Policy Brief
October 2013

MDG 5 in India: Whither reproductive and sexual rights?

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Introduction

India was the first country to have a national government supported family welfare programme beginning from 1952 and till the late 1990s, ie post ICPD, the Indian government has focused on sexual and reproductive health mainly through the population control policies (1). As a commitment towards the ICPD PoA, the Government of India introduced a number of changes in the national population and family welfare programme. Removal of method specific targets, and formulation of the National Population Policy (NPP 2000) (2) based on the principles of the ICPD and introduction of a programme dedicated to improvement of reproductive and sexual health – the Reproductive and Child Health Programme – were some of the milestones. The second phase of the Reproductive and Child Health Programme RCH II (3) – was launched in 2005 with a vision to bring about outcomes as envisioned in the Millennium Development Goals.

The major gains in the first and second phases of the Reproductive and Child Health Programme as outlined in the Project Implementation Plans, were lost because of the narrowed focus in the National Rural Health Mission (NRHM) only on reduction of the Maternal Mortality Ratio. The promises of increased gender sensitivity in health systems and health services, adolescent reproductive and health services, men's involvement in reproductive health, services for reproductive tract infections and sexually transmitted diseases at the Primary Health Centres, provision of safe abortion services, are all forgotten in the pursuit of the goal of increasing institutional deliveries to bring down the Maternal Mortality Ratio (MMR) to 109 by 2015.

In this backdrop, this policy brief is prepared with an objective of identifying gaps in the implementation of India's sexual reproductive health and rights programmes for suitable advocacy.

The Government of India response to MDG 5: Goal, Indicators

Since the original MDG Indicators were found inadequate, the revised MDG monitoring framework developed by the Inter Agency and Expert Group in 2005 included an additional goal of Universal Access to Reproductive Health, which was finally accepted in 2007 (4). The Goals and Monitoring Targets thus became (5):

Goal 5 Improve Maternal Health, and Achieve by 2015, Universal access to reproductive health

> Target 5.1 Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
> Target 5.2 Proportion of births attended by skilled health personnel

Target 5.3 Contraceptive Prevalence Rates
Target 5.4 Adolescent birth rate
Target 5.5 Antenatal coverage (at least one visit and at least four visits)
Target 5.6 Unmet need for family planning

The Government of India, however, decided to monitor only the MMR and proportion of births attended by Skilled Birth Attendants. In the overview section, the Mid Term Report of the GOI (6) states

"A revised UN framework of MDG indicators has been introduced ……. which India has not adopted for strategic and technical reasons. With problems persisting in complete harmonisation of MDG indicators, India persists with the original framework for MDG reports."

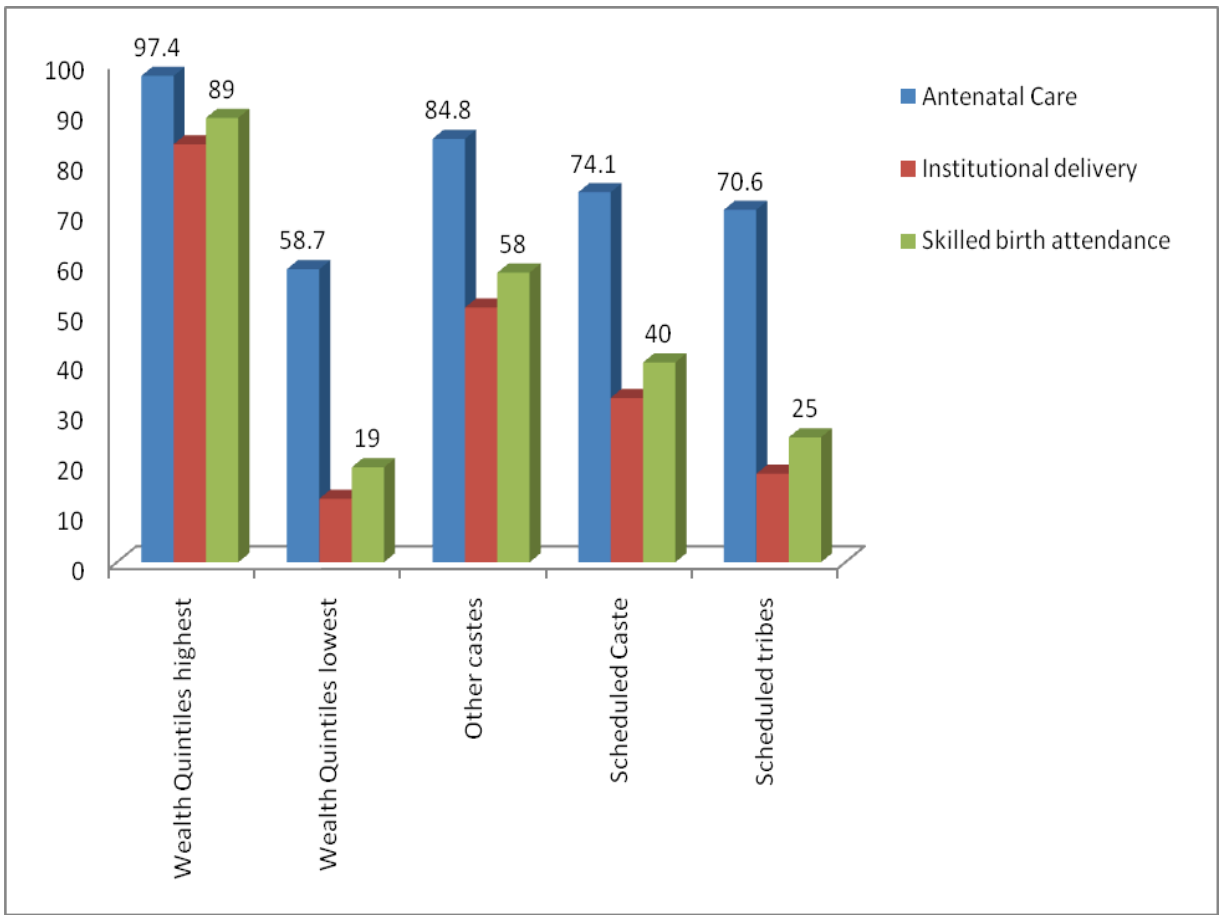
It is unclear why Contraceptive Prevalence Rate, Adolescent birth rate, ANC and unmet need for family planning have not been accepted as actionable indicators or considered 'strategic' or 'contextually relevant' for India. The argument of non availability of data related to these indicators is not tenable – the National Family Health Surveys, District Level Household Surveys yield data on these indicators (7, 8).

Maternal Health Situation in India

Antenatal and delivery care services

Despite the fact that there has been significant improvement in coverage of antenatal care coverage in the recent years, there are wide inequities. Data from the National Family Health Survey 3 (NFHS 3 2005-06) shows that women from poorer wealth quintiles and scheduled castes and tribes have poorer health indicators including in receiving antenatal care and skilled birth attendance, having an institutional delivery, and in levels of anaemia (see Figure 1) (9).

Maternal health indicators (as percentage) by wealth and caste status –NFHS- 3



Skilled Birth Attendance, Institutional Deliveries, or Safe Deliveries?

The National Family Health Survey 3 states that 47% of births in the five years preceding the survey were assisted by health personnel. 37% were assisted by a traditional birth attendant (TBA) and 16% were assisted by only friends, relatives, or other persons (9). According to the GOI, the unsatisfactory increase in skilled attendance at birth is due to poor progress in institutional deliveries (10). This equating of **institutional** deliveries with **safe** deliveries is in fact the biggest flaw in India's Maternal Health policy.

There are the various obstacles and barriers in access to and utilization of delivery care services like heavy out of pocket expenditure, combined with poor quality and accessibility issues. Despite these facts the Government continues to pursue the strategy of institutional deliveries to the exclusion of any other strategies. Under these situations, in an effort to promote institutional deliveries, the Government of India launched a conditional cash transfer scheme called the Janani Suraksha Yojana (11). The scheme gives a cash benefit – different across different states – to Below Poverty Line women who deliver in accredited private institutions. There is evidence that JSY has resulted in increasing the number of institutional deliveries (12, 13, 14). The rapid increase in institutional deliveries without adequate investments in health-system strengthening causes enormous strain on the public health system, contributing to further compromises in quality of care.

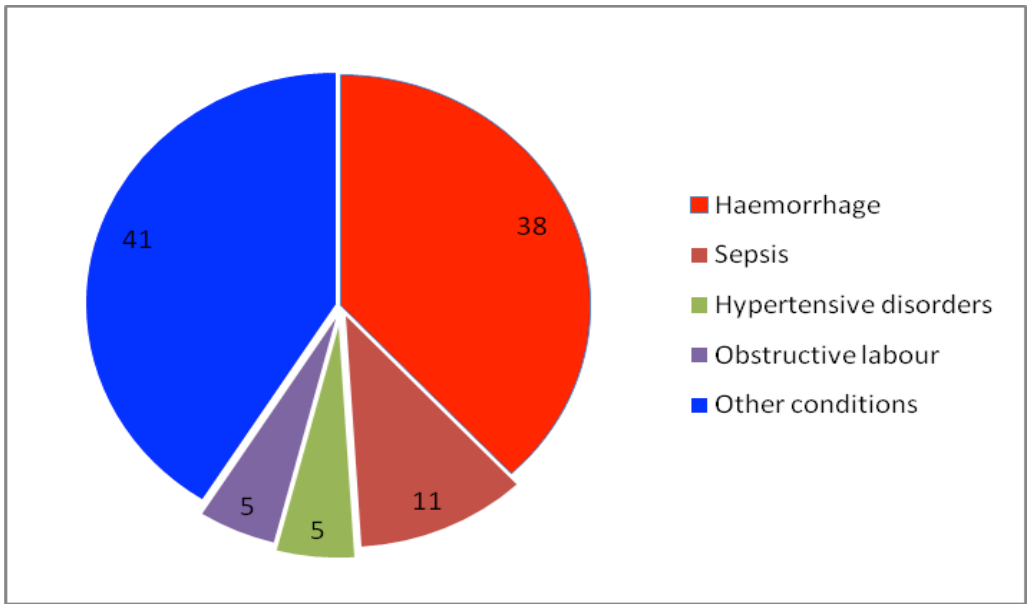
As a recent report of the UN Rapporteur on Health (12) points out,

" .. the focus in India is on increasing institutional delivery, but institutional delivery is not a proxy for access to skilled birth attendance or life saving care".

Maternal Mortality

The overall decreasing maternal mortality ratio for India as a whole again hides wide discrepancies between states and different communities in the area of maternal health. The GOI Review of the MDGs also does not look at **how** these women died. Figure 2 shows the causes of Maternal Deaths in India. While direct obstetric deaths from haemorrhage, infections and hypertensive disorders of pregnancy continue to claim a significant proportion of maternal lives, emerging evidence from recent studies points to the increasing importance of indirect causes of maternal deaths such as malaria and viral hepatitis, tuberculosis and other infectious diseases, anaemia, and in some parts of the country heart disease and gestational diabetes (15).

Causes of maternal deaths in India



India does not yet have an accurate system of collecting data on maternal deaths (14,16). Although several states have initiated maternal death audits, public declaration of annual maternal death reports with causes of deaths, profiles of women who died, and follow up action initiated by the state health systems, is done in very few states (17,18).

Universal Access to Reproductive Health

As mentioned above the GOI does not report on the revised MDG indicators for the goal of Universal Access to Reproductive Health although these are important as far as the government policy is concerned.

Contraceptive Prevalence Rates

Reducing Total Fertility Rate to 2.1 by 2012 is an important goal of the GOI – and the government acknowledges that both increase in the Contraceptive Prevalence Rate and reduction in the Unmet Need for Family Planning can contribute towards this (19). The contraceptive Prevalence Rate among currently married women is 56 percent, up from 48 percent in NFHS-2 (15). Contraceptive use in India is characterized by:

- the predominance of non-reversible methods, particularly female sterilization - 66% of all contraception use is female sterilisation (9)
- limited use of male methods – condoms 5.3%, male sterilisation 1% (9)
- high discontinuation rates among those who use temporary methods (9) and
- negligible use of contraceptives among both married and unmarried adolescents (20)

Adolescent Birth Rate

Adolescent birth rate (married women aged 15-49 years) has declined as per Sample Registration System from 76.1 in 1991 to 45.2 in 2006 (21). The NFHS 3 reports that 58% of all married women age 15-19 have experienced motherhood or a current pregnancy (15). The NFHS 3 data also shows that 16% of adolescent girls between 15 and 19 years had either had a child or were pregnant with their first child.
Sexuality education in schools - through a curriculum titled Adolescence Education Programme devised by the National AIDS Control Organisation - which was banned by 11-12 state governments in 2007, because they considered the content 'immoral', denies young men and women from making informed choices and reproductive decisions (22).

Unmet Need for Family Planning

Unmet need for family planning is an important indicator for assessing the potential demand for contraceptive services. According to NFHS 3 (15), 13% of currently married women in India have an unmet need for Family Planning. Unmet need for spacing is highest between 15 and 24 years. Unmet need for limiting is highest between 25 and 34 years (almost 20%).

According to a SEARO WHO Family Planning Fact Sheet (23), despite improved availability and access to contraceptive services, a substantial proportion of pregnancies (21% of all pregnancies that result in live births) are mistimed or unplanned.

Other Important Indicators for Universal Access to Reproductive Health

While working on women's health issues in remote areas of the country and based on available evidence, I feel that India needs several other indicators for Universal Access to Reproductive Health Care. They are;

Postnatal Care. Considering that 60% of deaths occur after delivery, only 1 in 6 women receives postnatal care (24).

Access to safe abortions: Abortion accounts for 8 % of maternal deaths. Yet access to safe abortion services is not an indicator for Universal Access to Reproductive Health.

Morbidities like Obstetric and Vesicovaginal Fistulas, Infertility and Reproductive Cancers: India lacks prevalence and incidence data on obstetric fistulae, which are contributed by obstructed labour and are a near miss maternal mortality.

Infertility: Among population groups, scheduled tribes have higher infertility rates (25). Only half the women belonging to low socio economic group used allopathic infertility treatment, probably because infertility treatment is limited or unavailable in public health sector.

Cancer screening: In 2004, Cancer Cervix was the third largest cause of cancer mortality in India. Over 70% of women report for diagnosis and treatment at advanced stages. The reasons for this are lack of access to screening and health services and lack of awareness of risk factors (26).

Nutritional status of women and girls. Anaemia and Malnutrition are not tracked as part of MDG monitoring. These are cross cutting issues between MDG 1 on Poverty and Hunger and MDG 5 on Maternal Health and are discussed below in the section on determinants of Maternal Health.

Unmet need for Reproductive Health. Ravindran and Mishra (27) suggest that the concept of unmet needs should be broadened to measure the extent to which women's reproductive intentions are met. Studies show that health services fail to meet the reproductive health needs of women. Sterilisation is often the first and only method of contraception. Women go through a series of wanted and unwanted pregnancies, induced abortions, and miscarriages and then opt for sterilization.

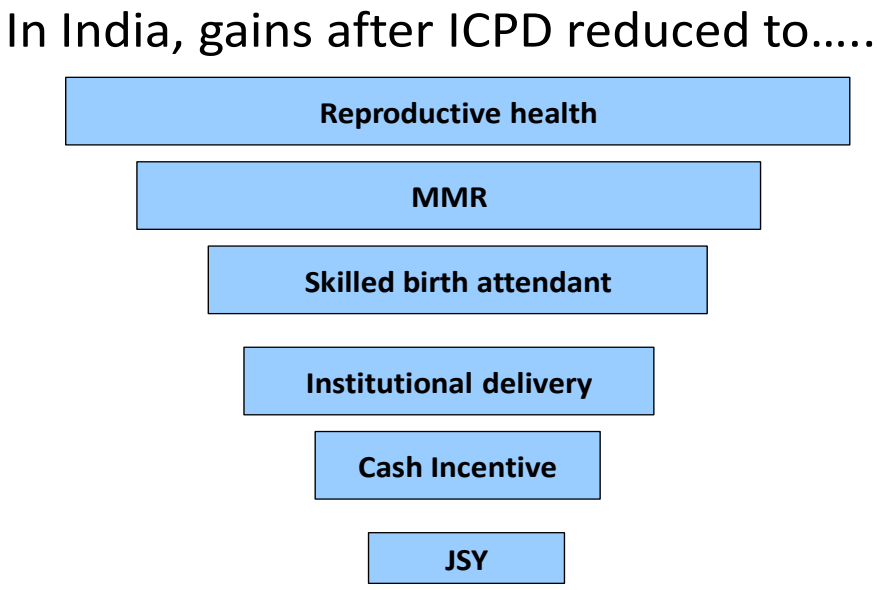
Issues around "Siloisation'

As seen from discussions above, socioeconomic status, (poverty), literacy and education, and rural–urban residence (place of residence) are all very important determinants of maternal health status. Maternal health cannot be analysed in its compartment of MDG 5. Several other MDGs have an important bearing on MDG 5.

MDG 1 on Poverty and Hunger, has serious consequences for on MDG 5. The Planning Commission notes that the incidence of income poverty amongst females tended to be marginally higher in both urban and rural areas and that there is not much improvement in women's poverty levels over the years[7] (28).

MDG 3 on Gender Equity is also intrinsically linked with Maternal Health. NFHS 3 shows that while a significant proportion of currently married women are employed, almost one in three are unable to convert such employment into financial autonomy because they do not earn cash for the work they do. Gender values and norms are deeply internalised. About half of all women and men agree with at least one or more reasons for wife beating. All these have a bearing on maternal health status (15).

MDG 6 on TB, Malaria and HIV is also related to Maternal Health. The consequences of malaria in pregnancy can be fatal. TB in pregnant women is not given a special consideration by either of the two vertical programmes – TB Control or Reproductive and Child Health. Women living with HIV face discrimination when they go to health centres for delivery. There is hardly any mention in the strategies for MDG 6 of gender dimensions of these diseases.



Conclusion and Suggestions

Although, India's health policies were somewhat progressive with respect to SRHR and after the ICPD at Cairo, became even more progressive, the main problem has been in the implementation of well conceived programmes.

The retraction from the broader SRHR agenda globally, and the siloisation of Maternal Health, Poverty and Gender Equity has had an adverse effect on India's health policies and programmes. The reductionist focus on increasing institutional deliveries in India as the main strategy for bringing down MMR, is perhaps a reflection of the global reductionist focus on MDG 5 and its very limited targets for the universal access to reproductive health services.

The health system in India has lost its focus on broader SRHR agenda of expanding the package of services - including safe abortion - through the Primary Health Centres, provision of adolescent friendly SRHR services, and promotion of gender equity, in the single minded pursuit of increasing Institutional Deliveries. Institutional deliveries are being equated with safe deliveries. But the quality of institutional deliveries in understaffed, underequipped institutions is far from satisfactory.

The MDG indicators at the global level do not reflect the realities in India. While people living below poverty line are showing a decrease in India, there is no measure of the growing inequities. Increasing poverty of the Scheduled Castes, Scheduled Tribes and women are not accounted for. Anaemia in women is not an MDG indicator, yet the reality in India shows that 55% of the women in India are anaemic and that the number of anaemic women is increasing. Universal access to reproductive health does not include indicators like cancer screening (pap smears or mammograms).

Suggestions for Ways forward

- Although fraught with complexities, there is need to bring greater match between broader SRHR issues in Cairo agenda, and the Beijing platform for Action and the post MDGs Sustainable Development agenda.

- As recommended by the independent Expert Review Group on Information and Accountability on Women's and Children's Health (29), accountability for women's health and social determinants, (including for quality) within countries for needs to be strengthened.

- Include focus on maternal morbidity. Develop standard definitions and mechanisms of reporting. Improve data on incidence and prevalence of maternal morbidities through large surveys like NFHS, DLHS, AHS. Initiate maternal morbidity audits to obtain stronger burden of disease estimates.

- The GOI needs to adapt any set indicators to suit poverty, gender/caste/other disparities and SRHR issues in the context of India.

- Linkages **between programs within a sector** need to be strengthened, as between TB, Malaria, HIV and SRH.

- The **linkages across programs of different sectors** also need strengthening, as for example, adding a nutrition and health/reproductive health component to National Rural Employment Guarantee Scheme.
- **There is a great need to ensure accountability at all levels** – including of Global Health Initiatives and provision for community monitoring, grievance redressal.

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