COUNTRY PROFILE

ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE RIGHTS: INDIA

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1. Introduction

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

As per the 2011 census, about 30 percent of the population in India are young men and women between the ages of 15- 24 and a little more than one-fifth are adolescents aged between 10-19 years (Census of India, 2011).While looking into the age structure of population over the last five decades, there has been a gradual decline in the population of individuals between the ages of 0-14 years in every census. The proportion of the population in the 0-14 age group declined from 41.2 percent in 1971 to 36.3 percent in 1991 and then further to 29.5 percent in 2011. On the other hand, the proportion of economically active population between the ages 15-59 has increased from 53.4 percent to 57.7 percent during 1971-1991 and further to 62.5 percent in 2011 (Sample Registration System, 2012). So, as a result of the steady decline in fertility and increase in life expectancy, India's age structure has moved from a predominantly child population to a predominantly adolescent and adult population.

According to the Sample Registration System estimates for 2012, the crude birth and death rates were 21.6 and 7 per one thousand population. Rural –urban differentials in birth rate was wide. The birth rate in rural areas was 23.1 compared to17.4 in urban areas. The infant mortality rate (IMR) was 42 per 1000 live births (Sample Registration System, 2012). The rural-urban and gender disparities in IMR was very significant. Unlike the situation in many developed countries and also as against biological theories, the IMR of India was higher among females (44) than males (41). This is mainly due to greater gender bias and discrimination of female infants. Again, the infant mortality rate in rural areas was 44, which is 1.62 times higher than the IMR in urban areas (28) (Sample Registration System, 2012). NFHS 3 results show that when comparing castes, Schedule Caste (66) and Schedule Tribe (62) women had higher infant mortality rates than Other Caste women (57). There is also a strong negative association observed between the IMR and household wealth index. The IMR was 70 in the lowest wealth quintile households, 58 in middle wealth quintile households, and was only 29 in the highest wealth quintile households. (International Institute for Population Sciences, 2007).

As per the latest statistics available for the year 2013, the male and female life expectancy at birth is 65 and 68 years respectively (Population Reference Bureau, 2013). The life expectancy at birth of both sexes has increased gradually over the years. The increase was slightly more among females than (Table-1) males. This could possibly be due to a decline in the maternal mortality rate.

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

The government spending on health in India is amongst the lowest in the world (about 1% of the GDP). The percentage of public spending on health to GDP was less than one percent during 2001-2010 and it has slightly increased to 1.04 for the years 2011-2012. (Planning Commission, 2012). In other words, the government spending on health to total health expenditure was 31 percent in 2011 (Table-2); it implies that 69 percent of the health expenditure in India is out-of-pocket expenditures paid by citizens from their own pocket. Among South East Asian countries, India ranks 3rd in terms of high out-of-pocket expenditures on health (World Health Organisation, 2012). A more recent study conducted in six states in India in 2011 reveals that the total out-of-pocket expenditure to households for non-hospitalized treatm ent per ailing person during last 15 days was ₹ 1063/- and for hospitalized cases it was ₹ 14,704/- annually (PRAYAS, 2012). The high out-of-pocket expenditures on healthcare is a heavy burden to poor and marginalised communities and it acts as a great barrier in universal access to healthcare. So, it is imperative to substantially increase public spending on health in order to cater to the health needs of billion plus population.

Table 1. Basic demographic profile of India

Indicators	Year			
	1991	2001	2011	2013
Population^ (in millions)	846	1026	1210	NA
Sex ratio^ (Females per 1000 males)	927	933	940	NA
Child Sex ratio - 0-6 years (Girls per 1000 boys)	945	927	914	NA
Percentage of adolescent population (10-19 years) to the total population^	21.2	22.8	21.2	NA
Percentage of young population (10-24 years) to the total population^	30.1	30.5	NA	NA
Life expectancy at birth in years*# Male Female	58 (1990) 59	60 (2000) 63	64 (2011) 67	65 68

Source: ^ Compiled from Census of India 1991, 2001 and 2011 reports :http://censusindia.gov.in/
*# Population Reference Bureau, World Population Data Sheet (2013) and World Bank Estimates.
NA: Data not available

Table 2. Health Financing Statistics of India

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

Sources: World Health Statistics, 2012. and World Health Statistics.2013.

India has signed number of international treaties and conventions. The important one are International Covenant on Civil and Political Rights (CCPR), International Covenant on Economic, Social and Cultural Rights (CESCR), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and Convention on the Rights of the Child (CRC). International Conference on Population and Development Programme of Action (ICPD PoA) (1994) and India is also reporting on the MDGs.

Under this background, this policy brief is developed with an aim to review India's sexual and reproductive rights (SRR) initiatives and policies introduced after International Conference on Population and Development- ICPD and identify gaps in implementation on universal access to SRR for evolving suitable advocacy recommendations.

2. The sexual and reproductive rights status in India

a. Policies on sexual and reproductive health

In 1951, India was the first country in the world that introduced an official family welfare programme. India's first population policy was introduced in 1976 with strong motive on population control where couples with two or more children were involuntarily forced to undergo sterilisation operation. During 1976-1996, there were targets at various levels – from a provider level, to district, to state and national levels for contraceptive operation.

Then, following the ICPD conference and agreement, the entire context of population control policies of the national government changed and consequently there were a number of programmes and policy documents issued for promoting sexual reproductive health and rights. The most important policies and programmes in the series were Reproductive and Child Health Programme (RCH) 1 and 2. (1997–2002, 2005-2010). The RCH programme was viewed as a paradigm shift from target and quantity-oriented to a client and rights-oriented approach. Under the programme, all the vertical programmes on family welfare and maternal and child health were converged. It also included adolescent and young adult's sexuality and management of RTI/STIs.

There was also the National Population Policy in 2000 and the National AIDS prevention and control policies (1992- 1999, 1999-2006 and 2012-2017)) National Youth Policy 2003 and National Rural Health Mission (NRHM) 2005-11, and National Health Mission- (NHM) 2012-2017. Each of these polices addresses one or more components of SRR for different target groups. (The main objectives and key area of intervention is listed in Table-3). Though SRR components are available in different SRR policies overall, there is no integration or cohesion between them even though each one addresses a specific area of SRHR.

Table 3. India's Policies and Programmes on Sexual and Reproductive Health

Name and year of the policy/ Programme	Objective	Main Components of SRHR
Family planning programme - (1951-1976)	To reduce population growth and maternal mortality	Antenatal care coverage and family planning
India's first population policy -1976	To reduce population growth	Family Planning, targets fixed for health workers; women with two living children were forced to undergo contraceptive operation
Child Survival and Safe Motherhood programme (CSSM) in 1992	To improve health status of women and children and reduce maternal, infant and child mortality rate	Maternal and child health, Family Welfare programme
Reproductive and Child Health (RCH -1) Programme – 1997-2002	To reduce infant, child and maternal mortality rates	Maternal care that includes antenatal, delivery and postpartum services. Prevention and management of unwanted pregnancy. Child survival services for newborns and infants. Management of Reproductive Tract Infection (TRIs) and Sexually Transmitted Infections (STIs)
Reproductive and child health (RCH -2) April 2005-2010	To bring a change in three critical health indicators 1) reducing total fertility rate, 2) infant mortality rate and 3) maternal mortality rate	In addition to RCH -1 components: Adolescent health services and Life skills education

National AIDS Control Programme Phase -1 (1992-1999)	To control the spread of HIV infection	Creating awareness and setting up Sexually Transmitted Diseases clinics at district level
National AIDS Control Programme, Phase -II 1999-2006	,,	Targeted intervention for high risk groups and bridge populations. Sexuality education in schools. Setting Integrated counseling and testing centres. Prevention of parent to child transmission
National AIDS Control Programme, Phase -III – 2007 -2012	To halt and reverse the HIV/AIDS epidemic by integrating programmes for prevention, care, support and treatment	Prevention, care support and treatment for people living with HIV/AIDS
National AIDS Control Programme, Phase – IV – 2013-2017	To consolidate the gains of NACP III.	Consolidating targeted interventions with high risk groups and other vulnerable sections. Comprehensive care support and treatment
National Population Policy -2000	To provide voluntary and informed choice and consent of citizens while availing of reproductive health care services, with continuation of the target free approach in providing contraceptive services	Reduce fertility rate, Infant mortality and maternal mortality rates. Reduce unmet needs of contraception
National Rural Health Mission (2005- 2011) Phase -1	To provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups	Maternal health – improving health infrastructure. Include components of RCH – 1 and RCH 2
National Rural Health Mission (2012-2017) Phase 2	Integration and converge of all the services. Reproductive Maternal, Newborn, Child Health and Adolescents (RMNCH+A) approach	Maternal Health, Child Health, Family planning and Adolescent health
National Health Mission –2013- Include two sub sections National Rural Health Mission, National Urban Health Mission	Universal access to equitable, affordable and quality health care services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health	Maternal Health, Child Health Family planning and Adolescent health
National Youth Policy -2014	Develop a strong and healthy generation equipped to take on future challenges	Maternal Mortality Family planning STI, HIV/AIDS Social Justice, Health and Healthy life style

The National Population Policy adopts a target-free approach in the provision of contraceptive services and focuses on 'method mix' in contraception. But, both India's national as well as state governments focus is more on limiting the family size particularly in promoting female sterilization (tubectomy). Male contraceptive methods, spacing between the births, delaying first pregnancy is not given due importance. Almost all the users of permanent methods of contraception in India are women. According to the 2013 Ministry of Health and Family Welfare statistics, in 2010-11, there were 50,09,322 sterilizations performed, and of these, 95.6 percent were tubectomies.

As per the NFHS-3 (2005-2006) results, about half of the currently married women between the ages of 15-49 were using a modern method of contraception. Of these women, eighty percent were permanent method users (Female sterilization 77.23% and vasectomy 2.12 %). A condom was used by only about 10 percent of the contraceptive users (IIPS, 2006). Similar trends were observed in the DLHS-3 2006-07 survey too. It is obvious that from all these findings that men's use of contraception is low in comparison to women. As expected, the contraceptive prevalence was noticeably high in urban (55.8%) areas than compared to rural (45.3%). Interestingly, there was no difference in contraceptive prevalence for permanent method use

between rural and urban areas (IIPS, 2006), but for spacing method use urban leads.

According to DLHS-3 (2007-2008) survey, about 77 percent of spacing method users obtained their method from private providers (IIPS, 2010). Evidence indicates that the lack of availability of spacing methods in the public health sector forces many women to use the services available in the private sector, which involves high out-of-pocket expenses. This makes spacing contraceptive services inaccessible to rural, poor and marginalised individuals. It is imperative to concentrate on men's use of contraception and take steps for spacing contraceptives available in public health facilities.

All the three major SRR policies; RCH 1 and 2, National Aids Control Programme and National Youth Policy 2003 emphasis the importance of sexuality education for adolescents and young adults. Sexuality Education programmes in India are popularly known as Adolescent Education programmes. These programmes have been implemented through the National Aids Control Organisation (NACO). However, the implementation of the policies has been a big challenge. Initially the curriculum developed by NACO was rejected by many state governments like Kerala, Karnataka, Madhya Pradesh, Rajasthan Chhattisgarh and Uttar Pradesh on the ground that it would be against moral values. Then the curriculum was revised, the revised core curriculum developed by NACO for sexuality education in schools does not address the core issues of sexuality, reproduction and conception. The delivery of the curriculums is also problematic The curriculum was not incorporated into school or college curricula. While only a few states like Tamil Nadu and Maharashtra have taken initiative to start implementing sexuality education sessions, but it does not work in many regions of the state in which in it is implemented. From our field interactions with students and teachers where the curriculum was implemented, we found school teachers were not comfortable in handling sessions on sexuality contraception and STI's (RUWSEC Annual Report 2008). Under the situations the recently appointed Verma Committee for suggesting an amendment in criminal law has also strongly recommended that sexuality education should be imparted to adolescents and young people.

The National Rural Health Mission's (2005-2011) primary aim was to strengthen the public health system by increasing the accessibility and availability of healthcare services. Under the programme there were significant investments to introduce 24x7 delivery care services at PHCs (Round the clock services on all days). There were also efforts to develop first level referral units through the up-gradation of certain PHCs as Basic Emergency Obstetric and Neonatal Care (BEmONC) centres and Comprehensive Emergency Obstetric and New Born Care Centres(CEmONC). Most of these improvements were focused only on maternal health care, the interventions of non-maternal health care services have been very limited.

Overall, it seems that India's current SRH programme implementation has focussed only on reducing of maternal mortality as outlined in Millennium Developmental Goal-5 (MDG- 5) through promoting institutional delivery with cash incentives like Janani Sureksha yojana . Few state governments like Tamil Nadu and Andhra Pradesh have also given some additional cash incentives for promoting institutional delivery. Even in this maternal mortality reduction approach, broad social determinants of maternal health have not been given any importance.

Maternal death audits were introduced in many states. This is performed by government officials mainly to capture health system factors. While social factors of maternal deaths such as poverty, anaemia, gender-based violence are not captured in the maternal death audits. Even the data on maternal death audits performed by governments are not available in the public domain for analysis. There is no evidence on why these women die and what causes/contributing factors for these heavy human losses. Social audits on maternal death are very important at this moment.

Again, siloisation of Maternal Health, Poverty and Gender Equality under MDGs has had an adverse effect on India's SRH policies and programme implementation. Though MDG 1, 3 and 6 are intrinsically linked with MDG-5 on maternal health, there is no connectivity in the vertical programmes implemented by different departments.

[1] Janani Suraksha Yojana is a central government sponsored conditional cash transfer scheme that gives cash benefit of Rs 800/- to poor women below poverty line who delivered in accredited health facility.

Under the above said situations and developments the provision of other SRH services like safe abortion, reproductive morbidities, adolescent friendly health care services at a primary healthcare level envisaged in the RCH programme have lost its importance. Consequently patients have to depend more on the services available in the private sector which involves heavy out-of-pocket expenditures and limits access to poor and mariginalised women and young adults.

Currently, the strategic document released under new phase of NRM (2012-2017) indicates key interventions across life stages with new Reproductive Maternal New born Child and Adolescent Health (RMNCH+A) approach.

RMNCH + A , recognizes that reproductive, maternal and child health cannot be addressed in isolation as these are closely linked to the health status of people in various stages of life cycle. It adopts a 'continuum of care' with a life cycle approach. The strategies outlined in the approach include, 1.inclusion of adolescence as a distinct 'life stage' 2.linking maternal and child health to reproductive health and other components (like family planning, adolescent health, HIV, gender and Preconception and Prenatal Diagnostic Techniques) and 3. linking community and facility-based care (Ministry of Health and Family Welfare, 2013). Under the new approach, a special emphasis is indicated for promoting spacing contraceptives. Community-based distribution of contraceptives through Accredited Social Health Activists - ASHAs has been introduced. ASHA charges a nominal amount from beneficiaries, Indian Rupee (INR) 1 for a pack of 3 condoms, INR 1 for a cycle of OCPs and Indian Rupees 2 for a pack of emergency contraceptive pills (ECP). The strategies for providing safe abortion services are also indicated in the new approach document, the provision of Manual Vacuum Aspiration (MVA) facilities and medical methods of abortion in 24 X 7 Primary Health Centres is to be introduced. Medical abortion pills are to be included in the essential drug list (Ministry of Health and Family Welfare, 2013).

b. Grounds under which abortion is legal

In India abortion has been legal since 1971 under the law on Medical Termination of Pregnancy (MTP). The act was amended in 2002 with the objective of increasing the number of approved medical facilities through simple approval procedures. The amendment also permits the provision of medical abortion services.

Abortion in India is legal under the six major grounds 1.to save a woman's life, 2.to preserve a woman's physical health 3.to preserve a woman's mental health, 4.in case of rape or incest, 5.because of foetal impairment and 6.for socio- economic reasons. However, abortion is illegal on request of other reasons. The MTP Act allows abortion up to 20 weeks of pregnancy, but requires opinions from two registered medical practitioners for terminating pregnancy between 12-20 weeks. The consent of a woman is needed for carrying out the procedure. If a woman is below 18 years or is mentally ill, then the procedure may be carried out with the consent of a guardian/parent.

Currently, the MTP Act does not provide women with a 'right' to abortion. The final decision on terminating an unwanted pregnancy is now with physicians. From our field work we noticed there are instances of denial of abortion care to women particularly to poor and marginalised women. Providers state false reasons such as "the fetus is more than four months old" or the woman's is very weak to undergo an abortion" (RUWSEC, Women's Voices Series 2, 2012).

It has been more than 40 years after the introduction of the abortion act and yet despite its legality, safe abortion services are not available to many rural women. Unsafe abortion is the one of the leading causes of maternal mortality and morbidity in our country. According to latest estimates, between 2010-12, the maternal mortality ratio of India was 178 per one lakh live births (Sample Registration System, 2013). About 46,000 maternal deaths take place annually and unsafe abortion accounted 8 percent of maternal deaths in India.

Post abortion complications

I had bleeding for a long time and it didn't get normal. Then we went to a government hospital. They refused to treat me and told me to go to the same doctor who had performed the abortion. After five months of bleeding every day, we went to a private hospital. The doctor found that there were some remaining pieces in my uterus. I stayed as in-patient for seven days. I still have several problems and am under treatment often.

Source: Sundari Ravindran.TK., Balasubramanian.P.,"Yes" to abortion and "No" to Sexual Rights: The paradoxical Reality of Married Women in Rural Tamil Nadu, India. Reproductive Health Matters- London UK, 2004, pp 88-99

As per the health and family welfare statistics for 2013, there were 6, 36, 306 number of abortions performed in the approved medical facilities during April 2012- March 2013. A national level study on abortion carried under (Abortion Assessment Project India- AAPI) by CEHAT and Health Watch trust in 2002 found that two-thirds of abortions in India were done in unsafe and unregistered facilities

(unregistered MTP facilities). Unqualified persons played a major role in the provision of abortion services in rural areas.

In the public sector, abortion services are provided only in the secondary and tertiary care hospitals and not available at the primary health centres.MTP services are not available in many public facilities. As per the NRHM statistics for the year 2011-12, only about 8 percent of the public facilities in Gujarat and 16 percent in Himachal Pradesh (16 %) provide MTP services (NRHM, 2012). As a result even states like Tamil Nadu, where a large majority of deliveries take place in the public sector, about two thirds of abortions in 2010-11 took place in private facilities.

Again, the poor quality and negative attitudes of providers in public facilities, and lack of confidentiality force a majority of women to use private providers despite having to pay costly out-of-pocket expenditures for accessing the services. Hence, the share of private sector for abortion services is high in India. This situation acts as a great barrier for rural and poor mariginised women to access safe abortion services. So, safe and cost-effective abortions are still a distant dream for many women in India. Evidence also shows there is a huge unmet need for abortion services (Malhotra et al, 2003).

Again traditional methods like Dilatation & Curettage[2] was more widely used for early trimester abortions. The use of safe and simple methods like medical abortion, manual vacuum aspiration (MVA) methods are not as widely used even in public facilities. The National Rural Health Mission (2007-2012) in India has made significant public health investments in medical as well as human resources in terms of promotion of delivery care services at a PHC level. However, these improvements have not contributed towards promoting safe abortion services. Using these infrastructures medical as well as MVA services could be easily provided at the primary care levels, which are more accessible to poor and rural women. Secondly, pre- and post-abortion counselling is almost absent both in the public and private health sector facilities, and as a result many women are forced into second and repeated abortions. It is very important to provide contraceptive counselling to couples for preventing repeated abortions.

c. Policies on HIV and AIDS

Under the ministry of health and family welfare, the National AIDS Control programme Phase-1, (1992-97), began with an objective to increase awareness of safe sex practices and prevent HIV transmission through blood, blood products and hospital wastes. The National AIDS Control Organisation (NACO) was established at the national level; State AIDS Societies were also formed in every state for better implementation. Then during the second phase of the programme (between 1999-2006), the National AIDS Control Policy of 2002 was introduced. Its aim was to initiate support programmes for people living with HIV/AIDS, create targeted interventions for high-risk groups, and to prevent mother to child transmission. Then, under the third phase of the programme, care and treatment components for HIV/AIDS patients were given more importance.

After having a series of consultations with employers and workers organizations, individuals living with HIV/AIDS, the International Labour Organization (ILO) and UNAIDS, the Ministry of Labour and Employment and the National AIDS Control Organizations (under the Ministry of Health and Family Welfare), have jointly developed a national policy guideline on HIV/AIDS interventions in the workplace in 2002. The policy prevents the arbitrary discrimination on the basis of HIV status of an individual, to avail healthcare services, education and employment.

Recently, there has been tabling of a bill on HIV/AIDS in the Parliament. After three years of preparation and consultation with many groups, the HIV/AIDS Bill took its final shape in 2006 and was submitted to the Law Ministry in 2007. Unfortunately, the Law Ministry took three years to clear it, and sent it back to the Health Ministry. From 2010 and now it has been shuttling between the two Ministries. The proposed bill aims to protect the rights of HIV/AIDS patients on issues like stigma and discrimination in health care services in the public and privatesectors.

[2]Dilation and curettage (D&C) is a medical method of abortion. It refers to widening or opening of the cervix and removal of part of the lining of the uterus and contents of the uterus by scraping.

Policies on Adolescent Sexual and Reproductive Health Services

The National Population Policy 2000, the National AIDS Prevention and Control Policy 2002, the National Youth Policy 2003 and the Reproductive and Child Health (RCH) Programmes (I and II) recognizes adolescents as distinct group and their SRHR needs require special attention. They recommend that the sexual and reproductive health information, counselling and services should be affordable and accessible to adolescents. Both RCH and National Youth Policy state that adolescent friendly healthcare services should be provided in PHCs for adolescents. As per the RCH policy, irrespective of one's own marital status, all services available are youth friendly, but abortion services for girls below the age of 18 require parental or guardian consent. In implementation, there is a strong social stigma in addition to provider bias and discrimination towards unmarried adolescents when they try to access SRH services. So, the implementation of broad topics of these policies continues to be limited and services for adolescents remain elusive.

The sexual and reproductive health needs and issues of adolescents and youth are rarely addressed in India. According to NFHS-3, youth in India are poorly informed to make responsible decisions on their sexual and reproductive health. A study among youth in five states of India by IIPS Mumbai (2006-07) has brought out a number of sexual and reproductive health needs of young people. The study found that knowledge about sex, pregnancy, contraception, and sexually transmitted diseases among youth were very limited. For example, 30 percent of young men and half of young women below 30 years were not aware that a woman could get pregnant during their first sexual intercourse (IIPS 2009).

Under the new policy on National Health Mission (2013-2017), RMNCH+A, approach there are some key interventions proposed for adolescents. It includes the following:

- Adolescent nutrition and folic acid supplementation. There are two components; 1) community-level health education sessions on nutrition using the existing structures like ICDS, NYKS, and schools. 2) Weekly Iron and Folic Acid Supplementation (WIFS) through schools and ICDS centres to address anaemia amongst adolescents (including boys and girls) in both rural and urban areas.

- Adolescent friendly health services. For providing SRHR information and services to unmarried and married adolescents, Adolescent Information and Counselling Centre is being created at PHCs, CHCs, Taluk and district hospitals. At the PHC level it will function on a weekly basis and for the other levels it will function daily.

- Information and counselling on adolescent SRH issues. Life Skills Education sessions are planned to impart relevant information in educational institutions and in community settings.

- Promotion of menstrual hygiene among rural adolescent girls: In order to promote menstrual hygiene among rural adolescent girls (aged 10 to 19 years), sanitary napkins are provided under NRHM's brand 'Free days.' These are sold at Indian Rupee 1 per pad through ICDS workers. In Tamil Nadu it is supplied free of cost to eligible adolescent girls.

- Preventive health checkups. In this plan, bi-annual health screenings are provided for students (6–18 years age group) enrolled in government and government-aided schools for disease, deficiency and disability. Students who need follow-up and further treatment services are referred to secondary and tertiary health facilities.

d. Difference between Median Age at Marriage and Legal Minimum Age at Marriage

In India, the Child Marriage Restraint Act[3] of 1929 (also called the 'Sarda' Act) came into effect on 1st April 1930. This Act clearly states girls and boys cannot get married before 18 and 21 years respectively. Some strong socio-cultural beliefs and practices intertwined with patriarchal factors with weak legal enforcement mechanisms. So even after 80 years child marriage among girls is still common in rural India. According to NFHS-3 results, the

[3]The act was amended two times in the year 1949 and 1978 then in the year 2006 it was repealed with new act "The Prohibition of Child Marriage Act 2006" which shifts it focuses from restraint to prohibition. But all these acts/amendment the minimum age at marriage of girls and boys remains 18 years for girls and 21 for boys.

median age at marriage of women in between 20-24 years was 18.3 and it was 23.7 among men in 25-29 years. The survey also shows that a little more than two-fifths of women in 20-24 years age group were married before they were 18. Using three rounds of NFHS survey data (NFHS-1 1994-95; NFHS- 2 1998-99 and NFHS- 3 2005-06), UNICEF has estimated that 40%of the world's child brides in the 20-24 years age group were from India (Table-4).

Table: 4. Percentage of women in the 20-24 years who married before 18 years

Data Source and year	Rural	Urban	Total
NFHS- 1 (1992-93)	62.8	32.6	54.2
NFHS -2 (1998-99)	58.6	27.9	50
NFHS 3 (2005-2006)	52.5	28.2	45.0
DLHS -3 (2007-2008)	48.0	29.4	42.9
Rate of Declining between 1992-93 and 2007-2008	-23.57	-20.85	-9.51
Rate of declining/Increase between 1998-99 and 2007- 2008	NA		22.5
Post ICPD	-18.08	+5.4	14.2

Source: : Compiled from National Family Health Survey 1 ,2 and 3 and District Level Health and Facility Survey -3.
NA: Data not available

According to DLHS-3 (2007-2008) of women married during the last three years, in states like Bihar, Rajasthan, Jharkhand Utter Pradesh, West Bengal, Madhya Pradesh Andhra Pradesh and Karnataka, more than 50%in the 20-24 age group was married before 18 years. However, the proportion of child marriages among women in Himachal Pradesh, Kerala, Pondicherry, Goa, and Uttarakhand was less than 20 percent. The other states in India fall in between the two extremes. So, state specific/ regional specific interventions are needed to stop child marriage.

In the time trend analysis, we found that the proportion of women who married below legal age has been declining over the years (Table-5), but the rate of decline has slowed down in recent years (2005-2008). Though the aggregate indicators show there has been a decline, in urban areas the proportion of women married below 18 has remained stagnant from1998-2008, and in fact has started increasing between 2005-6 and 2007-08 (NFHS 3 and DLHS -3).

Table 5. Median age at marriage for Men and Women DLHS 3 2007-2008

Current Age	Medium age at first marriage	
	Women	Men
15-19	NA	NA
20-24	18.3	NA
25-29	17.4	23.7
30-34	16.8	22.7
35-39	16.6	22.3
40-44	16.5	22.0
50-54	NA	22.5
20-49	17.2	23.4
25-49	16.8	22.7

Source: District Level Household and Facility Survey (DLHS-3), 2007-2008.
NA: Data not available

The median age at marriage of the younger cohorts of women and men shows there are wide disparities by caste groups' wealth quintile and education (NFHS-3) as compared to illiterate women educated above ninth grade married three years later. (Table-6) So, those who belong to poor caste and class, illiterate women and men are getting married at very younger ages when compared to other groups.

Table 6. Median age at marriage of men and women by background characteristics DLHS 3- 2007- 2008

Background Characteristics of Women	Median age of at marriage	
	Women 20-24 years	Men 25-29 years
EDUCATION		
No education	15.8	20.4
<5 years complete	16.9	21.3
5-7 years complete	17.6	22.5
8-9 years complete	19	23.9
10-11 years complete	19.9	NA
12 or more years complete	NA	NA
CASTE / TRIBE		
Scheduled caste	17.5	22.5
Scheduled tribe	17.3	21.5
Other backward class	17.8	23.2
Other	19.7	NA
Don't know	19	24.7
WEALTH INDEX		
Lowest	15.9	20.2
Second	16.6	21.5
Middle	17.8	22.8
Fourth	19.2	NA
Highest	NA	NA
TOTAL	18.3	23.7

Source: District Level Household and Facility Survey (DLHS-3), 2007-2008.
NA: Data not available

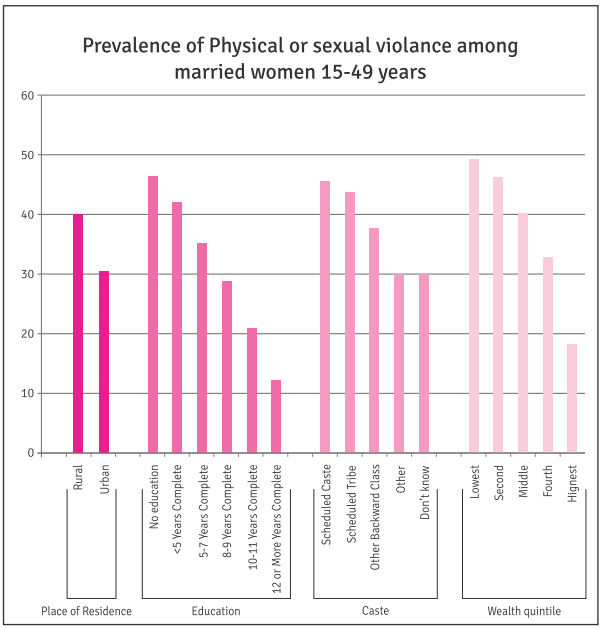
e. Gender-based violence

Gender-based violence (GBV) against women is a serious public health problem in India. Due to various socio-cultural and gender-related barriers, the statistics on GBV is under reported in India as in many other countries. Despite its under reporting, a recent NFHS-3 (2005-2006) study shows that the lifetime prevalence of intimate partner violence on physical or sexual violence among currently married women between15-49 years was 37.2%. About 35% of these women experienced physical violence and one-tenth faced sexual violence. About 8%reported experiencing both physical and sexual violence by their husbands.

The NFHS-3 survey also indicated that one in every four married women in India had experienced physical or sexual violence by their husbands during the 12 months preceding the survey. While looking into when violence happens initially we found that in 81% of cases, it happened within the first five years of marital life. So, we need to work with young couples to curtail the problem by inculcating healthy gendered attitudes and behaviours.

Though GBV is common among all sections, NFHS-3 results show that the extent of physical and sexual violence against women varied significantly by household economic status, place of residence, and by caste (Chart-1). When examining caste, rates of violence are highest for Scheduled Caste and Scheduled Tribe women. Again, the prevalence of spousal physical or sexual violence declines sharply with the wealth index from a high rate of 49% for women in the lowest wealth quintile to a lower rate of 18% for women in the highest wealth quintile. Overall, poorer women in rural areas and illiterate women are more vulnerable to physical as well as sexual violence.

Chart - 1



While comparing the prevalence of domestic violence between NFHS-2 and NFHS-3, the rate has increased significantly over the years; the lifetime prevalence was only 20% in 1998-99 and has increased to 37% in 2005-2006.

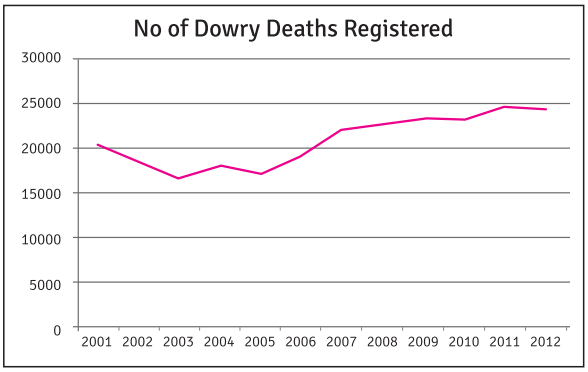
The reported number of rape cases under the Indian Penal Code in 2012 was 24923, if we look into the data over the last ten years, it has been constantly increasing over the years and the rate of increase was 55 percent during 2001-2012. This is a clear indication that incidence and reporting of rape is increasing day by day. It is seen from the table-7 that the reported cases of all other crimes against women like dowry deaths, cruelty by husbands and other relatives and assault on women on modesty has been constantly increasing over the years in India. Although, we have laws to prevent various forms of violence against women the increasing trend of reported cases of violence against women is a clear indication of weak implementation mechanisms.

In 2012, according to the National Crime Records Bureau (NCRB), dowry deaths – or murders of women by the groom or in-laws because of unmet high dowry expectations – constituted 3.4% of all crimes against women. In other words, last year in India on average 22 women were killed per day because their families could not meet dowry demands.

> "When I express reluctance for sex saying that I am worried about getting pregnant, he says, 'I will take care if it happens.' If I object strongly he shouts: 'Are you sleeping with someone else?' After my first childbirth, he called me for sex within a month. When I objected, he beat me. This is a regular happening in my life."
>
> Source : Sundari Ravindran.TK., Balasubramanian.P., "Yes" to abortion and "No" to Sexual Rights: The paradoxical Reality of Married Women in Rural Tamil Nadu, India. Reproductive Health Matters-London UK, 2004, pp 88-99

The reported number of crimes against women is increasing every day. The number of crimes registered under the Indian Penal Code under cruelty by husband or relative has increased 116 percent during 2001-2012. The NCRB statistics for 2012 also indicate that 44 % of all crimes against women constituted as "cruelty" inflicted by her husband and relatives. So, even a home is unsafe

Chart - 2



place for many women in India. The above statistics and trends on gender based violence provide us with some important information. Without addressing social norms, beliefs and values mere enactment of laws does not yield a fruitful result. What is equally important is to set up quick trial and strong legal enforcement mechanisms to reduce the number of crimes against women.

Table 7. Number of Crimes registered under Indian Penal Code during 2001-2012

Year	Rape	Kidnapping & Abduction	Dowry Deaths	Molestation	Sexual Harassment	Cruelty by Husband or Relatives
2001	16075	22487	6851	34124	9746	49170
2002	16373	21850	6822	33943	10155	49237
2003	15847	19992	6208	32939	12325	50703
2004	18233	23327	7026	34567	10001	58121
2005	18359	22832	6787	34175	9984	58319
2006	19348	23991	7618	36617	9966	63128
2007	20737	27561	8093	38734	10950	75930
2008	21467	30261	8172	40413	12214	81344
2009	21397	33860	8383	38711	11009	89546
2010	22172	38440	8391	40613	9961	94041
2011	24206	44664	8618	42968	8570	99135
2012	24923	47592	8233	45351	9173	106527
Rate Increase/ Decrease during 2001-2012	55.04	111.64	20.17	32.90	-5.87	116.65

Source: National Crime Statistics (2012).

f. Legislation related to gender-based violence

The Domestic Violence Prevention Act 2005 aims to protect women from physical, sexual, and emotional abuse. However, it does not address sexual violence that occurs within a marriage. It is an important law and women have begun to file cases. Even with the act, there are problems in implementation. Many of Domestic Information Reports (DIR) are resolved by protection officers appointed at the district level under the Act. From our experience working with women in rural areas, we have found women-centred counselling is absent in many cases since the protection officers were not given adequate gender sensitisation trainings. There are instances where women were asked to live with the husband against their wishes after the abuse.

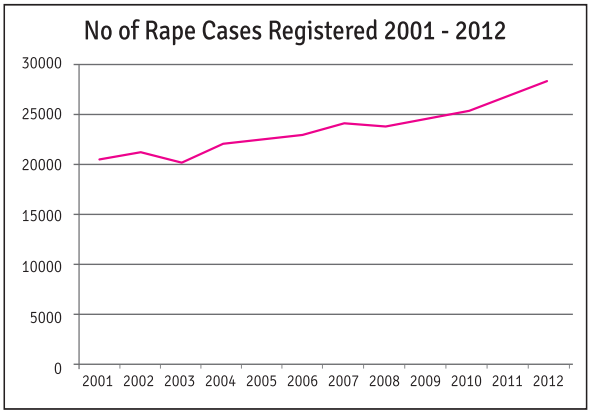
Rape is a crime under Indian Penal Code 375, and the latest criminal law amendment in 2013 defines rape as "1). a man is said to commit rape if he penetrates his penis, to any extent, into the vagina, mouth, urethra or anus of a woman or makes her to do so with him or any other person against her will or without consent or 2). inserts any objects or a part of the body part into vagina, urethra, and anus of women or makes her to do so for him or the

other person against her will or without consent." But marital rape is still not considered a crime. Though, the recently constituted Verma Committee suggested an amendment in the criminal law. The Committee clearly stated the exception to marital rape should be removed. It was not accepted by the parliamentarians and failed to be included in the recently amended Criminal Law Amendment Act in 2013.It is apparent from Table 7 that the reported number of rape cases under IPC has increased 55 percent between 2001-2012.

The more recently introduced act on sexual harassment in the work place (Prevention, Prohibition and redress) in 2013 also aims that no woman shall be subjected to sexual harassment at her workplace. It directs all employers to establish an internal complaints committee at their work place with clear guidelines for the criteria for members of the committee with a clear role and function. It also directs governments to form local complaint committees at the block and district level to file complaints against employers or from women working in small companies with less than 10 members (where an internal complaint committee was not formed). Since this is a recent bill, the formation of these committees will take time; we need to demand the government to create a timeline to form such committees.

Despite the Dowry Prohibition Act, 1961 which clearly specifies punishment of five or more years with penalty but the practice of giving money, wealth and assets, dowry is still prevalent. This was once a customary practice among elite and Other Caste groups having trickled down to all sections, irrespective socio-economic status. It becomes a common practice and accepted social norm. We need to work at two levels; to strengthen the law enforcement mechanism and to change deep rooted values and gender inequality. According National Crime Records Bureau (NCRB) statistics in 2012, there were 8233 dowry deaths in the year 2012 and it accounted 3.4 percent of crimes against women. The data on the number dowry deaths over the years show that it has constantly increased every year. There was about a 20 percent increase between the 2001-2012 (National Crime Records Bureau, 2012).

Chart - 3



More recently, based on the Verma Committee's recommendations in the Criminal Law Amendment Act of 2013, there is a punishment for selling of acid (to prevent acid throwing) in retail shops. The act also directs state governments to provide medical treatment in all hospitals free of cost and the act directs paid compensation for the survivors.

Legislation and policies on sexual orientation

Legal status of same sex activity in India is uncertain and unclear. It has been illegal since the British established Indian Penal Code (IPC) 377 in 1860. The IPC states "unnatural offences whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description or a term which may extend to ten years." But in 2009, Delhi High Court upon hearing a case of Naz Foundation lifted the ban on same sexual activity among consenting adults saying it violates basic human rights on protection of life and liberty. Recently, in February 2014, the case came to the Supreme Court and it upheld the IPC 377 saying same-sex sexual activity is a crime. It is a major setback to LGBTIQ community in India, but there is hope indicated in the judgement that the parliament can enact laws suitable to protect the rights of homosexuals. Under such situations, same sex marriage is illegal and there is no right for homosexuals to live together as couples.

Legislation and policies on gender identities

Change of name and gender is not legally allowed in India. Gender reassignment surgery is not permitted in India except the state of Tamil Nadu. The Tamil Nadu State Government has come up with a few supportive polices to protect the rights of the transgender community. They created a third gender category in the election and also issued ration cards and reimbursement benefits for gender reassignment surgery. These policies could be easily

implemented at the national level. So, the political will of the national government is the key to protect transgender rights.

Grievance redress mechanisms for sexual and reproductive health services

In India, there is a little space for demanding accountability and there exist few grievance redress mechanisms in public health facilities. Under the NRHM, committees have been formed at different levels – village health and sanitation committees at sub centre level and patient welfare societies at PHCs, taluk hospitals and CHCs, district hospitals as well as hospitals at the state level. The committee has members from the service providers and officials with a few community representatives. It is envisaged that the primary role of the committee is to act as interface between provider and community in resolving the local issues and grievances. However, obtaining compensation by the affected person/ taking the issue to judicial system is not under the preview of the committee.

In reality, the committee acts with no power to discuss the issues and grievances, but mainly functions to use the untied funds[4] . The committee is composed of only a few members from the community and users with a majority from the service providers. So, we have structures in place from a facility level to the state level for the grievance redress, but we need to push the committee by enhancing their skills and potential. The 6th common review mission reports also highlighted setting up grievance redress mechanism at all facilities is a challenge in India.

Lack of adequate grievance redress mechanism and systemic negligence were the main reasons for 26 maternal deaths in one tribal public hospital of Maharashtra during April- November 2010. The fact finding team of civil society groups brought out number of systemic failure, negligence and week accountability issues.- (Subhasri B and et al. 2012).

In addition to these, some state governments like Assam, Chhattisgarh, Tamil Nadu and Punjab have introduced toll-free help line numbers where the public can register their grievances regarding public healthcare facilities. However, the toll-free number introduced in Tamil Nadu was not functional after few months.

In the public sector, at least there is a structure in place, but in the private sector either there is no grievance redress mechanisms or accountability. There is no legal regulation to control the private sector in India. As a result, there are no uniform standard treatment procedures or protocols, or pricing for health care services. Ultimately the private sector aims to generate profit from all their services. The recently reported incidences of large-scale unnecessary hysterectomies in Andhra Pradesh, Tamil Nadu and Punjab illustrate the lack of accountability, grievance redress, and monitoring mechanisms in the private sector. Recent data released by Oxfam reported unnecessary hysterectomies were being performed in Indian private hospitals to economically exploit poor women as well as government-run insurance schemes.

"When women came with abdomen pain, doctors prescribed hysterectomy to women from poor economic backgrounds, telling them that it might be a cancer or a hole or a stone in the uterus without doing any thorough necessary investigations."- Oxfam official Mehta says- Times of India

Only consumer courts take up a few cases of patient exploitation, but these are not accessible to rural and poor marginalised sections of the society. There were very few instances where patients approached consumer courts. They were counter protective in a few instances. For example, a woman in Tamil Nadu approached a consumer court because of her post-abortion complications. After her case, the doctors who worked in the public hospitals in one administrative block stopped to perform an MTP procedure and referred patients to another facility stating they did not have adequate facilities to perform the abortion (Ramachandran and Pelto, 2002).

[4] Untied funds is a flexi fund given to each health centres annually. Rs 10,000/- for health and sanitation committees at Sub centre and Rs 25,000/- for Patient welfare societies in PHC's, and one lakh for district hospitals.

3. Recommendations

India spends less than 4 percent of its Gross Domestic product (GDP) on health care. The WHO's recent report on world health statistics in 2012 revealed about 60 percent of the total health expenditures in India were paid by citizens from their own pocket. We need to press for our national government, state governments, and UN agencies to do the following:

1. Increase the allocation of funds to the healthcare sector to reduce heavy out-ofpocket expenditures that burden households. Except for maternal healthcare services people have to heavily depend on the private sector for other SRH services. Socially and economically marginalised sections of the society overcome many barriers to access required SRH services. Out of pocket expenditures for accessing SRH services is very expensive in the private sector. Secondly, there are no regulation and standards in treatment procedures in the private sector. As a result, there have been a large number of irrational treatments that have been reported in India, including unnecessary C-sections and hysterectomies. In India the private sector in healthcare mainly functions for high profit motives. So, it is imperative to regulate the private sector in health care.

2. Adopt comprehensive SRH policy with life cycle approach and implement it . Despite a number of policies and programmes on SRHR in the country, there is a lack of integration/cohesion between them. Each programme focuses on one or more components of SRH. Again there is a huge gap in the policy/programme and its implementation. In fact the major gains achieved over in the RCH programme was lost in the recent NRHM progamme. So, it is important to shift away from a narrow or focused approach on institution delivery towards other SRH services with a life cycle approach. The non-maternal healthcare services like gynaecological morbidities, reproductive cancers and uterine prolapse should be given importance in SRH policy and its implementation.

3. Reduce unmet need for contraception and expand safe abortion services. There is a heavy unmet need for spacing methods and safe abortion. There is a need to strengthen efforts to increase the availability of spacing contraceptive methods. Men's involvement in contraception is also to be improved. It is also very important to move from traditional methods of abortion to modern and safe methods like medical abortion, MVA procedures. Using the current infrastructural facilities at PHCs, safe abortion services could be made easily available to poor and marginalised women.

4. Strengthen implementation mechanisms of young people SRHR policies. Though we have a number of policies and programmes addressing SRH issues of adolescents and young people, the implementation of many programmes is very weak. It shifts from a broad-base policy to a narrowed approach during actual implementation.

5. Implement sexuality education in schools and communities. Adolescents and young people's sexual and reproductive health rights are not adequately addressed. We need to ask the government to take concrete steps to strengthen monitoring mechanisms to impart sexuality education in schools and communities for young adults who have dropped out of school. Strict enforcement of laws to prevent marriage at an early age would reduce adolescent pregnancy rates and reproductive morbidities.

6. Enforce strict monitoring mechanisms to implement gender-based violence laws, and enact/amend laws to prevent sexual violence within marriage. Educating men on gender and consequences of gender-based violence is also equally important to create a violence free society. The mere existence of laws cannot result in reducing incidences of gender-based violence such as dowry, rape and sexual violence.

7. Protect sexual and human rights of sexual minorities. Sexual and human rights of persons of diverse sexual orientation and gender identities, and, HIV patients have been a long neglected issue in our country. So it is important to enact or amend laws suitable to give them social protection that allows them to live free from stigma and social discrimination.

8. Improve community accountability and grievance redress mechanisms: Strengthening networks, civil society groups, community level health committees formed under the NRHM to demand better accountability and grievance redressal and to monitor the quality of healthcare services provided in public health facilities. Introducing a suitable legislation or policy to create grievance redress mechanisms in the private sector hospitals.

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ABOUT RUWSEC

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

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

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

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

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