Evidence and Justice:
Making the case for adolescent health and rights post 2015

INDIA

The YP Foundation in India, Realizing Sexual and Reproductive Justice (RESURJ), and Columbia University's Mailman School of Public Health have produced this paper[1] to provide an overview of the social, economic and environmental context in India related to adolescents and young people, with a specific focus on adolescent girls and young women. This is one of five papers (the others are Brazil, Egypt, Nigeria and Mexico), which make clear that the Sustainable Development Goals will not be met by 2030 without the proper attention and investment in the health, development and human rights of adolescents young people over the decades to come. This paper can serve as a tool for activists, academics, researchers, policy makers and evaluators who are vested in advancing the health and human rights of adolescents and young women in the country.

Background

One third of India's population, approximately 373 million people, is between the ages of 10 and 24. It is one of the fastest growing economies in the world, with a 7% annual GDP growth rate between 1998 and 2008. Despite this economic growth, poverty rates remain high. Although India is expected to halve the proportion of its population living below the poverty line (earning less than $1.25/day) by 2015, a large proportion of the population will still be impacted by extreme poverty. Around 37% of the country lived below the poverty line from 2011 to 2012. About 92% of workers in India—including those from rural areas—work in the informal economy: the majority are own-account or self-employed. Protective social measures that ensure workers' livelihoods are mainly available only for formal workers, which represent a very small percent of the population, rendering the majority of the country's workers vulnerable. With sustained public financial investment in the health, education and empowerment of young people, this could significantly change.

Health (SDG 3) and Education (SDG 4)

India is the world's third largest economy but only spends between 3.9 and 5% of its GDP on healthcare, compared to 10 to 12% among other developing countries. **The Indian government's share of the total healthcare expenditure is around 1% of GDP, shifting more of the burden on the relatively unregulated private sector to meet the population's healthcare needs.** A greater proportion of the population resorts to private health facilities due in large part to the lack of affordable and accessible public health infrastructure and essential services and medication, an absence of public diagnostic and treatment facilities, doctor availability, and quality of care. The Indian Government has made limited efforts to ensure equitable access to health services, with health outcomes being strongly influenced by gender, caste, wealth, religion and geographical location amongst other factors. There is also a shortage of functional health facilities with effective coverage and availability in both urban and rural areas, a problem further exacerbated by barriers to access such as forms of structural discrimination and extreme inequalities.

India's maternal mortality ratio (MMR) was 178 per 100,000 live births between 2010 and 2012. **Twenty per cent of all maternal deaths worldwide occurred in India in 2010 of which half were young women aged 15 to 24.** Young women often face the highest risk of pregnancy-related complications and death during childbirth. Abortion is widely legal, but barriers prevent all women, especially adolescent girls, from accessing safe abortions. **Close to two-thirds of abortions in India are unsafe, and a woman dies every two hours from complications arising from unsafe abortion.** Over a quarter (27%) of women aged 15 to 19 indicated an unmet need for contraception, though it is likely higher.

India's legal framework for Sexual and Reproductive Health includes provisions for some forms of sexuality education (primarily focusing on reproductive/maternal health), the prevention of child marriage, access to safe and legal abortion, and family planning. The National Strategy on Adolescent Health puts an increased focus on increasing knowledge of SRH and health systems strengthening for adolescent girls. As comprehensive and progressive as these policies are, however, political commitment towards implementation and state level buy-in seem to be lacking.

Education

India's interventions at universalization of education have succeeded in higher enrollment rates, including an 18% increase in enrollment of girls for primary education in government schools. Despite greater enrollment, India's institutions are not sufficiently equipped to combat school dropout rates for girls than boys, a trend that demonstrates the effects of poverty and gender inequality. A number of existing national policies indicate that the Indian government is aware that it must prioritize the education and health of adolescents in order to successfully meet sustainable development goals. For example, India's National Youth Policies of 2003 and 2014 recognize that adolescents require uniquely tailored policy approaches and that these can contribute to ensuring sustainable development.

Education and Knowledge on Sexual and Reproductive Health and Rights

Adolescents face adverse reproductive and sexual health outcomes in large part because there is a significant lack of comprehensive knowledge about sexuality and reproductive health and limited access to related services that ensure confidentiality and privacy. India does not have a consolidated national policy that legislates Comprehensive Sexuality Education for adolescents and young people. Piecemeal information is provided through a variety of policies and curriculum frameworks. Currently, the legislation of education and health as state subjects allows government ministries or state governments to select/reject subjects on the basis of perceived cultural acceptance often instead of an evidence-based approach. **Comprehensive sexuality education would enable India's youth to develop sex-positive attitudes critical to empowering informed decision making on when to**

[1] Full paper LINK

become sexually active, preventing unwanted pregnancies and STI transmission and reducing gender based violence including child sexual abuse. As the government of India has acknowledged, adolescents both in and out of schools should be provided reliable, accessible, accurate, easily understandable information about their rights and the benefits and risks of particular health-related behaviors; the protection of their privacy and confidentiality; and the right to decide on matters of their health in both in-school and out-of-school settings. It needs to ensure such education is focused on health promotion instead of disease prevention and does not discriminate on grounds of marriage, class, caste, religion or gender.

In order to meet **SDG 3**, "ensure healthy lives and promote well-being for all at all ages" it is imperative that India strengthens its health system with a particular focus on **addressing the unique needs of adolescents and youth - married and unmarried, girls and boys- in all their diversity.** This includes decentralizing healthcare services so that adolescent girls and young women can access services where they live, especially those living in rural areas. It also requires that health workers are not judgmental and fully respect the rights and choices of young people to meet their sexual and reproductive health needs and reduce discrimination with the aim to strengthen quality of care.

In order to meet **SDG 4**, "ensure inclusive and equitable quality education and promote life-long learning and opportunities for all" India must address the high dropout rates for girls at both primary and secondary education levels, with a focus on increasing and sustaining the same. Addressing the social determinants that hold girls back from attending school and completing it include: attention to minimizing household responsibilities; providing clean and functional toilets in government schools; increasing public transport; and covering the hidden costs of schooling, including travel costs, uniform costs and daily expenditures. In addition, providing greater communication mechanisms for teacher-to-parent and teacher-to-student to help foster positive attitudes towards education is required. To meet this goal it will also require ongoing government programs **reach the most disadvantaged groups** by developing disaggregated data collection mechanisms of identifying marginalized groups and monitoring their progress.

To fully address the needs and rights of adolescents and young people under **SDG3 and SDG4 is vital that India fully recognize that comprehensive sexuality education** is an essential aspect of the right to education and health, by using evidence-based methods and providing full funding for the implementation of India's various national policies to provide comprehensive sexuality education both in and out of school settings that is accessible and meaningful for adolescents of all sexual orientations and gender identities.

Gender Equality and Women's Empowerment (SDG 5)

Gender inequality, combined with inadequate laws and policies that fail to protect women and girls, is a strong predictor of gender-based violence. Acts of violence against women, which are strongly predicted by gender inequality and patriarchal social structures, are alarmingly high in India despite national laws designed to combat gender-based violence. Over one third (34%) of young ever-married women between 15 and 24 experienced emotional, physical, or sexual violence at the hands of their spouse.

Pervasive and institutional gender inequality prevents women and girls from fully realizing their human rights. Violence against women, whether inflicted by a stranger or an intimate partner, reinforces deeply ingrained gender inequality and prevents the achievement of sustainable development goals.

In order to meet SDG 5, "achieve gender equality and empower all women and girls", India must adopt a broad and systemic policy approach to gender equality. This includes passing laws for more equitable property inheritance regimes; promoting multi-sectoral collaboration, both across the public and private sectors as well as NGO actors to prevent early and forced marriage and girls' education; taking measure to ensure that very young adolescent girls (ages 10-14), especially of lower socioeconomic status and living in rural areas, have access to education, health and safe spaces and can reject early and forced marriages and early pregnancy.

Inequalities and Discrimination (SDG 10)

A handful of relatively progressive policies coupled with a discriminatory climate work to obstruct access to reproductive and sexual health services for LGBT persons, for those in lower castes, and for the most structurally vulnerable populations, such as sex workers. There is also a lack of reliable, large-scale data disaggregated by population that would identify how different social groups fare on many social health and human rights indicators. Caste discrimination is illegal in India, yet people from Dalit communities and those belonging to religious and ethnic minority tribes face barriers to accessing quality education, health services, and economic and employment opportunities. Sex workers also reported stigma and discrimination in accessing health care, even though the government has made some serious attempts to provide prevention and treatment services in a non-stigmatizing environment for sex workers.

For India to meet SDG10 "reducing inequality within and among countries," it must repeal all discriminatory laws, policies and practices and ensure the human rights of people living within its borders. These protections should not just be confined to those who have legal citizenship in the country. Actions include: Removing punitive policies that penalize people's behavior or practices on the basis of their sexual orientation or gender identity; Instituting or otherwise update India's anti-discrimination legislation to prohibit discrimination in employment, housing, and social services on the grounds of sexual orientation or preference and gender identity; adopting data collection methodology that will enable the collection and analysis of socioeconomic and health patterns disaggregated by ethnicity, gender, age, and caste; and amending the penal code to remove penalties, civil and criminal charges against LGBT persons.

Conclusions

Two priorities which are likely to influence progress in India in the decades to come are the 1.) *dissemination and use of sex and age disaggregated data by five year cohorts (10-14; 15-19; 20-24)* and 2.) and the *implementation of a national policy on comprehensive sexuality education that is accessible for all in and out of schools and which includes modules on human rights, gender-based violence, and relationship negotiation skills.*

For India, bridging the gap between policy and implementation is key to meeting the needs of adolescent girls and young women, especially those from religious and ethnic minority communities. India's implementation of SDG indicators and targets needs to be outcome-based and oriented around the implementation of existing policies and the commitment of sufficient public funds to meet the education and health needs of the country's young people.

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