

COUNTRY PROFILE

ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES: INDIA



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1. Country context

India continues to be the second most populous country in the world with a population of 1210 million; 623.7 million males and 586.5 million females as on 1st March 2011 (Census of India, 2011). Unlike the previous decades, there is a significant decline in population growth rate in the recent decade. The decadal growth rate has declined from 21.5 per cent in 1991-2001 to 17.6 per cent for 2001-2011. The overall sex ratio was 944 females per 1000 males in 2011 which is more favourable to males. Although, the overall sex ratio has increased slightly from 933 to 944 during 2001-2011, the child sex ratio of 0-6 years population dropped from 927 to 914 (Census of India, 2011). The low sex ratio statistics is an indicator of greater gender inequality and low status of women in India.

As per the 2011 census, about 30 per cent of the population in India are young people in the age group 15-24 years and a little more than one fifth are adolescents aged between 10-19 years (Census of India, 2011). According to the Sample Registration System estimates for the year 2012, the crude birth and death rates were 21.6 and 7 per one thousand population. As a result of increased contraceptive prevalence, there was a 23.6 per cent reduction in birth rate in India during 1996-2012. Rural urban differentials in birth rate are wide, the birth rate in rural area was 23.1 per 1000 population as against 17.4 in urban area (Sample Registration System, 2012). As per the latest statistics available for the year 2013, the male and female life expectancy at birth is 65 and 68 years respectively (Population Reference Bureau, 2013). The life expectancy at birth of both sexes has increased gradually over the years. It was 60 years in 2000 and rose to 65 years for the year 2013. The increase was slightly more among females than males.

While India's health situation shows some gains in the recent decade, the country's investment in health has not been high despite relatively high growth of Gross Domestic Product (GDP) in the early 2000s. India spends less than 4 per cent of its GDP on health which is below the WHO's recommended level of 5 per cent (Table 1). The Total Health Expenditure (THE) as per cent of the GDP has remained constant for a long time; it was 4 in 1995 and increased to 5 in 2004 then it declined to 4 immediately in 2005. Then it remained constant till the latest information available for the year 2011 (World Health Organisation, 2012).

The government spending on health in India is amongst the lowest in the world (about 1 per cent of GDP). The percentage of government spending

on health to GDP was less than one per cent during 2001-2010 and it has slightly increased to 1.04 for the years 2011-2012. (Planning Commission, 2012). In other words, the government spending on health to total health expenditure was 31 per cent in 2011. As private insurance constitutes a negligible proportion of private health expenditure, low government spending on health implies that 69 per cent of the health expenditure in India is out of pocket expenditure (OOPE) paid by common people from their own pocket. Among South East Asian countries, India ranks 3rd in terms of high out of pocket expenditure on health (World Health Organisation, 2012). A more recent study conducted in six states of India in the year 2011, indicates that the total out of pocket expenditure to households for outpatient treatment per ailing person (during a period of two weeks before the survey) was Rs 1063/- and the cost for hospitalised cases was Rs 14,704/- annually (PRAYAS, 2012). The high amount out of pocket expenditure on health care is a heavy burden to poor and marginalised population and acts as a great barrier in universal access to health care. So, it is imperative to increase public spending on health much more for catering to the health needs of a billion plus population.

India has signed a number of international human rights treaties and conventions. The important agreements are, International Covenant on Civil and Political Rights (CCPR), International Covenant on Economic, Social and Cultural Rights (CESCR), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and Convention on the Rights of the Child (CRC), International Conference on Population and Development Programme of Action (ICPD PoA) in 1994 India is also reporting on the Millennium Development Goals – MDGs (2000). Recently, India has also signed and ratified the Convention on the Rights of Persons with Disabilities (CRPD).

Reducing infant, child and maternal mortality, ensuring universal access to reproductive health services and reducing the unmet need of contraception are the key goals of ICPD and MDGs. Even after 20 years of ICPD and 15 years after MDG, the achievements in sexual and reproductive health services (SRH) indicators in India are quite far from the targets set. In this context, this policy brief is developed with an aim to review India's SRH services implemented during the last two decades particularly after 1994 (ICPD agreement), with a special focus on assessing whether the services are universally accessible to all sections of the society.

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Table 1 Health Financing Statistics of India

Indicators	Year				
	1995	2004	2005	2010	2011
Total expenditure on health (THE) as a percentage of Gross Domestic Product- (GDP) In Million current PPP	4	5	4	4	4
General government expenditure on health (GGHE) as % of THE In Million current PPP	26	21		28	31
Out of pocket expenditure on health as a percent of total expenditure on health (THE)	68	72		62	60

Source: World Health Statistics, 2012 and 2013

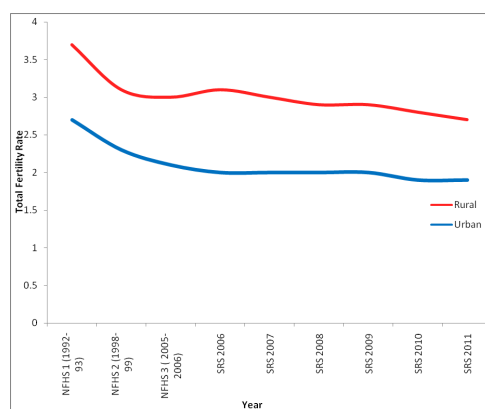
2. The status of sexual and reproductive health services in India

1. Contraception Total fertility rate

Fertility reduction has a direct effect on women's health and overall well being of the society. The total fertility rate (TFR) refers to the number of children a woman would have at the end of her reproductive life if she experienced the currently prevailing age-specific fertility rates from age 15 to 49 years. As per the latest statistics available for the year 2011, the TFR in India was 2.4 children. Overall there was 29.4 per cent reduction in TFR between 1992 and 2011, from 3.4 in 1992-93, to 2.8 in 2006 to 2.4 in 2011 (Sample Registration System, 2012). Although the overall TFR has declined, there are wide disparities by states, by rural and urban location (Chart 1) as well as by household social and economic status.

By region, the TFR is less than two per woman in most of the southern states of India; Tamil Nadu (1.7), Kerala and Andhra Pradesh (1.8), Karnataka (1.9). But it continues to be high in middle and northern regions; Rajasthan (3), Madhya Pradesh (3.1) Uttar Pradesh (3.4) and the highest TFR was observed in Bihar (3.6) (Sample Registration System, 2012). Rural women had significantly higher fertility rate (2.7) than their urban counterparts (1.9) (Sample Registration System, 2012). Information on TFR by caste, household economic status and education of women is not available for the recent period. So, we have to depend on old data sets for capturing caste and economic differentials. TFR was slightly more among poor caste groups: Scheduled tribes (3.12) and Scheduled castes (2.92) than the other backward caste (2.75) and forward caste (2.32) women (NFHS, 2005-2006). As expected, the fertility rate decreased with increasing household economic status and women's educational level; women from the poorest wealth quintile had the highest TFR of 4.1 as against 1.78 for the richest wealth quintile (DLHS, 2007-08). Similarly, an illiterate woman had twice the number

Chart- 1 Total Fertility Rate In India by Rural Urban -1992-2012



Source : Compiled from NFHS 1, 2 and 3 and Sample Registration System India

Table 2 Total Fertility Rate and Contraceptive Prevalence during 1992-2008

Year / Data	Total Fertility Rate	Contraceptive Prevalence - Any Method	Contraceptive Prevalence - Modern Method	Unmet Need for Contraception
NFHS-1 (1992-1993)	3.4	40.7	36.5	19.5
NFHS-2 (1998-1999)	2.9	48.2	42.8	15.8
NFHS-3 (2005-2006)	2.7	56.3	48.5	12.8
DLHS-3 (2007-2008)	2.8	54.0	47.1	14.4
Sample Registration System 2012	2.4	NA	NA	NA

Compiled from NFHS- 1,2 and 3, DLHS 3 and SRS 2012

Table 3 Total Fertility Rate by Place of Residence

Year	Rural	Urban	Total
NFHS-1 (1992-93)	3.7	2.7	3.4
NFHS-2 (1998-99)	3.1	2.3	2.9
NFHS-3 (2005-2006)	3.0	2.1	2.7
2006	3.1	2.0	2.8
2007	3.0	2.0	2.7
2008	2.9	2.0	2.6
2009	2.9	2.0	2.6
2010	2.8	1.9	2.5
2011	2.7	1.9	2.4
Rate of decline between 2006 and 2011	12.9	5	14.29

Source: NFHS-1, NFHS-2, NFHS -3 and Sample Registration System

of children (3.3) as compared with women who had 10 or more years of schooling (1.6). (Sample Registration System, 2012). So, rural poor, illiterate and women belonging to marginalised caste groups in India have had the highest fertility burden.

Contraceptive prevalence

Contraception is a promotive component of reproductive health and it is also the right of the individual and couples. United Nations population division estimates for the year 2014 indicates that the prevalence of contraceptive use in India was 59.4 per cent. Fifty-two per cent used modern method (UN Population Division, 2014). As we mentioned earlier, for contraceptive differentials we have to depend on old data sets. The results of NFHS-3 (2005-2006) shows, that the contraceptive prevalence among currently married women in the 15-49 years age group, was 56.3 per cent (48.5 per cent modern contraceptive users and 7.8 per cent traditional methods users). The prevalence had increased steadily from 40.7 in 1992-93 to 56.3 in 2005-2006. Particularly the use of modern methods

has increased about 32 per cent between the two survey periods (1992-93, 2005-2006). The steady decline in India's fertility rates during the current decade is a result of increasing contraceptive use. It is apparently clear from Table 4 that tubectomy (37.3) continued to be the single most contraceptive method widely used in the country, followed by condom (5.2), oral pills (3.1) and Intrauterine devices (1.7) (NFHS, 2005-2006). The prevalence of vasectomy has dropped noticeably in the recent years. But the use of condom and oral pills had almost doubled between NFHS2 and 3. The use of traditional methods was 7.8 per cent (NFHS, 2005-06) in India. In some states the prevalence of traditional method was more than 20 per cent. It could be observed that the two north eastern states namely, Assam (29.5 per cent) and Manipur (25.11 per cent) which had the lowest prevalence of modern method showed the highest use of traditional methods.

Despite the overall increase in contraceptive use, some patterns of use seem to remain unchanged. In 2005-06, about 80 per cent of modern contraceptive users in India were permanent method users, with

Table 4 Contraceptive Prevalence by Method at different periods

	Any Modern Method	Permanent Method	Spacing Method	Female Sterilization	Male sterilization	IUD	Oral Pills	Condom
NFHS - 1 (1992-93)	36.5	30.9	5.5	27.4	3.5	1.9	1.2	2.4
NFHS - 2 (1998-99)	42.8	36	6.8	34.1	1.9	1.6	2.1	3.1
NFHS - 3 (2005-2006)	48.5	38.3	10	37.3	1.0	1.7	3.1	5.2
DLHS-3 (2007-2008)	48.2	35	12	34	1	1.9	4.2	5.9

Compiled from NFHS- 1 2 and 3 , DLHS 3

use of tubectomy being 77.23 % and use of vasectomy 2.12 per cent (NFHS 2005-2006). The same trend is observed in the recent statistics released by the health and family welfare department, about 4.6 million people underwent sterilisation during 2012-13 and of them, 96.4 per cent was tubectomy and only 2.6 per cent was male sterilisation (vasectomy). It appears that women are disproportionately targeted by the family planning programme of India. Secondly, spacing between births and delay of the first child is not given adequate importance among health administrators and among couples. This was evident from the results of NFHS, 3 (2005-2006) that contraceptive use increases with the number of living children, from 7 per cent among women with no living children to 74 per cent among women with three living children.

Though the official position is that targets for “acceptance” of contraceptives were removed after ICPD, there continued to be indirect targets set by the state and district administrators, with serious negative consequences for women’s health and lives. There are reported incidences of IUD insertion without the consent of women when they go for delivery care and abortion services. Mass sterilisation camps are organised in high fertility states without meeting standard protocols. In November 2014 a mass tubectomy camp in Bilaspur district in Chhattisgarh resulted in ending 13 poor women’s lives and caused severe morbidity to 70 other women. This is probably an extreme example of indirect targets and poor quality of care and clear violation of policies, norms and international human rights agreements.

Wide disparity existed in contraceptive prevalence by states in 2005-06, and more recent data are not available on contraceptive prevalence by women’s household characteristics. The state of Himachal Pradesh had the highest prevalence (71) followed by Andhra Pradesh (67). The prevalence was around 60

per cent in all the southern states. Many of the north eastern states and Bihar recorded lowest prevalence; Meghalaya featured the lowest users with 18.5 per cent followed by Nagaland (22.5 per cent) Manipur (23.6), Assam (27 per cent) and Bihar (28.9 per cent). (NFHS, 2005-2006). Though the National government provide contraceptives services, its implementation entirely depends on the political will and efforts of the respective state governments, Sub-national level difference in contraceptive prevalence could be due to state government initiatives and involvement.

The use of modern contraceptives among currently married women in the 15-49 years age group varied widely by place of residence and household wealth index. The use of modern contraceptives was 11 points higher in urban as compared with rural areas (NFHS, 2005-2006). Further analysis reveals that in the case of permanent method use, there was no difference in prevalence between rural and urban areas. But urban lead in the use of spacing methods. The prevalence of spacing method use was 18 per cent in urban India which was about 2.25 times more as compared with rural areas (8 per cent). Caste disparities in contraceptive use were very minimum when it comes to permanent method use. But for spacing methods there were wide disparities by caste. Wealth had a positive effect on women’s contraceptive use. Among the women from the poorest wealth quintile the contraceptive prevalence was only 42.2 per cent and it gradually increased and reached the maximum of 67.5 per cent in the richest wealth quintile (NFHS, 2005-2006). The percentage of married women using spacing methods increased noticeably with the wealth quintile. The use of modern spacing methods increased sharply from 4 per cent among women in the lowest wealth quintile to 11 per cent among women in the fourth wealth quintile and rose to 22 per cent among women in the highest wealth quintile (NFHS, 2005-2006).

It is clear that there is a great inequity in contraceptive prevalence by region, rural-urban sex and social and economic status of women. A wide range of contraceptives as envisaged in the ICPD is not available and is not easily accessible to all sections of the people. The nature of differentials observed suggests that the main reason for disparities may lie in the lack of adequate attention by state governments in reaching out to all sections of society with contraceptive services. Secondly, gender stereotype in contraceptive use is apparent and male involvement in contraction is a neglected area which is of a great concern.

Unmet need for contraception:

Unmet need for contraception indicates the gaps between women's reproductive intentions and contraceptive behavior. In the South East Asia next to Maldives and Nepal, India has the highest unmet need for contraception (WHO World Health Statistics, 2013). Although the contraceptive prevalence has increased in India over the years, even today there is a huge unmet need for contraception (Table-2). As per the DLHS, 2007-2008, the total unmet need for contraception among the currently married women in the 15-49 years was 14.4 per cent; 9.2 per cent for limiting and 5.2 per cent for spacing methods. Importantly, unmet need for both spacing and limiting family size was very high among women in the 15-24 year age group (28). This high unmet need among young couples may affect their sexual and reproductive rights (DLHS, 2007-2008).

By states, the unmet need for limiting family size was very high in Bihar (35.9 per cent) Jharkhand (33.5 per cent) and Uttar Pradesh (32.5 per cent), the unmet need for spacing methods was also high in these states. The total unmet need for contraception was more in rural areas (21.8 per cent) as compared with urban India (17.5 per cent). Caste differences in unmet need were minimum. However, household wealth index has a positive association with prevalence of unmet need of contraception. The lowest wealth quintile had the highest unmet need for contraception (28.6) and the highest wealth class had the lowest unmet need (15.8) (DLHS, 2007-2008).

Time trend analysis indicates that the total unmet need for contraception had decreased slightly between 1992-93 and 2004-2005 (Table 2). However, more recently released results of DLHS - 4 (2012-2013) of some states show that the unmet need for contraception has increased significantly. For example, the unmet need increased from 32.5 to 55.5 per cent in Meghalaya between 2006-2007 and 2012-2013. Similar trends are visible in many states, which have a high contraceptive prevalence. Increase in unmet need for contraception during the above said period are as follows: Andhra Pradesh (8 to 16.2 per cent) Kerala (16 to 19 per cent) and Tamil Nadu (19.4 to 27.1 per cent), (IIPS, 2014). Non availability of spacing methods in the public sector is an important contributor to this situation. Field-level interactions with different community groups in various states suggest that there is a non availability and irregular supply of oral pills and condoms in public health facilities. To obtain contraceptives from the private sector involves a cost while they are available free of cost in the public sector. So, the non-availability in the public sector may act as a barrier for poor women and men to access the spacing contraceptives.

2. Maternal Health Maternal mortality:

The maternal mortality ratio (MMR) of India was 178 per 100,000 live births (Sample Registration System, 2013). It is seen from Table 5 that there has been a steady decline in MMR and there was a 63.79 percentage reduction in MMR within a period of ten years (2001 - 2011). Even with this sharp decline, we are still far behind the MDG target of MMR of 109 for the year 2015 .

Regional differences in MMR are noticeable. Among the 29 states in India, three states; Tamil Nadu, Kerala and Maharashtra have already achieved the MDG targets and three more states namely Andhra Pradesh, Gujarat and West Bengal are close to the targets. But the MMR of Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Odisha and Rajasthan and Assam was 257. About 62 per cent of maternal deaths in

Table 5 Maternal Mortality Rate In India during 2001-2011

Year	MMR	Rate of Decline
2001-2003	301	NA
2004-2006	254	-47
2007-2009	212	-42
2010-11	178	-34
MDG Target for year 2015	109	NA

Source: SRS India, 2014, NA- Not applicable

India have occurred in these states. Southern states accounts for 11.3 per cent and the remaining states accounted for 27.1 per cent of the maternal deaths (SRS, 2013). A few micro level studies reports that MMR was high among poor caste and poor women in rural areas (CommonHealth, Dead women talking Report, 2014)

Post Partum haemorrhage is the single most common reason for maternal mortality in India, followed by nutritional anaemia. These two causes accounted for about half of the maternal deaths in India (SRS, 2001-2003). There has been no change in the cause of maternal health over time. Although, the proportion of institutional deliveries has increased dramatically since 2005, the fact that post partum haemorrhage continues to claim the largest proportion of lives, points out the gaps in the provision of emergency obstetric care. As for nutritional anaemia, to address this cause would require attention on the social determinants of health. More discussion on the extent of this problem follows in the next section

Prevalence of anaemia among women and children

Anaemia is a major public health problem in India. It affects women and children's health very badly. Among south Asian countries, India has the highest prevalence of anaemia. Around 55 per cent of ever married women in the 15-49 years age group were anaemic in (NFHS, 2005-06). Of them 38.9 per cent were mild anaemic (10-11.9g/dl) 15.5 moderate (7-9.9 g/dl) and 1.7 severe anaemic (< 7 g/dl). Despite the country's overall socio economic developments, the prevalence of anemia among women had increased between NFHS 1 (1998-99) and NFHS 3 (2005-2006).

As expected the prevalence of anaemia was low in Kerala (32.81 per cent), Punjab (38 per cent) and Goa (38 per cent) and was very high in Assam and Jharkhand (70 per cent). It is to be noted that even some states with a high level of industrialization and good health infrastructures like Maharashtra (48 per cent) and Tami Nadu (53.2 per cent) had high level of anaemia. The prevalence of anaemia was high among women who belonged to marginalised caste and poor wealth quintile than the others. It was 64 per cent among lowest wealth quintile and 46 per cent in the highest wealth quintile, (NFHS, 2005 - 2006).

The adverse effects of anaemia on poor maternal health and perinatal health have been documented in many studies across the world. As seen earlier, anaemia among pregnant women is one of the leading causes of maternal mortality in India. The prevalence of anaemia among pregnant women was 59 per cent. Both demographic and socio-economic

factors are strongly associated with the extent of anaemia prevalence. The prevalence of anaemia among women increased with an increase in the number of children ever born and was lower among better educated women and those belonged to better household wealth index (NFHS, 2005-2006).

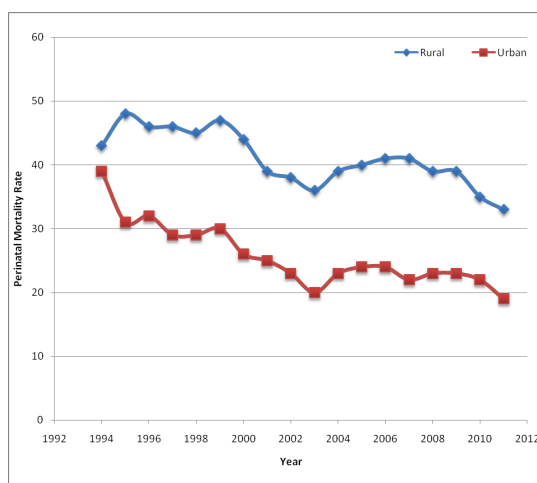
Among children of 6-59 months, the prevalence of anaemia was 69.5 per cent; 26.5 per cent were mildly anaemic, 40.2 per cent were moderately anaemic and 2.9 per cent were severely anaemic. In rural areas, 71.5 per cent of children were anaemic as against 63 per cent. in urban areas (NFHS, 2005-2006). So, in order to reduce MMR and IMR further, we need to reduce anaemia among women.

Perinatal mortality

The perinatal mortality rate in India was 30 per one thousand births (Sample Registration System, 2011). The early neo natal death and still birth rate were 27 and 6 respectively (SRS, 2012). Wide differentials exist by rural and urban location (Chart-2) and household economic status. The rate was 33 per 1000 births among rural mothers which was 1.7 times more as compared with their urban counterparts (19) (SRS, 2012). Perinatal mortality for households in the highest wealth quintile was half that as for households in the lowest wealth quintile. Unexpectedly, women who belong to scheduled tribes reported lower levels of perinatal mortality (41 per 1000) than scheduled castes (55 per 1000), other backward classes (49 per 1000) or other castes (45 per 1000) (NFHS, 2005-2006).

Perinatal mortality is also very high for very young mothers below 20 years of age (67) and for first pregnancies (66). The interval between the previous pregnancy and the current pregnancy had a strong negative effect on perinatal mortality. The perinatal mortality rate was 71 when the pregnancy interval

Chart- 2 Peri- Natal Mortality Rate



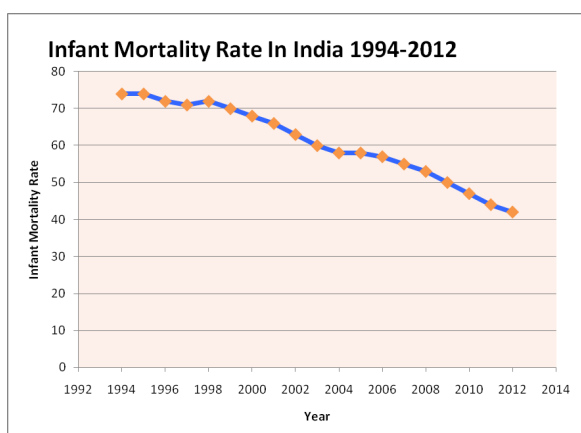
was less than 15 months, but was only 31 when the interval is 27 months or more (NFHS, 2005-2006). So, promoting spacing methods of contraception would be one of the key interventions to reduce perinatal deaths. While analysing the reasons for perinatal mortality in India. It was observed that prematurity, birth asphyxia, neonatal sepsis and congenital anomalies; and deaths caused by other diseases. Most of these deaths could be averted by improving health status of pregnant women and skilled birth assistance

Infant mortality rate

The infant mortality rate of India was 42 per one thousand live births (Sample Registration System, 2012). The rate has dropped consistently during the last two decades; it was 74 in 1994 and declined to 42 in 2012. The rate of decline was more pronounced during 2004-2012 as compared with the 1994-2004 (Chart-3). Comparison of three rounds of National Family Health Surveys 1992-1993, 1999-99 and 2005-2006 we found that the infant mortality rate declined by 22 deaths per 1,000 live births during the past 13 years.

Chart - 3

Unlike in many countries, the IMR in India is reportedly



high among females (44) than males (41). The IMR was very high in states like Madhya Pradesh (56) Assam (55), Uttar Pradesh and Odisha (53). But it was low in Kerala (12) and Tamil Nadu (21). There were large rural-urban differences. The infant mortality rate was very high in rural areas (46) as compared with urban areas of India (28) (SRS, 2013). Though the latest estimates on IMR is available at national level, for capturing socio economic differentials we have to depend on old data sets. According to earlier figures Infants whose mothers had no education were more than twice likely to die before their first birthday as compared to children whose mothers

had completed at least 10 years of school. Children from scheduled castes and tribes were at greater risk of dying than other children (NFHS, 2005-2006). The IMR was 70 among children in households of poorest wealth quintile 58 in households of the middle wealth quintile and only 29 in households of the richest wealth quintile. (NFHS 2005-2006). Peri-natal conditions, respiratory and diarrhoea diseases were the leading cause of Infant mortality In India.

Utilisation of antenatal care

Utilisation of antenatal care (ANC) is an important factor in maternal health status. As per the latest statistics available for the year 2009, 68.7 per cent mothers in India had three ANC visits (UNICEF Coverage Evaluation Survey, 2009). In the time trend analysis we observed that there was a slight increase in proportion who received 3+ ANC visits during 1994-2004. But the increase was so sharp between 2004 and 2009 as a result of Reproductive and Child Health Programme – Phase 2, under National Rural Health Mission¹ – NRHM (2005-2010).

Despite an overall improvement in ANC utilisation, the rural urban differentials were very wide. As expected the proportion of mothers who received three ANC visits was more in urban (82.7 per cent) as compared with rural areas (63.3 per cent) (UNICEF, 2009). Education of women had a positive impact on the with utilisation of ANC. Among illiterate women only 29.2 per cent had three or more ANC visits. It increased with educational level and reached its maximum of 78.7 per cent for women who had 10 and more years of education (DLHS, 2007-2008). Likewise, among women from scheduled tribes only 42 per cent had three or more ANC visits but among the others 60 per cent received the recommended ANC visits. One fourth of the pregnant women in the poorest wealth quintile received three or more ANC visits. This proportion increased with each successive wealth quintile and reached the maximum of 76.5 per cent for pregnant women in the richest wealth quintile (Chart 5). It may thus be concluded that the pregnancies of poorer and illiterate women are less likely to receive the recommended ANC visits when compared to others.

State wise analysis indicates that in Goa, Tamil Nadu and Kerala about 95 per cent of the women had three or more ANC visits, but in the following states less than one third of the women received 3+ ANC visits Jharkand (30 per cent); Rajasthan (27 per cent); Bihar (26 per cent); and Uttar Pradesh (21 per cent).

¹The National Rural Health Mission – (NRHM) was a central government programme launched in 2005 to make significant improvements in public health facilities in the country. Particular primary health centres were strengthened to provide maternal health care services.

The above results show socio economic and regional disparities in utilisation of ANC coverage is very wide, so universal access to ANC appears to be a distant dream in India.

Delivery care

Following ICPD, the Indian government came up with a number of policies and programmes to promote maternal health, particularly for increasing the proportion of institutional deliveries. The percentage of institutional delivery was only 33 per cent in (NFHS, 1998-99) and it increased slowly to 40.8 per cent (NFHS, 2005-2006). After the introduction of JSY² (Janani Suraksha Yojana) from the year 2005, there is a sharp upsurge in the percentage of institutional delivery. In the year 2011, almost 80 per cent of the deliveries in India was reported as institutional (Sample Registration System 2011).

Although there was an overall improvement in the proportion of institutional deliveries, there were wide variations by states. Almost all deliveries were institutional in states like Tamil Nadu (94 per cent) Puducherry (99 per cent), Kerala (99 per cent) and Goa (96 per cent), but in a few states less than one fourth of the women delivered in a health facility: Jharkhand (17.7 per cent) Chhattisgarh (18 per cent) Meghalaya (24.5 per cent) Uttar Pradesh (24.5 per cent) and Bihar (27.5 per cent) (SRS 2011).

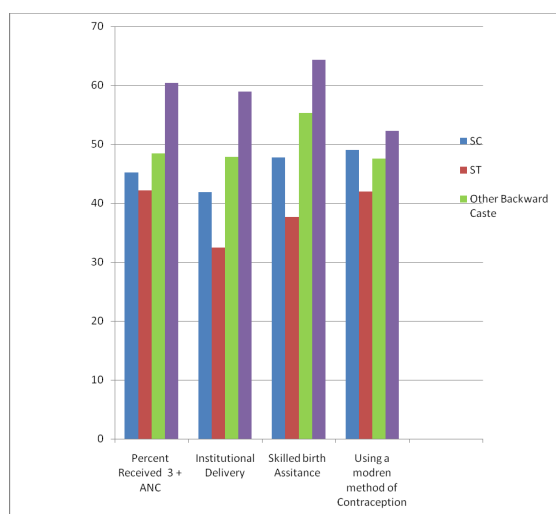
As the information on proportion of institution deliveries by socio - economic characteristics of

women are not available for the current period, we used earlier data sets. A large majority of deliveries in urban (70 per cent) as against rural (38 per cent) areas took place in a health facility (DLHS, 2007-2008). Caste and economic class based differentials in utilisation of delivery care were wide (DLHS 2006-2007). Among the Scheduled Tribes one out of three women had an institutional delivery, in the Scheduled Caste the proportion was 42 per cent and among the other communities, 58.9 per cent of women delivered in a health centre. Likewise in the poorest households less than 20 per cent had institutional delivery but in the richest wealth quintile 80 per cent of women delivered in a health facility (Chart-5). Similarly among illiterate women only one out of four had an institutional delivery whereas of those who had 10 or more years of education 80 per cent delivered their babies in a health facility (DLHS, 2007-2008).

Skilled birth attendance

Skilled birth attendance is considered as a proxy for safe delivery. Births with the help of trained attendant is nearly universal in the industrialised countries but in India one fifth of the mothers delivered their babies without any professional assistance (SRS, 2011). Over the last decade there has been a significant improvement in the proportion receiving skilled birth assistance. Starting from 33 per cent in 1992-93 (NFHS, 1), to 52.3 per cent by 2007-2008 (DLHS - 3). In 2005 the Janani Surakhsha Yojana (JSY) conditional cash transfer scheme was introduced to promote institutional delivery, and it resulted in

Chart- 4 Proportion of women who received different components of maternal health are by caste (DLHS, 2007-2008)



²Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented in India since 2005. The main objective of the programme is to reduce maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. JSY is a fully centrally sponsored scheme and a cash assistance of Rs 700 for women below poverty line in High performing states and Rs 1400/- for poor performing states having low institutional delivery rates (Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and Jammu and Kashmir). For the other states the cash assistance is ₹ 700 /-

multifold increase in the percentage of skilled birth assistance - [(76 per cent in 2009) (UNICEF 2009)].

The deliveries of poor caste and class are less likely to be assisted by health professionals. Less than 38 per cent of scheduled tribes and 47.7 per cent of scheduled caste women's deliveries were assisted by skilled persons whereas among other caste mothers 64 per cent received professional assistance in delivery (DLHS, 2007-2008). Similarly the proportion of deliveries assisted by skilled persons is positively associated with household wealth index (Chart-5). Less than one fourth of the deliveries of lowest wealth quintile had professional support.

Availability of Basic Emergency Obstetric Care (BEmOC) and Comprehensive Emergency Obstetric Care (CEmOC)

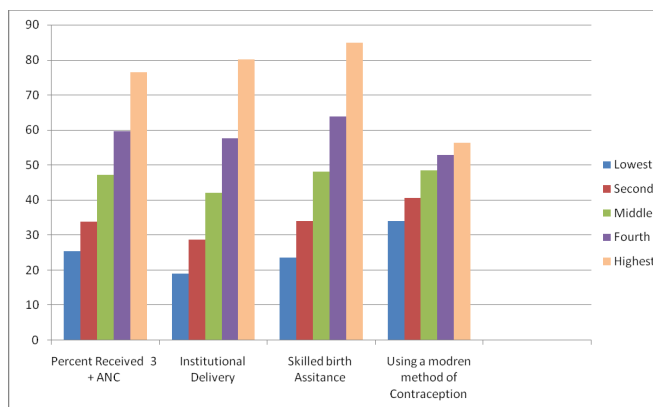
As per the government of India guidelines for maternal health care tool kit 2013, all the First Level Referral Units - FRU's, secondary and tertiary care hospitals are gradually converted to provide CEmOC services. It includes District Hospital (DH), Sub-district Hospital (SDH), Community Health Centre³ (CHC). The Structure of Indian Rural Public Health care system and type of services provided is given in the table 8 on page no 15 of this report.

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Chart 5 Utilization of different components of maternal health care services by wealth quintal- (DLHS, 2007 - 2008)



CEmOC centres provide the following list of services

1. Administer parental antibiotics
2. Administer uterotonic drugs (i.e. parental oxytocin)
3. Administer parental anticonvulsants for pre-eclampsia and eclampsia (i.e. magnesium sulphate)
4. Manual Removal of placenta
5. Remove retained products (eg. Manual vacuum extraction, dilatation and curettage)
6. Perform assisted vaginal delivery (eg. vacuum extraction, forceps delivery)
7. Perform basic neonatal resuscitation (e.g. with bag and mask) Perform signal functions
8. Perform surgery (e.g. Caesarean section)
9. Perform blood transfusion.

All 24 x 7 PHC's, Non-FRU/ CHC's are equipped to provide BEmOC services; conducting deliveries and management of medical complications not requiring

surgery or blood transfusion and having either a new born care corner or new born stabilization unit. The BEmOC centres aim to provide the list of services of 1-7 listed above for CEmOC centres (Ministry of Health and Family Welfare, 2013). The population coverage for BEmOC and CEmOC facilities in India varies from state to state and is unevenly distributed. So, there is no national level information of the number of emergency obstetric care centres.

Post Partum Care

Post partum care is an important and essential component of maternal and infant health. The information on post partum care was not available at national level prior to 2000. Of the women who delivered a baby during 2001-2004, only 36.8 per cent received PP care within 48 hours of delivery. The rural urban differentials in post partum coverage are very high. Less than one third of rural women as against 61 per cent of urban women received post partum care

³The Community Health Centre (CHC) is the third tier of the network of rural public health care system which acts as a referral centre for neighbouring Primary Health Centre.

within 48 hours (NFHS, 2005-2006). The likelihood of a birth being followed by a postnatal check-up within two days increased with the household wealth index (NFHS, 2005-2006). Thus post partum care within two days is still a distant dream for many rural poor women in India. Hence it is an imperative to strengthen facility based and community based post partum care services.

3. Adolescent and young people's sexual and reproductive health

According to UN MDG databases and World Bank reports the adolescent birth rate was very high in India in early 1990s (107 per every 1000 women in the 15-19 year age group in 2001). Then it started declining steadily and was 76 births every 1000 women in the 15-19 year age group in 2001 and reached 33 per 1000 women in 15-19 age group, in 2012. (Worldbank, 2013).

Under the Reproductive and Child Health Program (RCH 1 and 2)- 1998-2013, Adolescent Reproductive and Sexual Health (ARSH) was introduced to achieve the goals of reduction in IMR, MMR and total fertility rate towards achieving MDGs. The programme was designed to provide information and counselling on sexual and reproductive health issues such as safe sex practices, risk reduction counselling, and provision of regular contraception to adolescents. A separate section on information/advice on SRH issues states that adequate resource material are to be made to service providers in order for them to respond to questions posed by adolescents on topics related to growth and development, puberty, sexuality concerns, myths and misconceptions, pregnancy, safe sex and contraception, unsafe abortions, menstrual disorders, anemia, sexual abuse, RTI/STIs, etc. Though the ARSH comprehensive in its components, it did not incorporate a rights based approach. Importantly it did not address sexual rights of adolescents and rights of people with divergent sexual identities. Secondly it came under severe criticism for remaining on paper and for not being implemented uniformly across and within the states. The allocated budget was not being spent in 14 of the 35 states and UT which reported nil expenditure as of 2009. (Mona Gupta, 2010)

The sexual and reproductive health needs and issues of adolescents and youth are rarely addressed in India. According to NFHS-3 (2005-2006) and Youth in India study (2006-2007), young people in India are poorly informed to make responsible decisions with regard to their sexual and reproductive health and lives (IIPS, 2009).

A representative study done in six states of India [Tamil Nadu, Andhra Pradesh, Maharashtra, Jharkand, Bihar and Rajasthan] among 50844 youth (15-29 years) in the year 2006-2007 has brought out a number of sexual and reproductive health needs of young people. The study found that knowledge about sex, pregnancy, contraception and sexually transmitted diseases among youth was very limited. It also indicated that only very few youth in India (15 per cent) had attended family life / sex education programmes implemented by either the government or other voluntary sectors and conducted either in or outside the school. As a result young people in India have less awareness about sexual and reproductive health matters. For instance only 37 per cent of young men and 45 per cent of young women were aware that a woman can get pregnant after the first sexual intercourse. Less than half of the young women and little over three fourth of men had correct knowledge about at least one modern spacing method. Likewise, about 45 per cent of young men and 28 per cent of young women had comprehensive knowledge/awareness about HIV. Findings of considerable gender difference in the comprehensive awareness about contraception and HIV/AIDS raise concerns about the vulnerability of young women (IIPS, 2009).

Only one out of five currently married women in 15-24 years of age group currently used a modern method of contraception. Among married women in 15-19 year age group the contraceptive prevalence was just 7 per cent. Interestingly, 90 per cent of the married women in 15-24 year age group used a method of contraception only after their first delivery (NFHS, 2005-2006).

One fifth of the married young men aged between 15 - 24 years think that contraception is women's business and a man need not worry about it. Fifteen per cent believed that women who use contraception may become promiscuous (NFHS, 2005-2006).

The social pressure to bear children immediately after marriage is very strong in India. Moreover, both in the government policy and in its implementation, there is limited or almost no focus on delaying the first pregnancy. Young people are less informed about various contraceptives and also have less access to the contraceptive services in both public and private sector. As a result many young women in India rarely use contraceptives and get pregnant soon after marriage. A concentrated effort to delay first pregnancy is a great need of the hour for improving sexual and reproductive health of young people. (IIPS, 2006-2007 and Population Council, 2010).

While looking into the components of adolescent health care services in India, maternal and delivery care, certain contraceptive methods like provision of Cu- T, Condom and oral pills are available at primary care level. But other SRH services like medical abortion, STI/HIV treatment, gynaecological services are available only at secondary and tertiary care levels. Though the services are available, irrespective of marital status, young people experience stigma and discrimination in availing abortion and STI services. Psychological counselling and counselling on adolescent issues are totally absent in all the levels.

Following National Population Policy (2000) and National Youth Policy (2003), sexuality education programme was introduced in schools. The sexuality education programme in India is popularly known as Adolescent Education Programme (AEP). It is implemented by National Aids Control Organisation (NACO) with the support of education departments. The programme was implemented across 144,409 secondary and senior secondary schools (NACO, 2013). However, the topic on sexuality education itself is still a controversial one in India.

Initially the curriculum developed by the NACO was rejected by many state governments, saying it would be against moral values of Indian culture. Then it was revised and currently at the national level the AEP programme is co-ordinated by the National Council of Educational Research and Training (NCERT) and implemented in partnership with the Ministry of Human Resource Development (MHRD). It is designed to impart in four sessions (16 Hours total). The broad topics include Growing Up & Adolescence 2) STIs & HIV/AIDS 3) Skills for HIV Prevention 4) Question Box and Activity Session. This is implemented in few Central Board of Secondary Schools (CBSE), only in urban areas, AEP is not run in rural schools which are mainly run by state governments.

On analysing the national level data of District Level Household and Facility Survey (DLHS, 2007–08) and Youth in India study data sets (2006–07), Niharika Tripathi and et al reported that there was a huge unmet need for sexuality education. They found only half of the women in the age group of 15–24 years received sexuality education.

The HIV prevalence among the young people (15–24 years) has declined remarkably from an estimated 0.30 per cent in 2000 to 0.11 per cent in 2011. During 2000–2011, there was an overall reduction of 57.6 per cent in the HIV prevalence among young population (NACO, Annual Report 2012–13). However, it is estimated that over 35 percent of all reported HIV infections in India is among young people 15–24 years

of age (UN AIDS). There is no gender difference in the current HIV prevalence among young population.

4. HIV and AIDS

Prevalence burden

HIV prevalence in India shows a stable to declining trend. The prevalence among adults (15–49 years) has declined steadily from the estimated level of 0.41 per cent in 2001 to 0.27 per cent in 2011 (NACO, 2013, Annual Report 2012–13). Even though India has low HIV prevalence as compared to many countries in the world, due to its huge population size the country has the third highest number of estimated people living with HIV/AIDS (UN AIDS, 2013).

HIV prevalence rates have continued to be high in southern states (Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu) and north east areas (Manipur, Mizoram and Nagaland) than the other regions. The four southern states accounted for 53 per cent of all HIV infected population (NACO, 2013). Overall, the epidemic is focused in urban areas than in rural areas, has a higher prevalence among males than among females, and among high risk groups and among women whose spouses work in transport sector as compared to the general population (NACO, 2010).

There were 2.09 million people living with HIV/AIDS in India in 2011. Of these, 61 per cent were men (NACO, 2013). Research in India shows that HIV infections are mainly spread through heterosexual routes (87 per cent) followed by parent to child transmission (5.4 per cent), Injected Drug Use (IDU) (1.6 per cent) Men having Sex with Men (MSM) (1.5) blood and blood products (1 per cent) and unknown routes (3.3 per cent). High risk groups are the primary drivers of HIV epidemic in India. HIV prevalence is very high among transgender people (8.8 per cent), Injected Drugs Users (7.1 per cent), men who have sex with men (4.43 per cent) followed by female sex workers (2.67 per cent) and long distance truck drivers (2.59 per cent) in 2011. Data shows that despite the overall decline, prevalence of HIV continued to be high among transgender people, ID users and truck drivers (NACO 2013).

As seen above, the overall HIV prevalence among Female Sex Workers (FSW) in India is 2.67 per cent. Significant decline in HIV prevalence has been observed among FSW during the last decade. As a result of targeted interventions focusing on behaviour change and increased condom use among FSW, there was a 74 per cent fall in the HIV prevalence between

2003 -2011 (10.33 per cent in 2007 to 2.67 per cent in 2011). However, small scale studies show that HIV prevalence among female sex workers varies significantly between and within states (Ramesh et al 2008 and Singh RK 2012).

As seen in Table-6, noticeable decline in HIV prevalence has also been recorded among men who have sex with men (8.47 per cent in 2003 to 4.43 per cent in 2011). Transgender group is emerging as a major risk group with high vulnerability and high levels of HIV. Unchanged trend in HIV prevalence have been recorded among injecting drug users at the national level between 2007 and 2011 (7.23 per cent in 2007 and 7.14 per cent in 2011).

In fact recent statistics indicate that there is a slight upsurge in HIV prevalence among truck drivers. The time trend analysis and rate of decline statistics indicates that the prevalence continued to be high among truck drivers, ID users. Secondly, there is an increasing trend in the prevalence among truck drivers between 2009 and 2011. In North east states IDU remains the major route of HIV infections.

India has shown an overall reduction of 57 per cent in the annual new HIV infections; from 2,96,000 in 2001 to 1,16,000, 2011 (NACO, 2013). This must be

due the result of the concentrated efforts of national AIDS prevention strategies. Also, the estimated number of people living with HIV has decreased from 2.41 million in 2000 to 2.09 Million in 2011. Wider access to ART has resulted in 29 per cent reduction in the estimated annual deaths due to AIDS related causes between 2007 and 2011. It is estimated that around 1.50, 000 lives have been saved due to ART till 2011 (Chart-8).

Availability of services for HIV and AIDS

During 2013-14, 7.12 million pregnant women have been provided with free counselling and testing for HIV till December, 2013. Also 75 per cent of HIV positive pregnant women and their babies received ARV prophylaxis for prevention of mother to child transmission (UNAIDS, 2014). As seen in table 7 the proportion of pregnant women detected as HIV positive and receiving ARV has improved significantly in the recent years. At the time of delivery, the pregnant woman and the newborn baby are given a single dose of Nevirapine to prevent mother to child transmission of HIV.

Table 6 HIV Prevalence Among Different Target Groups 2001-2011

Year	People living with HIV/AIDS in Millions	HIV prevalence among										Number of Annual New HIV Infections (All ages) in Thousands	Number of AIDS related Deaths in Thousands
		Adult Population (15-49 Years)	Children below 15 years	Young Population 15-24 Years	Injected Drug Users-IDU	Men who have sex with men MSM	Female sex workers	Ante-natal care users	STD Clinic attendees	Long distance truck drivers	Transgender people		
2001	-	0.41	-	-	-	-	-	-	-	-	-	274	-
2002	2.73	0.41	-	-	-	-	-	-	-	-	-	230	-
2003	2.67	0.40	-	-	13.15	8.47	10.33	0.8	-	-	-	200	-
2004	2.61	0.39	-	-	11.16	7.47	9.43	0.95	-	-	-	179	-
2005	2.54	0.37	-	-	10.16	8.74	8.44	0.9	-	-	-	164	-
2006	2.47	0.35	-	-	6.92	6.41	4.90	0.6	-	2.37	29.60	152	-
2007	2.31	0.33	0.04	0.15	7.2	7.4	5.10	0.48	3.60	2.87	42.21	143	206
2008	2.27	0.31	0.04	0.13	-	-	-	-	-	-	-	134	192
2009	2.14	0.30	0.04	0.12	9.2	7.3	4.90	0.49	2.5	1.57	16.40	132	180
2010	2.11	0.28	0.04	0.11	-	-	-	-	-	-	-	130	164
2011	2.09	0.27	0.04	0.11	7.1	4.43	2.67	0.40	3.6	2.59	8.8	116	147
Rate of Decrease/ Increase	23.44 >	34.15	0	26.67	46.01	47.70	74.15	50.00		9.3 <up	70.27	57.66	

Source: Compiled from NACO annual reports, NACO 2012 Report HIV Sentinel Surveys.

Table 7 Coverage of HIV Positive Pregnant Women with Prophylaxis During 2005-2014

Year	No of pregnant women counselled (in Thousands)	No of pregnant women detected HIV positive	ARV prophylaxis	% of pregnant women detected and prophylaxis
2005	1300	11817	5413	45.81
2006	2130	16860	7007	41.56
2007	3380	20250	11460	56.59
2008	4150	21349	10613	49.71
2009	5560	19357	11483	59.32
2012 April - December	571	9451	9108	96.37
2013-14		12008	10085	83.99

Source: Compiled from NACO annual reports

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In India, HIV counselling and testing services are provided through Integrated Counselling and Testing Centres (ICTC). In these centres a person is counselled and tested for HIV at his or her own free will or as advised by a medical provider. Currently, there are two types of ICTCs

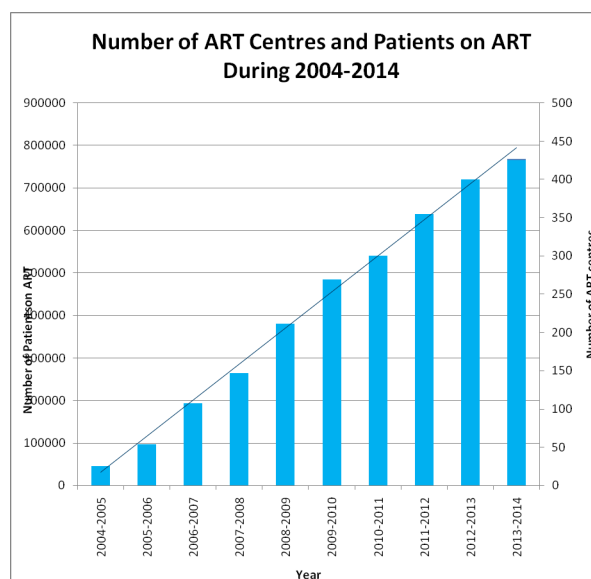
1. Stand alone ICTCs which are mostly located in government medical colleges, district and taluk hospitals and community health centres, There is a full time counsellor and a lab technician appointed to provide the counselling and testing services.
2. Facility integrated counselling and testing centres (FICTC) which are located 24 X 7 in PHC's where the existing staff in the health centre are trained for HIV counselling and testing.

In selected regions mobile ICTCs are also run to reach hard to reach groups. Community based screening is also initiated in selected areas where the front line health worker in the health sub centre is trained to conduct HIV testing for pregnant women. The mobile and community based services are provided only at a few places.

Number of ICTC's set up during 2007-2014

In the year 1997, there were only 67 Integrated HIV testing and counselling centers (ICTC) in the country. There was a gradual increase in the number

Chart 6



Source: Compiled from NACO annual reports

of facilities over 1998-2007 but in the past three to four years it has increased considerably (Chart-6). Currently, there are about fifteen thousand health centres offering the testing and counselling services. In the year 2014, 13 million people and 10 million pregnant women used the services of these ICTCs (NACO Annual Report, 2013-14).

Free antiretroviral treatment (ART) has been available in India since 2004. It is estimated that the scale up of free Antiretroviral treatment (ART) has saved over 1,50,000 lives during 2004-2011 by averting deaths due to AIDS-related causes. Wider access to ART has led to 29 per cent reduction in the estimated annual AIDS related deaths from 2,07,000 in 2007 to 1,48,000 in 2011 highlighting the impact of the scale up of free ART services in the country.

5. Availability of Sexual and Reproductive Health Care Services at different levels of care

In India Sexual and Reproductive Health Care (SRH) services are provided through a wide network of government health facilities, namely, Health Sub Centre, Primary Health Centre, Community Health Centres and District Hospitals. Basic maternal health care and provision of spacing contraceptives are available in the Sub centres and Primary Health Centres. Prevention, Counselling and testing of STI/AIDS are also provided at the primary care level. But other SRH services like safe abortion, treatment for gynaecological problems and reproductive cancer screening are available only in the secondary and tertiary care levels. The lists of essential SRH services agreed to be provided under Indian Public Health Standard (IPHS) in each of these centres are provided in Table 8.

In India Sexual and Reproductive Health Care (SRH) services are provided through a wide network of public health facilities namely, Sub Centre, Primary Health Centres, Community Health Centres and District Hospitals.

As on March, 2012, there were 148,366 Sub Centres, 24,049 Primary Health Centres (PHCs) and 48,333 Community Health Centres (CHCs) functioning in the country. After the introduction of the programme on National Rural Health Mission (NRHM) in 2005, there was a significant improvement in public health infrastructural facilities in rural areas. During 2005-2012, there was a 44.4 per cent increase in number of CHCs, about 3.4 per cent in number of PHCs and about 1.6 per cent in number of Sub Centres.

(Ministry of Health and Family Welfare Rural Health Statistics India 2012). But even today there is a short fall of facility required as per population size. For example, there was a short fall of 40 per cent in CHC, 26 per cent in PHC and 23 per cent in Sub Centres (Ministry of Health and Family Welfare, Rural Health Infrastructure, 2012).

Public and private sector share in maternal health care services

Antenatal care

Public health sector is predominantly used for antenatal care which is provided free of cost. Around fifty-five per cent of pregnant women received ANC check-up from public health care facilities, 36 per cent from the private health care facility and 9.5 per cent from community based services provided by trust hospitals and outreach activities (DLHS, 2007-2008). For the less privileged sections of the population, public health facility is the major source for ANC 67.4 per cent in the Scheduled Tribal population and 60 per cent in the Scheduled Caste population received ANC check-ups from public hospitals as compared to the population average of 54.5 per cent. Among the poorest households only 16.5 per cent utilised the private sector hospitals and the proportion increased to 58 per cent among the highest wealth status (DLHS, 2007-2008). So, public health facilities are mainly catering to the needs of the poor and socially less privileged women.

Delivery Care

As per NFHS - 3 data (2005-2006) 46.5 per cent of the deliveries took place in public health facility and 53.49 per cent of the deliveries happened in the private health facility. People from the lowest economic quintile (66 per cent) had accessed public health facilities for delivery care whereas among the highest quintile 72 per cent have used the private health facilities for delivery care. After the introduction of the Janani Surksha Yojana (JSY) maternity benefit scheme in 2005, deliveries in public sector hospitals has increased. In the financial year 2012-2013 there were 1.66 crore women delivered a baby in a health facility in India, of them three fourth (73.9 per cent) used public facilities. (MOHFW, 2014)

Contraceptive methods

For a permanent method of contraception, women heavily depend on public health facilities; an overwhelming majority of 84 per cent of current contraceptive users underwent the sterilisation

Table 8 Structure of Sexual and Reproductive Health Care Delivery in India

Sub Centre - HSC	Primary Health Centre- PHC	Community Health Centre- CHC	District Hospital
One per 3000-5000 Population. Health Sub-centre is largely for preventive and promotive, but it also provides a basic level of curative care.	One per 20000 – 30000 thousand population. PHC acts as a referral unit for 6 Sub-Centres and refer out cases to CHC (30 bedded hospital) and higher order public hospitals located at sub-district and district level.	One Per one lakh- 1.20 lakhs population The Community Health Centres (CHCs) acts as a referral unit for 4 – 5 PHCs	One per administration district
Maternal and Child Health. Early registration of pregnancies and associated services like provision of general examination such as height, weight, B.P., anaemia, abdominal examination, breast examination, Iron & Folic acid supplementation Injection on tetanus toxoid. Promoting institutional deliveries, skilled attendance at birth, Maternal and child immunization Counselling and appropriate referral for safe abortion services (MTP) for those in need. Follow up for any complication after abortion/MTP and appropriate referral if needed.	Maternal and Child Health. ANC: Early registration of all pregnancies ANC check ups and services Including basic lab services to screen high risk pregnancies; 24 hour delivery services- Natal care Intra-natal care: (24-hour delivery services both normal and assisted) Identification and basic first aid treatment for PPH, Eclampsia, Sepsis and prompt referral, Post natal care services new born complications referral and transportation services, routine immunization.	Maternal and Child Health ANC: Provision of ANC checkups and services Delivery Care 24 hour delivery care services including normal and assisted deliveries; essential and emergency obstetric care including Cesarean section and management of pregnancy and obstetric complications; blood storage and transfusion facilities, Post Natal care services New born Care new born care, new born stabilization unit, routine and emergency care of sick children routine immunization essential laboratory services and referral and transportation services	Maternal and Child Health. Specialist Obstetric and gynecological services – full range of obstetric and gynecological care and treatment, pediatrics including neonatology dermatology and venerology including STI/ RTI care immunization and new born care
Contraception counseling and provision of birth spacing, including CU- T, IUD insertion, Counseling and referral for safe abortion	Contraception, Counseling and provision of birth spacing, including CU- T, IUD Insertion, Performing female and male sterilization operation, Counseling and referral for abortion and medical termination of pregnancies, using manual vacuum aspiration wherever trained personnel and facilities exist	Contraception; Full range of contraceptive services including IEC, counseling, provision of contraceptives, Non Scalpel Vasectomy (NSV), Laparoscopic sterilization services and their follow up. Safe Abortion Services as per MTP act	Contraception Full Range of family planning services including laparoscopy abortions including mid trimester abortions.
	Other SRH Services Management of RTI/STIs including counselling and treatment	Other SRH Services; Management of RTIs/ STIs, Tuberculosis, HIV/AIDS control programme including Integrated Counselling and Testing Centre. Blood storage centre .Sexually transmitted. Infection, clinic, basic screening, provision of parent to child transmission control services, condom promotion, School Health Programme screening and treatment of minor ailments, De- worming, Anaemia screening, Weekly supervised distribution of Iron-Folate tablets coupled with education about the issue Adolescent Health Services: Adolescent friendly clinic for 2 hours once a week on a fixed day. Services. Information, counseling and services related to sexual concerns, pregnancy, contraception, abortion, menstrual problems STI/RTI management Referral Services for VCTC and PPTCT services and services for safe termination of pregnancy	Other SRH Services Management of RTIs/ STI's Voluntary counseling and testing, parent to child transmission control and Tuberculosis

Source: PATH, *Options and Challenges for Converging HIV and Sexual and Reproductive Health Services In India: Findings from an Assessment in Andhra Pradesh, Bihar, Maharashtra and Uttar Pradesh, June 2007*, and MOHFW IPH reports 2013

operation in government hospitals (NFHS, 2005-2006). But, the situation is totally different when it comes to spacing methods. Seventy-six per cent of spacing method users accessed private health care facility (DLHS, 2007-2008). Evidence shows poor or non availability of spacing methods in the public sector. This may be one of the reasons for the low prevalence of spacing method in India.

Recommendations

Following ICPD and towards meeting MDGs, the Indian government has introduced different RCH services in the public health facilities. The overall focus of SRH services is only on reducing maternal and infant mortality rates. As a result of these there is an improvement in the proportion of skilled birth assistance and institutional delivery. Though the overall indicators have improved significantly, there are wide gaps between states, among various sub groups of the population. The other SRH services like abortion, gynaecological morbidities and adolescent health care services are not given adequate attention at the primary care level. Based on this review we put forward the following recommendations to our national and state governments and donor communities.

Government spending on health care in India is the lowest in the world (1 per cent of GDP). Among the South East Asian countries, India ranks third in terms of high out of pocket expenditure on health (World Health Organisation 2012). The heavy OoPE is a great barrier for universal access to SRH services particularly, poor and downtrodden people are unable to access the required SRH services. Hence, the national government at the centre should increase the public spending on health to attain the goal of universal access to health care as outlined in the ICPD and MDGs.

- There is an urgent need to shift from the narrow focussed approach on increasing institutional deliveries to address the broader social determinants of health including rural urban, caste and class inequities, nutritional anaemia gender and health systems factors. Without addressing these issues, further reduction in the mortality rates would be impossible to achieve MDG's.
- Provision of a wider range of contraceptives as envisaged in the ICPD is far from satisfactory. Use of spacing methods of contraceptives for promoting the health of women and children is a long neglected area, which is of great concern. In fact, the unmet need for contraception is

increasing in the recent years. So, both the state and national governments should strengthen their IEC activities by ensuring easy and regular availability of spacing contraceptive in the public health facilities. The Government should also make concrete efforts to popularize male contraceptives and men's involvement in contraception should be given adequate attention in policy and service provision. Overall, India has made significant progress in promoting contraceptive use and reducing unmet need. Consequently, TFR has declined noticeably. But there are wide regional and socio-economic disparities. Some sections of the population are progressing well and others are lagging behind.

- Adolescents, and young peoples SRH needs and issues are not properly addressed in the current health system. There are barriers and stigma in accessing the services which are available in the secondary and tertiary, care centres. Providing SRH information and counselling for adolescent issues should be available at the grassroot levels. Sexuality education should be imparted in schools and community for young people through the different support structures available in the community like Anganwadi/ICDS workers and Nehru Yuva Kendra Sangam volunteers. Public health facilities play an important role in the provision of antenatal, delivery and contraceptive services to rural poor women. So, it is imperative to improve the quality of care in these centres and increase the availability of services at the primary care level.
- There is a need to strengthen targeted intervention to prevent HIV transmission among high risk groups as the prevalence continued to be high among transgenders, injected drug users, men having sex with men, truckers and female sex workers.
- Due to the socio economic cultural and political diversity of the country, there is wide inequity in access to and utilization of SRH services between states and social categories. So, in addition to having a uniform health policy or programme, the national government should introduce targeted/ special SRH services for backward states, and for rural as well as disadvantaged caste and class groups, so that we can reduce the inequity gap between those in the poorest and these in the better off groups.

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ABOUT RUWSEC

Rural Women's Social Education Centre [RUWSEC] is a women's organization working for sexual and reproductive health and rights. The organization was founded by 13 women in the year 1981 and it is located at Karumarapakkam village Thirukazhukundrum, near Chennai, Tamil Nadu, South India. Achieving women's wellbeing through women's empowerment is the mission of RUWSEC.

RUWSEC's main focus has been on enabling women to gain greater control over their bodies and their lives, and achieving well being through promotion of gender equality, sexual and reproductive rights. RUWSEC's overall approach has been to motivate, educate and organise women from poor and marginalised communities to stand up for their rights and become agents of social change. The core values of our organization's work focuses on two important themes 1) Empowerment and rights based 2) Women centered and participatory. The strategies of our work are to

- Bringing forth the voices of women (and men) from the most marginalized sections of society, especially dalit and rural poor communities;
- Promoting leadership skills of the above groups so that they can effectively participate in existing governance and accountability structures and other spaces for community participation.
- Developing critical thinking and alternative models in health care provision, research and planning for social action.
- Currently, our intensive field programme activities focus on the following four major themes.
- Promoting general health and well being in the community.
- Promoting sexual and reproductive health and rights (SRHR) of adolescents and young people.
- Promoting sexual and reproductive health rights of adults with a special focus on women.
- Prevention of intimate partner violence against women.

In each of the above said themes we work on four strategies namely 1) Community capacity building 2) Providing health care services 3) Monitoring, research and bringing out popular health education materials 4) Advocacy for wider policy change.

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