Volunteer National Report

India

2017

The document traces the trajectory of the progress of SDG Agenda 2030 for India, with focus on youth people and women and recommends actions to fulfil the same.

Methodology

A previously established and published data has been taken from official websites of Indian Government, News articles, scholarly journals and books. The data also has been analysed furthermore with the help of ARROW, and again refined by peer reviews. The major work has been done through available information and case studies on various areas such as health, education, inequality etc. The report has been written with a youth focused approach and tried to take the relevant themes and issues faced by youth of India. The report also focuses on Sexual and Reproductive Health Rights of youth and bases the analysis on evidences and case studies to legitimize the findings.

Executive Summary

With the Sustainable Development Goals officially coming into force on 1 January 2016, there is renewed international commitment for and optimism towards ending global poverty during the next two decades. The global community is well on track to supporting economic growth and ending extreme poverty in the least-developed countries – with the global rate of people living in poverty reduced from 37.1 per cent in 1990 to 9.6 per cent in 2015[i]. Human development outcomes have also greatly improved, with the number of out-of-school children at the primary level nearly halved, compared to 2000; the global under-five mortality rate reduced by more than half between 1990 and 2015; and the maternal mortality ratio reduced by 45 per cent worldwide since 1990. Sustainable development is a common agenda for global concern, which everybody agrees upon, but bringing this global concern into public policies is a difficult task. The most accepted definition of sustainable development according to the Brundtland's report is, “To meet the needs of present without compromising the ability of future generations to meet their own needs”. The implementation of SDGs needs every country to judiciously prioritise, and adapt the goals and targets in accordance with local challenges, capacities and resources available. For development to be sustainable countries must take into account the social and economic factors as well as the ecological ones as well. With the breadth of 17 Goals and 169 Targets drafted by the Open Working Group on SDGs, this report aims to present civil society analysis of the progress, gaps and challenges in regards to sustainable development goals 1,2,3,5, and 17, with a focus on young people’s issues in India.

Experiences from the economic reform indicate that while there have been improvements in economic growth, foreign exchange, IT revolution, export growth, and so on, inequality in income distribution has been growing simultaneously (ratio of urban to rural income is 4.5). Exclusion from benefits of economic revolution has been continued in terms of low agricultural growth (agriculture's share in GDP has been reduced to half, with no decrease in dependent population in the agricultural sector), low quality employment growth, concentration of poverty in certain groups (SC / ST), occupation (agricultural and casual labour), and region; and inadequate development of women and children. Our sex ratio continues to remain favourable to men. All the above factors have resulted in the widening of economic and social disparity, which is a threat to sustainable development. To meet the challenging situation of widening economic and social disparity, inclusive growth is the best tool, but it is a dream without improvement in agricultural growth, employment generation, poverty reduction, and involvement of the social sector (health, education, and women empowerment).

In light of the above mentioned realities, this report has been drafted keeping in mind the marginalised and vulnerable sections of the society. The report details out the current status of the SDGs in India, the realities with respect to Goal 1: Eradication of Poverty, Goal 2: reducing Hunger, Goal 3: Ensuring health and wellbeing for all, and Goal 4: Achieving Gender Equality. It also highlights the myriad challenges and problems posed in achieving Agenda 2030. The report therefore highlights recommendations to be considered and deliberated upon to achieve agenda 2030 and make sure “no one is left behind”.

Young people are at the centre of sustainable development. As equal partners in turning the 2030 Agenda into reality, we reiterate that this ambitious agenda can only be achieved with young people’s leadership, meaningful participation and support, and empowering youth-adult partnerships. Acknowledging that the SDGs are the young people’s agenda, spaces should be created for young people to meaningfully engage in its implementation, monitoring, and evaluation at all levels—from the local and national levels to the regional and global. Shrinking spaces for civil society need to be addressed, and institutional spaces and funding for youth and women’s organisations and marginalised voices must be ensured by the UN and governments. Young people must also be able to engage in the revaluation of indicators to reinforce accountability amongst stakeholders. Youth-centric indicators across all goals should be introduced in the national and local SDGs roadmap. It is also recommended to sign and ratify all relevant international human rights instruments, including optional protocols and strengthen human rights accountability and application of human rights-based frameworks from the local to the global levels. The state should end the impunity of human rights violators, and put in place grievance and redressal mechanisms. It is also the responsibility of the state to institute inclusive, responsive, transparent, and participatory monitoring, review, and accountability mechanisms at all levels, from local to global. Improve monitoring systems to ensure provision of disaggregated data according to age, gender, disability status, migration and citizenship status, income groups, education, spatial, ethnicity and indigenous status, amongst other variables, across all goals, in order to inform decision-making, budgeting, programming, and monitoring. Obtaining and dissemination of data must conform to rights-based and ethical principles. Alternative reporting from community and civil society, including youth groups, needs to be recognised as part of the monitoring and review process.

Introduction

India, officially the Republic of India, is a country in South Asia and the second most populated country and most populous democracy in the world with a population of 1210 million(623.7 million males and 586.5 million females)(Census of India, 2011). A nuclear weapons state and regional power, it has the third largest standing army in the world and ranks fifth in military expenditure among nations. India is a federal republic governed under a parliamentary system and consists of 29 states and 7 union territories. It is a pluralistic, multilingual and multi-ethnic society and is also home to a diversity of wildlife in a variety of protected habitats. Unlike the previous decades, there is a significant decline in population growth rate in the recent decade. The overall sex ratio has increased slightly from 933 to 944 during 2001-2011. (Census of India, 2011). The low sex ratio statistics is an indicator of greater gender inequality and low status of women in India. As per the 2011 census, about 30 per cent of the population in India are young people in the age group of 15-24 years and a little more than one fifth are adolescents aged between 10-19 years (Census of India, 2011). According to the Sample Registration System estimates for the year 2012, the crude birth and death rates were 21.6 and 7 per one thousand populations. As a result of increased use of contraceptives, there was a 23.6 per cent reduction in birth rate in India during 1996-2012. Rural urban differentials in birth rate are wide; the birth rate in rural area was 23.1 per 1000 as against the 17.4 in urban area (Sample Registration System, 2012). As per the latest statistics available for the year 2013, the male and female life expectancy at birth is 65 and 68 years respectively (Population Reference Bureau, 2013).

With being the 7th largest economy in the nominal GDP and 3rd largest in the purchasing power India's per capita income (nominal) was $1570 in 2013, ranked 112th out of 164 countries by the World Bank, while its per capita income on purchasing power parity was US$ 5350 and ranked 100$^{th.ii}$ (Statistics by the World Bank, 1960-2015, 2015)

India is the second-most unequal country globally, with millionaires controlling 54% of its wealth. In India, the richest 1% own 53% of the country's wealth, according to the latest data from Credit Suisse. The richest 5% own 68.6%, while the top 10% have 76.3%. At the other end of the pyramid, the poorer half jostles for a mere 4.1% of national wealth. (Agarwal, 2016). Poverty is especially pronounced among the Scheduled castes and tribes, and among agricultural labourers. There is also a growing class of urban poor, economic refugees seeking an income in the city and finding themselves with no job or housing. Beggars are still very common, and provide the western visitor with their most disturbing images of India. Inequalities in India are not only very widespread: they are very visible, with beggars living on the pavements outside luxury

hotels. Another marker of inequality in India is the caste system and the practise of un-touchability which has plagued the countries for centuries. The 1955 Untouchability Act declared Untouchability illegal. Untouchables were grouped with Scheduled Tribes, and given reserved seats in central and state legislature, a quota of about 12% of higher-level civil service posts. Deep prejudices remained, and children from Untouchable families were excluded from schools, or ignored if they were allowed to attend. By the 1960s, the Scheduled caste literacy rate was still only 30% of that for the nation as a whole. Lack of education is also perpetuated by economic necessity: the need for children to earn income limits the hours available for education. Discrimination against girls and women is widespread in India, in both Hindu and Muslim communities. The dowry system (payment of money or goods by the family of a bride) means that girls are a financial burden, whereas boys are viewed as a source of income and prosperity. Nationwide, girls are fed less and taken to doctors less frequently, so mortality is greater. Death in childbirth is also unacceptably high: maternal death rates are over 0.5% of births. Education is also less available to women, and as a result, literacy rates are lower: nationally, literacy rates are 64% for males, but only 39% for women. In the poorer states, female literacy may be less than 25%. (Gurría, 2014). As a result, the level of opportunity for women is low. Lack of female education and power has been linked to high birth rates and population increase in the developing world.

Policy and Enabling Environment

Goal 1: End Poverty in all its forms everywhere

Eradicating poverty in all its forms remains one of the greatest challenges facing humanity. While the number of people living in extreme poverty dropped by more than half between 1990 and 2015 – from 1.9 billion to 836 million – too many are still struggling for the most basic human needs. In recent years, India has enjoyed consistently high rates of growth and steady improvement in human development. India ranks 131st on the Human Development Index in the world (medium level of development) with 0.624). The country's Human Development Index value when adjusted for inequality loses up to 28 percent of its value. (UNDP, 2015)

Poverty lines in India

Country	1994	2002	2007	2010	2012 as stated by the Indian Govt.
India	35	25	25	29.8	22%

Number of people living below the Income Poverty line was 21.9per cent (NPL) in 2011-14. The population of people living in multidimensional poverty is 642,391 and 55.3% (HDI)

Fig 1: Population below Poverty Line

Population Profile(in Millions)		
Year	India rural	India urban
2000–2001	328	454
2005–2006	368	558
2011-12	363	

In the last 15 years, India has seen the adoption of a rural connectivity scheme (PMGSY), a universal primary schooling initiative (SSA), a rural health initiative (NRHM), a rural electrification scheme (RGGVY), a rural employment guarantee (NREGA), a food subsidy (Food Security Act), and a new digital infrastructure for transferring benefits directly to the poor (UID).

According to the World Bank, 80 per cent of India's poor live in rural areas. The low income states are home to around 45 per cent of India's population. The poverty rate in rural areas is 25 per cent and 14 per cent in urban areas.

A third of the world's malnourished children live in India according to UNICEF, where 46% of all children below the age of three are too small for their age, 47% are underweight and at least 16% are wasted. The financial requirement for India to meet its costs for food security is around USD 729 billion from 2015-24. The first level of estimates indicate a financial shortfall of USD 8.5 trillion over the mandated 15 years for achieving SDGs. Per year, on average, this works out to INR USD 565 billion.

Public Health Expenditure

The Public Health Expenditure for the years 2015-16 is 1.3%. As per Economic Survey 2015-16 brought out by Ministry of Finance, public expenditure on health (Centre and States) as percentage of Gross Domestic Product (GDP) for last three years is as under: (Press Information Bureau, 2016)

2013-14 - 1.2%
2014-15 – 1.4%
2015-16 – 1.4%

Year	Allocation (BE) (Rupees in crore)	Expenditure (Rupees in crore)
2013-14	136763.66	118166.83 (Actual)
2014-15	159491.84	141254.10 Actual)*
2015-16	169544.54	157729.76 (RE)
Key Indicators		
Economic indicators	Demographic indicators	Health indicators

· GDP (in $ billion, 2004) 674.8 · Per Capita (in $, 2004) 603 · Real Growth (in %, 2004) 6.4 · Health expenditure (in $ billion, 2003) 29.3 · Health expenditure as % of GDP 5.1 · Public expenditure as % total 20 · Private expenditure as % of total 80	· Population (in million 2004) 1,065,462 · Population growth (in %, during 2004) 1.9	• Life expectancy (years) 65.4 • Birth rate (per 1000) 25.4 • Death rate (per 1000) 8.1 • Infant mortality rate (per 1000) 66 • Healthcare Infrastructure Hospitals (numbers) 15,393 • Public 4,049 • Private 11,344 • Hospital beds (numbers) 875,000 • Doctors 592,215 • Nurses 737,000 • Dentists 80,000 • Medical colleges 170 • New doctors every year 18,000 • Retail chemist (pharmacy) outlets 350,000 • Size of medical and pharmaceutical market Pharmaceutical market (in $ million for 2004) 8,790 • Estimated growth rate per year (for 2004) 7-8 % • Medical equipment market (in $ million for2004) 1,318 • Estimated growth rate per year (for 2004) 6-7%

A statement showing allocation of fund and expenditure by Government (Central and State Government combined) on health. The Centre proposed[1] the long-awaited National Health Policy 2017, which promises to increase public health spending to 2.5% of GDP in a time-bound manner and guarantees health care services to all Indian citizens, particularly the underprivileged. Given that spending on health is limited, increasing private sector participation in health care services is stimulating change in the Indian healthcare industry The health market is estimated at billion $30 billion and includes retail pharmaceutical, healthcare services, medical and diagnostic equipment and supplies. Structure of the government healthcare service: - Primary Care (in rural areas): 22,271 primary healthcare centres and 137,271 sub-centres. - Secondary Care (healthcare centres in smaller towns and cities): 1,200 PSU (public sector units) hospitals, 4,400 district hospitals, and 2,935 community healthcare centres. - Tertiary Care (hospitals): 117 medical colleges and hospitals. (Mukherji, 2015)

[1] The national health policy is not passed yet and under the debate sessions of the Parliament of India, the basic draft of the policy suggest an inclusion of public private partnership to make healthcare accessible for all.

Goal 2 End Hunger, Achieve Food Security and improved Nutrition and Promote Sustainable Agriculture

The SDGs aim to end all forms of hunger and malnutrition by 2030, making sure all people – especially children – have access to sufficient and nutritious food all year round. It also requires international cooperation to ensure investment in infrastructure and technology to improve agricultural productivity. Together with the other goals set out here, we can end hunger by 2030.

Child malnutrition

Out of total malnourishment in the world, South Asia has 36%. A nationwide survey called the RSOC conducted by the ministry of women and child development in 2013-14 in league with UNICEF showed that the proportion of underweight children in India was 29.4%, and that of stunted children 38.7%. Malnutrition in India has been divided at state level, where 5 states and 50% villages has the burden of 80% malnourishment in India. As per the data given by Global Hunger Index (GHI) in 2016 India has a score of 28.5 on the index which raises an alarming situation.[4] A year wise analysis of the GHI evolution in India has shown some betterment but by keeping in mind the massive population of India the situation is still at a serious level where 194.3 million people sleep hungry every day. ((NFHS-4), 2015-2016). In India 1 in every 4 child is malnourished, some facts about malnourishment in India are: 15.2% of India's population is undernourished, 194.6million people go hungry every day, 38.7% of children under 5 years of age are stunted, 3,000 children in India die every day from poor diet related illness, 24% of under-five deaths in India, 30% of neonatal deaths in India. In country 44% of children under the age of 5 are underweight. 72% of infants and 52% of married women have anaemia. Research has conclusively shown that malnutrition during pregnancy causes the child to have increased risk of future diseases, physical retardation, and reduced cognitive abilities. ((NFHS-4), 2015-2016) The 2015 Global Hunger Index (GHI) Report ranked India 20th amongst leading countries with a serious hunger situation. Amongst South Asian nations, it ranks third behind only Afghanistan and Pakistan with a GHI score of 29.0.

Year	1992	2000	2008	2016
Score	56.4	38.2	36	28.5

Table: GHI Evolution in India

Anaemia

Iron-deficiency anaemia has remained the top cause of disability[2] in India for 10 years now. India ranks in the top in most anaemic women and children. (Yadavar, 2016). Farm output has been setting new records in recent years, having increased output from 208 million tons in 2005-2006 to an estimated 263 million tons in 2013-2014. India needs 225-230 million tons of food per year. A high proportion of the food that India produces never reaches consumers. There are several reasons why so much perishable food is lost, including the absence of modern food distribution chains, too few cold-storage centers and refrigerated trucks, poor transportation facilities, erratic electricity supply etc. The Indian Institute of Management in Kolkata estimates that cold-storage facilities are available for only 10% of perishable food products, leaving around 370 million tons of perishable products at risk.

India has various plans which shows the commitment towards achieving zero hunger is vast. Below are the major policies and schemes to end hunger:

- **National Food Security Mission (Core)**
- **Mission for integrated Development of Horticulture**
- **National Mission on Sustainable Agriculture**
- **National Oilseed and Oil Palm Mission**
- **National Mission on Agriculture Extension and Technology**
- **Rashtriya Krishi Vikas Yojana (RKVY) (ACA) (Core)**
- **National Livestock Mission (Core)**
- **Livestock Health and Disease Control (Corre)**
- **National Programme for Bovine Breeding and Dairy Development**
- **Targeted Public Distribution System (TPDS)**
- **National Nutrition Mission (NNM) (Core)**
- **National Food Security Act (NFSA), passed in 2013 4)**
- **Mid-Day Meal Scheme**

Goal 3: Ensure healthy lives and promote well being for all at all ages

[2] Here disability is not physically, it basically means the lack of essential energy to work the basic routine of a person. An anaemic person is drained out of energy so much so that the person in some cases no longer finished the daily chores.

Globally, the MMR fell by nearly 44% over the past 25 years, to an estimated 216 (80% uncertainty interval [UI] 207 to 249) maternal deaths per 100 000 live births in 2015, from an MMR of 385 (UI 359 to 427) in 1990. India is estimated to account for over one third of all maternal deaths worldwide in 2015, with an approximate 45 000 maternal deaths (15%), respectively.

Maternal Mortality Ratio and Adolescent Pregnancy

The maternal mortality rate in India is 167 as of 2012-13, as per the data provided by National Institute of Transforming India (NITI) Aayog.The national MMR reported by the SRS is 167 deaths per 100 000 live births (2011-2013). Rural areas of poorer states had the highest MMR (397, 95%CI 385–410) compared to the lowest MMR in urban areas of richer states (115, 95%CI 85–146). Three-quarters of maternal deaths were clustered in rural areas of poorer states (estimated total maternal deaths 52 800), whereas these regions have only half the estimated live births in India (13.3 million births). The proportion of maternal deaths to all-cause deaths in women, 15–49 years, was three times higher in rural areas of poorer states (16.3%) compared to urban areas of richer states. (Ministry of Health and Family Welfare (MOHFW), 2014)

Pregnancy related deaths of women have declined over the years. Though, more than 50 per cent reduction has been registered in the approximate number of maternal deaths in the last two decades, the present status shows that, even now, 120 women die of causes associated with pregnancy, in a day, in India. (Ministry of Health and Family Welfare (MOHFW), 2014)

Adolescent-specific reproductive health services continue to be scarce and inadequate, and targeted toward married adolescents. 26.8%—of young women in the age group of 20-24, in India married before the age of 18- the legal age at marriage for women, with rural per cent of 31 and urban being 17.5. Nearly 7.9 per cent of women aged 15-19 years are married and/or pregnant, with 5 per cent urban adolescent women and 9.2 per cent rural adolescent women. Percentage of successful pregnancy outcome among adolescent women is 88.9% whereas 11.1% pregnancies result in stillbirth or abortion. From the bivariate analysis, it is clear that, stillbirth and abortion are higher among adolescent women at their lower age (13.1%), in urban areas (13.5%), among those adolescents who had not ever used any contraception (12.2%), among higher educated women (11.5%) and women having higher educated husband (12.6%), among non-working women (11.2%), among women belong to higher economic status (15.1%), among Hindu (11.4%) and other castes (12.4%). ((NFHS-4), 2015-2016) MSD for Mothers in India', aimed to help improve the quality of health care of pregnant women in India. The

government offers various well-thought schemes for the expecting mothers like Indira Gandhi Matritva Sahyog Yojana (IGMSY) and the Pradhan Mantri Gram Sadak Yojana (PMGSY). The Government of India set up three-tier health care delivery system to reach out to remote areas to provide primary care at a village level, secondary care at a subdistrict and district level, and tertiary care at a regional level. Medical colleges and specialist care centers were developed as apex institutions.

During the last 50 years, India has greatly expanded the public health infrastructure to include more than 1,44,000 sub-centers (SCs) each covering a population of about 5000, 22,600 primary health centers (PHCs) (for a population of 30,000), 4000 community health centers (CHCs) (for 100,000-300,000 population) and 242 medical college hospitals (for a 5-8 million population). A large proportion of these SCs, PHCs, and CHCs are not fully equipped and competent to provide quality midwifery care or deal with complications of pregnancy and childbirth. (Digvijay Singh, 2015)

Births attended by skilled health personals

The proportion of births attended by skilled health personnel in India was 52.3 per cent in 2008 and have increased to 81.4 per cent in 2015-16 with rural assistance comprising of 78 per cent and 90 per cent in urban areas. (World Bank: Births attended by skilled health staff (% of total), 2015). Institutional births constitute 78.9 per cent with 75 percent in rural areas and 88 per cent in urban areas. Since 2005, India has implemented a national cash transfer programme, the Janani Suraksha Yojana (JSY), which provides women a cash transfer upon giving birth in an existing public facility (there have been more than 50 million beneficiaries thus far) This has resulted in a steep rise in facility births across the country. The national scale-up of the JSY scheme—and more recently, Janani-Shishu Suraksha Karyakram (JSSK) as an effort to guarantee care entitlements—have sought to minimize these barriers to seeking skilled attendance at delivery. This scheme is an initiative to provide free and cashless services to pregnant women including normal deliveries and caesarian section, and sick newborn (upto 30 days post birth). Regardless the schemes and system provided in the facilities unsafe abortions are still taking place.

Emergency Obstetric Care & Comprehensive Emergency Obstetric Care

Given that in India, where 70 % of the people lives in 550,000 villages, providing obstetretic care is a considerably difficult task. In many districts there are only one or two government obstetricians for an average of 2 million people. On the other hand each district already has

about 60-70 basic doctors in various government hospitals in and health centers. Among institutional deliveries, 17 per cent birth were through caesarean section in India, with 28 per cent in urban areas and 12 per cent in rural areas. A figure below 5 per cent implies that a substantial proportion of women do not have access to surgical obstetric care; on the other hand a rate higher than 15 per cent indicates over utilization of the procedure for other than life saving reasons (Ministry of Health and Family Welfare (MOHFW), 2015)

Postpartum Care

A large proportion of maternal and neonatal deaths occur during the 48 hours after the delivery. It is therefore recommended that all the women receive a health check up within two days of delivery. Key elements of such care includes monitoring for blood loss, pain, blood pressure, postpartum depression and other warning signs that can lead to maternal death. The single common cause of maternal mortality continues to be obstetric haemorrhage. The WHO estimates that, of the 529,000 maternal deaths occurring every year, 136,000 or 25.7% take place in India, where two-thirds of maternal deaths occur after delivery, postpartum hemorrhage being the most commonly reported complication and the leading cause of death (29.6%) which contributes to the high Maternal Mortality Ratio (MMR), 167 per 100000 deaths, in India. Though MMR has decreased from the 2004-06, 254 per 100000, but still the rate is high considering the fact the MMR varies from state to state such as Assam has 300 women dying per 100000 during the childbirth. (Ministry of Health and Family Welfare (MOHFW), 2015)

Antenatal Care

Indicators	NFHS-4(2015-16)	NFHS-4(2015-16)	NFHS-4(2015-16)	NFHS-3(2005-06)
	Rural	Urban	Total	Total
Mothers who had antenatal check-up in the first trimester	61.1	54.2	58.6	43.9
Mothers who had at least 4 antenatal care visits	66.4	44.8	51.2	37.0
Mothers who had full antenatal care	31.1	16.7	21.0	11.6
Mothers who consumed iron folic acid for 100 days or	40.8	25.9	30.3	15.2

more when they were pregnant				
Mothers whose last birth was protected against neonatal tetanus	89.9	88.6	89.0	76.3
Registered pregnancies for which the mother received Mother and Child Protection (MCP) Card	87.7	90.0	89.3	na

As per the National Family Health survey (2005-06) there were 37.0% women were able to access the antenatal check-ups which increased into 51.2% in the NFHS survey (2015-16). The number of mothers accessing antenatal check-ups, minimum number of 4, was also 51.2% in the year of 2015-16 as 37.0%. Under the Janani Suraksha Yojna (JSY) 21.4% women in urban and 43.8% women in rural areas were benefited. A worrying figure shows that in the period between 2000 and 2013, when the UNFPA report was released, with 11,875,182 pregnancies, India topped the chart of 10 countries with the greatest numbers of women aged between 20 and 24 who gave birth before their age was 18. (Sulabha Parasuraman, 2009). The young girls being pregnant in the context of marriage and out of the context of marital practice is being increased. Under the Indian Law The Protection of Children from Sexual Offenses Act any pregnancy under the age of 18 is a rape and in case of abortion the MTP Act states the involvement of a parent or legal guardian is a must for the abortion. With such environment mixed with shame, law, stigma a minor girl often moves towards unsafe abortion practices. A brief analysis of maternal health is being shown in the table below:

Poverty and Limited Access to Health Care make childbearing women to not to seek healthcare because of financial gaps.

Total Fertility

The total fertility rate in India is 2.2 births per women and the adolescent fertility rate in India is 2.3. The TFR for rural areas stands at 2.4, but that for urban India is down at 1.8. ((NFHS-4), 2015-2016)

Country	2007	2008	2009	2010	2011	2012	2013	2014
India	2.81	2.76	2.72	2.65	2.62	2.48	2.35	2.31

Age Specific Fertility Rate (ASFR) for the 15-19 year age group declined by 32% from 45.2% in 2006 to 30.7% in 2011. For the 20-24 age group, it declined by 5% from 208.1 in 2006 to 196.7 in 2011. For the 25-29 age group, 9% decline of the ASFR from 168 in 2006 to 153.4 in 2011 was observed. For the age group 30-34, it declined by 12% from 79.1 in 2006 to 69.8 in 2011. For the age group 35-39,it declined by 26% from 35.7 in 2006 to 26.4 in 2011. For the age

group 40-44, it declined by 42% from 15 in 2006 to 8.7 in 2011 and for the age group 45-49, it declined by 53% from 6 in 2006 to 2.8 in 2011. ((NFHS-4), 2015-2016) Which basically means that birth rate by per age group is declining with still a scope to reduce more in order to curb the population. The fall in fertility below replacement levels does not mean that population growth will immediately stop. Indians now live longer and more and more young people are added to the workforce and more people are becoming old. Although the overall TFR has declined, there are wide disparities by states, by rural and urban locations as well as by household social and economic status. Information on TFR by (background indicators) caste, household economic status and education is not available for the recent period.

Contraceptive Prevalence Rate

53.5 percent of women currently use contraceptive methods, with 57 per cent in urban India and 51 per cent in rural India. (2015-16). Around 47 per cent women in India use modern methods, with 51 per cent in urban India and 46 per cent in rural India. 36 per cent of women in India are sterilised, with 35 per cent in urban India and 36 per cent in rural India. Tubectomy (36 per cent) continues to be the most widely used contraceptive method in the country, with 35% urban women and 36% rural women preferring it. ((NFHS-4), 2015-2016)

The major challenges of current situation includes the unmet need for family planning among Indian women (currently married, aged 15-49) is 12.9 per cent, with 12.1 per cent in urban areas and 13.2 per cent in rural areas , about 80 per cent (05-06) of modern contraceptive availing in India were permanent method users, with the tubectomy being 77. 23 per cent and use of vasectomy being 2.12 per cent. The same trend is observed in the recent statistics released by the health and family department. About 4.6 million people underwent sterilization during 12-13

and of them, 96.4 per cent was tubectomy and only 2.6% vasectomy. ((NFHS-4), 2015-2016)

Safety and Legality of Abortions

In India the abortion rate per 1000 from the age group of 15-44 years is 2.2. In India 45.2% women give birth by the age of 20. Legality of abortion depends on the religious structure of the state. India has one of Asia's broadest abortion laws. Under the 1971 Medical Termination of Pregnancy (MTP) Act, abortions may be performed by a registered physician in a government-approved hospital or facility during the first 20 weeks of pregnancy. Underage pregnancy is also a rising factor in countries like India where in various circumstances girls get pregnant and lack of SRH information adds into it. MTP Act lays down the grounds on which a woman can seek safe abortion which are as shown in the table no. (DLHS, 2015)

Table no. : Grounds on which Abortion can be Sought	Yes/No
To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	No

Case Study 1

"Medical Termination of Pregnancy (MTP) cannot be done without the consent of a woman even if she is mentally retarded and not in a position to understand the consequences" - The Supreme Cou

In 2009 in a case of a mentally challenged girl who was willing to keep the child without understanding the responsibilities of motherhood, as suggested by the expert body. The Court also said that since under article 21 reproductive capacity is a personal liberty of a woman, thus a 'child' cannot be aborted without her consent.

Case Study 2

In 2016, the Chhattisgarh high court allowed a 23-year-old tribal woman to undergo an abortion even though her foetus was older than 20 weeks—the deadline set by the Medical Termination of Pregnancy Act, 1973.

The woman from Jashpur district in Chhattisgarh had been raped by her boyfriend, who abducted her and took her to Alwar in Rajasthan, where she remained for nearly a year. The court case took so much time that ideal time period was crossed to conduct a safe abortion and she could not access the abortion service.

As mentioned in the case study 1 Supreme Court has said that seeking abortion is a personal choice and under the MTP act abortion is not a right as a woman cannot access it on request.

As per the religious beliefs the child in a woman's womb is a gift of God thus terminating the child will translate into rejecting the holy gift. This interpretation often stops women to seek abortion as if they do so they will have to face the anger from the husband and family members. The MTP act in many cases does not allow women with a history of rape, incest, sexual assault to seek abortion.In many cases a family often think that if they will have more children then after a time period there will be many hands to generate capital for the household which will result in the inhalation of poverty but it often ends up having a huge families with more financial troubles. Indian society often blames women for not giving birth to a son, where in scientific studies it has been proven that whether there will be a girl or a boy child depends on the man. The preference of a son in a case where there have been girls before the current pregnancy women do not think of abortion unless there is son. If a woman decides to abort the foetus it is occasionally translates into the murder of a child which leads to the public shaming of the woman, due to this a lot of women do not seek abortion. Seeking abortion services in a private facility can be expensive and due to economic conditions of a family a woman cannot seek abortion. Abortion services in India are mostly available in major hospitals which is always populated with people seeking medical needs. The health providers of such hospitals are usually not friendly especially towards young women and youth making such services out of reach. Such judgemental attitude towards access of reproductive health services makes access more difficult for young people.

HIV/AIDS

India is home to the world's third-largest population suffering from HIV/AIDS, the AIDS prevalence rate in India is lower than in many other countries, at approximately 0.26%(2014) — the 90th highest in the world. The prevalence of HIV among the youth population is 0.11 percent, or, in other words, 1 youth per 1,000 is HIV positive. HIV prevalence is lower among youth age 15-19 (0.04%) than among both older youth (0.18%) and the older cohort age 25-49 (0.38%). ((NACO), 2015)The Government of India has done considerable work in raising the bar of awareness about HIV, every major hospital in India is equipped with HIV counseling and testing. For youth under the RKSK Scheme Government of India has directed all the hospitals to set up a youth friendly health services. A detailed profile of HIV among youth in India is shown below:

HIV prevalence among young people by background characteristics

Percentage HIV positive among women and men age 15-24 who were tested for HIV, by background characteristics, India, 2005-06

*Table Excludes Nagaland						
Background characteristic	Percentage HIV positive	Number	Percentage HIV positive	Number	Percentage HIV positive	Number
Age	Women		Men		Total	
15-19	0.07	10,704	0.01	8,663	0.04	19,366
15-17	0.03	6,354	0.00	5,293	0.02	11,647
18-19	0.12	4,350	0.02	3,369	0.07	7,719
20-24	0.17	9,573	0.19	7,825	0.18	17,398
20-22	0.21	5,964	0.17	5,129	0.19	11,093
23-24	0.10	3,609	0.21	2,696	0.15	6,305
Residence						
Urban	0.16	6,382	0.11	6,024	0.14	12,406
Rural	0.09	13,895	0.08	10,464	0.09	24,358
Marital Status						
Never Married	0.02	9,993	0.08	13,624	0.06	23,616
Ever had sex	0.00	70	0.17	1,611	0.16	1,681
Never had Sex	0.02	9,923	0.07	12,013	0.05	21,936
Currently Married	0.17	10,068	0.15	2,809	0.16	12,877
Widowed/divorced/separated/ deserted	1.91	216	0.00	55	1.53	270

Total age 15-24	0.11	20,276	0.09	16,488	0.10	36,764
Total age 25-49	0.28	33,055	0.50	30,019	0.38	63,074

However, shame and stigma related to HIV: HIV means a literal death to some people that is why a lot of people consider committing suicide instead of living with HIV. Lack of awareness among youth and a lot of misinformation and judgemental attitude towards youth trying to access such services by the healthcare provider is one of the primary roadblocks to this cause.

Comprehensive Sexuality Education

The sexual and reproductive health needs of adolescents in India are currently overlooked or are not understood by the Indian healthcare system. This could be owing to the lack of knowledge of scientific evidence along with the gross unpreparedness of the public health system. Healthcare professionals often lack the knowledge themselves that impacts upon imparting information to the adolescent population who seek it. Often comprehensive sexual histories are not taken, and sexual health is not openly discussed due to cultural and traditional norms in society. Incorrect information has the potential to create misunderstanding in the youth making them less likely to adopt healthy practices and attitudes toward sex enabling them to maintain lifelong sexual health. Sex education at school level has attracted strong objections and apprehension from all areas of the society, including parents, teachers, and politicians, with its provision banned in six states which include Maharashtra, Gujarat, Rajasthan, Madhya Pradesh, Chhattisgarh, and Karnataka. Legislators contend that it corrupts the youth and offends “Indian values,” leading to promiscuity, experimentation, and irresponsible sexual behavior. Some opponents argue that sex education has no place in a country such as India with its rich cultural traditions and ethos. These views lie at the heart of the traditional Indian psyche and will need to be approached tentatively with psychological insight when challenged. Expertise from healthcare professionals along with patience and time will be required in order to bring about what is likely to be a gradual change in the existing conservative attitudes. The current existing program of sexual education incorporate in the Indian curriculum is termed adolescent FLE and was proposed by National AIDS Control Organization and the Ministry of Human Resources and Development.

Suicide Mortality Rate

India alone accounts for approximately 30 percent of the world's suicide deaths. India ranks second globally for its female suicide rate of 17.9 deaths per 100,000 people. In 2013, suicide claimed the lives of more than a quarter of a million Indians. (Dr. Mahima Sukhwal, 2017) Opportunities that have come with two decades of economic boom and open markets have also brought more job anxiety, higher expectations and more pressure to achieve, lack of information on mental health experts said. Research suggest that the rigid marriage system in India may be contributing to the country's high rates- the expectations placed on Indian women to marry and stay married, no matter the cost or negative circumstances such as mistreatment or mental illness contribute to suicide. Societal pressure and abuses against women may be pushing many over the edge. Women are frequently subject to "psychopathology and psycho-social stressors including arranged and early marriage, young motherhood, low social status, domestic violence and economic dependence." Moreover, mental health is not a priority in India. There are few facilities in India for mental health problems, and stigmas prevent many people from seeking support. Telephone help lines are often not adequately staffed, and many schools do not have counsellors. There is also a lot of stigma attached to seeking help-when youths start to despair, they often don't think to seek help, or shun the idea because "they think psychiatry is only for crazy people".

Health Worker Density and Distribution

According to the 2015 World Health Report, India had 0.60 doctors, 0.80 nurses, 0.47 midwives, 0.06 dentists and 0.56 pharmacists, respectively, per 1000 population. This means India faces a substantial overall deficit of health workers; the density of doctors, nurses and midwifes is a quarter of the 2.3/1000 population World Health Organization benchmark. Importantly, a substantial portion of the doctor (37%), particularly in rural areas (63%) appears to be unqualified. The workforce is composed of at least as many doctors as nurses making for an inefficient skill-mix. Women comprise only one-third of the workforce. Most workers are located in urban areas and in the private sector. (Hazarika, 2013). States with poorer health and service use outcomes have a lower health worker density.

Goal 5: Achieve Gender Equality and empower all women and girls

The persisting gender gaps in terms of women and girls' wages constitute between 70-90 %, while labour force participation is 25% less than that of men. Millions of girls are coerced into unwanted sex or marriage, them at risk of unwanted pregnancies, unsafe abortions, STDs and dangerous childbirth. The harmful practice of female genital mutilation/cutting is another human rights violation that affects girls and women worldwide. (ARROW, 2017)

Laws and Policies

There are over 586.5 million females as on 1st March,2011 (Census of India), the overall sex ratio being 944 per 1000 males. The Constitution of India has granted both men and women equal rights and forbids any discrimination on the basis of sex. Legal frameworks in India provide a woman with a number of powers and weapons to tackles discrimination, violence and harassment:

Existing Laws	What it means?
The Dowry Prohibition Act, 1961 (28 of 1961) (Amended in 1986)	Effectively prohibits the demanding, giving and taking of dowry. Although providing dowry is illegal, it is still common in many parts of India for a husband to seek a dowry from the wife's family and in some cases, this results in a form of extortion, violence against the wife such as killing or suicides
The Immoral Traffic Prevention Act, 1986 (PITA)	Prohibits trafficking in relation to prostitution and outlines the illegality of prostitution
The Commission of Sati (Prevention) Act, 1987 (3 of 1988)	The Act seeks to preventSati practice or the voluntary or forced burning or burying alive of widows.
Protection of Women from Domestic Violence Act, 2005	A civil law which provides for a definition of "domestic violence", including not only physical violence, but also other forms of violence such as emotional/verbal, sexual, and economic abuse.
The Sexual Harassment of Women at Workplace (PREVENTION, PROHIBITION and REDRESSAL) Act, 2013	Protects women from any form of sexual violence/harassment at workplace. The act comes from the Vishakha guidelines which came as a judgment after the Bhanvari Devi case in the State of Rajasthan
The Criminal Law (Amendment) Act, 2013	Expressly recognises certain acts as offences against women such as acid attack, sexual harassment, voyeurism, stalking and have been have been incorporated into the Indian Penal Code.
Prohibition of Child Marriage Act, 2006	Defines child marriage as marriage in which either the girl or the boy is underage, i.e., the girl is under 18 years of age or the boy is younger than 21 years and any anomaly as a violation under the Constitution

Child, Early and Forced Marriage

India has the highest number of child brides in the world. It is estimated that 47% of girls in India are married before their 18th birthday. As per the NFHS-4, the percentage of women age 20-24 years married before age 18 years was 32.7% and in 26.3% were in urban and 35.5% in rural. For men (aged 25-29 years) married before age 21 years was 23.5% and in 13.5% were in urban and 28.3% in rural. ((NFHS-4), 2015-2016)

Data Source Year/women age 20-24 years married before age 18 years	Rural (%)	Urban (%)	Total (%)
NFHS-1 (1992-93)	62.8	32.6	54.2
NFHS-2 +-(1998-99)	58.6	27.9	50
NFHS-3 (2005-06)	52.5	28.2	45.0
NFHS-3 (2007-08)	48.0	29.4	42.9
NFHS-4 (2015-16)	26.3	35.5	32.7

The Prohibition of Child Marriage Act (PCMA) of 2006 establishes punishments for those who do not prevent child marriages and creates Child Marriage Prohibition Officers. It includes a right to annul marriage if underage, but this relies on families to report the act.A National Action Plan to prevent child marriages was drafted by the Ministry of Women and Child Development in 2013, however, it has not yet been finalised.

Violence against Women

Crimes against women have become a chronic problem in India. 337,922 cases have been reported in 2014, according to the National Crime Records Bureau. That's over 848 women who are harassed, raped or killed after abduction every single day. As per the UN-Women's data on intimate partner violence 35.1% women accepted physical violence in sometime their lives. 10% women accepted sexual violence by their intimate partner. 35.4% women were sexually or physically violated by an intimate or non-intimate partner in their lives. 7.2% women accepted that they have been a subject of sexual violence by their partners. Compared to this, the Lifetime Non-Partner Sexual Violence is 0.3%. (ARROW, 2017)

Political Representation of Women

While the global average for Women in Parliament stands at 22.4%, India is at the 103rd place out of 140 countries with a mere 12% representation. Within Asia, India is at the 13th position out of 18 countries. Women occupy just 66 seats in the 543 member Lok Sabha, and the scenario for women Members of Legislative Assemblies (MLAs) across all state assemblies in India is even worse, with the national average being a pitiable 9%.

In 1994 established quotas (reservations)-the 73rd and 74th constitutional amendments to reserve 33 per cent of the seats in local governments for women. The Women's Reservation Bill (108th amendment) has also been introduced in the national Parliament to reserve 50 per cent of the Lok Sabha seats for women, but the bill is yet to be passed. (Rao, 2016)

Recommendations

We call upon our Government, UN Agencies, development partners, funding agencies and other duty bearers to address the following priority issues and take the following actions related to the sustainable development goals.

1. Finances

- Financial needs are the most important aspect in order to achieve the targets by the year 2030, the study conducted by Technology and Action for Rural Advancement has shown the gaps which needs to be full filled and addressed.
- Allocate a minimum of 15% of the national budgets on health, in line with the Maputo Call of Action.
- Revitalize global partnership and participation with Agenda 2030 by evoking the committed donations made by the member states to LDCs and developing countries (0.7% of GNI)
- Costs of implementing and scaling up agricultural intensification techniques, urban agriculture, agroforestry, horticulture, etc. have also not been included.
- These are components of the targets in the other SDGs. Therefore financial assessments are the need of the hour to eradicate poverty from all its roots.
- Improved coordination between public sector, community organisations and civil society organisations.
- Access to contraceptive methods, medical health facilities, emergency obstetric care system should be free of cost and judgement.

2. Technology

- Govt. needs to start the advocacy on the transfer of free technology between the state and the spread of information amongst the citizen in country so there is a flow of transparency
- Build infrastructure and technology to match the demand with supply and to reduce food waste throughout the process chain analysis / monitoring.
- Involvement of new technology in the fields of agriculture, medical healthcare, service sector, food production & distribution etc. should be done.
- Provide access to medicines and healthcare by building adequate technologies and increasing investments towards health and education.

3. Capacity Building and Strengthening

- Encourage young people to choose agriculture, fishery, food handling, and nutrition as career opportunities to ensure rapid local growth, innovation and sustainable solutions and ensure entrepreneurial and employment opportunities.
- Conduct consultations involving all communities.
- The proper inclusion of more ASHAs, (Auxiliary nurse midwife)ANMs, medical practitioners and healthcare provider and Improving the situation of them at the same time
- A proper setting up of youth friendly sexual and reproductive health helpline should be done.
- Involvement and encouragement of trained psychologists and psychiatrists.

4. Trade

- Ensure that Trade related treaties and agreements between countries do not overshadow the basic welfare state nature of India.
- Entrepreneurship for young people, people from low income groups, backwards groups should be given more preference, space and financial support.
- Trade treaties should not compromise with the basic human rights, rights of indigenous people, rights of marginalized people, peasants, domestic traders etc.

5. Systemic Issues

- Pro poor, environment friendly, gender responsive, intersectional friendly programmes should be initiated and promoted by the government for the youth
- To address the issue of poverty in India, governments must address the political process of challenging the layers of discrimination that keep people trapped in poverty, including addressing the human rights , especially those of young people, vulnerable and marginalised groups, women and children and people of diverse sexual orientation.
- Ensure the right to adequate, culturally appropriate and safe food and nutrition for all, including addressing the specific needs of different groups.
- Access to accurate, evidence based information on health and well being, including life skills based and comprehensive sexuality education for youth and adolescent in formal and informal set ups , as well as out of school and workplace setting needs to be provided for.
- There needs to be age appropriate and scientifically evidence based, context specific , gender responsive, disability friendly sexual education and information. Confidential, non judgemental, adolescent and youth friendly access to health services need to be at place.
- To cater to postpartum maternal health, we recommend making postpartum stay a compulsory time period for a woman’s stay in the hospital with a friendly environment.

6. Data Monitoring and Accountability

- Review and amend existing laws and policies, enact new ones, and implement these effectively.
- There should be multi-stakeholder approach to curb corrupt practises that directly perpetuates poverty and reduces the impact and reach of poverty reduction strategies and programmes.
- Governments must consider the multidimensional nature of poverty that go beyond daily average income and expenditure, to include for example, universal access to healthcare and education basic resources like housing, sanitation, potable water and nutritious food.
- Building up a proper monitoring and evaluation system for SDGs across India.

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