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MDG 5 in India: Whither reproductive and sexual rights?

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Introduction

Critique of MDG 5 from the perspective of Sexual and Reproductive Health and Rights (SRHR) is now well established. Feminists and women's health advocates, globally as well as in India, have asserted that the United Nations and international policy makers have gone back on the commitments of the ICPD Programme of Action and the Beijing Platform for Action, which contained a comprehensive reproductive and sexual health approach (1, 2, 3).

India's response to the ICPD PoA and MDGs and the progress in the direction of meeting targets set by the MDGs needs to be analysed in the context of the history of Indian population and family welfare programmes. India was the first country to have a national government supported family planning/ welfare programme beginning from 1952 and till the late 1990s, ie post ICPD, the Indian government has focussed on sexual and reproductive health mainly through the population control policies (4). 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) (5) 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

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– were some of the milestones. The second phase of the Reproductive and Child Health Programme RCH II (6) – was launched in 2005 with a vision to bring about outcomes as envisioned in the Millennium Development Goals.

However, the implementation of the paradigm shift in accordance with the ICPD PoA, remained unsatisfactory. Though the NPP reflected principles upheld by the PoA, these were not reflected in the population policies developed by individual states and some states continued with targets for achieving population control (7). The gains of the 'Target Free Approach' 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. The Report on Progress and Performance of the National Rural Health Mission and Suggestions for the Twelfth Five Year Plan (2012-2017) in a section on Gender Concerns in the Health Sector recognizes that little progress has been made in areas like adolescent girls' health, empowerment of women to make informed contraceptive choices, safe and quality abortion services, and outlines these as specific focus areas for Gender and Health in the Twelfth Plan period (8).

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 (9). The Goals and Monitoring Targets thus became (10):

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 (11) 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."

This report does not give any further explanations. 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 (12, 13).

The Eleventh Five Year Plan (2007-12) in its 27 National Targets has a target on reduction of anaemia amongst women and girls, which has a direct bearing on Maternal Health and Maternal Mortality (14). But this is not part of the government's Report on MDGs (15).

In relation to the Maternal Mortality Ratio and deliveries attended by Skilled Birth Attendants, the report states:

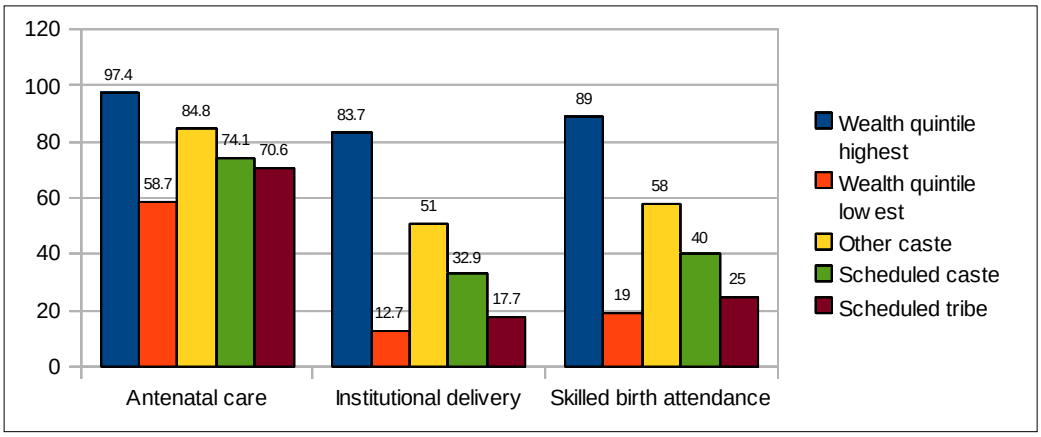
"SRS data indicates India has recorded a deep decline in MMR of 35% from 327 in 1999-2001 to 212 in 2007-09 and a fall of about 17% happened during 2006-09. The decline in MMR from 1990 to 2009 is 51%. From an estimated MMR level of 437 per 100,000 live births in 1990/1991, India is required to reduce the MMR to 109 per 100,000 live births by 2015. At the historical pace of decrease, India tends to reach MMR of 139 per 100,000 live births by 2015, falling short by 29 points.

The rate of increase in coverage of institutional deliveries in India is rather slow. It increased from 26% in 1992-93 to 47% in 2007-08. As a result, the coverage of deliveries by skilled personnel has also increased almost similarly by 19 percentage points from 33% to 52% during the same period. With the existing rate of increase in deliveries by skilled personnel, the likely achievement for 2015 is only to 62%, which is far short of the targeted universal coverage."

Analysis of the Maternal Health Situation in India

While a state wise disaggregation and analysis has been done of states with high and low MMRs (16), an analysis of **who** are the women who die has not been included in this report. The decreasing maternal mortality ratio for India as a whole hides wide discrepancies between states and different communities in the area of maternal health.

Figure 1: Maternal health care indicators (as percentage) by wealth and caste status (NFHS 3) (17)

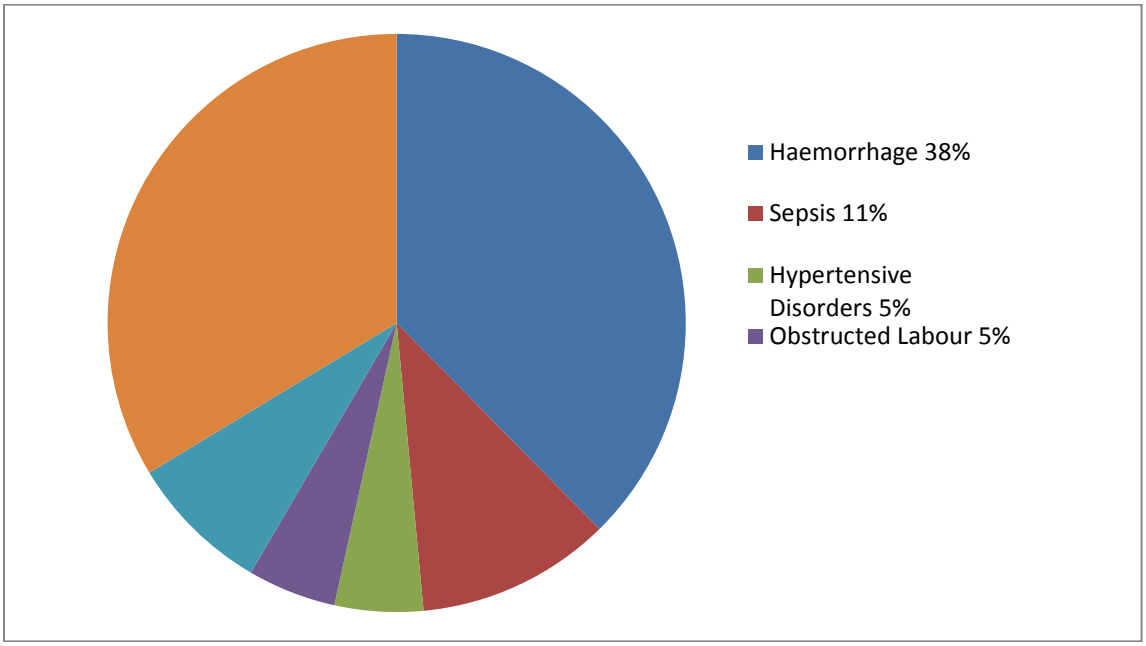


Data from the National Family Health Survey 3 shows that women from poorer wealth quintiles and scheduled castes and tribes have poorer health indicators including in receiving antenatal care and skilled birth attendance, having an institutional delivery, and in levels of anaemia (see Figure 1).

Social grouping, education and economic class are thus important social determinants of maternal health in India which the official MDGs monitoring effort ignores.

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 (18).

Figure 2 Causes of Maternal Death in India



India does not yet have an accurate system of collecting data on maternal deaths (19, 20). 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 followup action initiated by the state health systems, is done in very few states (21, 22).

Skilled Birth Attendance, Institutional Deliveries, or Safe Deliveries?

The National Family Health Survey 3 (NFHS 3, 2005 -06) 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 (17). According to the GOI, the unsatisfactory increase in skilled attendance at birth is due to poor progress in institutional deliveries (15).

Promotion of institutional deliveries

This equating of **institutional** deliveries with **safe** deliveries is in fact the biggest flaw in India's Maternal Health policy.

NFHS 3 reports that a large majority of the women who did not deliver their last birth in a health facility (72%) said they did not feel it necessary to deliver in a health facility. In addition, 26 % reported that it costs too much to deliver in a health facility. Eleven percent said that the health facility is located too far away or that transport was not available to reach the facility (17). Despite these statistics and the fact that many places in India are extremely difficult to reach, the Government continues to pursue the strategy of institutional deliveries to the exclusion of any other strategies. There is a denial of the fact by several health administrators both at the state and

national levels[2] that trained traditional birth attendants may be able to play a positive role in difficult to reach areas (23).

In an effort to promote institutional deliveries, the Government of India launched a conditional cash transfer scheme called the Janani Suraksha Yojana (24). 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 and probably contributed to reducing neonatal deaths (29, 30, 19)[3].

However, there are problems with the JSY. The poorest and the least educated women do not consistently have the highest odds of being JSY recipients – maximum benefits are going to women in the middle wealth quintiles (25). 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. These include poor availability of appropriately trained health professionals, equipment and supplies at different levels of care; lack of effective referral systems; poor technical quality of care, and most importantly, a pervasive disregard for the rights of clients and an endemic lack of accountability for avoidable maternal death and injury (26, 27). Studies also show that despite the significant increase in institutional deliveries there is no evidence of decreasing MMR (28).

As a recent report of the UN Rapporteur on Health (29) 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".

According to the UN Rapporteur's report,

"health work force is a major bottleneck in India achieving the MDG 5 on maternal health. Skilled birth attendants are not available in sufficient numbers. The Auxiliary Nurse Midwives who are supposed to be resident at the village sub centre and facilitate child births, are often absent from the communities that they are supposed to serve. Additionally, they do not have the competencies of a skilled birth attendant".

Life saving care is unavailable in rural, and disadvantaged areas. There is an acute shortage of Obstetricians and Anaesthetists in the public sector. Over 30% First Referral Units and 50% Community Health Centres do not have anaesthetists and the same number do not have Obstetricians (30).

[2] In meetings of the Maternal Health Task Force appointed by the GOI, of which I am a member, several central and state level health officers have refused to accept traditional birth attendants as a viable alternative to institutional deliveries and skilled birth attendants.

[3] The Coverage Evaluation Survey 2009 indicates that institutional deliveries increased from 53.3% in 2005 to 72.9 % in 2009 (30). This trend is also confirmed by District Level Health Survey (DLHS) which shows an all India increase in institutional delivery from 40.5% in 2002-03 to 47% in 2007-08 (19).

Public Private Partnerships while increasing access and providing some degree of financial protection to the vulnerable populations, are not without problems of quality of care. A recent study (31) which sought to examine whether Public Private Partnerships have contributed to increasing accessibility of quality maternal health services to poor and marginalised women, concludes that they have not increased either availability or physical access to services for a vast majority of women living in rural areas. The study states *'The investment of substantial government and donor resources in PPPs without robust evidence on their contribution to reduction of maternal mortality does not appear justified.'*

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

This is a globally accepted indicator of health, population, development and women's empowerment and a proxy indicator of access to reproductive health services. 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 (32). The contraceptive Prevalence Rate among currently married women is 56 percent, up from 48 percent in NFHS-2 (18). Contraceptive use in India is characterized by:

- the predominance of non-reversible methods, particularly female sterilization - 66% of all contraception use is female sterilisation (17)
- limited use of male methods – condoms 5.3%, male sterilisation 1% (17)
- high discontinuation rates among those who use temporary methods (17) and
- negligible use of contraceptives among both married and unmarried adolescents (33)

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 (34). This decline is largely attributed to increase in girls' school education,[4] although secondary and tertiary education for girls is still regarded as a luxury.

The NFHS 3 reports that 58% of all married women age 15-19 have experienced motherhood or a current pregnancy (18). 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.

[4] Primary completion rate for girls has increased from 61.5% in 1999 to 94.3 5 in 2008, female literacy rate has gone up from 49.3 % in 1991 to 74.4% in 2006 (34).

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 (35)[5].

Antenatal Care

Three Antenatal care checkups, a sensitive indicator of access to outreach care in pregnancy has improved in rural areas from 36.7% in 2005 to 63.3% in 2009, according to a recent NRHM review (36). The NFHS 3 points out the usual inequities in ante natal care - women not receiving antenatal care tend disproportionately to be older women, women having children of higher birth orders, scheduled tribe women, women with no education, and women in households with a low wealth index (18).

Quality of ANC is a serious issue.[6] Complete ANC is hardly provided. Skills of measuring blood pressure, assessing anaemia amongst Auxiliary Nurse Midwives are woefully deficient (26, 37).

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 (18), 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 (38), 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. While the family planning needs of the majority (86%) of women who wish to stop childbearing are supposedly being satisfied, many of these women may also be terminating an unwanted pregnancy and simultaneously having sterilization in the absence of being given other contraception options.

The accepted definition of unmet need for contraception is the percentage of fertile married women in reproductive age group who do not want to become pregnant and are not using contraceptives. The concept of unmet need however should assess the need for contraception based on **whether** and **when** a woman wants a child. Adolescents' and single women's unmet

[5] The ban has subsequently been reversed by half the states. Another Adolescent Life Skills Programme is being run by NCERT in collaboration with UNFPA is running in five States.

[6] NFHS 3 (18) points out that among women who received ANC:

- Less than two-thirds had weight, blood, or urine taken, or blood pressure measured
- Three-fourths had their abdomen examined
- 36% were told about pregnancy complications

In NFHS 3, women who received antenatal care for a birth in the five years preceding the survey were asked (for their most recent birth) whether they were told about the signs of pregnancy complications and where to go if they experienced any of these signs. Only 20 % were told about prolonged labour as a sign of a pregnancy complication, and even fewer (15-17 percent) were told about convulsions and vaginal bleeding as signs of pregnancy complications.

need for contraceptives is not taken into account while calculating Unmet Need for Family Planning. Unmet needs of women with primary and secondary infertility who actually want to have children but are unable to conceive, is also not addressed by the existing notion of Unmet Needs (39). Also all users may not be using a method of their choice – government policy and providers' preferences many times guide which contraceptive methods are promoted. Unmet need for disease prevention is not considered by the current definition of Unmet Need. A valid measure of Unmet Need from the women's perspective would be the difference between the Total Fertility and the Total Wanted Fertility and the reasons for nonuse of contraceptives. Accounting for differences between Total Fertility Rate (2.68) and the Wanted Fertility Rate (1.9), resulted in women having 41% more children than they desired (39).

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. Some of these are mentioned below as illustrative examples.

Postnatal Care. Considering that 60% of deaths occur after delivery, only 1 in 6 women receives postnatal care (40). Urban, literate, women living in households with higher standards of living, those who delivered with the assistance of a health professional rather than a traditional birth attendant were more likely to be followed up with a post partum check up (18).

Access to safe abortions. As mentioned above, abortion accounts for 8 % of maternal deaths. Yet access to safe abortion services is not an indicator for Universal Access to Reproductive Health. Access to services for Medical Termination of Pregnancy (MTP) is still limited at peripheral levels due to a various factors including lack of fully equipped facilities, trained staff and drugs (41).

A related issue is the effect of the deteriorating sex ratio on access to safe abortions. Census of India 2011 shows that the existing child sex ratio (0 to 6 years) has further deteriorated (from 927 females per 1000 males in 2001 to 914 females per 1000 males in 2011) (42). Fears of sex selection and sex determination and the ineffective implementation of the Pre Conception Pre Natal Diagnostics Techniques Act (1994), are causing a knee jerk reactions in the highest government circles and there are moves to tighten access to safe abortions, like 'mandatory counselling of women seeking abortion', and restricting second trimester abortions (43).

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. A few studies analysing the District Level Household Survey data indicate a prevalence rate ranging from 0.3 to 4.6 % in selected states of India (44, 45). Considering the high rate of adolescent pregnancies and child bearing, as well as high levels of malnutrition amongst adolescent girls, the extent of vesicovaginal fistulas occurring in India need to be tracked - the consequences of these are drastic for young women.

Infertility
Childlessness has serious demographic, social and health consequences. Motherhood is important in India for sociocultural reasons and continuity of marriage.

Analysis of the NFHS and DLHS data shows infertility rates are high among women in urban areas, maybe because of higher educational attainment and later age of marriage. Among population groups, scheduled tribes have higher infertility rates (46). 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. Basic low cost diagnostic and treatment services including health education are required at community level health facilities (47).

Cancer screening.
Data from population based registries under National Cancer Registry Program indicate that leading cancer sites among women are cervix, uterus, breast and oral cavity and that 50 - 60% of all cancers among women in India are related to cervix, uterus, breast and ovaries (48). 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. Organised Pap smear screening programmes have not reached majority of population due to lack of infrastructure, costs and necessity of follow ups (49).

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 (50) 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. Rights violations related to contraceptive services continue to occur. Though India adopted a target-free approach to family planning in 1996, the 'target mind-set' has remained and continues to lead to direct and indirect coercion. There are also serious concerns about issues of informed consent around post partum IUCD insertion (51).

ARROW (52) suggests additional indicators for MDG 5 like: Maternal deaths due to violence against women, Met need for EmOC services, Legal age of marriage vs. Median age of marriage, Accessibility and quality of adolescent - and youth - friendly SRH services.

Reproductive and Sexual Health and Rights of women living with disabilities are also emerging as an area that needs visibility and recognition.

Determinants of Maternal Health

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] (53). The proportion of women 15-45 years who are anemic has increased between 1998-99 to 2005-6 as per NFHS 2 and 3 (18). The intensity of poverty as it affects females is also reflected in higher rates of infant mortality rates of females than males in India (against the fact of greater resilience of females at birth), pointing to not only lesser nutrition (anemic and underweight), but also lesser investment in health care of females.

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. Further, when married women do earn cash, they do not necessarily have a say in how their earnings are used. In addition, almost one in three women does not have a say in how their husbands' earnings are used. Finally, more than a fifth of currently married women who earn cash earn about the same or more than their husbands or have husbands who have no earnings. Women's mobility is restricted - only about half of all women are allowed to go to the market or to the health facility alone. 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 (18).

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

As described earlier, 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 National Rural Health Mission has attempted to bridge some of the implementation gaps by attempting to strengthen the public health system. Even so, the progress on the MDGs is slow in India (15, 54)

[7] The Planning Commission notes also notes that the percentage of females in poor households in 2004-2005 is 29% and 23% in rural and urban areas, when compared to 27% and 26% in rural and urban areas in 1993-1994 (Planning Commission).

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 (55), accountability for women's health and social determinants, (including for quality) within countries for needs to be strengthened.

- 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.

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