tr>
<td>- Rural</td>
</tr>
<tr>
<td>- Conflict affected</td>
</tr>
<tr>
<td>Where</td>
</tr>
<tr>
<td>Uttar Pradesh, Madhya Pradesh, Rajasthan and Bihar and Rajasthan plus 184 HPDs</td>
</tr>
<tr>
<td>Where</td>
</tr>
<tr>
<td>Social Conflicts include long term conflicts like the Maoist movement, north-eats insurgency as well as sudden eruptions of conflict like the Dalit Movement, communal riots</td>
</tr>
<tr>
<td>Natural disasters like floods, droughts</td>
</tr>
<tr>
<td>MMR</td>
</tr>
<tr>
<td>- Max load</td>
</tr>
<tr>
<td>- SC&amp;ST</td>
</tr>
<tr>
<td>- Lowest wealth quintiles</td>
</tr>
<tr>
<td>- Muslim groups</td>
</tr>
<tr>
<td>Where</td>
</tr>
<tr>
<td>Assam, Bihar, UP, MP and Maharashtra, Rajasthan, Chhattisgarh, Jharkhand, Gujarat and Andhra Pradesh. plus 184 HPDs</td>
</tr>
<tr>
<td>Where</td>
</tr>
<tr>
<td>Social Conflicts include long term conflicts like the Maoist movement, north-eats insurgency as well as sudden eruptions of conflict like the Dalit Movement, communal riots</td>
</tr>
<tr>
<td>Natural disasters like floods, droughts</td>
</tr>
<tr>
<td>U5 Mortality</td>
</tr>
<tr>
<td>- Gender</td>
</tr>
<tr>
<td>- SC/ST</td>
</tr>
<tr>
<td>- Urban poor</td>
</tr>
<tr>
<td>- lower wealth quintile</td>
</tr>
<tr>
<td>Where</td>
</tr>
<tr>
<td>UP, Bihar, MP and Rajasthan plus 184 HPDs</td>
</tr>
<tr>
<td>Where</td>
</tr>
<tr>
<td>Social Conflicts include long term conflicts like the Maoist movement, north-eats insurgency as well as sudden eruptions of conflict like the Dalit Movement, communal riots</td>
</tr>
<tr>
<td>Natural disasters like floods, droughts</td>
</tr>
<tr>
<td>Immunization</td>
</tr>
<tr>
<td>- SC/ST</td>
</tr>
<tr>
<td>- Urban poor</td>
</tr>
<tr>
<td>- Lower wealth quintile</td>
</tr>
<tr>
<td>Where</td>
</tr>
<tr>
<td>Madhya Pradesh, Rajasthan, Chhattisgarh, Jharkhand, and Uttar Pradesh.</td>
</tr>
<tr>
<td>Where</td>
</tr>
<tr>
<td>Social Conflicts include long term conflicts like the Maoist movement, north-eats insurgency as well as sudden eruptions of conflict like the Dalit Movement, communal riots</td>
</tr>
<tr>
<td>Natural disasters like floods, droughts</td>
</tr>
<tr>
<td>Adolescent pregnancies</td>
</tr>
<tr>
<td>- SC/ST</td>
</tr>
<tr>
<td>- Urban poor</td>
</tr>
<tr>
<td>- Lower wealth quintile</td>
</tr>
<tr>
<td>Where</td>
</tr>
<tr>
<td>UP, Bihar, MP and Maharashtra, Rajasthan, Chhattisgarh, Jharkhand, Gujarat and Andhra Pradesh.</td>
</tr>
<tr>
<td>Where</td>
</tr>
<tr>
<td>Social Conflicts include long term conflicts like the Maoist movement, north-eats insurgency as well as sudden eruptions of conflict like the Dalit Movement, communal riots</td>
</tr>
<tr>
<td>Natural disasters like floods, droughts</td>
</tr>
</tbody>
</table>
Adverse sex ratio
- Rural CSR worst
- CSR worst in higher wealth quintile
- Urban poorest quintile worst
J&K, PNB, HR, RJ, MH, UK have less than 900

HIV
- Preg mothers w HIV, sex workers, IV drug users
UP, Bihar, Jhk, WB, Chhattisgarh

Table 3 - Scoring of Deprivations

<table>
<thead>
<tr>
<th>Filters</th>
<th>Unfinished agenda of MDGs</th>
<th>SDG opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NMR</td>
<td>MMR</td>
</tr>
<tr>
<td>Criticality of national challenges</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Mandate</td>
<td>5</td>
<td>4.5</td>
</tr>
<tr>
<td>Actors in the same field</td>
<td>4</td>
<td>3.5</td>
</tr>
<tr>
<td>Capacities</td>
<td>4</td>
<td>3.5</td>
</tr>
<tr>
<td>Lessons learned</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>19</td>
</tr>
</tbody>
</table>
Annex 5: Causality Analysis for High Child Mortality, Especially for Girls

RCH Causality Analysis

**Immediate causes**
- Perinatal Infections
- Pneumonia
- Severe Anemia
- Congenital Malformations
- Perinatal Asphyxia
- Preeclampsia/Eclampsia
- Prolonged Obstructed Labors
- Vaccines' preventable illnesses
- Injuries/Accidents
- Malaria and other Vector Borne Diseases in Endemic States

**Underlying causes**
- Lack of Essential Medicines & Equipment
- Indoor Air Pollution
- Inadequate Skills of Health Workers
- Access to Healthcare (Poor, Tribal, Remote Areas, Vulnerable Populations)
- Lack of Community Awareness (Entitlements)
- High Vulnerability to Climate Change Effects and Disasters
- Low Maternal Education and High Illiteracy Level
- Inadequate Knowledge of families on Care-Giving Practices
- Low Early and Exclusive Breast Feeding
- Poor Hygiene & Sanitation Practices by Care Providers and Care Givers
- Discrimination Attitude and Practices of Health Providers
- Lack of Evidence and Real Time, and Monitoring data for Planning (Especially Demand Side Disaggregated Data)
- Delay in Recognizing Danger Signs
- High Unmet Need for Family Planning
- Low Routine Immunization Coverage
- Adriate Number and MHR Distribution Gender imbalance in management and supervisory roles
- Adequate Background Knowledge of and HR in Health Facilities
- Delivery Without Skilled Birth Attendance
- Women not Empowered to Take Decisions
- Anemia in All Age Groups
- Underutilization of Available Essential Services
- lenghty in Decision Making to Seek Care
- Low Maternal / Adolescent Undernutrition
- Inadequate Number and HRH Distribution in Health Facilities
- High Unmet Need for Family Planning
- Low Quality and Delayed Care

**Structural causes**
- Conflict Affected Regions
- Inadequate funds Allocation + Utilization
- Poverty
- Non Resilient Critical Health Infrastructure
- Varying Political Commitment to Improve Health Outcomes
- Inadequate + Inequitable Infrastructure + HR
- Weak Governance
- Poorly Regulated Private Health Sector
- Policies, social organization, governance, culture, political issues

Most obvious link

High Child Mortality (MMR + NMR/Stillbirths + IMR + USMR) Especially for Girls

Deprivation

Lack of Evidence and Real Time, and Monitoring Data for Planning (Especially Demand Side Disaggregated Data)

High Unmet Need for Family Planning

Inadequate + Inequitable Infrastructure + HR

Inadequate Knowledge of families on Care-Giving Practices

Delay in Decision Making to Seek Care

Lack of Evidence and Real Time, and Monitoring data for Planning (Especially Demand Side Disaggregated Data)

Access to Healthcare (Poor, Tribal, Remote Areas, Vulnerable Populations)

Lack of Birth Preparedness

Low Maternal Education and High Illiteracy Level

Inadequate funds Allocation + Utilization

Inadequate + Inequitable Infrastructure + HR

Shortfalls in social services, access, harmful beliefs and practices

Policies, social organization, governance, culture, political issues
Annex 6: Key Deprivations in WASH

WASH Scoring of Deprivations

<table>
<thead>
<tr>
<th>Filters</th>
<th>Unsafe Hygiene Practices</th>
<th>Unsafe Drinking Water</th>
<th>Unsafe disposal faeces</th>
<th>Unclean environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criticality</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Mandate</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Actors in the same field</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Capacities /position to act</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Lessons learned</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>23 (3)</td>
<td>24 (2)</td>
<td>25 (1)</td>
<td>15 (4)</td>
</tr>
</tbody>
</table>

Annex 7: Causality Analysis of Open Defecation

Causality Analysis

<table>
<thead>
<tr>
<th>Deprivation - Open Defecation - Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Causes</td>
</tr>
<tr>
<td>Open defecation due to a lack of availability and/or access to a toilet at household, institutional (school, community, AWC, health centre, or work setting)</td>
</tr>
<tr>
<td>Infrastructure /facilities</td>
</tr>
<tr>
<td>Underlying Causes</td>
</tr>
<tr>
<td>Open defecation due to a lack of use of toilets at household, institutional (school, community, AWC, health centre) or work setting</td>
</tr>
<tr>
<td>Lack of physical space to build a toilet especially for the poor</td>
</tr>
<tr>
<td>Recurrent shocks and stresses undermine sustainability of toilets use</td>
</tr>
<tr>
<td>Poor hygiene and maintenance of toilets deter people from using the toilet</td>
</tr>
<tr>
<td>Root Causes</td>
</tr>
<tr>
<td>Lack of citizen's participation and voice – adolescents, middle class, &amp; women</td>
</tr>
<tr>
<td>Lack of women's social, economic, and political empowerment and decision making limits expression of demands or agency</td>
</tr>
</tbody>
</table>

*More detail on gender, equity, and risk informed programming is found in the Word Document*
## Annex 8: Causality Analysis of Lack of Safe Drinking Water

**Deprivation:** Lack of safe and adequate drinking water for all, especially for marginalized communities, all the time (rural)

### Immediate Causes
- Lack of knowledge and demand of safe drinking water
- Lack of access to safe and adequate drinking water at households and institutions throughout the year

### Underlying Causes
- Lack of knowledge and demand of safe drinking water
- Inadequate focus and investment by govt. on SBCC interventions
- Absence of at scale community water, sanitation and Hygiene (WASH) planning
- Poor institutional capacity to manage/protect water quality including during emergencies
- Existing social structure, hierarchy and gender norms prevent equitable access and information
- Limited technology options for “high risk” contamination with poor existing O&M and loss of traditional knowledge on water security and safety
- Lack of availability and/or equitable access to water (including for toilets)
- Absence of at scale community water security and safety planning – poor HH treatment practices
- Weak governance and ineffective policies for safe water
- Overall lack of O&M systems
- Inadequate community involvement – women, youth, SC/ST (VWSC)
- Inadequate focus and investment by govt. on SBCC interventions
- Inadequate technical and financial resource allocations
- Limited research on technological options for safe water, Limited funds for water treatment
- Limited research on technological options for safe water, Limited funds for water treatment
- Insufficient funds for O&M, Limited HR (skilled) for O&M
- Lack of convergence in water programme implementation – agriculture; irrigation, water resources, Health, Water and Sanitation, Industries

### Root Causes
- Insufficient funds for O&M, Limited HR (skilled) for O&M
- Lack of administrative monitoring and support
- Limited focus on demand generation in government policies for water
- Weak governance and ineffective policies for safe water
- Limited research on technological options for safe water, Limited funds for water treatment
- Low willingness to accept risks associated with bacteriological, arsenic/Fluoride contamination
- Widespread open defecation and leach pit toilet proximity to drinking water sources and widespread solid and liquid waste
- Lack of convergence in water programme implementation – agriculture; irrigation, water resources, Health, Water and Sanitation, Industries
- Geographical reasons aggravated by over-withdrawal of water
- Insufficient funds for O&M, Limited HR (skilled) for O&M
- Inadequate focus on demand generation in government policies for water
- Lack of administrative monitoring and support
- Limited research on technological options for safe water, Limited funds for water treatment
- Low willingness to accept risks associated with bacteriological, arsenic/Fluoride contamination
- Widespread open defecation and leach pit toilet proximity to drinking water sources and widespread solid and liquid waste
- Lack of convergence in water programme implementation – agriculture; irrigation, water resources, Health, Water and Sanitation, Industries

### Governing principle:** SDG 6.1

**Deprivation:** Lack of safe and adequate drinking water for all, especially for marginalized communities, all the time (rural)
### Annex 9: Key Deprivations in Education

#### Score 1-5 (5 is good, 1 is poor)

<table>
<thead>
<tr>
<th>Category</th>
<th>Criticality</th>
<th>Mandate</th>
<th>Other Actors</th>
<th>Capacities and resources</th>
<th>Lessons Learnt</th>
<th>Final Score</th>
<th>Rank</th>
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<td>4</td>
<td>2</td>
<td>3</td>
<td>18</td>
<td>3</td>
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<tr>
<td>Low levels of learning</td>
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<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>Not transitioning</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>16</td>
<td>4</td>
</tr>
</tbody>
</table>

### Annex 10: Causality Analysis of Early Childhood Education

[Diagram showing causality analysis of early childhood education, with children not having access to quality pre-primary education and various immediate, underlying, and root/structural causes identified.]
Annex 11: Causality Analysis of Out-of-School Children

Annex 12: Causality Analysis for Low Learning Outcomes
Annex 13: Key Deprivations in Child Protection

Right to protective environment

30% children marry early, 10.1 million child workers, 1.5 million in institutions, 17% children in conflict areas, high prevalence of violence at home, in schools and public places

Different Setting:
Urban/Rural/Tribal/Conflict
More girls than boys affected patterns of greater incidences during earth quakes, drought, forced migration, conflict; urban poor, poorest quintile, SC/ST/Minority, rural

Gender
Risk
Equity
Lens

Violence against children – girls more vulnerable

Limited livelihood options – natural calamities/conflict accentuate the problem, violence, displacement

Poor enforcement of legal protective framework

Low value of girls – dowry, preferential treatment of boys

Limited social safety nets and limited access – SC/ST/Minority/Lower quintile are at disadvantage

Violence and discrimination in schools
SC/ST/minorities
Girls and boys

Secondary education not compulsory –

Lack of decision making ability –

Social and religious acceptance

Equity

High value of education (perception that education is not beneficial)

Girls in selected communities prefer to get married and be in a union –

Lack of productive employment for girls (lack of exposure and lack of opportunities)

Impunity from law (low enforcement), tacit/illegal involvement of religious, political and caste leaders

Inadequate secondary and higher secondary schools – second chance and skills training – poor quality of education

Risk

More girls than boys affected – patterns of greater incidences during earth quakes, drought, forced migration; urban poor, poorest quintile, SC/ST/Minority, rural

Girls don’t have a say in decisions that affect their lives –

Inadequate focus of educational policy on life skills

Lack of education and perceived lack of benefits

Lack of political will, not a priority

Social and religious acceptance

30% of girls get married before age 18 in India

Annex 14: Causality Analysis of Early Marriage

30% of girls get married before age 18 in India

Widespread inequitable economic assets –

Social and cultural gender norms, including caste

Low economic security at home – girls pulled out of school; help at home worse during disasters, migration, conflict, displacement

Limited livelihood options – natural calamities/conflict accentuate the problem

Limited social safety nets and limited access – SC/ST/Minority/Lower quintile are at disadvantage

Violence against girls –

Low labour force participation of girls – numbers, wage, value

Not a political priority –

Secondary education not compulsory –

Ineffective implementation of acts/laws –
Annex 15: Causality Analysis of Child Labour

- 4.5m girls and 5.6m boys engaged in labour (5-14 years)
- Demand for child labour in family and market – more common in domestic/agricultural labour/construction labour
- Gender Lens
  - Boys more in hazardous forms of labour or primary labour
  - Girls pulled out of school, lack of education and knowledge of alternatives to child labour
  - Impunity from law – poor capacity of labour law enforcement
  - Traditional family based small scale industries

Risk Lens
- Weak safety nets – food security, minimum wage, employment guarantee – access and availability
- Ineffective social protection system/family strengthening programs
- Lack of minimum wages/composition/accrual stability/governance

Equity Lens
- Access to education
  - Beach and non availability to schools (especially secondary)
- Low capacities of service providers
- Violence and discrimination in schools
- SC/ST/minorities
  - Girls and boys
- Low value of education and perceived lack of benefits
- Quality of education – Retention and transition

Gender Lens
- Trade per child format – proliferation of institutions – normalization of institutional care
- Normative framework on prevention and alternatives weak
- Issues not a priority for Government
- Lack of life skills and vocational skill options

Social Lens
- Lack of political will to change legal framework
- Lack of minimum wages/composition/accrual stability/governance
- Widespread inequitable economic assets –
- Socio cultural and gender norms

Children without adequate family care and protection

- 1.5m children in institutions
- Children in conflict with law most poor and least education
- A child in India goes missing every eight minutes mostly girls
- 17% of the child population in conflict affected districts

Risk/Conflict Lens
- Gender Lens
  - Low Economic security at HH – girls pulled out of school
  - Unusual migration/institutions
  - Lack of knowledge of alternatives to child labour
  - Girls more vulnerable than boys

Children without adequate family care and protection

- Lower value of girls – sent for labour
- Missing/trafficked
- Weak CP Systems – accountability and coordination/lacking
- Social Norms
- Normative framework on prevention and alternatives weak
- Issues not a priority for Government
- Lack of life skills and vocational skill options

Annex 16: Causality Analysis of Children Without Adequate Family Care and Protection

- Poor processes amongst adolescents – aspirations, urbanisation, influence of masts, education not valued
- Suspicious & hostile social environment especially towards adolescent boys
- Weak community based protection mechanisms
- Tracking systems weak
- Ineffective implementation of acts/laws – multiple laws and age of children defined differently
- Inequity in poverty and child poverty not understood well
- Poor implementation of social protection schemes
- Lack of resources, HR and adequate skills and weak min standards of care
- Political patronage – charity approach even among NGOs
- Weak parenting and guidance for adolescents
- Changing values and lifestyles – substance abuse, mental health, life skills
- Weak parental participation especially of girls
- Inadequate secondary and higher secondary schools –
- Lack of secondary education policy (RTE covers only till 14 years) – and secondary education not compulsory
- Lack of awareness on risks
- Lack of knowledge of alternatives to child labour

Gender Lens
- Girls and boys
- SC/ST/minorities
- Conflict/Disasters
- Greater incidences of greater incidences

Risk Lens
- Ineffective social protection system/family strengthening programs
- Limited livelihood options – natural calamities/conflict
- Girls pulled out of school
- Weak child participation especially of girls
- Poverty and unemployment
- home and outside work
- Inadequate and unsafe schools
- Lack of education facilities (remote areas/conflict areas)
- Inadequate secondary and higher secondary schools –
- Lack of secondary education policy (RTE covers only till 14 years) – and secondary education not compulsory

Equity Lens
- Inadequate and unsafe schools
- Poverty and unemployment
- home and outside work
- Inadequate and unsafe schools
- Lack of education facilities (remote areas/conflict areas)
- Inadequate secondary and higher secondary schools –
- Lack of secondary education policy (RTE covers only till 14 years) – and secondary education not compulsory

Gender Lens
- Girls and boys
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- Weak child participation especially of girls
- Poverty and unemployment
- home and outside work
- Inadequate and unsafe schools
- Lack of education facilities (remote areas/conflict areas)
- Inadequate secondary and higher secondary schools –
- Lack of secondary education policy (RTE covers only till 14 years) – and secondary education not compulsory
Annex 17: Causality Analysis of Child Victims of Sexual and Physical Violence

Boys/girls (0-19) are victims of sexual/physical violence in homes, schools and online

- 65% of children (age 5-14) are victims of corporal punishment in schools, higher incidence for boys but also for girls
- 45% of girls/47% of boys justify wife beating
- High prevalence of sexual violence (age 0-17): 13% married girls (15-19); Higher for girls but also boys
- Online sexual violence/bullying on the rise

Exposure, experience of violence of child, caregiver, perpetrator

Lack of awareness, knowledge and skills of child, caregiver, perpetrator re: rights, how to protect

Culture of silence/taboo

Low value/status of child gender, power, roles

Lack of political will, budget, coordination

Discrimination based on social hierarchies: race, minorities, ethnicity, linguistic identity

Lack of quality/integrated services: Health, Edu, CP...

High level of poverty, social inequalities

Inadequate policies, laws and regulations

Poor enforcement of legal protective framework

Violence widely accepted, normalized, not punished: discipline, power, conflicts

Unsafe public, online, media spaces for women/children: migration, urbanization, ICT

Gambling & substance abuse

Perception of authority, power structure

Lack or limited access to information, capacity, incentives

Lack or weak convergence/accountability between key actors

Disaster, Conflict Lens

Equity Lens

Gender Lens

IMMEDIATE

UNDERLYING

STRUCTURAL

Social norms on gender and caste

Lack of quality/integrated services: Health, Edu, CP...

High level of poverty, social inequalities

Inadequate policies, laws and regulations

Poor enforcement of legal protective framework

Children, caregivers, perpetrators of violence

Lack of awareness, knowledge and skills of child, caregiver, perpetrator re: rights, how to protect

Culture of silence/taboo

Low value/status of child gender, power, roles

Lack of political will, budget, coordination

Discrimination based on social hierarchies: race, minorities, ethnicity, linguistic identity

Lack of quality/integrated services: Health, Edu, CP...

High level of poverty, social inequalities

Inadequate policies, laws and regulations

Poor enforcement of legal protective framework

Disaster, Conflict Lens

Equity Lens

Gender Lens