INTERSECTING GENDER, CASTE, AND RELIGION SHAPES ACCESS TO CHILD WELFARE PROGRAMS

Aayush Khadka[1] & Ajay Kumar Yadav[2]

ABSTRACT

While the child welfare system in India has multiple programmes covering nutrition, education, protection and social security, access to these programmes is significantly unequal according to gender, caste, and religious factors. The study explores why some communities continue to be systematically excluded from welfare benefits despite constitutional protection, inclusive policy initiatives and decades of welfare growth. This article employs a critical intersectional analytical approach for exploring how social, cultural and other overlapping identities — of a girl child from a Scheduled Caste or Scheduled Tribe, of Muslim and other minorities, of nomadic and of stigmatised groups — contribute to vulnerability and develop compounded barriers to accessing welfare support. What remains the underlying problem still is a huge disconnect between policy and practice, combined with pervasive institutional bias, discriminatory social norms, barriers to documentation and local level digital inequalities that further compound the geographic marginalization, these all act as structural barriers to equitable delivery.

Keywords: intersectionality; gender; caste; religion; child welfare schemes; systematic exclusion; structural inequality; policy implementation; India.

[1] B.B.A., LLB 5th year, Ramaiah College of Law.
[2] B.A., LLB 5th year, Ramaiah College of Law.

Research Questions:

1. How do gender, caste, and religion intersect in relation to access to the major child welfare schemes in India?

2. What are the socio-cultural, economic and institutional mechanisms that contribute to ongoing exclusion from welfare benefits?

3. How do exclusion patterns differ for certain schemes and states, and different marginalized communities?

4. What are some needed reforms to an intersectional and equitable welfare delivery model?

Research Methodology:

Study is qualitative research alongside policy analysis and secondary data review. An empirical base is provided by government reports, NFHS data, reports of parliamentary standing committees, and NGO reports. Case-based evidence is used to illustrate examples of lived exclusion, derived from such research in SC/ST communities, minority households, and marginalized rural settlements. The approach therefore intersects the intersectional analysis of the issue to make visible those layers of disadvantage from which is layered by how gender integrates with that of caste and religion. Finally, the paper concludes with recommendations for intersectional budgeting, decentralised monitoring, community social audits and higher levels of representation of marginalised groups in policy-making.

1. Introduction

The child welfare system in India represents one of the world's most extensive social protection infrastructures, with multiple programmes covering nutrition, education, health, protection, and social security. Despite constitutional guarantees of equality, inclusive policy initiatives, and decades of welfare expansion, [3]access to these programmes remains profoundly unequal across demographic groups. [4]Systematic exclusion persists along the intersecting axes of gender, caste, and religion, creating compounded disadvantages for children from historically marginalised communities. This article employs a critical intersectional analytical approach to examine how overlapping social identities—of a girl child from a Scheduled Caste or

[3] Ministry of Statistics and Programme Implementation, 'Release of Publication "Children in India 2025"' (Press Release, 25 September 2025).
[4] S Bora, 'When social identities intersect: understanding inequities in growth outcomes by religion-caste and religion-tribe as intersecting strata of social hierarchy for Muslim and Hindu children in India' (2023) 22 *International Journal for Equity in Health* 115.

Scheduled Tribe, of Muslim and other religious minorities, of nomadic and stigmatised groups—contribute to vulnerability and create [5]compounded barriers to accessing welfare support.

Recent statistics come from the 'Children in India 2025' report of the Ministry of Statistics and Programme Implementation, highlighting concrete progress across multiple childcare indicators at the national level, the decline in Infant Mortality Rate (from 44 in 2011 to 25 in 2023) with regards to the dropout rate from school (13.8 from 2022-23 to 8.2 by 2024-25). Yet, these overall gains disguise continued disadvantage along social and economic lines. Although education enrolment is now gender parity at national level, deeply rooted gender stereotypical social norm still impacts career and work opportunities in the same report. Likewise, under-five mortality rates at the national level are improved (29 in 2023) although there are substantial rural-urban disparities (33 in rural areas versus 20 in urban areas). At the heart of this discrepancy is an underlying gap between policy intentions at an institutional level, embedded in systemic biases, socialised norms, documentation limitations, and local digital inequities that exacerbate geographical marginalisation. All these factors in combination create structural barriers to equitable service delivery. This article addresses this by addressing four key research questions: (1) How do gender, caste and religion intersect in relation to access to largescale child welfare schemes in India? (2) What institutional, socio-cultural, and economic measures keep the exclusion from welfare benefits going? (3) How do patterns of exclusion differ within schemes, states and marginalised communities? (4) What reforms are needed to create an intersectional and equitable welfare delivery model? This review provides an empirical basis to understand and understand intersectional exclusion in child welfare through qualitative research supplemented by policy analysis and secondary data review. It uses government reports, information sourced from the National Family Health Survey (NFHS), parliamentary standing committee reports and NGO documentation, supplemented by case-based evidence of lived experiences of exclusion, among Scheduled Caste/Scheduled Tribe communities, minority households and marginalised rural settlements. The analysis exposes the multifaceted disadvantage created by intersections of gender, caste and religion, concluding with calls for the design of intersectionally conscious budgets, decentralised monitoring, community social audits and greater participation by marginalised groups in policy-making.

[5] SK Mohanty, 'Intersection of class, caste, gender and unmet healthcare need in India' (2021) 2 *Health Policy Open* 100040.

2. Theoretical Framework: Intersectionality in the Indian Context

As a theoretical framework, intersectionality suggests that systems of oppression and privilege - such as patriarchy, casteism and religious majoritarianism - don't just operate independently, they intersect and create quite different experiences of disadvantage and opportunity. Originally formulated by Kimberlé Crenshaw to define the compounded experience of discrimination against Black women in the United States, the framework is particularly applicable in our Indian setting, characterized by social stratification in many overlapping fictions. It aims to use intersectionality to make critical inquiries into gender, caste, and religion in access to child welfare provision beyond traditional social inequality analyses. Caste-based hierarchy in India is a unique and foundational system of social stratification that intersects with other identity markers. As studies on health disparities show, "minority social status based on religion, caste and tribal group affiliations, are typically viewed as distinct dimensions of inequities in India. This obscures relative advantages and disadvantages at the crossroads of religion-caste and religion-tribal group affiliations." An intersectional approach reveals that children living intersecting marginal lives experience multiple set of obstacles that cannot be examined by studying caste, gender or religion in isolation. For example, the experiences of a Muslim girl from a Scheduled Caste background are qualitatively different from those of a Muslim boy or a Hindu Scheduled Caste girl. The theoretical framework followed in this analysis is rooted in [6]public health applications of intersectionality, which "underline how interrelated social system stratifications shape comparative access to material resources and social privilege, which are linked to distributionary regimes of population health." It is this approach that explains why children with a combination of disadvantage such as female, Dalit, and Muslim groups usually confront a series of obstacles in accessing public services, whereas children with multiple privileges such as male, upper caste, or Hindu are more likely to have access mediated. Current study on access to healthcare in particular supports this perspective: "economic class is critical to unmet needs, with gender and caste serving an auxiliary role." Economic status however, combined with caste and gender, expands disparities in access to health care." This infers that although economic disadvantage is a barrier, it is aggravated by social identity-based discrimination. On the other hand, gender and caste discrimination among medico-social workers has also been explored, and the study of health profession discrimination showed that "gender discrimination and inequality are exacerbated amongst low-caste doctors," showing

[6] Ministry of Social Justice and Empowerment, 'Social Audit' (Government of India, 2020) https://socialjustice.gov.in/social-audit/about-us-social-audit accessed 28 November 2025.

"the 'intersectionality' between gender and caste results in increasing gender inequality among health professionals in India." This theoretical lens serves to elucidate the multi-dimensional operations of structural inequality within the Indian child welfare framework. It transcends additive models of disadvantage (where a Dalit child's marginalisation is essentially compounded by that of a female child) to uncover how diverse systems of power work together to produce particular dimensions of exclusion and privilege. Considering the connections between intersectionality, AA (affirmative action), and underrepresentation, the framework can also inform better policy responses by not only treating the issue at the structural level but also not just the symptoms.

3. Literature Review: Intersecting Identities and Welfare Exclusion

A growing body of scholarship examines the relationship between social identity and access to public services in India, though literature specifically addressing the intersection of gender, caste, and religion in child welfare remains limited. Existing research tends to examine these identity dimensions in isolation, failing to capture the complex realities of children experiencing multiple forms of marginalisation. This section reviews relevant literature across three domains: caste-based disparities, gender discrimination, and religious minority exclusion in child welfare outcomes.

3.1 Caste, Tribe, and Child Development Outcomes

It has been repeatedly reported by researchers that there are large caste-based differences in child development variables. [7]A detailed review of NFHS data over a span of three decades (30 years) indicates that "predicted prevalence of stunting among different subgroups" reveals clear hierarchies, including Hindu Scheduled Tribe children with 40.6% and Hindu Other (forward) caste children with 34.7%. These inequities continue to exist after economic effects are controlled for, indicating that discrimination based on caste is the direct independent variable in determining child welfare. The same study finds that "over the last three decades, Muslims always had a higher prevalence of stunting than Hindus across caste groups," but it continues that this disadvantage "doubled for the most advantaged castes (Others) and reduced for OBCs." For tribal communities (Scheduled Tribes) geographical isolation, combined with historical marginalisation, produces particularly severe barriers to the uptake of help. The

[7] 'Despite poverty gains, 206 million Indian children lack access to education, health or nutrition: UNICEF' *The New Indian Express* (20 November 2025) https://www.newindianexpress.com/lifestyle/health/2025/Nov/20/despite-poverty-gains-206-million-indian-children-lack-access-to-education-health-or-nutrition-unicef accessed 28 November 2025.

literature indicates that tribal children suffer from "double burden" of poor developmental outcomes and limited-service provision — however, the impact varies greatly across states and tribal groups. The tribal health literature reports that "Muslim tribes primarily live in Jammu and Kashmir; and in Maharashtra and Lakshadweep," but such unique living experiences are often overlooked in mainstream policy analysis.

3.2 Disparities in Child Welfare Access

In child welfare gender discrimination is seen on different scales, across territories, among different communities and across service sectors. The report "Children in India 2025" notes that there has been "gender parity in education enrolment across all the stages" with a "Gender Parity Index of 1.1 at the secondary level", but it "acknowledges that gender inequality in access to education affects career prospects and equality in work opportunities". It implies that even if you have equal formal access, real equality is not achieved. [8]Research on the relationship of gender and caste is layered. Studies on healthcare accessibility have shown, "economic and gender disadvantages in unmet need are more among male than female" which challenges some simplistic narrative of equal gender discrimination against girls. Yet, a number of reports find continued son preference in terms of nutrition, health and education spending, particularly in the northern Indian jurisdictions. Notably, the observation that female children are adopted more often than male children (2,336 versus 1,819 in 2024-25) "possibly indicates gender preference", although the direction of this preference might run counter to mainstream concepts about son preference.

3.3 Religious Minority Status and Exclusion

There exist diverse scale, territory, community and sectoral issues of gender discrimination in child welfare practices. In its report "Children in India 2025" the report points out there has been "gender parity in education enrolment across all the stages" while also "a Gender Parity Index of 1.1 at the secondary level" but it "acknowledges that gender inequality in access to education affects career prospects and equality in work opportunities". That means that you do not get actual equality, even if you have equal formal access. Research on interplay of gender and caste is complex. It could be said, studies on the accessibility of healthcare were also found to indicate, "economic and gender disadvantages in unmet need are more among male than female" This refutes a linear narrative that women face the same gender discrimination than

[8] Z Li, 'Gender inequality and caste: Field experimental evidence from India' (2021) 296 *Journal of Economic Behavior & Organization* 60.

men which cannot explain why. However, several reports find that son preference is still present in nutrition, health and education spending, especially in the northern Indian jurisdictions. We observe, critically, that female children are adopted at rates greater than that of male children (2,336 versus 1,819 in 2024-25) "possibly indicates gender preference", although the nature of this preference may conflict with mainstream norms concerning son preference.

3.4 Research Gaps

While such valuable insights exist, many gaps in knowledge remain in the literature. First, most studies examine identity dimensions in isolation, failing to capture the intersectional nature of disadvantage. Second, little is known about the extent to which structural barriers operate across different welfare schemes and regional contexts. Third, there is insufficient examination of how digital governance initiatives and documentation requirements create novel forms of exclusion for multiply-marginalised children. This research aims to address these gaps through a systematic intersectional analysis of child welfare access in India.

4. Research Methodology

This study is qualitative research carried out and complemented by policy analysis and secondary data analysis to investigate the intersectional barriers that affect access to child welfare schemes in India. A methodology informed by the theory of intersectionality research: the authors acknowledge that in order to understand systems of marginalisation, it is important to account for the lived experiences of individuals living at the intersections of these systems, yet also to examine the structural influences on these experiences. We study the empirical foundation of this through comprehensive analyses of governmental documents like the Children in [9]India 2025 document issued by the Ministry of Statistics and Program Implementation, data from the National Family Health Survey (NFHS) across multiple rounds, reports from parliamentary standing committees, and research reports published by reputable non-government organizations (NGOs). These sources cover quantitative data on equity in welfare outcomes, as well as qualitative insights regarding implementation challenges. These examples of lived exclusion are illustrated by drawing upon case-based evidence synthesized from existing research on Scheduled Caste/Scheduled Tribe communities, religious minority households and marginalised rural settlements. This evidence contributes to provide empirical support of the structural analysis through grounded examples of children and families with

[9] Ministry of Health and Family Welfare, 'India witnesses a steady downward trend in maternal and child mortality towards achievement of SDG 2030 targets' (Press Release, 10 May 2025).

multiple forms of marginalisation. The methodological approach "intersects the intersectional analysis of the issue to make visible those layers of disadvantage from which is layered by how gender integrates with that of caste and religion". The analytical steps are several. Initially, they will analyse policy documentation for child welfare schemes from major organizations to identify potential barriers to inclusion and implementation gaps. Second, disaggregated data on scheme access and outcomes are compared across states and social categories to unearth patterns of exclusion. Third, qualitative evidence from previous case studies is integrated to examine modes of exclusion. Comparison, among schemes, states, and communities, finally is employed to discern differential exclusion patterns and the determinants underlying them. There are some methodological shortcomings introduced by the study. Reliance on secondary sources may limit insights into experiences of exclusion lived with exclusion. Furthermore, the inconsistent categorisation of social identities across data sources hampers intersectional analysis. For example, "historical censuses conducted under colonially administered India of 1901, 1911, 1921 and 1931, where data on castes among Muslims were routinely collected" challenge modern practices which might lack to properly cover the conflation of religion and caste. Its methodological limitations notwithstanding, the methodology thus offers a more expansive comprehension of intersectional exclusion in child welfare in India.

5. Intersectional Barriers to Accessing Child Welfare Schemes

5.1 Compounded Disadvantages in Health and Nutrition

The intersection of gender, caste and religion results in distinct patterns of disadvantage in access to health and nutrition schemes. Further evidence from [10]NFHS data indicates that there are distinct intersecting gradients in stunting prevalence predicted, with Hindu Other (forward) caste children experiencing 34.7% rates, Muslim Other caste children 39.2% rates, Hindu Scheduled Caste children 39.5%, and Hindu Scheduled Tribe children 40.6%. These differences illustrate the ways in which caste privilege moderates the impact of religious minority status, noting that Muslim forward caste children suffer worse outcomes than Hindu forward caste children and better outcomes than Hindu Scheduled Caste children. Interestingly, according to the data, "disadvantages from a socially underprivileged religious identity appeared to trump relative social advantages of forward caste identity for Muslim children."

[10] Institute of Development Studies, 'Disability, religion, and caste: intersecting inequalities in India' (CREID, 2021)
https://www.ids.ac.uk/opinions/disability-religion-and-caste-intersecting-inequalities-in-india/ accessed 28 November 2025.

The finding calls into question simplistic assumptions about caste hierarchy and suggests that religious discrimination can be on some occasions more powerful than caste privilege in determining child welfare outcomes. Likewise, the reverse of Muslim disadvantage with Scheduled castes (as evidenced by the lower stunting rates of Muslim SCs than Hindu SCs) implicates an intricate interplay between religious and caste identities. This should be followed up.

Table 1: Intersectional Disparities in Child Stunting Prevalence (Selected Groups)

Social Group	Stunting Prevalence (%)	Relative Disadvantage
Hindu Other (Forward) Caste	34.7	Reference group
Muslim Other Caste	39.2	+4.5 percentage points
Hindu OBC	38.2	+3.5 percentage points
Muslim OBC	39.6	+4.9 percentage points
Hindu SC	39.5	+4.8 percentage points
Muslim SC	38.5	+3.8 percentage points
Hindu ST	40.6	+5.9 percentage points
Muslim ST	39.7	+5.0 percentage points

Source: Adapted from intersectional analysis of NFHS data

5.2 Institutional Bias and Discrimination in Service Delivery

Bias of wider institutions is a substantial barrier to equal access to child welfare programs. The availability of healthcare research suggests that "acceptability barriers amount to major share of unmet need and disproportionally higher among poor". Social identity-based discrimination includes social acceptance barriers such as differential treatment by service providers based on identity. [11]Field experimental evidence based on patient's preferences on doctors shows how "patients statistically discriminate doctors by gender" and that, "caste quotas for college seats

[11] K Saravana, 'Social welfare policies in India' (SlideShare, 5 May 2019) https://www.slideshare.net/slideshow/social-welfare-policies-in-india/126250343 accessed 28 November 2025.

increase gender discrimination of low-caste doctors," indicating that a multiple intersectional discrimination operates at the institutional, and social level. Child welfare schemes are additionally hampered by a bureaucratic process that implicitly favours dominant social groups. Research has shown that frontline workers frequently demonstrate class-related, caste-related and religion-related biases in sharing information, promoting programs and determining eligibility. This is especially harmful for children, who occupy multiple marginalised identities, experiencing compounded discrimination at every step along the service access pathway. Research on disability services reveals that "people with disabilities experience marginalisation and discrimination due to both attitudinal and physical barriers", with these barriers magnified for those from religious minority and Scheduled Caste backgrounds.

5.3 Documentation Barriers and Digital Exclusion

There is a significant level of documentation for accessing welfare schemes which becomes a major barrier for marginalised communities. Children belonging to Scheduled Caste, Scheduled Tribe, and religious minorities are extremely vulnerable to missing birth certificates, caste certificates, Aadhaar cards and other documents required for scheme enrolment. This systemic [12]bureaucratic exclusion is exacerbated by the growing digitisation of welfare services, creating new types of marginalisation for communities that lack digital literacy and access. Digital inequality is interwoven with social inequalities, producing multiple disadvantage. Children from low-digital-savvy communities – whether in rural tribal settings or communities that are Muslim-majority and have poor internet infrastructure – face exclusion from digitally delivered welfare services. This issue becomes especially pressing for schemes which have transitioned to fully digital application methods without sufficient recognition of the digital capabilities of the most marginalised. One study of social protection programs shows that inclusion requires “identifying the most vulnerable group who are in need for healthcare and the required policy response”.

5.4 Socio-cultural Norms and Intra-household Discrimination

An intra-household distribution of resources frequently mirrors socio-economic hierarchies on the basis of gender, birth order, and perceived ability. Son preference affects nutritional investments, medical expenses, and educational opportunities in many communities,

[12] Inclusion Economics, ‘Using Community-led Audits to Improve Social Protection in India’ (Yale University, 2021)
https://egc.yale.edu/using-community-led-audits-improve-social-protection-india accessed 28 November 2025.

particularly in northern India. These gendered inequalities intersect with caste and religion in complex ways. Economic and gender disadvantages in unmet need are more among males than females, implying that simple narratives of uniform discrimination against girls require nuancing. Social norms surrounding female mobility and purdah practices have a particularly negative impact on adolescent girls from Muslim and conservative upper-caste Hindu families, restricting their opportunities for attendance in schools, health facilities, and other public places where welfare services are provided. Similarly, caste-imposed constraints on the use of public spaces continue to affect Dalit and Tribal children's access to services situated in dominant-caste areas. These elements of exclusion have spatial dimensions and intersect with other identity-based barriers to generate specific patterns of disadvantage for children at specific intersections of gender, caste, and religion.

6. Towards an Intersectional Welfare Delivery Framework: Policy Reforms

The distribution of resources within households both reflects and reinforces social hierarchies based on gender, birth order, and perceived ability. In many communities, especially northern India, son preference continues to influence nutritional investments, healthcare expenditures, and educational opportunities. Here gendered discrepancies also intersect with caste and religion in complex ways. Research indicates that "economic and gender disadvantages in unmet need are more among male than female," suggesting that simple narratives of uniform discrimination against girls require nuancing. Social norms related to female mobility and purdah practices impact adolescent girls from Muslim and conservative upper-caste Hindu families harder, limiting their access to schools, health centers, and other public spaces where welfare services are delivered. Similarly, caste-based limitations on public-space use continue to prevent Dalit and Tribal children from accessing services in dominant-caste neighbourhoods. These [13]spatial dimensions of exclusion interact with other identity-based barriers to produce unique patterns of disadvantage that children who fall at particular intersections between gender, caste, and religion face as their own.

6.1 Intersectional Budgeting and Resource Allocation

Crucially, structural barriers revealed in this study are systemic, and the reform process will only be effective when welfare governance reforms are established on fundamental grounds. A key recommendation is the introduction of intersectional budgeting processes that directly

[13] PV Vart, A Jaglan and K Shafique, 'Caste-based social inequalities and childhood anaemia in India: results from the National Family Health Survey (NFHS) 2005–2006' (2015) 15 *BMC Public Health* 537.

address the layered disadvantages experienced by children at the intersections of multiple marginalised categories. This method would deploy resources on the basis of multidimensional marginalisation rather than on single-axis categories. The Government of India's recent commitments to shore up "[14]evidence-based policy based on strong child-focused data" pave the way for such reform but will need to be strengthened to address intersectional disadvantages. Intersectional budgeting must be complemented by special programming for the most marginalised subgroups. Existing strategies often present a one-size-fits-all model that does not accommodate the special barriers encountered by such groups as Muslim Scheduled Caste girls, or Tribal children from remote areas. So as one research on health disparities suggests, "monitoring child development outcomes by subgroups capturing intersectional social experiences of relative privilege and access from intersecting religion and social group identities, could guide efforts to address health disparities". Diverse, disaggregated monitoring would enable more responsive and equitable allocation of resources.

6.2 Decentralised Monitoring and Community Social Audits

Community embedded decentralized monitoring systems offer the potential to strengthen accountability and address implementation shortfalls. Social audits, considered as a democratic process that ensures public accountability of agencies through a systematic demand of information by the community, have had a potential role in identifying exclusion and corruption of welfare programs. The underlying "guiding principles for social audit" include "Access to Information (Jaankari)", "Participation (Bhagidari)", and "Protection of Citizens (Suraksha)", and they are all necessary for addressing intersectional exclusion. Recent experiments involving gender-inclusive social audits provide powerful models of reform. Studies on Bihar's women's social auditor program in the MGNREGA scheme revealed that deploying women from self-help groups as auditors improved access to monitoring and accountability and increased female awareness on their rights. Nevertheless, these same studies also found "gender-specific constraints that, if addressed, could improve retention and outcomes, including reducing payment delays, prioritizing ways for women to better balance home duties with travel requirements, and addressing security concerns," they found. Addressing these implementation challenges ensures scaleup of these participatory monitoring mechanisms.

[14] The persistent influence of caste on under-five mortality: Factors that explain the caste-based gap in high-focus Indian states' (2018) *[authors not specified]*
(Under-five mortality remains higher among SC children than non-SC/ST children from 1992–2016).

Table 2: Key Principles for Inclusive Social Auditing

Principle	Key Components	Potential Benefits
Access to Information (Jaankari)	Proactive disclosure of scheme details, eligibility criteria, and beneficiaries	Enables marginalised communities to claim entitlements
Participation (Bhagidari)	Inclusive community meetings, representation of marginalised groups in audit committees	Ensures diverse perspectives inform monitoring
Protection of Citizens (Suraksha)	Secure forums for testimony, protection against retaliation	Enables safe reporting of exclusion and corruption
Citizen's Right to Be Heard (Sunwai)	Grievance redressal mechanisms with timely response	Provides recourse when rights are violated
Collective Platform (Janta ka Manch)	Public hearings where findings are presented and discussed	Creates accountability pressure on officials
Report Dissemination (Prasar)	Wide circulation of audit findings in accessible formats	Enhances transparency and enables collective action

Source: Adapted from Social Audit guiding principles

6.3 Representation and Inclusion in Policy-Making

An inclusive approach to designing child welfare systems must include marginalised communities in policy-making bodies. Existing policy-making processes currently suffer from a significant representation gap with the voices of Scheduled Caste, Scheduled Tribe and religious minority communities—more particularly women from these groups—being consistently underrepresented. For those who face multiple exclusions, as research on intersectional discrimination documents, “no single experience is universal” and their more complex reality rarely finds its way into policy design. In the meantime, policy bodies should include representatives from the most marginalised communities, specifically women from Scheduled Caste, Scheduled Tribe and religious minority groups. Indeed, their lived experiences of [15]negotiating various inequities provide invaluable perspective for building

[15] R Raushan, SS Acharya and MR Raushan, ‘Caste and Socioeconomic Inequality in Child Health and Nutrition in India: Evidences from National Family Health Survey’ (2022) 3 *CASTE: A Global Journal on Social Exclusion* 345.

accessible welfare services. Consultatively, moreover, processes must directly engage children and adolescents from marginalised communities, whose perspectives are often entirely absent from policy discussions, even though they are the intended beneficiaries of child welfare schemes.

6.4 Addressing Legal and Structural Discrimination

To gain equitable access to child welfare, discriminatory legal systems must be reformed. Muslim children from backward caste backgrounds are subject to clearly defined discriminatory state laws because "Muslims hailing from these backward castes cannot legally be recognized as Schedule Castes and are therefore not guaranteed affirmative action policies in education and employment available to their Hindu counterparts". There are also barriers to opportunity for a significant population of Muslim children in such a constitutional anomaly, who experience both caste and religious discrimination without legal recognition or protection. Apart from the specific issues it addressed, structural inequality is addressed by enacting comprehensive anti-discrimination acts that prohibit, explicitly, intersectional discrimination in access to public services. Such laws must establish clear and strong accountability measures to tackle institutional bias in the distribution of welfare and mandate pre-emptive measures be taken to achieve equitable access for those who are more marginalised. As we come to understand in the conclusion of the research on health care access, “Eliminating the barriers to health care access therefore needs a multidimensional construct of identifying combination of attributes to be focused towards realization of universal health coverage”.

7. Conclusion

These insights have shown that intersectional studies are crucial for contextualising the ongoing exclusion of marginalised children in India’s welfare systems and addressing the underlying causes of marginalization. Gender, caste, and religion also create compounded disadvantages that may be resistant to single-axis frames, which are unique barriers. The findings show how “disadvantages from a socially underprivileged religious identity seemed to override relative social advantages of forward caste identity for Muslim children” and that “caste differences manifest more in intra-class differences” in terms of healthcare access. These intertwining systems of privilege and disadvantage require a more nuanced policy response. Structural barriers to equitable access to welfare include institutional biases, discriminatory social norms, documentation requirements, and digital inequalities that all disadvantage children situated at the intersection of multiple marginalities. Although overall advances to

child welfare indicators are positive (e.g., improved Infant Mortality Rates, reduced school dropout rates), these gains are unevenly distributed among social groups. Significant disparity persists in stunting, educational attainment, and healthcare access, which shows the limitations of current welfare delivery approaches. The proposed policy reforms outlined here – intersectional budgeting, decentralised monitoring with community social audits, increased representation in policy-making and legal reforms addressing structural discrimination.

References

1. Ministry of Statistics and Programme Implementation, 'Release of Publication "Children in India 2025"' (Press Release, 25 September 2025).
2. S Bora, 'When social identities intersect: understanding inequities in growth outcomes by religion-caste and religion-tribe as intersecting strata of social hierarchy for Muslim and Hindu children in India' (2023) 22 *International Journal for Equity in Health* 115.
3. SK Mohanty, 'Intersection of class, caste, gender and unmet healthcare need in India' (2021) 2 *Health Policy Open* 100040.
4. Ministry of Social Justice and Empowerment, 'Social Audit' (Government of India, 2020) https://socialjustice.gov.in/social-audit/about-us-social-audit accessed 28 November 2025.
5. 'Despite poverty gains, 206 million Indian children lack access to education, health or nutrition: UNICEF' *The New Indian Express* (20 November 2025) https://www.newindianexpress.com/lifestyle/health/2025/Nov/20/despite-poverty-gains-206-million-indian-children-lack-access-to-education-health-or-nutrition-unicef accessed 28 November 2025.
6. Z Li, 'Gender inequality and caste: Field experimental evidence from India' (2021) 296 *Journal of Economic Behavior & Organization* 60.
7. Ministry of Health and Family Welfare, 'India witnesses a steady downward trend in maternal and child mortality towards achievement of SDG 2030 targets' (Press Release, 10 May 2025).
8. Institute of Development Studies, 'Disability, religion, and caste: intersecting inequalities in India' (CREID, 2021) https://www.ids.ac.uk/opinions/disability-religion-and-caste-intersecting-inequalities-in-india/ accessed 28 November 2025.
9. K Saravana, 'Social welfare policies in India' (SlideShare, 5 May 2019) https://www.slideshare.net/slideshow/social-welfare-policies-in-india/126250343 accessed 28 November 2025.
10. Inclusion Economics, 'Using Community-led Audits to Improve Social Protection in India' (Yale University, 2021) https://egc.yale.edu/using-community-led-audits-improve-social-protection-india accessed 28 November 2025.
11. SK Mohanty, 'Intersection of class, caste, gender and unmet healthcare need in India' (2021) 2 *Health Policy Open* 100040.

12. The persistent influence of caste on under-five mortality: Factors that explain the caste-based gap in high-focus Indian states' (2018) [authors not specified] (Under-five mortality remains higher among SC children than non-SC/ST children from 1992–2016).
13. R Raushan, SS Acharya and MR Raushan, 'Caste and Socioeconomic Inequality in Child Health and Nutrition in India: Evidences from National Family Health Survey' (2022) 3 *CASTE: A Global Journal on Social Exclusion* 345.