



नीति आयोग  
National Institution for Transforming India

# National Consultation Gender & SDGs

2nd-3rd February, 2020  
We the People Hall, UN House  
55 Lodhi Estate, New Delhi



Azād Foundation

Nazariya  
A Queer Feminist Resource Group



Sahaj  
towards alternatives in health and development



## **Gender & SDGs Consultation**

**Anchored by Jagori**

**Report:** February, 2020

**Contributors:** Anagha Khot, Menaka Rao, Shruti Batra

**Editorial Support:** Aarthi Pai, Devaki Nambiar, Kalpana Viswanath, Sonal Shah, Suneeta Dhar, and Jagori-Sangat Team.

**Photographs, Design and Layout:** Jagori Team

Jagori

B 114 Shivalik Colony, Malviya Nagar,  
New Delhi, 110017, India

Tel: 011 2669 1219 & 26691220

Telefax: 011 2669 1221

Helpline: 011 2669 2700, 8800996640 (Mon-Fri, 9.30am-5.30pm)

Email: [jagori@jagori.org](mailto:jagori@jagori.org)

Websites: [www.jagori.org](http://www.jagori.org) [www.safedelhi.in](http://www.safedelhi.in)

Facebook: Jagori Jagori

Twitter: @JagoriSafeDelhi

## **Acknowledgements**

We would like to convey our heartfelt appreciation for the support provided by Niti Aayog, UNRC, UN Women, UNICEF and Wada Na Todo Abhiyan in the organisation of this consultation.

We also extend a special thanks to UN Women for supporting us in the preparation of the Report of the Consultation and providing us with an excellent venue for the consultation.

Finally, we thank all our speakers and participants - many of whom travelled to Delhi from all over India on short notice - especially those who shared their stories with us.

- AIWC, Azad Foundation, Bebaak Collective, Nazariya, NCDHR, NEN, NNSW, Sahaj and Jagori

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# Background

## VNR 2020

India is preparing to present its second Voluntary National Review (VNR) on Sustainable Development Goals (SDGs) during the UN High-Level Political Forum (HLPF) 2020 to be held in July 2020 in New York. Niti Ayog is coordinating the process and thus convened a meeting with Civil Society Organisations (CSOs) on 29th November 2019 in New Delhi where they were briefed on the VNR process. With the support from UN Resident Commissioner's Office (UNRC), Niti Aayog proposed to integrate CSO's perspectives, data and inputs in the “**Leave No One Behind**” section of the VNR report.

Thus, a series of consultations were planned with CSOs working with: children, adolescents and youth, women, elderly women, dalits, adivasis, nomadic tribes/ denotified nomadic tribes, bonded labour and victims of human trafficking, LGBTQIA+ groups, farmers, migrants, urban poor, people with disabilities, people living with HIV, religious minorities, refugees and people from North-East India. This was followed up with a consultation organised by Wada Na Todo Abhiyan (WNTA) in December 2019, and anchor organisations were identified to co-convene regional and national consultations on specific themes and vulnerable groups. Anchor organisations were selected on various criteria – location, knowledge, expertise and depth of experience with identified select communities.

## Consultation Process

Jagori anchored the consultation on “Gender”. Co-organizers both volunteered and were invited on board, based on their relevant thematic expertise and outreach to specific vulnerable groups of women including dalits, religious minorities, LBTQIA, sex workers and from North-Eastern region. They included: All India Women's Conference (AIWC), Azad Foundation, Bebaak Collective, Nazariya, National Campaign for Dalit Human Rights (NCDHR), North East Network (NEN), National Network of Sex Workers (NNSW) and Sahaj.

The Consultation brought together **74 participants** from **45 organisations/networks**, working across **20 states** in urban, peri-urban, rural and tribal areas from diverse sectors. The aim was to track the progress of SDGs and identify gaps in and barriers to achieving these. There was also a discussion on good practices and formulation of recommendations. UN Women offered the UN House conference room as the venue, which was deeply valued as it was seen as a neutral space for many stakeholders with access for people with disabilities.

## Why SDGs from a Gender Lens?

SDGs aim to develop a world which is inclusive, people-friendly and sustainable – leaving no one behind. SDG discourse is incomplete without voicing the concerns of half of the population, which are women. In keeping with the principle of substantive equality, greater focus on a gender lens in both policy and practice is needed to counter-balance the historically disadvantaged position of women. The last few decades have seen some efforts to address inequalities and the violence that women suffer, but evidence shows that these have not hit their mark. The needs of women and girls need to be more obviously prioritised. A stronger focus on gender in all SDGs

can create a more comprehensive approach to better understand, examine and address the systemic barriers that leave women behind.

### **This Consultation focused on three key SDGs.**

*SDG 5: Achieve Gender Equality and empower all women and girls*

*SDG 3: Ensure healthy lives and promote well-being for all at all ages*

*SDG 11: Make Cities and human settlements inclusive, safe, resilient and sustainable*

#### **India's Commitment on Gender Equality**

India draws upon its Constitution that has established a powerful mandate for equality of women in its Preamble, Fundamental Rights and the Directive Principles of State Policy. India is a signatory to several UN Conventions, including the Universal Declaration of Human Rights (UDHR), 1948; Convention on Elimination of all Forms of Discrimination against Women (CEDAW), 1979; International Conference on Population and Development Programme of Action (ICPD-POA), 1994; The Beijing Platform for Action, 1995; and Convention on Rights of the Child (CRC), 1989 thus underscoring its commitment to gender equality.



# SDG 5: Achieve Gender Equality and Empower all Women and Girls

## Overview

SDG 5 encompasses a multi-dimensional approach to gender equality with a wide range of intersectional targets. They range from ensuring women's access to education, health care, decent work, representation in political and economic decision-making processes, sexual and reproductive health rights and services, recognition of women's unpaid care work and the need to implement gender sensitive laws and policies to address discrimination, violence and end harmful cultural practices.

## Progress

There have been some efforts over the years which reflect GOI's commitment towards gender equality:

- Launch of flagship programmes and schemes – Beti Bachao Beti Padhao (focused on promoting girls' education), Sukanya Samridhi Yojana (focused on promoting savings for future education), Janani Suraksha Yojana, Jan Dhan Yojana (focused on enabling women's access to bank accounts), microcredit schemes and accessing loans through self-help groups (focused on ensuring women's access to credit), MGNREGS (focused on enabling women's 100 days of guaranteed employment) etc.
- Institution of Gender Budgeting by the Union Government and some State governments.
- Adoption of Laws against sex selection, child marriage, domestic and sexual violence, sexual harassment in public spaces and at workplace and Maternity Benefit Act.
- Establishment of One stop centres, helplines for women, *Mahila Thanas* (all women police stations) and victim compensation schemes
- Increased representation of women in local governance through Panchayati Raj Institutions and Urban Local Bodies. Today, India has about 253,400 local bodies at the village level (Gram Panchayats), and 6613 intermediary or block-level *panchayats*, and 630 district level *panchayats*. There are about 3 million elected representatives of these *panchayats*, out of which 1.3 million are women.
- Greater availability of data on forms of violence through the NCRB and NFHS.
- Reduction in the practice of child marriage to half with 26.8% of girls getting married in 2015-16 as opposed to 47.4% a decade ago (NFHS 2015-16).
- Increase in reporting on VAW data and an increase in the conviction rate of rape cases over the years with the highest being reported in 2017 (NCRB, 2018). The following field level experiences and insights emerged during the national consultation. Specific inputs for vulnerable/LNOB groups are also included.

## Voices from the field: Challenges, Gaps and Recommendations

Despite efforts to address gender inequality, several challenges remain.

- **A Draft National Policy for Women (2016)** that will ensure a gender perspective across all Ministries **still awaits adoption.**

- **The data reflects a worrisome picture.** In the World Economic Forum's Global Gender Index 2020, India's position slipped from 108 to 112. Niti Aayog's dashboard on SDGs in 2019 does not have a single state in the country faring well in terms of gender equality (World Economic Forum, 2019; NitiAayog, 2019). In the 2019 Lok Sabha elections, 78 out of 542 seats were won by women. This is a record high for India well below the global average. The sex ratio at birth continues to be abysmal at 919 girls for every 1000 boys. Only 68.8% of girls who are six years and above have ever attended school. A third of women (31.1%) experience spousal violence. More than 600 women are trafficked every hour. There is a 6% increase in total crimes against women since 2016 and a 9% increase since 2015. There is also a 77% increase in cyber crimes since 2016 (NCRB, 2017-18). This increase in violence is accompanied by a decrease in access to employment and other opportunities. The female labour force participation rate has fallen to 23.3% in 2017-18, a fall from 28.15% in 2011-12. (PLFS –NSSO, 2019). According to a survey conducted by the Economic Times (2017-18), among regular women employees, 63% earn less than Rs. 10,000 a month. Further in rural India, this figure stands at 55% while in urban India, it is 38%. 73.2% of rural women are farmers and yet only 12.8% own land holdings, as per the Agriculture Census report, 2015. Less than half the women in the country own a mobile phone that they themselves use (NFHS 2015-16).
- **There is an absence of disaggregated data across gender, age, disability, caste, class, tribe, marital status, occupation and location.** There are also concerns related to which agency collects the data, at what levels it is collected, how it is tabled, and how it is further used. Key agencies such as NCRB do not record certain kinds of violence such as that against transgender persons, sex workers and other marginalised women. The data on sexual harassment also is not segregated based on rural or urban indicators, or the kind of workers who complain about it (NCRB, 2017-18). The data on the number of people with disabilities in India in the Census is limited as it does not recognise categories beyond physical disability. Certain categories of women are completely ignored by the data collection processes. For instance, the suicide of a woman farmer is considered as the death of a housewife and does not count as a farmer suicide.
- **There are gaps in implementation of laws and policies and some of them that are meant to address oppression of women and other marginalised sections of society are regressive and require critical attention and amendments.** Some examples include:
  - » The Immoral Trafficking (Prevention) Act (ITPA) and section 370 of the Indian Penal Code criminalise trafficking of women but end up criminalising sex workers and sex work. The sex workers are often “rescued” and sent to shelter homes, depriving them of their livelihood.
  - » The Transgender Person (Protection of Rights) Act, 2019 compels transgender persons to go through a sex reassignment surgery to be recognised as transgender under the Act.
  - » The Protection of Children from Sexual Offences (POCSO) Act, 2012 that raised the age of consent from 16 to 18 criminalises consensual sexual relationships of young people. Cultural practices that allow youth to have friendships, relationships of choice are getting eroded as a result.
  - » The Prevention of Sexual Harassment (POSH) Act, 2013 does not have mechanisms to address anonymous complaints, or complaints given beyond 3 months of the alleged incident of harassment. The law allows the employer to take appropriate action against the woman complainant if the complaint is classified as “false” or “malicious” giving them an opportunity to harass the complainant herself.
  - » The Prohibition of Employment as Manual Scavengers and their Rehabilitation Act, 2013 has not been implemented, even in the government sector let alone the private sector.
  - » Female Genital Mutilation and marital rape are not recognised by any law as an offence.

- There is lack of recognition of the everyday economic, social, political and cultural discrimination and violence faced by women from marginalized communities including Dalits, tribal, LBTQIA, women with disabilities, sex workers etc.** Customary practices and laws in North-Eastern states are used to further marginalise women. For instance, in Nagaland, women cannot inherit property. In Meghalaya, even though the line of family is matrilineal, the youngest daughter is only the custodian of the land/property and is not allowed to sell it without maternal uncle's advice. Women face concerns related to citizenship, displacement and access to social security. Women constitute 59% of the beneficiaries for the National Assistance Programme, but the actual benefit is meagre. The old age pension is Rs 200 per month and the security for widows and people with disabilities is Rs 300. The Rights of Persons with Disabilities Act, 2016 mandates 5% reservation in the allotment of agricultural land, and housing in all relevant schemes and development programmes, poverty alleviation schemes for people with disabilities with a priority for women with disabilities, the work on which is yet not done by the state governments. The implementation of the law is contingent upon the state. However, neither in the Central rules or State rules which help implement the law, there is a mention about women with disabilities. For Dalit sex workers, it is hard to obtain caste validation certificates denying them certain reservations. For *Devadasis* in Maharashtra their caste certificates from Karnataka are not accepted. Stigma and methodological barriers make it difficult to get data of the LBTQIA persons and their concerns.
- Inadequate budgetary allocation for programmes and schemes for women and girls is also a serious challenge.** An analysis by National Campaign on Dalit Human Rights (NCDHR) of the Union Budget 2020-21 highlighted the inadequate budget allocations for Dalit and tribal women. The government has allocated only 0.8% of the Union Budget 2020-2021 for Dalit women and 0.34% for tribal women. For the post matric scheme, among both Dalit and tribal girls, the allocation is meagre. Despite growing incidences of violence against scheduled caste and scheduled tribe women, there is only a marginal allocation of budget for their access to justice. The Union Budget 2020 has allocated 110 crores for rehabilitation of manual scavenging which will be inadequate to holistically eliminate the practice. (NCDHR, 2020). The Nirbhaya Fund for compensation of rape survivors, one stop centres and domestic violence protection is mostly left unutilised. The Supreme Court mandates compensation between Rs 5 lakhs to 10 lakhs to rape victims. This kind of compensation would require considerably higher allocation of funds. (Duggal, 2018).





## Recommendations

### Disaggregated Data Collection On Gender And Its Intersections

- Collect reliable statistics on women's earnings from self employment, ownership of business and management.
- Capture aspects of women's migration.
- Data collection on access to child care, expectations and perceptions about the economy, saving and spending patterns, and entrepreneurial behaviour.
- Gender-wise information on ownership of assets and utilisation of basic amenities to understand intra-household distribution of resources and power, effectiveness of laws in changing social structures and empowerment of women.
- NSSO should focus on gendered patterns of access and use of digital technologies, including the internet.
- Follow the set of questions formulated by Washington Group of Disability Statistics while collecting data on women with disabilities (Washington Group, 2004).
- Micro-studies undertaken by CSOs to be also considered credible sources.

### Formulation/Implementation/Amendments in Laws

- Implement Section 42 of the Right to Fair Compensation and Transparency in Land Acquisition, Rehabilitation and Resettlement Act, 2013 that retains reservation benefits for tribes, particularly community rights over the forest.
- Formulate a comprehensive labour policy that helps bring more women in the workplace. Initiate creches all over the country. The Integrated Child Development Scheme programme that provides food and pre-school education for children should run till 6 pm in the evening.
- Amend the Transgender Person (Protection of Rights) Act, 2019 on the lines of the guidelines issued in the 2014 Supreme Court judgement – National Legal Services Authority vs. Union of India. Additionally, access to sex reassignment surgery should be provided free of cost. The punishment for sexual offences against a transgender persons is much lower (6 months - 1 year imprisonment) than the one prescribed in the Indian Penal Code and needs revision
- Repeal ITPA and decriminalize sex work.
- Revisit the age of consent under the POCSO Act, 2012.
- Configure the POSH Act as an equal opportunity law.

### Policy Inputs

- Develop state-specific comprehensive policies for rehabilitation and reintegration of violence survivors with greater coordination between multiple service providers and state agencies including District Legal Service Agencies, one-stop centres, health facilities, skill development centres and women's organisations. Encourage vocational training in shelter homes that challenge stereotypes about women's work and is designed in accordance with the duration of the stay of survivors, Conduct periodic audits by rights-based civil society organisations. Ultimately, the aim should be to provide safe, secure and affordable housing to violence survivors.

- The tourism policy of Goa Government has given a boost to the casino industry and making of beach hotels. This has resulted in loss of livelihoods, displacement without rehabilitation and increase in violence against women. Hence, every policy needs to be scrutinised for the adverse impact it may have on women.

### Elimination of Harmful Practices

- Recognise and ban the practice of FGM among girls belonging to communities like Dawoodi Bohra. Also, conduct systematic studies on the issue.
- Formulate a national law banning witch-hunting. The legislation can be informed by experiences from the states of Assam, Rajasthan, Jharkhand and Odisha where such laws are in place.

### Re-Imagine Technology To Help Prevent Violence Against Women

- There is a need for more apps that focus on safety, precautions and prevention rather than on emergency services. Safetipin is one such app.

### Capacity Building

- Develop comprehensive training programmes for Elected Women Representatives, particularly in the rural and tribal belts.



## Good Practice 1

### Comprehensive capacity building of EWRs as crucial component for their effective political participation

#### A testimonial

Sumantai Thorat is a Sarpanch of the Shewalwadi Gram Panchayat in Pune. She has been involved in social work for many years. She has previously worked in the Beti Bachao Beti Padhao campaign, on school improvement, on water availability, and with the adivasis population. Even before she became a Sarpanch, the villagers knew her and had confidence in her. She recalls how she did not have to spend a penny and villagers raised money for her to contest elections. She won from the general category, not a reserved one.

She does not want to be just a nominal representative, like the titular head of the village. She considers the village her family and she wants to work towards making it better. Mahila Rajsatta Andolan conducted a training programme which helped her with some technical aspects related to administration, such as how to formulate and allocate a budget. Such training programmes help women leaders like her in performing their duties well and successfully counter the pressure tactics employed by male Panchayat leaders.

## Good Practice 2

### Gramin Mahila Kendras (GMK) as an alternative community space for conflict resolution

North East Network (NEN), Assam has set up three GMKs - Rural Women's Centres in select districts of Assam. Women facing domestic violence are provided socio-legal counselling through trained barefoot counselors in these Kendras, enabling them to navigate through the criminal/civil justice system at different stages, thereby providing a safe space for survivors of DV to share their experiences of violence in both private and public spaces and negotiate for their rights.

**Impact:** GMKs have become popular meeting places for women and girls to talk about gender based discriminatory practices in their communities and build collective responses for prevention and elimination. Women Helpline (181), *Mahila Samitis* (Women's Committees) and local police stations have been referring cases of VAW to them. They are now registered as service providers under PWDVA, 2005 and work together with the District Social Welfare Department and other stakeholders.

## Good Practice 3

### Mapping Safety: From Audit To Budget

Indrawati (49) is from Purwa Village of Chandwa Block in Latehar district, Jharkhand. She participated in short sessions on the use of the safety audit tool conducted by Jagori. She used the tool in her *panchayat* to highlight safety issues and submitted key demands to the *panchayat*. She convinced the *panchayat* head to participate in the audit.

**Impact:** She and her collective - Ekal Nari Shakti Sangathan (ENSS) followed up and successfully influenced the *panchayat* to sanction the requisite budget for repair and maintenance of roads. The safety audit allows people to monitor access to services thus empowering them to ensure government accountability.

## SDG 3: Ensure Healthy Lives and Promote Well-Being for all at all Ages

### Overview

Men and women have varying life expectancy, levels of burden of disease and health care needs. Further, access to health care, control over household resources is affected by gender inequalities. Women and girls are particularly disadvantaged due to their unequal nutritional and health status. They also face gender-specific health risks such as complications during pregnancy and childbirth amongst other.

Of the SDG-3 targets, while targets 3.1 and 3.7 directly relate to women's health, gender-specific aspects among other targets is equally critical. There are six gender-specific indicators within SDG-3 on health: (i) maternal mortality ratio; (ii) births attended by skilled health personnel; (iii) new human immunodeficiency virus (HIV) infections, by sex; (iv) satisfactory family planning with modern methods; (v) adolescent birth rate; and (vi) coverage of essential health services, including reproductive and maternal health. Aside from the SDG-3 targets, SDG-5, which includes the elimination of violence against women and girls, has important implications for health.

### Progress: RMNCH+A, Tuberculosis, NCDs, Universal Health Coverage

India has made some gains in health in the past two decades – most notable being eradication of polio as well as eliminating maternal and neonatal tetanus. Life expectancy at birth has increased from 49.7 years (1970-75) to 68.7 years (2012-16). The country has made significant progress on key maternal, new-born and child health indicators. There has been an impressive decline in the number of maternal deaths per 100,000 live births from 437 in 1990 to 167 in 2011-13 and further to 122 in 2015-2017<sup>1</sup>. Institutional deliveries have increased from 38.7% in 2005-6 to 78.9 percent in 2015-16<sup>2</sup>. The national total fertility rate (TFR) of 2.2 close to the replacement level fertility of 2.1. While there has been reduction in the national infant mortality rate as well as under five mortality rate over years, there continue to be substantial gender differences in mortality rates.

The RMNCH+A strategy under the National Health Mission (NHM) seeks to adopt a continuum of care approach. NHM has also led to the creation of a million strong workforce of frontline workers – Accredited Social Health Activist (ASHA), who have been at the forefront of preventive, promotive and service delivery activities, particularly pregnant women to health facilities amongst other. Safe pregnancy and delivery have been central to several government initiatives. Key initiatives in **maternal health** include, but are not limited to: Comprehensive improvements in delivery points, creation and/or expansion of facilities like MCH wings, obstetric ICUs; Janani Suraksha Yojana (conditional cash transfer for institutional delivery); Dakshata (quality of care during childbirth in the public health facilities); LaQshya (quality of care around child birth); Pradhan Mantri SurakshitMatritva Abhiyan (fixed day assured antenatal care); SurakshitMatritvaAashwasan (service guarantee to achieve zero preventable maternal and newborn deaths); Maternal Death Surveillance and Response among others. Recent efforts to

<sup>1</sup> Sample Registration Survey, 2017

<sup>2</sup> National Family Health Survey, 2015-16

create a midwifery cadre and introduce midwife-led units in public health facilities; the focus on Respectful Maternity Care are applaudable for its intent. **SRH services** in the National Health Mission include the provision for contraceptives, access to comprehensive and safe abortion services, diagnosis and management of reproductive tract and sexually transmitted infections, including HIV.

Efforts are underway to improve **child health and nutrition** through initiatives like Intensified Mission Indradhanush (accelerate immunization coverage); Janani Shishu Suraksha Karyakram (cashless care for women and infants in public health facilities); Rashtriya Bal SwasthyaKaryakram (screening and early intervention services); POSHAN Abhiyan (improve nutritional status and attain malnutrition free India) and India Newborn Action plan to name a few. Rashtriya Kishor SwasthyaKaryakram (focused adolescent health initiative) seeks to increase awareness; engage peers; provide access to information and cater to their specific health needs through adolescent friendly health clinics.

There has also been a renewed focus on **Tuberculosis (TB)**, a leading infectious killer. India has set a target for complete elimination of TB by 2025, five years ahead of the global target of 2030. The National Strategic Plan (2017-25) adopts a multi-pronged approach that is gender-responsive approach in order to identify and counter the influence of gender on the causes and consequences of TB, as experienced by men, women and transpersons.

Premature mortality from NCDs accounts for 61% of total mortality among 30-69 years old<sup>3</sup>. As part of efforts to control **Non-Communicable Diseases**, there is a focus on screening women for four most common cancers under the National Program on Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke amongst other. Also, India has included indoor air pollution as one of the SDG targets/indicators though it is not present in the global SDG targets.

2018 also saw the launch of India's most promising initiative – Ayushman Bharat as part of its effort for moving towards **Universal Health Coverage** provides an unique opportunity to create a complementary policy where primary health care is strengthened through the HWCs and the burden of expenditure incurred in secondary and tertiary care is addressed through the health insurance scheme, including for women.

## Voices from the field: Challenges, Gaps and Recommendations

While varying efforts and government programmes are laudable, the health sector challenges are enormous and complex. There are widespread inequities in health outcomes with large differences in morbidity and mortality across socioeconomic status, caste, class, gender, and geographic location. Nuanced policy analysis using disaggregated data to address health and related needs of vulnerable communities such as women migrants, single women, homeless women, elderly women, women living with HIV/AIDS, sex workers, women with disabilities, LBTQIA persons among others is not available. There are no specific strategies/programmes supported with appropriate costed state and district plan to address the needs of the most vulnerable groups. In case where it may exist, it tends to remain as a notable intent without being translated to action leading to a “policy to practice” gap. Several civil society organisations have been partnering with the government (across levels) and/or engaged in identifying and finding fit-for-purpose solutions to some these intractable health challenges especially to address the needs of vulnerable groups. Three such “good practice” initiatives presented at the national consultation are listed at the end of this section.

<sup>3</sup> India, Health of the Nations States; India State Level Disease Burden Initiative – IHME, ICMR and PHFI Report 2017

Despite the various health sector achievements mentioned above, public spending on health has remained stagnant at around 1% of GDP since the mid-1980s. The National Health Policy 2017 calls for more than doubling in government health spending as a percentage of GDP by 2025, from 1.15% to 2.5%. Further, it outlines ambitious set of goals and targets to improve the population's health status and its access to quality health services in the public sector. Attaining “universal access to good quality health care services without anyone having to face financial hardship” is one of its key goals.<sup>4</sup> However, low government health investment over a prolonged period has resulted in low financial protection and high out of pocket expenditure; critical health workforce shortages, low health outcomes leading to a relatively weak public health system. These challenges are accentuated given the wide inter and intra state and district variations and inequities.

The following **field level experiences and insights** emerged during the national consultation. While several of these insights are inter-related, for ease of presentation they have been grouped under select themes. Where applicable, specific inputs (if any) for LNOB groups is also included.

### **National & State Level Disparities, Missed Opportunities**

While the national level maternal mortality rate has significantly declined and stands at 130 per 100,000 live births wide-spread inequities exist. Comparison across states shows a wide variation ranging from 46 per 100,000 live births in Kerala to 237 per 100,000 live births in Assam. Similarly, though national TFR is reaching close to replacement levels, there exists a high unmet need for family planning. 30 million currently married women in the age group 15-49 years and 10 million young women in the age group 15-24 years wish to delay or avoid pregnancy but do not have access to contraceptives.

### **Reproductive and Sexual Health Information and Services**

(LNOB: Women; Adolescents, Tribal adolescents; women living with HIV/AIDS; female sex workers; single women)

- Access to sexual and reproductive health information and services is particularly limited among adolescents and young people as well as people living in remote rural areas. Lack of access is accentuated in case of adolescents from vulnerable communities (e.g. needs of unmarried tribal adolescents where children out of marriage is an accepted social norm are not addressed and they do not have access to contraceptives)
- Teenage pregnancy continues to be a challenge in the rural areas. Nearly 1 in every 10 women in rural areas in the age group 15-19 have already had children. (NFHS 2015-16).
- RKSK programme is silent on addressing reproductive and sexual health needs of the adolescents with disabilities as well as for LBTQIA persons.
- Myths related to menstruation and discrimination during menstruation continue to exist.
- Cabinet approval of the MTP Amendment Bill 2020 (increasing the limit from 20 weeks to 24 weeks) is a welcome move but the conditionality could result in denial of reproductive rights of women. Also there is need to remove barriers to safe abortion services for adolescents. Adolescents may choose to involve their parents in their decision making process but there need not be a mandate to do so.
- Reproductive and sexual health needs of women living with HIV/AIDS (WLHIV) are

<sup>4</sup> National Health Policy 2017. New Delhi: Ministry of Health and Family Welfare; 2017 (<http://164.100.158.44/showfile.php?lid=4275>)

grossly neglected. ANC/PNC services for WLHIV receive low priority at the public health facilities. Women living with HIV are discouraged to get pregnant or advised abortion by the counsellors. They are rarely counselled about contraceptives and other reproductive and sexual health needs.

- Single women are often advised to get hysterectomy done when it is not the cause of their ill-health or illness.
- Health issues of sex workers get limited to HIV and reproductive health along and their overall health issues are not recognized nor addressed by the health system.

### Maternal Health, Pregnancy and Delivery:

- Though maternal mortality ratio has reduced over the years, nearly 32,000 pregnant women each year still lose their lives during pregnancy, childbirth and the postnatal period each year. In addition, 5, 90, 000 newborns die each year in the first month of life. More than half the women in the country are anaemic and about 20% of them have body mass index below normal.<sup>5</sup>
- Reporting of maternal death continues to be low. Governmental maternal death reviews in each district is still not made public. Less than a quarter of the deaths are reported in the maternal death review and only two thirds are reviewed. There is no real time transparent data on how women are dying of childbirth in the country (Khanna and Subha Sri, 2017)
- While the Janani Suraksha Yojana has increased the numbers of women having institutional deliveries, the quality of maternal health services is still a challenge.
- Pradhan Mantri Matru Vandana Yojana that provides cash transfer for nutritional support for the mother is given only for the first pregnancy, thereby making it discriminatory towards women.
- LaQshya labour rooms stand as islands of excellence within otherwise not optimal health facilities, concerns remain as to how many women can reach LaQshya labour rooms
- Health facilities continue to have shortage of essential medicines for women's health (e.g. IFA tablets for anaemia, oxytocin, availability of safe blood)
- In spite of the massive increase in institutional deliveries through schemes such as JSY, JSSK women continue to face hardships and at times there is delay in cash transfers and/or request for informal payment.

### Delay in Availing Entitlements and Benefits

**Testimonial:** S, Uttar Pradesh (who was carrying her 8 months old son in her arms)

It has now been eight months since my son was born. But I have still not received JSY benefit. I have submitted my papers thrice to the health department, but to no avail. I was told by the health workers that 'Sarkaarghatemeinchalrahihei'. (Government is going through loss/ deficit). Now my question is how government going to cover their 'ghaata' from poor people like us? Moreover, in the government hospital, when a boy is born, the doctor and nurses asks for Rs 1000-2000, and when a girl is born, Rs 500 is demanded.

I had to pay all that and to many other helping staff who demanded money in the name of 'khushi' (happiness). I also had to pay to make the birth certificate for my child. I did not get an ambulance neither to go to the hospital nor after childbirth for dropping me back at my home. The government should be providing JSY benefits to all women, whether it is the first child or the fourth child and should

<sup>5</sup> Sample Registration Survey, 2017

make sure that women get that money immediately after childbirth as we have to spend so much from our own pocket.

## Child Health and Nutrition

LNOB - Tribal, PVT Groups, Girl Children

- While efforts to reduce maternal and child mortality rates have had an impact, stillbirths and newborn deaths have over the same period missed out on the attention they need.
- In the area of child health and nutrition, there is a massive missed opportunity. Of the 79% institutional deliveries, only 36% of neonates had a postnatal check, while only 27% were checked within 2 days of birth (NFHS).
- Groups such as rural communities, Scheduled Castes and Scheduled Tribes and minorities have a higher IMR and U5MR. For instance, wide variations are seen in terms of under-5 mortality among tribal (57.2 per 1,000 live births) as compared to 38.5 among others (National average 50); Infant mortality rate (IMR) among tribal being 44.4 per 1000 live births versus others of 32.1. (National 41) and also neonatal mortality Rural Tribal at 33.4 per 1000 live births versus 27.7 for others (National 30)<sup>6</sup>
- Decline in neonatal mortality has been much slower compared with under-5 mortality.

## Adolescent Health

- In terms of implementation, menstrual hygiene programme largely focuses on promotion of products often without disposal strategy often being operational.
- Adolescents and youth do not reach to adolescent friendly health clinics. Gender dimensions particularly impact adolescent girls' access and use of these clinics.
- Health workers accord low priority to RKSK programme as compared to their other responsibilities. Health workers do not necessarily provide information and services to adolescents in a confidential and non-judgmental manner.

## Occupational Health with a focus on Silicosis

- Occupational health and safety of workers, especially in unorganized sector is a neglected area. Specific health and safety issues of women workers, especially migrant workers are missing from the government discourse.
- Health and safety issues of unorganized sector workers fall between the cracks as neither the Department of Health nor Department of Mines nor Department of Labour claims responsibility for their health and well-being.
- Lack of any information and data about health status of unorganized sector workers, including migrant workers and women migrant workers.
- Lack of recognition of silicosis as an occupational health issue of significant dimension (2017 Survey at the behest of the Supreme Court shows 235,447 workers across 36 states are exposed to the risk of silicosis).
- Lack of adequate expertise and capacity for diagnosis of silicosis – tends to be confused with tuberculosis.

<sup>6</sup> National Family Health Survey, 2015-16



**Testimonial: Sukli Bai** is a survivor of Silicosis. She belongs to the village of Badhiyar in the Dhar district of Madhya Pradesh. She migrated to Gujarat to be a wage labourer in a factory, along with her husband. She earned Rs. 300-400 in a week. She recalled how there was so much dust at her work-site that she was not able to see. The factory did not provide any protection against this, like a mask or a cloth around the nose and mouth. She and her husband worked there for a year. They both fell sick and heard about people from surrounding villages going through the same thing. She experienced symptoms such as a cough, joint-pain and weight-loss. The factory did not support her by sending her to the hospital. She went to private hospitals at her own expense and was diagnosed with Tuberculosis. It was much later that a health camp was set up and she found out that she was suffering from Silicosis. Her husband perished from this illness. There are roughly 300 households in her village and members from 45 households were diagnosed with Silicosis. Some victims have received compensation for the illness but most have not. Her husband had received Rs. 3 lakhs in compensation but she did not. The illness has left her so weak that she cannot work much anymore. She is a member of Silicosis Peedit Sangh - an organisation of Silicosis survivors.

## Women and TB

- Examining the gender dimensions of TB is important for overcoming barriers to effective prevention, coverage and treatment of tuberculosis. While the National Strategy Plan for TB<sup>7</sup> outlines a gender-responsive approach and states that it will develop relevant gender guidance for TB, there is no action plan in place along with timelines and requisite resources thereby serving as a critical barrier to implementation.
- Sex and gender differences impact upon tuberculosis notification rates – e.g. lower rates of notification for women could be a consequence of a smaller proportion of women than men with tuberculosis visiting a health facility and/or submitting sputum specimens for testing. This may be due to reasons such as difficulty in accessing health care, lack of female health providers, embarrassment and/or fear of stigma
- Women may have a longer period of delay before diagnosis, for instance due to fact that they often sought care from a private practitioner or a less qualified professional, and waited for the treatment to take effect before going to the hospital or due to distance to be covered and restrictions on their physical mobility among other.
- Social and economic consequences of tuberculosis vary by gender – e.g. women patients' inability to spend time on childcare and difficulty in carrying out household chores because of the deterioration in their physical condition.
- Social isolation due to stigma associated with tuberculosis is harsher for women and girls. For instance, women often face rejection by husbands and harassment by in-laws, the diagnosis of TB is not disclosed due to concerns about reduced chances of marriage.
- TB Champions who are TB survivors engaged in the programme should be provided financial support of some sorts.

## Women and Non-Communicable Diseases (NCDs)

- Women's health as a lens largely focuses on RCH and ignores NCDs.
- Evidence shows that gender affects the causal pathways for NCDs: differential exposure to NCD risk factors, differential vulnerability in terms of developing NCDs and differential consequences (i.e. different outcomes for same disease). For instance, obesity rates are higher in women. Also, cancers in men and women are quite different. However, NCDs are not examined from a gender lens, both in the Indian context (e.g. India's NCD Multi-sectoral action plan) as well as globally.

<sup>7</sup> <https://www.tbcindia.gov.in/WriteReadData/National%20Strategic%20Plan%202017-25.pdf>

- Women have better chance of being diagnosed with Diabetes / Hypertension due to investigation during pregnancy. However, they are less likely to be on treatment and more likely to use public sector for treatment.
- Air pollution is a special case where women are at very high-risk indoors due to use of biomass fuels for cooking which puts women at a higher risk of chronic obstructive pulmonary disorder, heart disease, lung cancer, stroke and pneumonia
- Research shows that women are less likely to be given same quality of care as men by health care providers.
- Heart surgery data from PM-JAY shows a gender skew, with women comprising just 29 per cent of total hospital admissions in the country for cardiothoracic and vascular surgery (CTVS) procedures, indicating that women do not get the care they deserve.
- Cultural factors coupled with gender have an impact on exposure, vulnerability, treatment and consequence for women with NCDs.
- Women living with HIV/AIDS are accorded low priority for regular screening for cervical cancer.

### Universal Health Coverage

- The Health and Wellness Centre component of Ayushman Bharat has not taken off with as much aplomb as the insurance scheme. 27,020 HWCs were operational as of 31 Dec 2019 which is 66% of the cumulative target till 31 March 2020.
- PMJAY only provides for hospitalization, and not outpatient care that most people need, thereby not fully catering to the health needs of the people.
- It is unclear when and how the continuum of care across the two components of Ayushman Bharat (namely, HWC and PMJAY) will be implemented.
- Further, number of hospitalizations under the PMJAY are higher in private hospitals than in public hospitals. The number of hospitals empaneled under the scheme was also higher in the private sector than in the public sector.
- Thrust towards public private partnership models, including plans to hand over district hospitals to private medical colleges (NitiAyog, 2019) can reduce the access to healthcare considerably especially for vulnerable groups and also lead to incurring of out of pocket health expenses.
- Research on government sponsored health insurance – e.g. Rajiv Arogyasri in Andhra Pradesh showed that women had a lower share of hospitalisations (42%), bed-days (45%) and hospital costs (39%) for sex-neutral conditions than men (George Institute, 2018).
- PM-JAY data shows that 75 percent of all hysterectomy claims—the surgical removal of the uterus—have been generated in 6 states: Chhattisgarh (21.2 percent); Uttar Pradesh (18.9 percent); Jharkhand (12.2 percent); Gujarat (10.8 percent); Maharashtra (9.0 percent); and Karnataka (6.6 percent)<sup>8</sup>.
- Further, is shocking is that between September 2018 and April 2019, almost 9 percent of the 1,146 hysterectomies conducted in Karnataka under AB-PMJAY were on girls aged under 15 years<sup>9</sup>
- Continuing shortfall of doctors, surgeons and specialists in community health centres in rural areas has worsened over the past 15 years. Despite the increase in the number of seats in medical education, there is a shortfall of nearly 19,000 doctors and specialists in 2019, more than twice the shortfall as recorded in 2005 (Rural Health Statistics. 2019) thereby impact the nature and quality of services available to communities and vulnerable populations.

<sup>8</sup> <https://www.pmjay.gov.in/sites/default/files/2019-08/NHA%20Working%20paper%20series%20001%20.pdf>

<sup>9</sup> <https://www.orfonline.org/research/ayushman-bharat-pmjay-at-one-a-step-closer-to-universal-health-coverage-55807/>

## Recommendations

### Vulnerability and Gender Lens

- Health system has to provide services to people on the margins.
- End discrimination faced by female sex workers, women living with HIV and third gender at health facilities.
- Staff of health facilities need to be trained in understanding the diversities of patients, on LGBTI and sexuality

### Monitoring SDG Progress

- Differential approach needed to address health care needs of women including sex workers, Women Living with HIV, single women, tribal women, migrants, etc.
- Availability of disaggregated data, especially by gender, caste, and for vulnerable groups is critical not only for review and monitoring of programmes but also as an accountability measure.

### Maternal Health, Pregnancy and Delivery

- Count every maternal death
- Improve reporting of maternal death. Social autopsies of maternal deaths looking into social determinants and health system contributors from human rights perspective, like the Dead Women Talking initiative will help understand the causes of maternal deaths better.
- Maternal Death Review reports to be made public
- Improve the quality of antenatal care
- Maternal benefits schemes (e.g. JSY, PMMVY) should be universal and unconditional for every woman in the country

### Reproductive and Sexual Health Information and Services

- Ensure access to reproductive and sexual health related information and services to the elderly women and single women, female sex workers
- Expand abortion services till the village level, ensure adequate and continuous supply for medication abortion drugs, and increase the number of trained providers.
- Enhance knowledge and awareness about legality, public health importance, availability and various abortion methods amongst community and health workers to reduce the stigma associated with abortion

### Adolescent Health

- Implement the holistic concept of RKSK, AFHC and incorporate monitoring by young people.
- Sexuality issues of young people to be addressed, including of boys and third gender.
- Converge RKSK with livelihood and other youth-focused initiatives.
- Training of service providers on gender and health with special focus on women from the marginalized community is needed
- Train youth/young elected members to support community to access benefits and entitlements available through various programmes, including through setting up Information centres at district and block level.
- Educate and mobilise community members on the harmful health impacts of child marriage

### Women and NCDs

- NCD data (disaggregated by sex) should be analyzed with a gender lens.
- Policies that limit out-of-pocket costs will especially be beneficial for women, who may otherwise be unable to afford essential NCD medication and treatment.
- Special attention to be paid to needs of women seeking NCD care in health insurance programmes and social protection initiatives for unpaid healthcare workers.
- Strengthen primary health care services for NCDs.
- Integrate MCH services that have a high level of coverage to provide NCD screening, management, treatment and education, and for detecting vulnerability to NCD risk factors.
- Health Promotion messages should take care to promote gender sensitive messages.
- Cervical screening for female sex workers should be prioritised and ensured.

### Occupational Health

- Recognition of Occupational Health and Safety issues especially for unorganised sector.
- Health facilities to be available for unorganised and migrant workers
- Put in place a National Policy on Safety, Health and Environment at Work Place which also covers unorganized sector.
- Health impact assessment to be compulsory in all factories.
- Profiling of Work Place and possible health risk of health workers and compilation of data
- Establish mechanisms to collect disaggregated data about exact number of workers working in mines and other settings

### Convergence And Synergies Across Various Programmes

- Address women's post-reproductive needs as well as infectious and non-communicable diseases where they may be affected disproportionately
- Foster integration and synergies across the health system. (e.g. TB care into reproductive health services, including family planning, antenatal and postnatal care. Similarly, NCD with MCH services; HIV and Reproductive and sexual health services)
- Treatment for common mental health conditions should be integrated in primary health care

### Universal Health Care

- Increase tax funded public health expenditure – Move from intent to action
- Legislate a Right to Health Act that provides entitlements a clear set of entitlements to people and will ensure free diagnostics, medicines, grievance redressal systems in the country.
- Monitor health expenditure incurred for maternal health as well as NCD care for women (in comparison to men)
- Address shortfalls in human resources (e.g. Overall, shortfall of 81.8% specialists at CHCs during 2019 in comparison with the IPHS norms as per Rural Health Statistics 2018-19)
- Implement Community monitoring and grievance redressal mechanisms
- Invest in community workers as a resource and provide them requisite recognition and benefits.
- CBM and planning very important, examine ways to undertake CBM at the level of gram sabha.
- Government should incorporate inputs and feedback received through CBM to address how people experience inequities

## Essential Medicines

- Implement a universally applicable free medicines scheme to guarantee that every citizen seeking health care from public health facilities has access to all essential and life saving medicines entirely free of cost, right from the primary to tertiary level of care.
- Make adequate budgetary provisions to ensure that medicine needs of the population are amply met and effective systems are in place to ensure regular supplies, procurement, distribution and quality assurance of medicines.
- Ensure adherence to rational prescription practices along with effective processes for monitoring.
- Establish a grievance redressal cell at the state level to cater to complaints by the patients regarding unavailability of medicines or irrational prescription practices.
- Introduce a free National Free Medicines Scheme covering most commonly used essential and lifesaving medicines for all across all the government hospitals in the country.



## Good Practice 1

### Community based monitoring (CBM) through Swasthya Darpan

Background: Under aegis of the National Health Mission, CBM provides a mandate to the community to undertake inclusive need based planning and monitoring of health services for ensuring accountability. The National Alliance for Maternal Health and Human Rights (NAMHHR), a national level network and Centre for Health and Social Justice (CHSJ) have long-standing experience of implementing CBM initiative. As part of its initiative 'Strengthening Coalitions of Marginalized People's Groups for Inclusive Reproductive Health Advocacy', CBM has been undertaken in select districts across 5 states (Bihar, Uttar Pradesh, Jharkhand, Madhya Pradesh and Karnataka). The use of mobile application – "Swasthya Darpan" – for CBM was developed and tested in 2019. It is available in 3 languages – Hindi, Kannada and English. Besides providing information, Swasthya Darpan is a monitoring tool based on Indian Public Health Standards.

#### Objectives:

- Assess community level health services from the perspective and first-hand experience of vulnerable and socially excluded communities covering 33 districts across 5 states.
- Undertake evidence-based advocacy with government demanding quality health services.

#### Process:

- Community mobilization, data collection and evidence generation using Swasthya Darpan application by interviewing over 1,100 women who had childbirth in last 6 months, observing fix day service (271 Village Health and Nutrition Days), observing 97 Primary Health Care facilities for maternal health services, 75 CHCs, and 191 Sub Health Centres.
- Findings on status of health services based on community feedback and direct observation were analyzed, reports and score cards generated and shared with the community through village level campaigns.
- Dialogues were organized at district level/CHC wherein app-based data backed by testimonials were presented by women. Community, Panchayat members, district level health officials, health officers from CHCs/PHCs and front-line health workers (ANM, ASHA) and officials from Department of Women and Child Development participated in these dialogues.

#### Changes seen due to CBM:

After the dialogues, corrective action was taken and several of the locally identified issues were addressed. For example:

- Curtains provided to ensure privacy for ANC check-ups.
- Available medicines list displayed in PHC
- Home visit by ANM as part of post-natal care started and information displayed on the door of the house mentioning date of the visit and next visit schedule.
- JSY benefit given to tribal women who had childbirth at home (Madhya Pradesh)
- Appointment of HWs

- Activation of VHNDs
- Ambulance service activated (Karnataka)

#### Next steps:

The app empowers the community, especially the women and helps strengthen women's network's resources and capacity. The second round of CBM is scheduled to be carried out in 2020, and will cover the same health facilities and villages to track the changes.

## Good Practice 2

**Mainstreaming Creches to Reduce Malnutrition in Odisha - The 'Red Flag' Protocol: A community-led model to address the issue of malnutrition among children under three years of age (since 2017)**

#### Objectives:

- To establish and run 150 community-based crèches across five most vulnerable districts of Odisha that will eventually be scaled-up by the Government of Odisha.
- To achieve continuity of care between the community [Integrated Child Development Scheme (ICDS), Accredited Social Health Activist (ASHA), Auxiliary Nurse Midwife (ANM)] and Nutrition Rehabilitation Centres (NRCs) and develop a model for scale-up.

#### Geography:

150 creches across Kalahandi, Koraput, Malkangiri, Navrangpur, Raygada in Odisha

**Programme Design: Three models with each model being restricted to one block per district**

- Anganwadi cum Crèche: Co-locating the creche within existing Anganwadi Centers (AWCs) involving the ICDS functionaries. While the AWC caters to children from 3-6 years, the crèche focuses on children aged under 3 years.
- Crèches in Villages with Particularly Vulnerable Tribal Groups (PVTG) Communities: These crèches address the most vulnerable communities in the state, including innovation to address challenges of logistics and lack of capacity.
- Crèches in Remote Villages/Blocks with Non-PVTG Communities: These crèches are located in remote areas/villages/hamlets of designated blocks with non-PVTG communities.

A centrally managed MIS supported early identification and prevention of malnutrition among crèche children at the community level. It also enabled real-time monitoring of the crèches, as well as helped in generating data regarding the status of crèche children. This data will also help in the mainstreaming of the model and support advocacy.

Source: <http://phrsindia.org/mainstreaming-of-creches-to-reduce-malnutrition-in-odisha/>

### Good Practice 3

#### **Establishing Silicosis as an Occupational Health Issue: A Decadal Journey of Research, Campaign, Advocacy and Judicial Action.**

The Problem: Occupational safety and health is a neglected issue despite the fact that rapid industrialization places a risk on the working population. And the fact the death and disease due to some of these conditions is preventable.

#### **Background:**

In 2004-05, in absence of any livelihood opportunities, tribal families from Alirajpur, Jhabua and Dhar, Madhya Pradesh were pushed to Gujarat in search of seasonal employment opportunities in the mines, stone crushing and quarrying. Several tribal migrant workers were affected and died due to what was colloquially came to be known as “Godhra ki factory wali bimari” (The Godhra factory illness). These workers had inhaled fine silica dust far beyond permissible quantities and by the turn of a year started returning home with common symptoms like coughing, shortness of breath and fatigue. Instances of “white powder” were found in their lungs even after their death. However, this phenomenon was unrecognized and the “cause of death” was reported as “unknown”. Early efforts by local groups to highlight this issue were unsuccessful. This issue was taken up by a group of activists, known as Silicosis Peedit Sangha.

#### **Summary of Key Events:**

- Creating evidence and mobilizing community : A study planned to document the extent of spread of silicosis and process of its causation; highlight the socio-economic impact of the disease on families and village and to use this evidence to seek relief/compensation for affected families and seek punitive action against the factories. Standard medical protocols were used to identify silicosis as an occupational illness. Community mobilization activities were carried out alongside this action research by a team of researchers, activists and medical professionals, continuing till after the research.
- 2006-07 - Destined to Die, first ever survey showed that 489 persons had a definite exposure to silica dust of varying intensity and duration across 21 villages of Alirajpur Tehsil of Jhabua District (now Alirajpur district). out of these 489 persons, 158 were dead and 266 ill, indicating a whopping 86% of workers who were either ill or dead. Engagement with district hospital and doctors revealed lack of expertise to diagnose and treat the condition. “Silico-tuberculosis” given as the potential diagnosis. Complete apathy and lack of response from Departments of Health as well as Labour.
- Engaging with NHRC: Several cases of double burden of death and debt within the families emerge. Complaints sent to the National Human Rights Commission (NHRC), who took cognisance of the issue. 1st Hearing held in May 2006 wherein for the first-time cases of silicosis from 5 states presented and evidence generated. NHRC recorded statements from villagers, visited factories, met officials and collected evidence.
- 2008: Destined to Die survey highlighted the spread of silicosis, denoting an increasing



number of patients and a rising death toll. It revealed a total number of affected persons of 809 (increasing from 424) in 40 villages of 3 districts between 2007 and 2008. It was also found that 117 children from 10 villages had lost their parents to this dreaded disease

- 2009: Public Interest Litigation filed in Supreme Court, NHRC joins as party. Supreme Court asks NHRC to recommend medical relief to those suffering from the disease and order compensation.
- 2009: Destined to Die survey showed steady rise of silicosis patients, providing detail of a total 1,701 victims in 102 villages of Alirajpur, Dhar and Jhabua
- 2010: NHRC passes an order holding State Enforcement Agencies of Gujarat accountable for failure to prevent the lives of poor people and directed Govt of Gujarat to pay Rs 3 Lakh to 238 persons who died due to silicosis and directed Govt of Madhya Pradesh to rehabilitate 304 persons suffering from Silicosis. Both the Governments fail to comply with the order of NHRC.
- 2011: Silicosis Policy formulated by Government of Madhya Pradesh. However, the same was not implemented.
- 2016: Destined to Die - Destined to Die report reveals that a total of 1,721 cases from 105 villages of Dhar, Jhabua and Alirajpur in the State of Madhya Pradesh is affected with Silicosis and a total of 589 people have died from 2005-2016
- 2016: RTI used as tool to gather data from DGMS and DGFASLI about cases of silicosis – Lack of data, low and under-reporting of cases seen.
- 2016: As per DGMS affidavit in Supreme court, a total 44,155 mines across 36 States where 235,447 workers are at risk of Silicosis, out of them only 77 cases (6 deaths) of Silicosis is confirmed
- 2016: Supreme Court passes an order - applicable across the country - It orders compensation of Rs 3 lakh each to be awarded for 589 cases. Till date, 555 persons have received compensation.

### Impact:

Recognition of silicosis as an occupational health issue. The decade old struggle continues even today, with a focus on rehabilitation and ensuring that the rights of these tribal workers are realized.



# SDG 11: Make Cities and Human Settlements Inclusive, Safe, Resilient and Sustainable

## Overview

SDG 11 envisions inclusive, safe, resilient and sustainable cities and human settlements. The experience of women and girls is different from that of men. Women's experiences are further layered – there are elderly women, working women, women whose major responsibility is in the domestic sphere, women who balance multiple roles at the same time, poor women living in low resource areas, women headed households, single women, women with disabilities and LBTQIA persons.

A gender lens on the SDG 11 will help promote equitable cities that ensure women's, girls' and LBTQIA persons' right to city and their access to essential infrastructure and services, safety in public spaces and active participation in local governance and decision-making. SDG 11 has two targets – 11.2 and 11.7 that directly relate to women's access to cities; it is also crucial to take into account gender specific aspects among other targets.

## Progress

Some positive measures to address gender concerns include: Provision for house registration either in the name of the female head of household/both the male and female heads of household jointly under Pradhan Mantri Awas Yojana (PMAY) – Housing for All (2015); Swachh Bharat Mission (2014) Urban Guidelines state that “care should be taken to ensure that there is adequate provision for separate toilets and bathing facilities for men and women”- in community and public toilets; and also measures related to women's safety and mobility in public transport. In addition, Jawahar Lal Nehru Urban Renewal Mission (JNNURM) and Smart Cities Mission provide some opportunities for addressing gender concerns in urban planning and infrastructure development.

## Voices from the field: Challenges, Gaps and Recommendations

- **Planning of the city spaces is not gender responsive and done without consultative processes with women**

Smart Cities Mission misses out the gender perspective in all its sub-components. Most of the Smart City DPRs do not talk about gender inclusivity and provisions are mostly restricted to security and safety concerns.

Master Plans often fail to address women's and girls' needs to safety and access to basic amenities including water, sanitation, waste management etc. The impact of inadequate services manifests in different forms for women and girls such as time poverty, unpaid care work, lack of access to opportunities, loss of social reputation, and threat to safety and security.

- **Structural barriers discourage women's access to safe and affordable housing**

There are gender inequities in the labour, income and credit markets that discourage women to realize their right to housing. Government schemes like PMAY leave provisions like the allotment

of housing for women open to the interpretation rather than making it mandatory. The needs of homeless women are often not recognised. Shelters are only temporary measures; the aim should be to provide safe and affordable housing.

- **Women's inadequate access to safe, inclusive and accessible transport and streets**
  - » **Shortage of public transport:** Analysis of the travel to place of work data in Census (2011) by The Urban Catalysts revealed that 45% of the 22.18 million women walked to their place of work. The same analysis showed the estimated annual cost of time poverty from transport on women's earnings in Bihar to be around Rs. 42 crores. This is indicative of the huge opportunity cost borne by women due to shortage of affordable public transport. 22% women used buses and only 5% used bicycles. There are 30,000<sup>1</sup> buses in the cities, and the requirement is nine times the number.
  - » **Lack of safety:** Women and girls often travel longer distances with higher costs in search of safer transport options and avoid sites of harassment and violence such as bus stops. To avoid harassment, they are forced to adapt their clothing, behaviors, regulate timings, avoid walking alone, use taxis that have emergency apps, or else opt to stay home (Jagori, 2010). Study undertaken by Safetipin in 2019 in Bhopal, Gwalior and Jodhpur showed that absence of streetlights, poor or no lighting at transport stops, effective pedestrian infrastructure, overcrowding or lack of seats or lack of lighting in public transport facilities can make women feel unsafe (Safetipin, 2019). Further, road safety policy is mostly geared towards the needs of men.
  - » **Gender inequality increases the vulnerability of women in disaster situations**  
Women are the last ones to step out of homes in the wake of a disaster as they have to take care of various household aspects. Men step out for rescue purposes and even if women sense the danger of the impending disaster, they lack the power and independence of decision making of leaving home or any other exigencies. In most post disaster situations, the number of female headed families increases exponentially because the male heads move out of the house in search of occupation to reconstruct what the disaster took away. Further, household violence often increases mostly due to the frustration borne out of their loss and financial insecurities.



## Recommendations

### Ensure Women's Voices in Master Plans and Local Area Plans

The plans should encourage poly-centric cities with mixed land uses; allocate land for affordable housing (with connectivity to frequent bus-based public transport) with special reservations for single women and women-headed households. While master plans provide broad guidelines for the provision of amenities, the spatial location of the following amenities should be determined at the scale of local area plans/ town planning schemes/ ward plans. These amenities should include:

- Affordable housing/hostels for single/migrant women, students;
- Crèches and nursing rooms;
- Skills development, apprenticeship/ placement and entrepreneurship development training centres for women and transgender persons;
- Public toilets, sanitary napkin vending machines;
- Drinking water facilities;
- Reading rooms, especially for girls;
- Anganwadi centres under Integrated Child Development Scheme;
- Shelters/ housing for homeless women and for survivors of domestic violence;
- Health facilities including counselling services for survivors of violence;
- Ensure “eyes on the street” – presence of street vendors. Address specific needs of women street vendors – for child care, access to water and sanitation services and safe vending zones in the street design.

### Ensure Women's Safe and Affordable Access to Housing

- Informal settlements should be upgraded with services and/or undertake in-situ rehabilitation in participation with residents.
- Resettlement and relocation should only be considered as a last option. While planning for upgrading slums or building housing colonies, women and their perception of safety should be paramount.
- The government bodies should promote residential typologies with well lit corridor spaces; lift areas, low-rise walk up apartments with external stairs and corridors that are safer for women.
- Residential neighbourhoods and typologies should be designed as pedestrian and cycling friendly areas, encourage natural surveillance of public spaces, provide shortest and most direct connections to public transport stops, and provide a range of play spaces catering to different age groups.



### Ensure Women's Safe and Inclusive Access to Transport and Last Mile Connectivity

- The entire trip chain – starting from stepping out of home to reaching destination – needs to be made safe and accessible for women, girls and LBTQIA persons.
- The transport as well as street infrastructure should be friendly for women and girls with disabilities, pregnant women, elderly and other vulnerable groups. For example, to access the metro system rapid, accessible feeder buses and compatible bus shelters are needed.
- Regular safety audits will help monitor safety concerns on the bus stops, metro stations etc.
- The government should conduct gender sensitisation workshops for transport crew, professional drivers, safety marshalls and traffic police.
- Further, women need to be visible across the transport sector; they need to be employed in jobs, including those related to operations and management department, not just housekeeping.

### Promote Women's Economic Participation

- Prioritize the needs of women informal sector workers including domestic workers, street vendors, sex workers, home based workers, waste collectors, construction workers.
- The spatial planning of industrial and economic areas must account for gendered employment patterns.
- There should be reserved spaces for women workers in sites of economic activity at the neighbourhood level such as community work stations, women's markets, skill building centres etc.

### Promote Women's Leadership In Disaster Management

- Women's leadership is critical in creating local level disaster management plans, conducting risk assessments, monitoring and evaluation.
- There needs to be coordination between government, local women leaders, women's groups and community based organizations.
- Concept of psychosocial care for the most vulnerable should be included in the Urban Disaster Management Guidelines.

### Financing For Women's Safety

- Bring about improvements in governance, fiscal and budgetary processes to strengthen interventions that have a bearing on women's safety.
- The specific challenges to women's safety across sectors need to be addressed through appropriately designed interventions backed by adequate budgetary outlays.
- Gender Responsive Budgeting is an important strategy, which if implemented could significantly strengthen such interventions.



## Good Practice 1

### Safe Cities Programme of Jagori

In order to build safe and gender-inclusive cities for women and girls, Jagori has developed a comprehensive Strategic Framework for Cities<sup>10</sup> Midentifying key sectoral areas of intervention in the short, mid and long term. These include:

1. Urban Planning and Design of Public Spaces, 2. Provision and Management of Urban Infrastructure, 3. Public Transport, 4. Policing, 5. Legislation, Justice and Support to Survivors, 6. Education, 7. Public Awareness, 8. Information Technology

Jagori has popularised this model both geographically and across sectors through community actions and campaigns, research and education and capacity development of stakeholders

Further to provide technical support to community groups and networks across select cities/districts (Bahadurgarh, Bengaluru, Bhopal, Bhuj, Cochin, Guwahati, Hazaribagh, Jhajjar, Karnal, Kolkata, Ranchi, Rohtak, Mumbai and Thiruvanthapuram), a Feminist Network of **Cities** has been established.

#### Impact:

- Community women and girls are learning methodology and tools to audit safe and unsafe spaces and reclaiming public spaces
- Men and boys are transforming from bystanders to interveners/ gender champions
- Stakeholders including Police and other government officials have been sensitized which has resulted in gender inclusion in their protocols and curriculums

## Good Practice 2

### Right to Pee Campaign

This campaign was initiated by CORO in city of Mumbai in May 2011 to demand adequate public toilets for women. Innovative methods, community actions and surveys were carried out to highlight complete apathy about this basic need of women.

#### Impact:

Changes in policy making and budget provisions for gender equitable sanitation are as follows:

- The very first Municipal Corporation of Greater Mumbai budgetary provision for special women's toilets/urinals – 75 lakh in 2013-14, 100 lakh in 2014-15 and 525 lakh in 2015-16.
- The inclusion of a separate chapter on Right to Pee in the Maharashtra State Women Policy 2015 and the provision for reserved toilets for women in the Urban Planning document of the MMR region.
- Overall number of available toilets has increased and the ratio of toilets for women to that of men has increased too.

<sup>10</sup> <http://www.safedelhi.in/sites/default/files/reports/Strategic%20Framework%20.pdf>

### Good Practice 3

#### Employing women and trans persons in Kochi Metro

Kochi Rail Limited decided to partner with Kudumbashree – a poverty eradication and women’s empowerment programme mission implemented by the Kerala State government to employ women and transpersons. The job notifications attracted about 40,000 women applicants. Kochi Rail Limited started operations in 2018 and currently employs 682 women and 12 transpersons as employees in the metro.

#### Impact:

Jobs in house-keeping, ticketing, crowd management, customer relations and gardening were created in every metro station. Another first came in the form of employment of transpersons.

### Good Practice 4

#### Pedestrianisation Initiative, Karol Bagh, Delhi

With an attempt to control congestion in the over-populated area of Karol Bagh in Central Delhi, a stretch of Ajmal Khan Road was pedestrianised as a pilot project of the New Delhi Municipal Corporation (NDMC) in early May, 2019. Street lamps were erected to keep the road well-lit and pedestrian walkways were paved on both sides of the road. This project allows pedestrians – including shoppers and visitors at the market- to walk along the central stretch of the area which has been converted into a strictly non-motorized vehicle zone.

#### Impact:

This initiative has had some positive impacts on women’s mobility and sense of security. One suggestion can be that it needs to develop further so that street vendors gain advantage as well.

### Good Practice 5

#### Parivartan - Slum Networking Programme, Ahmedabad, Gujarat

In 1995, Ahmedabad Municipal Corporation (AMC) initiated a unique partnership with local NGOs and the private sector to provide a package of basic infrastructure services in an affordable and sustainable manner to city slums, including water and sanitation facilities, paving of internal roads, street lights and secure land tenure for 10 years.

#### Impact:

- By 2005, this programme had benefitted 41 slums with 8703 families and 43, 515 people.
- Greater engagement of NGOs and community representatives with civic administration created a sense of legitimacy among some residents of the programme areas and increased women’s confidence, making them feel more empowered.
- Provision of basic infrastructure, in particular, water, sanitation and paved roads improved the quality of life of residents, especially that of women - their psychological well-being and community relationships.

## **Non-Negotiables for Policy and Practice**

1. Collect and analyze disaggregated data on gender and its intersections (caste, class, disability, regional focus, worker categories, trans\*, etc.)
2. Make Gender Equality and Social Inclusion (GESI) action plan integral to all policies and programmes.
3. Ensure accountability systems and mechanisms for effective implementation.
4. Ensure that monitoring and evaluation of schemes and programmes is undertaken so as to have an evidence base for what works and identify gaps. The need for gender indicators across all SDG goals is imperative.
5. Ensure adequate central and state financing for gender equality measures.
6. Mobilize communities through an accountability mechanism and participatory and action learning groups. Community-based monitoring and social audits to be part of all government policies.
7. Consistent partnership of Niti Aayog and UN agencies with women's organisations to follow up the consultation with periodic and sustained dialogues.



# Annexure



UNITED NATIONS  
INDIA



WADA NA  
TODO

**AGENDA**

National Consultation on Gender and SDGs

Anchor Organization: Jagori

Co-Organizers: AIWC, Azad Foundation, Bebaak Collective, Nazariya QFRG, NCDHR, NEN, NNSW, Sahaj

2nd-3rd February 2020

We the People Hall, UN House, 55 Lodhi Estate, New Delhi



सत्यमेव जयते

नीति आयोग  
National Institution for Transforming India



Azad  
Foundation



N a z a r i y a  
A Queer Feminist Resource Group



NEN  
National Network of Non-SW



Sahaj  
towards alternatives in health and development



30 Years  
1990-2020

## Day 1

Theme	Presenters	Time
<b>Registration</b>		8.45 - 9.30 am
Inaugural Session Facilitated by: Jayashree Velankar (Jagori)	Vidya Warrior (Niti Ayog), Nishtha Satyam (UN Women), Annie Namala (WNTA), Kalpana Viswanath (Chair, Jagori)	9.30 - 10.10 am
<b>Tea Break</b>		10.10 - 10.30 am
<b>Session 1: SDG 5-Gender Equality</b> Moderated by: Suneeta Dhar (Senior Advisor, Jagori)		
Discrimination	Vasavi Kiro, Ruth Manorama (NAWO), Shampa Sengupta (Sruti Disability Rights Centre), Ritambhara Mehta (Nazariya QFRG), Aarthi Pai (NNSW), Rachana Mudraboyina, Radha Raghwal (National Forum for Single Women's Rights), Hasina Khan (Bebaak)	10.30 am - 1.00 pm
Dalit women and budgets	Beena Pallikal (NCDHR)	
Forced and Early marriage and Harmful practices (FGM)	Neeta Hardikar (ANANDI), Shama Abbasi (We Speak Out)	
Violence – Domestic, Public, Trafficking	Meera Velayudhan, Pooja (Srijan), Nilanju Dutta (NEN), Jagori, Testimonies: 1) Woman from Nomadic Tribe-Pardhi (Maharashtra), 2) Ayesha (NNSW, Delhi)	
Leadership and Decision making	Mamta Kujur (Adivasi Mahila Mahasangh), Bhim Raskar (Mahila Raj Satta Andolan), Helam Haokip (IRMA), Neelam Chaturvedi (Sakhi Kendra)	
<b>Lunch</b>	Testimony: Woman Sarpanch (Maharashtra)	1.00 - 1.45 pm

<b>Session 1: Continues</b>			
Unpaid care work	Amrita Gupta (Azad Foundation)		1.45 - 2.45 pm
Equal rights to economic resources	Ranjani Murthy, Soma KP (MAKAAM)		
Enabling Technology	Safetipin		
Policies and enforceable legislations	Sabina Martins (Bailancho Saad), Renu Mishra (AALJ), Bharat (Vishakha)		
<b>Session 2: SDG 11-Make Cities inclusive, safe, resilient and sustainable</b>			
Moderated by: Sonal Shah (Urban Catalysts)			
Housing and Urban planning	Neera Adarkar		2.45 - 4 pm
Transport, Disabilities	Sonal Shah (Urban Catalysts), Anjali Agarwal (Samarthyam)		
Disasters	Dr. Nirjala (Sakhi)		
Basic Services (Right to Pee Campaign)	Supriya Jaan (CORO)		
<b>Tea Break</b>			4 - 4.30 pm
<b>Session 3: SDG 3-Ensure healthy lives and promote wellbeing for all at all ages</b>			
Moderated by: Renu Khanna (Sahaj)			
Maternal mortality ratio, reduce neo-natal, preventable deaths of new- borns	Dr. Vandana Prasad (PHRS), Renu Khanna (Sahaj) Shubhada Deshmukh (Amhi Aamchya Aarogyasathi)		4.30 - 6 pm
Universal access to sexual health and reproductive rights, services and national strategies	Pallavi Patel (Chetna), Dr. Sana Contractor, Sandhya Gautam (NAMHHR) Testimony: Maternity benefits (UP)		
<b>Day 2</b>			
<b>Session 3: SDG 3-Ensure healthy lives and promote wellbeing for all at all ages Continues</b>			
Moderated by: Devaki Nambiar (The George Institute for Global Health)			
Universal health coverage, death and illnesses from hazardous chemicals and air, water and soil pollution and contamination	Amulya Nidhi (Silicosis Pudit Sangh & JSA) Testimony: Woman Survivor of Silicosis (MP)		9.20 - 11.20 am
Communicable and Non - communicable diseases	Bijayalaxmi Rautaray (Sahayog, Odisha) Dr. Anand Krishnan (AIIMS, New Delhi)		
Access to Safe, Effective, Quality and Affordable and Essential Medicines	Chhaya Pachauli (Prayas)		
<b>Tea Break</b>			11.20 - 11.45 am
<b>Report and Vote of Thanks</b>			11.45 am - 1 pm
Moderated by – Aarthi Pai (NNSW, Sangram, VAMP)			
<b>Lunch</b>			1 - 2 pm

<b>Participant Organisations/Networks and States</b>	
<b>45 Organizations/Networks</b>	
Association for Advocacy and Legal Initiatives (AALI)	National Network of Sex Workers (NNSW)
Adivasi Mahila Mahasangh	Public Health Resource Network (PHRN)
All India Institute Of Medical Sciences (AIIMS)	Prayas
All India Women's Conference (AIWC)	Safetipin
Amhi Aamchya Aarogyasathi	Sahaj
ANANDI	Sakhi Women's Resource Centre
Azad Foundation	Sakhi Kendra
Bailancho Saad	Samarthyam
Bebaak Collective	Sangram
Centre for Health, Education, Training and Nutrition Awareness (CHETNA)	Silicosis Peedit Sangh
Committee of Resource Organisation (CORO)	Srijan Foundation
Integrated Rural Management Association (IRMA)	Sruti Disability Rights Centre
Jagori	Sahayog Odisha
Jan Swasthya Abhiyan (JSA)	The George Institute for Global Health
Mahila Raj Satta Andolan	The Urban Catalysts
Mahila Kisan Adhikar Manch (MAKAAM)	UNICEF
National Forum for Single Women's Rights	UN Women
Nazariya Queer Feminist Resource Group	UN Nations Resident Coordinators (UNRC)
National Alliance of Women's Organizations (NAWO)	Veshya Anyay mukti Parishad (VAMP)
National Campaign on Dalit Human Rights (NCDHR)	Vishakha
Niti Aayog	Wada Na Todo Abhiyan (WNTA)
North East Network (NEN)	We Speak Out
National Alliance of Maternal Health and Human Rights (NAMHHR)	

<b>20 States</b>	
Andhra Pradesh	Karnataka
Assam	Kerala
Bihar	Madhya Pradesh
Chhattisgarh	Maharashtra
Delhi	Manipur
Goa	Odisha
Gujarat	Tamil Nadu
Haryana	Telangana
Himachal Pradesh	Uttar Pradesh
Jharkhand	West Bengal

<b>SDG Targets</b>	
<b>SDG-5</b>	
<b>5.1</b> End all forms of discrimination against all women and girls everywhere	<b>5.2</b> Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
<b>5.3</b> Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation	<b>5.4</b> Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate
<b>5.5</b> Ensure women’s full and effective participation and equal opportunities for leadership at all levels of decision making in political, economic and public life	<b>5.6</b> Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences
<b>5.a</b> Undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources, in accordance with national laws	<b>5.b</b> Enhance the use of enabling technology, in particular information and communications technology, to promote the empowerment of women
<b>5.c</b> Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels	
<b>SDG-3</b>	
<b>3.1</b> Reduce the number of mothers who die giving birth to their children.	<b>3.2</b> Reduce deaths of newborns and children under five years old.
<b>3.3</b> End epidemics such as HIV/AIDS, TB, Malaria and other diseases such as hepatitis or waterborne diseases.	<b>3.4</b> Reduce deaths due to premature mortality from non-communicable diseases
<b>3.5</b> Strengthen prevention and treatment of substance abuse	<b>3.6</b> Halve deaths and injuries from road traffic accidents.
<b>3.7</b> Ensure universal access to family planning, sex education and reproductive health services.	<b>3.8</b> Ensure that everyone enjoys the right to health, which includes high quality medical care, and accessible and economical medicines and vaccines – achieve universal health coverage

<p><b>3.9</b> Reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination.</p>	<p><b>3a.</b> Strengthen implementation of the WHO Framework Convention on Tobacco Control</p>
<p><b>3b.</b> Support R&amp;D of vaccines and medicines</p>	<p><b>3c.</b> Increase Health Care Financing and better HRH management</p>
<p><b>3d.</b> Strengthen early warning and risk reduction</p>	
<p><b>SDG-11</b></p>	
<p><b>11.1</b> Ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums</p>	<p><b>11.2</b> Provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons</p>
<p><b>11.3</b> Enhance inclusive and sustainable urbanization and capacity for participatory, integrated and sustainable human settlement planning and management in all countries</p>	<p><b>11.4</b> Strengthen efforts to protect and safeguard the world's cultural and natural heritage</p>
<p><b>11.5</b> Significantly reduce the number of deaths and the number of people affected and substantially decrease the direct economic losses relative to global gross domestic product caused by disasters, including water-related disasters, with a focus on protecting the poor and people in vulnerable situations</p>	<p><b>11.6</b> Reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management</p>
<p><b>11.7</b> Provide universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities</p>	<p><b>11.a.</b> Support positive economic, social and environmental links between urban, peri-urban and rural areas by strengthening national and regional development planning</p>
<p><b>11.b.</b> Substantially increase the number of cities and human settlements adopting and implementing integrated policies and plans towards inclusion, resource efficiency, mitigation and adaptation to climate change, resilience to disasters, and develop and implement, in line with the Sendai Framework for Disaster Risk Reduction 2015-2030, holistic disaster risk management at all levels</p>	<p><b>11.c.</b> Support least developed countries, including through financial and technical assistance, in building sustainable and resilient buildings utilizing local materials</p>

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