Policy Booklet for Parliamentarians

Sexual and Reproductive Health Rights under the Reproductive and Child Health Policy –

Compromising Women's Dignity



UN Millennium Campaign
Oxfam India
Centre for Legislative Research and Advocacy

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Foreword

International laws and declarations recognise certain rights that all human beings are entitled to. One of these rights, which the Constitution of India has recognised, is that of sexual and reproductive health. Yet despite being written down on paper, many people are denied their right to sexual and reproductive health in India every day. If India hopes to reach the targets placed on maternal mortality, child mortality, gender equality, and HIV/AIDS reduction prescribed by the Millennium Development Goals, it will need to focus on sexual and reproductive health rights.

At 1.1 billion people, India has the second highest population in the world. The issue is lack of access to contraception and sexual and reproductive services. As a consequence, women are at risk of unwanted pregnancies, face higher risks of complications in childbirth, and resort to unsafe abortions. Lack of health services means people affected by HIV do not receive the necessary medication, and sexually transmitted diseases go untreated. Without easily accessible information on health, people are at a disadvantage when it comes to making informed decisions on family size. Furthermore, India's health systems are not in a position to provide universal access to maternal and child health services, and there is a lack of oversight in ensuring that people have access to everyday needs conducive to maintaining daily health, such as sanitation facility, drinking water and adequate nutrition.

Young children, infants and women, are especially at adisadvantage in procuring these basic amenities. Due to socio-economic factors women often do not or cannot seek treatment for sexual, reproductive and maternal health. Economic insecurity, gender inequality, lack of awareness due to little sexual education, and social stigmas associated with various diseases attribute to the disadvantage. Other factors can include marriage at a young age, frequent pregnancies, familial pressure, and lack of access to pre and antenatal health services.

If we wish to see progress, steps will need to be made with special attention to children's and women's health. This policy booklet attempts to take Parliamentarians through a policy plan with the ultimate goal to empower India's citizens with the ability to take control of their sexual and reproductive lives. Only in this way can each person raise their chances at improving their standard of living.

On behalf of UN Millennium Campaign, Oxfam India and CLRA, I am pleased to present this policy booklet outlining a 3-step Urgent Action Plan that will hopefully help lead the way towards ensuring the protection of citizens' sexual and reproductive rights. This booklet will provide MPs with the facts and figures needed to understand the gravity of the situation and the challenges blocking citizens' universal access to these rights. It takes a cursory look at public health in India as it stands, assesses the flaws in current Reproductive and Child Health policies, and highlights the roadblocks that will be faced in combating these weaknesses. It is time for the state to formulate and commit to a pragmatic and comprehensive policy plan, and to back it up with financial support. If India wants to achieve its MDG targets by 2015, it will need to start here.

Vinod Bhanu
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Sexual and Reproductive Health Rights under the Reproductive and Child Health Policy – Compromising Women's Dignity

Overview

Sexual and reproductive health rights are critical for achieving MDG targets related to maternal mortality, child mortality, gender equality, and HIV/AIDS reduction. Currently, India does not have the health systems in place to provide universal access to maternal and child health services, nor does it have a system of non-health interventions in place to ensure that the social determinants of health like sanitation, access to clean drinking water, and food are secured or adequate nutrition for mothers and infants ensured. What makes the situation most alarming is that the lack of health systems is coupled with a lack of any political and concrete fiscal commitment to secure the women's right to health. This is reflected in the general budget of 2010 that fails to allocate specific financial resources to address maternal and child health even though specific commitments were made as part of the 11th Five Year Plan.

In addition to a strong financial commitment from the state, the reproductive and health services in the country need to move away from a limited focus on population control, sterilisation and obstetric care to ensure that couples and individuals can make informed decisions about reproduction and women have access to essential pre- and ante-natal healthcare, education, income security and basic nutrition and the safe contraceptives to use. The success of this would depend on how far these programmes are based on gender equality, and universal and equitable access to health services. Maternal mortality will not be solved by lateral interventions alone: deaths occur because of underlying disease such as anemia, often undiagnosed urinary tract infections and pelvic inflammation. There are socio-economic factors underlying the reasons why women do not or cannot seek treatment for these conditions, primarily related to economic insecurity and gender inequality as well as lack of access to the full range of pre and antenatal health services. States such as Kerala show that it is possible to make progress in women's health through pro-poor development policies. Without due accord to women's health, India will fail not only its mothers but its children and generations to come.

This policy booklet is an attempt to bring women's and children's health to the attention of Parliamentarians, with detailed policy recommendations and actions for MPs. The genuine lack of real progress made towards the achievement of MDGs on maternal health, child mortality, gender equality and HIV/AIDS, etc is noted and it lists policy recommendations that they could take up and discuss in the legislative spaces of India.

Introduction

> [R]eproductive rights… rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence.
>
> *International Conference of Population and Development Programme of Action, Paragraph 7.3 (1994)*

Sexual and reproductive health rights are an important component of any strategy to address the woeful progress India has made towards achieving the Millennium Development Goals (MDGs) related to child mortality, maternal health, combating HIV/AIDS and other diseases. Gender inequality and unequal access to the aforementioned rights mean that India contributes more deaths than any other country to the global figure of 500,000 women and girls dying from pregnancy, childbirth or unsafe abortion every year. India is responsible for a quarter of global maternal deaths, the vast majority of which are preventable. In a 2009 report, Human Rights Watch found that 1 out of 70 girls who reach reproductive age will die of pregnancy, childbirth, or unsafe abortion in comparison to one in 7300 in 'developed' countries: a shameful statistic for a country known for its medical prowess. More are likely to suffer preventable injuries, chronic infections and disabilities due to failures in maternal care.

The Indian government systematically addressed the issue of maternal mortality under the National Rural Health Mission (NRHM). This programme includes a focus on maternal healthcare, with 'service guarantees' of free care before and during childbirth, in-patient hospital services, comprehensive emergency obstetric care, referral in case of sudden complications and postnatal and antenatal care. In a critical lapse, however, the government has routinely failed to monitor whether standards are being met on the ground. An additional problem concerns the poor levels of information about the scheme.

To date, there has been a sustained reluctance to openly discuss reproductive rights in India, particularly in the context of sexuality and women's empowerment. National family planning programmes remain fixated on technical innovations in contraception and sterilisation rather than addressing the wider sociological problems that endanger the health of the mother and infant.

This policy booklet is an attempt to highlight a way forward in the fight against maternal and infant mortality through a redefinition of reproductive and child health policy. It argues that problems in conception and delivery of RCH are largely a consequence of four key factors: gender inequalities, inaccessible health systems, a lack of preventative and potentially lifesaving interventions during women's childbearing years, and too little attention to reproductive rights.

It makes a series of recommendations on how progress can be made towards the international commitments spelled out in the MDGs on maternal health, child mortality and gender equality.

This Policy Booklet includes

URGENT ACTION PLAN FOR MPS

1. **Increase Budgetary Allocation** – The Indian government spends little more than 1 per cent of Gross Domestic Product (GDP) on health. Compared to other South Asian countries, this is extremely low. The Common Minimum Programme committed to 3 per cent GDP on healthcare before the UPA government ended its term in 2009. Health outcomes are dictated by this critical expenditure. Performance auditing and outcome-based audit mechanisms need to be introduced in order to review the existing pattern of investment in health and determine gaps and oversights that need urgent attention.

2. **Parliamentary Standing Committee on Health and Family Welfare** – This committee is empowered to make recommendations to the government regarding investments and to suggest avenues for future expenditure. Previous reports have highlighted the improper systematic allocation of funding and visible incongruities, which have led to a waste of public resources. The Parliamentary Committee must emphasise the expenditure required to improve primary infrastructure and emphasise outlays in the basic and as yet unmet health needs of women. Steps should be taken to improve female nutrition, combat anaemia, guarantee antenatal and post-natal care and safe abortion facilities, provide health education, raise awareness, promote reproductive and sexual equality, and to ensure comprehensive family planning services. Legal aid should be incorporated to counter violations of human rights.

3. **Laws: what to make, what not to make** – the existing legal framework has often directly contradicted the principles of sexual and reproductive health rights. Legislation promoting or

enforcing incentives for population control (such as electoral incentives or withholding development benefits) should be revoked in favour of increased promotion of reversible methods of contraception. While the Protection of Women from Domestic Violence Act recognises marital rape, stronger laws are needed to protect women who exercise their right to deny sex to their partners or command the use of contraception. Furthermore, abortion law needs to emphasise women's rights over their own bodies and reproduction. Section 377 of the Indian Penal Code should be modified to protect the rights of people with diverse sexual orientations, and separate legislation should be enacted to protect children from sexual abuse. MPs are expected to participate in mature dialogue and utilise their decision-making authority to ensure a legal framework that protects and promotes the rights of all Indian citizens.

4. **Member of Parliament (MP) Local Area Development Fund** – Each MP receives Rs 2 crore per annum for development works in his/her constituency. This amounts to Rs 10 crore of public money over a five year period. Improving the infrastructure and accessibility of public health services should be a top priority for strengthening service provision at the primary level, as well as targeting gender inequality in health and nutritional care services.

5. **Political Representation** – MPs hold the authority to direct the bureaucracy and pressurise the political capital to address poor planning and spending. As people's representatives, MPs should be demanding measures to ensure the safeguarding of universal sexual and reproductive health rights. They can also provide political representation by raising issues of denial and injustice experienced in a public facility.

What are reproductive rights?

The 1994 International Conference on Population and Development (ICPD) in Cairo demanded a fresh approach to reproductive rights in reproductive and child health (RCH) policy. Whereas earlier political dialogue was largely restricted to population control, it was now recognised that the reproductive needs of a population are not purely bio-medical, but also social and economic. Reproductive and child health policy was therefore expected to further universal accessibility of services, gender equity, sexual equality and the protection of women's rights.

Reproductive rights are understood to be the foundation for men and women's self-determination over their bodies and sexuality. They are critical for the achievement of gender equality and to ensure global progress towards fair and democratic societies. The evolving reproductive rights framework is based on two key principles: the right to reproductive healthcare and the right to reproductive self-determination.

These rights include:

- The right to a full range of safe and affordable contraception
- The right to safe, accessible and legal abortion
- The right to safe and healthy pregnancies

(Contd. on next page)

- The right to comprehensive reproductive healthcare services provided free of discrimination, coercion and violence
- The right to equal access to reproductive healthcare for women facing social and economic barriers
- The right to be free from practices that harm women and girls (such as female genital mutilation)
- The right to a private and confidential doctor-patient relationship

Based on an outline by the **Centre for Reproductive Rights**, **New York**[1]

[1]Source: http://www.reproductiverights.org/about.html

What are sexual rights?

A political approach to sexual rights must go beyond a preoccupation with sexual behaviour and assumed "deviancy". Rather, policy-makers must consider the social, cultural and economic factors that place individuals at risk and affect the ways in which sex is sought, desired and/or refused by women, men and young people.

This means re-interpreting sexual health as emotional and social as well as the physical absence of disease or infirmity. Rather, sexual health requires a safe and respectful approach to sexuality and relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

All persons have rights to:

- the highest attainable standard of sexual health, including access to sexual and reproductive healthcare services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;

(Contd. on next page)

- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and
- pursue a satisfying, safe and pleasurable sexual life.[2]

Based on an outline by the World Health Organisation, 2010

[2] World Health Organisation, http://www.who.int/reproductive-health/gender/sexualhealth.html

Sexual and Reproductive Rights and Women

Traditional gender assumptions have denied women the right to sexual expression and the freedom to negotiate sexual relations on their own terms.

It is now widely recognised that physically or psychologically unhealthy mothers do not have healthy children,[3] and that safe and consensual relationships are a necessary condition for healthy reproduction. Even in the most straightforward terms, violence, abuse or sexual inequality can result in physical and psychological illness, injury, infertility, risky/spontaneous abortion and even mortality.

Ensuring sexual equality is therefore an extremely important public health issue, and health interventions cannot ignore the socio-economic factors that hinder the fulfilment of sexual and reproductive health needs. Women need to be able to decide about child-bearing and spacing on their own terms, must know how to protect themselves from sexually transmitted infections, and be able to make decisions about sexual relationships. Issues such as the status of the girl child, adolescent health and education, domestic violence, and women's empowerment must become integral components of government interventions in reproductive and sexual health.

Sexual Equality in India

Maternal and Child Health Policy (MCH), Reproductive and Child Health Policy (RCH), the National Rural Health Mission (NRHM) and the Janani Suraksha Yojana (JSY) have all fallen short in targeting basic gender prejudice and addressing gender-specific needs in health service provision. In a recent report, the United Nations has highlighted how discrimination makes a woman more vulnerable to disease and mortality:

> "Out of every 1,000 children born in India, almost 70 die within a year. But conditions for child survival show a clear prejudice against the girls with **female infant mortality rates being higher than male infant mortality rates**. This difference is more pronounced in rural areas than in urban areas.

[3] State of the World's Children Report, The Double Dividend of Gender Inequality (UNICEF; 2007)

"**Female foeticide and female infanticide** signal the grossest form of discrimination against women in India. But this is not the only reason for a steep declining sex ratio. Girls in India suffer from some special disadvantages, reflected in **fewer months of breast-feeding**, **less of nurturing and play, less care or medical treatment if they fall ill, less of special food, and less of parental attention**. As a result, girls are far more susceptible than boys to disease and infections, leading to poor health and a shorter lifespan. It is this life-long discrimination in nurturing and care that is the real killer of girls – less visible and dramatic, but as unequivocally lethal as female foeticide and infanticide.

"Many so-called female conditions are not considered health problems either by healthcare professionals or by women themselves. As a result, most illnesses remain unrecognised and go unreported. The fact that the **majority of doctors in rural areas are men** is another deterrent. Women are reluctant to describe their symptoms to a male doctor, or allow themselves to be physically examined by a man".

– United Nations, *Women in India: How Free? How Equal?* (2001)

The fact that women have little autonomy even in household decisions directly and indirectly affects their access to health services. For example, in the UN report nearly a third of women in Uttar Pradesh were shown to be excluded from decision-making about cooking. The implications of such statistics are serious. A woman who cannot decide what and how much to cook for the family will have little control over her own diet, and, 'being the last to eat', she is also likely to eat the least. Her special needs during periods of illness, pregnancy or breastfeeding will go unrecognised and ignored. Added to this, **less than 50% of women in Uttar Pradesh, Madhya Pradesh and Andhra Pradesh are involved in decisions about their own healthcare.**

Lack of due priority to female health and nutrition also affects prenatal care, a vital factor in reducing the incidence of both infant and maternal mortality. Most Indian women do not have the luxury of **maternity leave**. Women who are dependent on a daily wage often work through to the very end of the third trimester, and return to work as soon as possible after the birth. This leaves little time for care of the infant or the mother herself, and work, particularly rigorous manual labour, demands extremely high energy consumption among pregnant and lactating women. It has been found that the largest deficits of calorie consumption actually occur among new mothers and pregnant women. This not only affects the health of the mother, but contributes to foetal loss, low birth weight and infant mortality.

In some parts of the country, female malnutrition during pregnancy is a consequence of misinformation among the public, something which government health initiatives have not addressed. For example, **papayas, pineapples, eggs and drumsticks are sometimes thought to cause abortions** and are therefore avoided by pregnant women. Ironically, all of these foods are rich in iron and Vitamin A, essential nutrition for a safe pregnancy and a healthy baby. In many regions, pregnant **women are not given rich foods like milk and fats, because it is thought that these will make the baby too large and difficult to deliver.**

An important step is for the government to target inequality through education, beginning at the primary stages. However, the **difference between male and female literacy rates remains intimidating**. There are only three states - Kerala, Mizoram and Meghalaya - where the gap is less than 10 percentage points. Education can promote gender equality and level differences, as well as offer alternatives to early

marriages which jeopardise female health. Unfortunately, recent reports have shown that the majority of schools do not even have usable toilets for girl pupils.
In addition, women are still not represented in higher political structures and the Women's Reservation Bill has not been passed. This sets a precedent of denying women political presence and decision making authority in high legislative spaces.

Current Reproductive and Child Health Policy

The RCH policy was launched in 1997 (Ninth Five Year Plan) to incorporate the recommendations of the ICPD. The focus of RCH policy was on participative and community needs-based assessments and its remit included a wide range of services. For the first time, men were also involved as equal partners in taking responsible decisions in regard to family size and the health of the mother and child.

From 1st April, 2005, The RCH programme entered into its second phase. Phase II aims to:

- **Reduce maternal mortality ratio (MMR), infant mortality rate (IMR), total fertility rate (TFR) and increase immunisation coverage** of children
- **Minimise regional variations**
- Make provisions for a common essential package of service delivery mechanisms.
- Ensure that the **system is geared up to mission mode** through clear benchmarking.

Public Health in India

Reproductive rights cannot be guaranteed without first addressing the dire state of India's public health facilities.

- **India's Infant Mortality Rate (IMR) is estimated to be 57** per 1000 live births. The National Rural Health Mission (NRHM) envisages reducing the IMR to 30 by 2012. At the current rate of progress, this target cannot be achieved without the introduction of immediate reforms. The **Under-5 Mortality Rate for girls is 81** and **for boys is 72**. The Under-5 Mortality Rate for the **lowest wealth quintile is 100.5** (WHO, 2006).
- The **Maternal Mortality Rate (MMR) in India is 450** per 100,000 live births, which amounts to a massive 20 per cent of the world's maternal deaths. Targets established in the Eleventh Five Year Plan (including a reduction of the MMR to 100) are far from being met.

- **India invests just slightly more than one per cent** (i.e. US $6.39 per capita per annum) of its Gross Domestic Product (GDP) in healthcare, despite the fact that the international Commission for Macroeconomics and Health advises minimum expenditure of US $30-$40 per capita. To reach the target of three per cent GDP, **both Central and State Governments would have to more than triple their budgets**.[4] As a point of contrast, the Sixth Pay Commission has increased salaries and in so doing reduced the amount available for expenditure on essential health services.

- A **focus on "vertical, campaign-like" interventions** – for example, polio eradication and HIV/AIDS – has detracted from the need to first secure universally accessible, available and equitable health services. **The World Health Organisation (WHO) has identified severe bleeding, infection, unsafe abortions, hypertensive disorders, and obstructed labour as the most common causes of India's high maternal mortality rate,**[5] many of which result from pre-existing and unaddressed health conditions such as anaemia and malnutrition. However, over-concentration on technical failures has curtailed critical interventions to reduce risk factors. These include combating malnutrition among women and children; realigning skewed gender relations; improving inadequate supportive infrastructures such as transport; addressing unemployment and poverty, and challenging discriminatory attitudes of health personnel to certain sections of the populace.

- National Family Health Survey (NFHS) data suggests that the lack of progress in reducing infant and maternal mortality can largely be attributed to high rates of female malnourishment and limited access to pre/ante-natal care and other essential services. Surveys suggest it is difficult to find even a general practitioner in rural areas (WHO, 2005), since doctors tend to gravitate towards urban locations. There is **a national shortage of 20,903 Sub-Centres (SCs), 4803 Primary Health Centres (PHCs) and 2653 Community Health Centres (CHCs),** as per the 2001 population norm, and there is only **one bed per 6000 people.**

- **The density of community and traditional health workers is under 1 per 10,000 population**. A Civil Society Review of the National Rural Health Mission (NRHM)[6] highlighted severe deficiencies in terms of community staffing.

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4 Ravi Duggal – "Health Budget 2006-07: New Directions?" Express Healthcare Management Issue, April 2006

5 WHO, 1999 "Reduction of Maternal Mortality. A Joint WHO/UNFPA/UNICEF/World Bank Statement."

6 The People's Verdict - 4th Civil Society Review of the National Common Minimum Programme, May 2008. "NRHM Needs to Survive the UPA Government" by Dr. Abhijit Das and Dr. Jashodhara Dasgupta

- Although current Reproductive and Child Health (RCH) policy clearly identifies 8 poorly-performing "Empowered Action Group" (EAG) states, there is still **marked inequality in the availability of essential healthcare** facilities and services. Focus states include Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Rajasthan, Orissa, Chattisgarh and Madhya Pradesh. According to UNICEF, Madhya Pradesh, Assam and Uttar Pradesh have Maternal Mortality Rates (MMR) of 700 or more per 100,000 live births.[7]

[7] The Hindu, 11th February, 2007 – 'Maternal Mortality Rate High in MP' - http://www.hindu.com/2007/02/11/stories/2007021102940700.htm

RCH: Conceptual Flaws

- **Obsession with obstetrics** – The RCH policy places an excessive emphasis on obstetric care as a means of curtailing maternal mortality. It is important to recognise that mothers will use emergency services if they are accessible, available and required. The Janani Suraksha Yojana (JSY) serves only to sideline basic antenatal and postnatal health, as well as questions related to nutrition, child marriage, anaemia and family planning. Providing these basic services would be far more effective in reducing maternal mortality, ensuring child survival, and providing long term health benefits to both mother and child.

- **Masked targeting –** One of the goals of the RCH-2 policy is to "ensure that the system is geared up to mission mode by using performance benchmarking and accountability tools". This indirectly implies the use of targets. Thus, while RCH has been labelled a "Target Free" approach, this is mere rhetoric. Surveys by NGOs and health associations have revealed that every state has a target for sterilisation. 'Expected levels of achievement' are given to Primary Health Centres (PHCs), Community Health Centres (CHCs), and municipal and public hospitals for motivating people to undergo sterilisation.

- **Education and Information** – Poor health indicators are largely a consequence of unavailability of information, and women remain uninformed about their reproductive rights. RCH policy fails to address the health needs of young people who are just entering their reproductive years. Schools and colleges are easy entry points to disseminate information on RTIs/STDs, sexual abuse, sexual health, sexual and reproductive rights, contraceptive options, family planning, as well as gender awareness, but this is not discussed in RCH.

- **Inability to integrate related issues** – RCH policy does not advocate empowerment of women and children to counter inequality – for example, female foeticide and infanticide, child marriage, domestic violence, child sexual abuse, the low female literacy rate, unavailability of services and unequal access to services, non-existent maternity leave and welfare benefits for women in the unorganised sector. In turn, minimal sexual education creates a lack of awareness among children and young people, which increases their risk of sexual ill-health, abuse and/or victimisation. These cross policy issues are vital for the creation of sustainable programme

activity with an emphasis on prevention and promotion of good health and safe sexual practice.

- **Gender bias** – In order to meet the health and reproductive needs of women, RCH supposedly presents a woman-specific plan of intervention. However, the issue of reproductive health and reproductive rights pertain to both 'wife and husband', and both need to be considered equal participants. It is found that less than 5 percent of couples in India rely on condoms and vasectomies for contraception (Outlook[8] – UNFPA). Women and men both have to be able to make conscious decisions regarding the best contraceptive and family planning strategy for their family. Condoms are not exclusively a male prerogative; women too should possess information and access so that they can insist on condom usage.
- **Poor infrastructure** – While institutional deliveries are accorded top priority, adequate infrastructure and services often cannot deliver the necessary care to women before, during and after birth. Moreover, institutions lack female doctors which are a priority in order to promote women's participation and confidence.

Disadvantaged SECTIONS

Health policies in India have largely excluded the concerns of minority segments, Scheduled Castes (SC), Scheduled Tribes (ST) and below poverty line (BPL) families, and this is likely to affect the rate at which India is able to achieve MDG targets.

- **Infant mortality (IMR) and under 5 mortality rates (U5MR) are lower for Muslims** than for the state of India as a whole. Muslims have the second lowest IMR and U5MR rate of any socio-religious community in India. Other indices show that Muslims have far less "daughter aversion" than other communities in India. Despite these positive statistics, there is still a high rate of malnutrition among Muslim children, as well as low vaccination rates and high incidences of diarrhoea.
- In terms of contraceptive prevalence, there is a **gap of ten percentage points between Muslims and the non-Muslim average**.
- For Nomadic Tribes of Andhra Pradesh, the **maternal mortality rate is more than 1000,** whereas the national average is around 500 (per 1 lakh). Their 2.2 per cent of families are HIV affected and 1.35 per cent of these have Tuberculosis.

Measuring India's progress on the MDGs: A Citizens' Report, Wada Na Todo Abhiyan (2005)

[8] Outlook – UNFPA, Volume 21, Number 3

HAS THE RCH FAILED? - FACTS AND CHALLENGES

MATERNAL HEALTH AND CARE

1. Less than half (43%) of women received adequate care during the first trimester of pregnancy. Just over half of mothers had three or more antenatal care visits, and urban women were much more likely to receive three or more visits than women in rural areas (NFHS-3).

   Antenatal care was accorded a very high priority in RCH policy. Even after a decade of its execution, however, a majority of women are not receiving proper attention at the time of pregnancy. Vaccination for tetanus, a critical intervention to help prevent infection at childbirth, has also received limited commitment.

2. Only 37 per cent of mothers receive a postnatal check-up within 2 days of birth, as is recommended in existing guidelines; most women receive no postnatal care at all. (NFHS-3).

   Given the extent to which maternal and infant death occurs in the first days after birth, the early postnatal period is the ideal time to deliver interventions. According to data provided by the United Nations, the neonatal mortality rate (the number of deaths of children under 28 days of age per every thousand live births) is 43 (2008). As a point of contrast, this is 4/1000 in the United Kingdom and 11/1000 in neighbouring Sri Lanka. Even in lower income Bangladesh, the incidence stands at 36/1000.[9]

Inner Spaces Outer Faces Initiative (ISOFI): A Gender and Sexuality Project in Uttar Pradesh

Inner Spaces Outer Faces Initiative (ISOFI), an operation research project implemented by CARE India with research support from the International Centre for Research on Women (ICRW), attempted to analyse how gender and sexuality (G&S) integration into Sexual Reproductive Health (SRH) has positive effects on cognitive, behavioural and health outcomes. The case control pilot implemented in two districts of Uttar Pradesh (India), namely Barabanki and Raibareily, has shown a demonstrable improvement in maternal and newborn health outcomes by integrating gender and sexuality into interventions. The project designed interventions to address the gender inequities with individual couples, with women in groups, and at the community level through service providers, i.e. by enhancing access and control over resources, improving restricted mobility, tackling unequal power relations and addressing son preference.

At the end of the project, women in the intervention districts reported an increase in their discussions about family planning with spouses, from 42.3% to 90%; an increase in the use of family planning methods, from 7% to 35%; more women reported being involved in decision-making at home, up from 49% to 71%; more women reported that they felt they had a right to refuse sex if they wished, from 37% to 95%; and more women reported expressing sexual needs to her spouse, from 25.4% to 67.5%.

This was a pioneering project in India due to its unique design, process and approach, involving the most marginalised women through a participatory and rights-based methodology.

Source: Care India

[9] United Nations Children's Fund, State of the World's Children (2008). Available online at http://data.un.org

3. More than half of women in India—55 per cent—are anaemic, including 39 per cent with mild anaemia, 15 per cent with moderate anaemia, and 2 per cent with severe anaemia (NFHS-3).

   High rates of anaemia confer a higher susceptibility to casualty during child birth. Furthermore, anaemia among pregnant women has translated into high rates of anaemia among children. This weakens the child's immune system and therefore makes him/her more prone to infection. The introduction of Iron-Folic Acid (IFA) tablets, as postulated by RCH policy, has had limited success in breaking the vicious cycle of malnutrition.

WOMEN'S EMPOWERMENT

4. Almost half (46%) of women aged 18-29 years were married before the legal minimum age of 18. Furthermore, 16% of girls in the age group 15 to 19 years have borne a child, which increases to one out of every four teenage girls in Jharkhand, West Bengal and Bihar (NFHS-3).

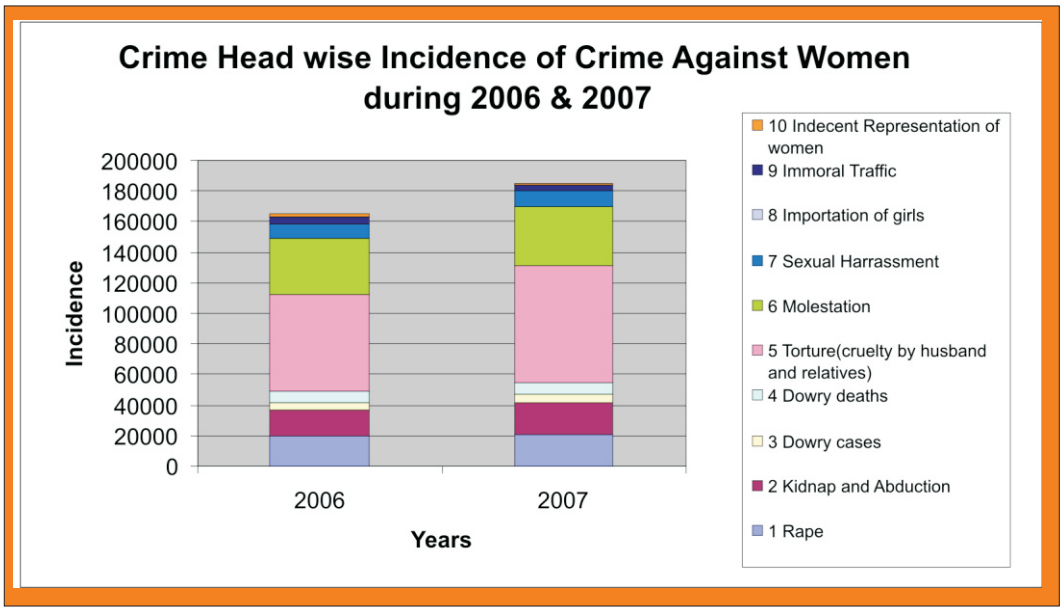
   Children born to mothers under age 20 are more likely to die in infancy than children born to mothers in the prime childbearing ages. Infant mortality is 77 per 1,000 for teenage mothers as compared with 50 for mothers aged 20-29, and the mothers themselves are also more exposed to major risk factors such as high blood pressure. Women are not exercising the right to decide when they can marry and begin childbearing, and as a consequence they and their children are being exposed to significant health risks. RCH policy has no mechanism to address this concern.

5. More than half of women in India—54 per cent—believe it is justifiable for a husband to beat his wife under some circumstances. Thirty-five per cent of women in India have experienced physical or sexual violence, including 40 per cent of ever-married women (NFHS-3)

   Subjection to physical and sexual violence deprives a woman of the right to participate in decisions that immediately impact upon the health, wellbeing and welfare of both her and her family. These include factors that directly correspond with the mandate of RCH policy, such as child birth and spacing and the use of contraception. If women are not able to negotiate satisfying, safe and consensual sex, this will have significant repercussions on reproductive health. Lack of societal and judicial support perpetuates mass acceptance and submission to such crimes.

6. Crime against women in 2007 has increased by 12.5% over 2006 and by 31.8% over 2003. High incidence of domestic violence and a continuing rise in cases of molestation and rape underline the inability of women to prevent their victimisation. It also indicates state inertia in protecting women and penalising the perpetrators of violence and abuse.

   The Indian police and judicial system rarely take action to resolve cases that are reported and bring justice to women victims. Such inaction ultimately lends support to the crime and discourages other women from coming forward and reporting abuse (see next page).



7. Only one in four women who have ever experienced violence has sought help to end the violence. Two out of three women have neither sought help nor told anyone about the violence (NFHS-3).

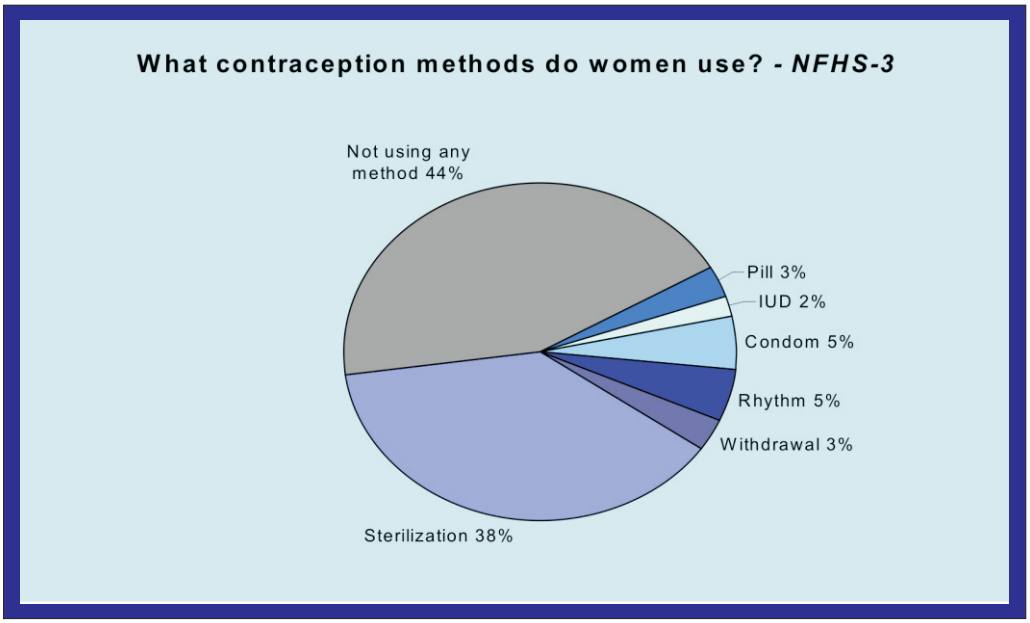
If women are treated as mere objects of sexual gratification, they will be unable to negotiate conditions for consensual sexual relationships and they are less likely to seek or be able to access adequate care. Women who leave violent spouses are also commonly victim to social exclusion. Lack of awareness about rights and a corresponding absence of support –counselling, medical help, and legal recourse – can lead to shame and concealment. Both the NRHM and the RCH policy do not consider domestic violence and sexual equality to be within their remit

FAMILY PLANNING, CONTRACEPTION AND ABORTION

8. Among all births in the five years before the survey, 10 per cent were mistimed (wanted later) and 11 per cent were not wanted (NFHS-3). If all women were to have only the number of children they wanted, the total fertility rate would be 1.9 instead of 2.7 (NFHS-3).

Lack of awareness among women is still a major problem, and there is limited access to needs-based services. Instead, national programmes have continued to promote sterilisation as a means of birth control, thereby restricting women's access to alternative and reversible methods of contraception.

9. The contraceptive prevalence rate among currently married women is 56 per cent, up from 48 per cent in NFHS-2. However, female sterilisation accounts for two-thirds of all contraceptive use. (NFHS-3)



RCH does not promote the use of condoms in family planning, nor does it discuss the possibility of male along with female sterilisation. RCH has failed to realise promises to expand provisions of alternative methods of contraception. In contrast, the high prevalence of irreversible sterilisation reveals a hidden objective of population stabilisation. Even the recently initiated Janani Suraksha Yojana (JSY) carries a clause which determines that, after the third live birth, financial assistance will be extended to below poverty line (BPL) families if the mother elects to undergo sterilisation.

10. Only about **one-third of modern contraceptive users were told about the side effects** of their chosen method, and just one-quarter were told what to do if those side effects occurred. Fewer than 3 in 10 were informed about alternative methods. Women who know about alternative contraceptive methods and their side effects can make informed choices.

Today, there exists a wide range of contraceptive options. However, people face considerable misinformation about these options and their side-effects, accessibility and affordability. Moreover, people also remain inadequately informed about what to do if their contraception fails and possibilities for obtaining emergency contraception (EC), commonly known as "the morning after pill". Although not suitable for regular usage, EC is highly effective when there is risk of conception in case of condom bursts, missed oral contraception pills, rape, etc.

11. Public investment in abortion services is grossly inadequate. **87% of the abortion market is controlled by the private sector**, and the average (median) cost of seeking abortion privately is Rs. 1294 - 7.5 times more than the cost in public facilities. This constitutes a major handicap for women who come from poorer classes or other disadvantaged groups such as Dalits and Adivasis (Abortion Assessment Project, India or AAPI – 2000).

Sexual Education

Historically, 'Adolescent Education' emerged out of discourse over population policy in India. When the Government of India launched the Family Planning Programme in 1952, it was among the first of its kind in the world. By the mid 1960s, under pressure from international agencies and as a result of internal economic crises, the Indian government decided to intensify population control measures.

According to the ICPD PoA, "The response of societies to reproductive health needs of adolescents should be based on information that helps them attain a level of maturity required to responsible decisions. In particular, information and services should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility" (POA, Chapter VII, Adolescents, 7.41. It further mentions that "Governments, in collaboration with non- governmental organizations are urged to meet the special needs of the adolescents and to establish appropriate programmes to respond to those needs. Such programmes should include support mechanisms for the education and counseling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behavior, responsible family planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention. Programmes for the prevention and treatment of sexual abuse and incest and other reproductive health services should be provided" (POA, Chapter VII, Adolescents, 7.47).

In India, sexual education is yet to be included in the school curriculum. It is ironic that nearly 60 years since India launched its Family Planning Programme (1952), 35 years since the legalization of abortion in the country (1971), 25 years since the first infection was detected in the country (1985), and 15 years after the ICPD, there is still silence and confusion around the importance of providing sexual education to young people.

Source: TARSHI, New Delhi

Even though abortions have been legalised, **legal does not necessarily imply safe**. Abortion facilities and services have never been user-friendly. Service providers, especially in formal and certified facilities, do not provide services to women if they come alone and/or if the spouse or a close relative does not provide consent. Visits to government hospitals are also not cost-free because women have to pay for medicines. They are sometimes required to make repeat visits before the abortion is performed, which proves very costly (AAPI). Moreover, illegal abortions are rampant. According to the Consortium on National Consensus for Medical Abortion in India, out of the four million induced abortions in India only 4-5 lakh are legal.

12. Premarital sex varies from **17% among schoolchildren** to 33% among young workers in the typical north Indian population. Of 3300 respondents to a recent study, around one-third was found to be lacking in awareness of safe sex. Two common reasons for not using condoms were reluctance in obtaining them (39.3 percent) and the fear of side effects (34.3 percent) (National Institute of Heath and Family Welfare, 2001) A 1997 study of 966 Mumbai college-goers revealed that 47% of male and 13% of female participants had engaged in some form of sexual activity (International Family Planning Perspectives).

Sexual education is not a focus of RCH policy, although clearly it is a necessary preventative intervention in promoting and protecting both reproductive and sexual health and rights. According to the UN Convention on the Rights of the Child, young people have a

fundamental right to information that will empower them to protect their own health and wellbeing. Educators can make children aware of sexual abuse and exploitation as well as STIs, HIV/AIDS and pregnancy, and provide information for appropriate channels of redress. Moreover, participatory sex education encourages discussion of relationships, including those between men and women. International research has shown that life skills education programmes defer rather than encourage sexual activity, motivate the use of contraceptives and reduce the number of sexual partners. Programmes can also be coordinated with health and support services and, where appropriate, contraceptive distribution.

REPRODUCTIVE TRACK INFECTIONS (RTIS)/SEXUALLY TRANSMITTED DISEASES (STDS)

13. Nationwide, **only 17 per cent of women and 33 per cent of men have 'comprehensive knowledge' of HIV/AIDS** (NFHS-3).

RCH policy places special emphasis on Prevention and Management of RTIs and STDs, including HIV/AIDS. However, awareness is far lower among rural and lower income populations. Combating lack of information among the public is a major and necessary intervention both for disease prevention and to avert victimisation of people living with HIV/AIDS, especially among the rural populations.

INDIAN ADVERTISEMENT ON CONDOMS WINS UN AWARD

Innovative strategies to catch the attention of youth and disseminate crucial information for promoting safe sex practices are becoming popular. **The campaign, "Condom Bindaas Bol" ("Say Condoms Freely") has won a United Nations award for excellence in public information campaigns that tackle priority issues. It was created to overturn a decline in condom use and sales in eight states in northern India - Delhi, Rajasthan, Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chattisgarh, Bihar and Jharkhand. "Condom Bindaas Bol" is the result of a joint effort of PSP-One, a US Agency for International Development (USAID) and the Indian Government's Ministry of Health & Family Welfare and ICICI Bank. This campaign could be expanded and replicated across states.**

14. Only **9 percent of the women in the poorest fifth** of the population are aware that **condom use can prevent transmission of STIs**. (NFHS-3)

Condoms are an effective and cheap form of contraception, as well as one of the best methods of preventing STIs. Information, Education and Communication (IEC) initiatives should therefore be strengthened to incorporate promotion of condoms in facilities that are easily and universally accessible to all members of the community.

Helpline for Sexual Problems

The National Population Stabilisation Fund has started a helpline to provide confidential counselling services and immediate answers to queries on sexual problems. The toll free service at 1800116555 is available from 9 a.m. to 6 p.m. A team of health executives and doctors answer questions about sexual health concerns, sexually transmitted infections, contraception, pregnancy, infertility, abortions, menopause and puberty and can explain the functioning of the reproductive systems of males and females. The helpline will also work towards removing popular misconceptions about sex, important in a country such as India where the subject is still socially taboo. When experimented with in schools, confidential information services have been shown to be in high demand. They can help in providing objective advice from a respected source rather than peers, the internet and word of mouth, increase public knowledge of their rights and trust in public facilities, and can reduce the bridge between users and services.

POLICY RECOMMENDATIONS FOR THE REALISATION OF REPRODUCTIVE RIGHTS

The right to sexual equality

Ensure access to sexual health information and care services for women and men alike, beginning with sexuality education in schools and continuing through education campaigns and confidential service and advice. Educators and policy makers need to take a firm stand on the matter of introducing participative sex education in schools in order to offer the best degree of protection for India's youth and to promote sexual equality.

- Scrap Section 377 of the Indian Penal Code as a top priority. The right of people of alternative sexual orientations to sexual expression should be protected, instead of penalising, harassing and ultimately forcing them underground. This will bring them within the remit of public and sexual health interventions, and will therefore allow effective targeting of a high risk group for HIV/AIDs and other sexually transmitted infections.

The right to a full range of safe and affordable contraception

- Introduce safe, affordable alternative methods of birth-spacing and raise awareness about available methods among both the public and the medical community. The advantages and potential side-effects of each should be highlighted. The availability of condoms, the contraceptive pill and male sterilisation should be universally secured.
- Widely promote and introduce campaigns for condom use, since they are not only cheap but can be made widely available through chemist shops, grocery shops, local health centres, self help groups and even in colleges. They are not only effective contraceptives but also prevent transmission of sexually transmitted diseases. Girls should also be targeted and included in the promotion of condoms.
- Facilitate access to emergency contraceptive pills, which enhance the reproductive rights of the woman and have the potential to reduce unintended pregnancies and subsequent abortions. These need to be supplied to ASHA workers for immediate action in case of condom bursts, missing a dosage of oral contraception pills or rape.

The right to safe, accessible and legal abortion

- Clear the political and social confusion between safe and illegal abortions. A concrete strategy for promoting confidential abortions for women and teenage girls is essential to prevent women falling prey to illegal service providers.
- Integrate abortion services through Primary Health Centres and Community Health Centres. Train public abortion providers and take steps to eradicate illegal (and unmonitored) abortion facilities.
- Improve awareness about contraceptive options and universal access to these methods, which will reduce the demand for abortions (see above). Abortions will persist as long as women face unwanted pregnancies, and unwanted pregnancies will continue to occur until women gain the power to determine their sexual behaviour.

The right to safe and healthy pregnancies

- Improve the condition of health centres as well as promoting institutional deliveries. Adequate infrastructure needs to be provided before incentivising use of services, which means guaranteeing an optimum number of beds (according to village/district population), 24 hour availability of doctors, nurses and other medical staff, necessary diagnostic and treatment equipments, provisioning of essential drugs and injections and appropriate storage facilities.

- Increase budgetary allocation for the health sector to the established target of 2-3% GDP. Install incentives and higher remuneration for doctors working in rural areas and the public sector and consider higher taxation on doctors working in private hospitals. Also, additional mechanisms need to be introduced and enforced to ensure the availability of health professionals at all times.

- Identify loopholes in existing policies, such as overambitious targets and inadequate emphasis on primary issues such as maternal health and nutrition of women/children. Look at ways of incorporating interrelated and cross-departmental issues into RCH Policy – for example, child marriage; adolescent sex education; child sex abuse; domestic violence, and reproductive rights. This will enable a more comprehensive and inclusive policy.

- Initiate preventative steps to improve the health and nutritional status of local women through ASHA workers and local dais. This means monitoring of weight/deficiencies, distribution of supplements and counselling where necessary, and providing information about reproductive health/care during pregnancy.

- Evolve mechanisms for accountability and monitor service delivery, including ante-natal and post natal care, the Child Development Scheme and iron and folic acid (IFA) distribution. Records of post and antenatal care visits should be maintained and checked without intimation by a higher authority, with penalties imposed for fraudulence. Ensure intake of Iron-Folic Acid (IFA) through proper administration by local workers/ASHAs or alternative programmes. Examples can be taken from TB control initiatives, whereby medicine is administered by nurses/health workers and records of immunisations are maintained.

- Ensure ASHAs, dais and field workers have access to the necessary medicines and equipments for proper diagnosis, treatment and care.

- Incorporate factors such as transport availability into planning processes, which often escape the purview of a health specific policy but greatly impact upon its effectiveness.

The right to comprehensive reproductive healthcare services provided free of discrimination, coercion and violence

- Initiate constitutional reform for recognition and inclusion of reproductive and sexual rights as fundamental obligations which can be contested in the court of law.

- Take steps for the capacity building of policy makers, judiciary, law-enforcement agencies, state government and district or village level bodies so that they are willing and capable of safeguarding and promoting universal sexual and reproductive rights.

- Introduce gender sensitive training programmes for health personnel, ASHAs and other local workers for the proper understanding and implementation of reproductive rights.

- Evolve mechanisms and strategies to disseminate education and awareness about sexual and reproductive health. Use schools, universities and health centres as entry points for such interventions, particularly focusing upon adolescent populations, and develop community-based peer-education programmes. Peer educators should be equipped to provide referrals to

other services in the community. Utilise information, education and communication (IEC) for spreading awareness about issues related to sexual health.

- Target the vulnerable and marginalised. In addition to education through the formal school system, it is necessary for campaigns to reach the 70 million young people who are currently out of school. These are likely to represent the most vulnerable and high-risk groups, including street children, children living with disabilities, children in institutions and child labourers.

The right to equal access to reproductive healthcare for women facing social and economic barriers

- Improve access of disadvantaged sections of society to reproductive and child health services, including teenage girls, divorced/separated women, and widows. These women have difficulty accessing contraceptives and abortion facilities as a result of social exclusion and stigmatisation. Implement financial assistance programmes for below poverty line (BPL) families to allow equitable access.
- Introduce affirmative action for improving access to health services through provisions such as the Tribal Sub Plan and Sub Plans for Other Disadvantaged Sections (SC/Minorities/OBCs). These allow additional funding to reduce inter-community variation.

The right to be free from practices that harm women and girls

- Ensure adherence to the legal marriageable age of 18 years for women. Focus must be increased on communities where customary practices of early marriage are high. The Prohibition of Child Marriage Act must also be amended to make all child marriages void, irrespective of who files the complaint.
- Implement a law to combat child sexual abuse, protect minors and offer them legal protection. This is still not covered under the Indian Penal Code (IPC). Such inadequacies protect the offenders and promote the crime.
- Recognise forced sex or marital rape between couples within Section 375 of the IPC. This will accept the right of a woman to disallow non-consensual sex. The laws that do not protect women's dignity and her right to make autonomous decisions about her body and sexual behaviour must be scrapped.
- Sensitise law enforcement agencies about issues related to non-consensual sex, child sex abuse and domestic violence.
- **Emphasise the gender-sensitive, life skills training** aspect of the Adolescent Education Programme (AEP) in order to promote gender awareness in boys and girls from a young age. Due to a lack of information, many fall victim to trafficking, forced marriages, unwanted pregnancies, unsafe abortions, sexually transmitted diseases and child abuse.
- Use community led programmes to educate and raise awareness about legislation and policy. Formally structured critical masses of women such as Self Help Groups are good support systems to counter domestic violence. The involvement of all sections of society should be promoted, including men and boys. Links should also be created between health programmes and support groups, education and information campaigns in order to raise awareness about

legislation against domestic violence. This will help address social attitudes towards women's rights and domestic abuse.

The right to a private and confidential doctor-patient relationship

- Ensure that all services are universally available. This means eliminating restrictions that insist on familial/spousal consent for females, which act as a deterrent to women seeking abortions and sterilisations. Provisions are needed to ensure confidentiality for women consulting a doctor, with well documented and publicised avenues for legal redress if this confidentiality is breached.
- Provide urgent legal and infrastructural arrangements to allow women access to medical aid and confidential bonding with care/support providers. Cases of domestic violence and spousal abuse are frequently concealed and suppressed by the family, and women are consequently unable to avail the medical aid that they require.
- Spread awareness about the toll free helpline for providing immediate answers to problems related to reproductive health and contraception. Telephonic counselling with doctors and health service providers can deal with the taboo associated to sexual health concerns, and bridge the gap between the users and necessary information and services.

Social Audit of Maternal and Infant death: To Ensure Transparency and Public Accountability

A Social Audit to analyse the medical, social, economic, systemic, and underlying causes of maternal and infant death is possible. CARE India's USAID/Futures Group supported a Social Audit and verbal autopsy project in five tribal dominated districts of Jharkhand, showing the way for ensuring public accountability in a democracy. The process of questioning and inquiry through a systematic demand for information by the community ensures public accountability, besides raising awareness about rights and entitlements in the community. In Phase I, the project started with identification of deaths covering 1143608 households following a house-to-house listing process. The approach resulted in the identification of 47129 infant death cases and 4152 maternal death cases in a three year period. During Phase II, verbal autopsies, social audits and in-depth interviews among service providers were conducted in select cases with active facilitation by the Care team with participation from civil society organisations and functionaries from the state government. The process involved display (entitlements and deprivations in health and nutrition services and supplies), discourse (interactive engagements with the most marginalised) and discussion (questioning).

The findings from the Social Audit project revealed that the marginalised communities, especially women entitled to health and nutrition services and supplies were excluded from services due to factors related to (a) social – cultural/ethnic, (b) geographic, (c) policy, and (d) economic constraints. There were many issues of poor transparency and public accountability.

The social audits proved to be an effective means for understanding the social construct and issues of local governance that have a bearing on effectiveness of services. As the conduct of social audit is founded on partnerships with health departments and other civil society organisations, corrective actions were initiated by all stakeholders. It empowered the most marginalised women to raise their collective voice and demand for services and hold the system accountable.

Source: Care India

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