Analysis Of Sexual And Reproductive Health

Executive Summary

India is located in Southern Asia with a population of 1.37 billion people consisting of 48% female and 52% male (“India Population,” 2019). India has the 17th largest export economy in the world with a national GDP of $2.6 trillion (India, n.d.) Although it is the seventh largest country by area, it is the second most populous country; one in every sixth person in the world lives in India (“India Population,” 2019). There are 29 states that make up the country and it is very diverse in terms of religions practiced and languages spoken. The majority of people (67%) live in rural areas where health facilities, resources, and health practitioners are limited (“India Population,” 2019). India has a medium human development with 27.5% of the population living in poverty and an HDI of 0.640 (“HDI and its components,” 2018; “Multidimensional Poverty Index: developing countries,” 2018). Additionally, the sexual and reproductive health status of the country needs improvement, especially when focusing on contraception, abortion, maternal health, and gender-based violence.

Contraception

The India National Family Health Survey (NFHS) of 2015-16 stated that 99% of individuals who were married knew of at least one method of contraceptive use (NFHS 4 2015-16: India, 2017). Modern methods of contraception utilized in India is female sterilization (36%), condoms (5.6%), birth control pill (4.1%), IUD (1.5%), and male sterilization (0.3%) (NFHS 4 2015-16: India, 2017). Female sterilization remains the most common form of modern contraception use even with other non-reversible, long-acting methods available. The contraceptive prevalence rate (CPR) and the modern CPR (mCPR) of married women is 54% and 48%, respectively (NFHS 4 2015-16: India, 2017). The CPR and mCPR of unmarried women is 34% and 32%, respectively (NFHS 4 2015-16: India, 2017). Whereas roughly half of married women utilize contraception, only about one-third of unmarried women utilize contraception. This is concerning as it increases risk of unwanted pregnancies and contracting diseases. Additionally, there is a high unmet need for family planning in India. Thirteen percent of married women have an unmet need for family planning: 6% for spacing births and 7% for limiting births (NFHS 4 2015-16: India, 2017). If these women were to utilize contraceptives, then the CPR would increase to 66% (NFHS 4 2015-16: India, 2017). The total fertility rate (TFR) is 2.1 children per woman, however the wanted fertility rate is 1.8 children per woman. (IHME, 2018). There are many unwanted or mistimed pregnancies occurring in India each year emphasizing the importance of increased awareness and access to family planning.

Abortion

Abortion has been legal in India since 1971, however the country has lacked necessary resources, skilled staff, and health facilities to perform safe abortions. Information about the incidence of abortion, access to abortion services, and unsafe abortion rates have been insufficient and scare. The first national study of the incidence of abortion and unintended pregnancies in India was conducted in 2015 (Rose, 2017). The study estimated that there were

15.6 million abortions in 2015 (5% were unsafe) with an abortion rate of 47 per 1,000 women aged 15-49 and accounting for 33% of all pregnancies (Singh et al., 2018). These abortions were performed in a variety of places: 3.4 million (22%) in health facilities, 11.5 million (73%) were medicinal methods of abortion (MMA) performed outside of health facilities, and 0.8 million (5%) were performed outside of health facilities and were unsafe (Singh et al., 2018). Less than a quarter of abortions were performed in health facilities due to the fact that the public sector is the main source of care for women who are poor and living in rural regions. However, the public sector makes up only 25% of facility-based abortion services because many of these facilities do not perform abortions due to a lack of trained staff, medications, and equipment to perform surgical abortions (Singh et al., 2018). Often, women who are poor and living in rural areas cannot afford the cost of private sector abortions and buy MMA drugs from chemists and informal vendors. Although abortion has been legal for some time, India lacks the necessary resources to provide women with safe abortions at public health facilities.

Maternal Health

The maternal mortality ratio (MMR) continues to decrease each year. In 2016, the MMR was 130 deaths per 100,000 live births, which is a reduction from the MMR of 167 deaths per 100,000 live births in 2013 (NITI Aayog, n.d.; NFHS 4 2015-16: India, 2017). This decrease is in part due to the introduction of the Janani Shishu Suraksha Karyakaram (JSSK) by the Ministry of Health and Family Welfare (MoHFW) in 2011 (“Janani Shishu Suraksha Karyakaram [JSSK],” 2015). This initiative offers free maternity services to women such as caesarean sections, drugs, diagnostics and screening, and transport from the home to health facilities (“JSSK,” 2015). Additionally, the JSSK works to improve the management of health services at all health levels in India, the emergency referral systems, and maternal death audits (Maternal Health in Focus, n.d.). India recognizes its high MMR and has implemented different initiatives to combat this issue and provide better services to women.

The median age at first marriage and first sexual intercourse for women is 19 years old while the age at first birth is 21 years old (NFHS 4 2015-16: India, 2017). Eight percent of women aged 15-19 have teenage pregnancies in India, however, the rate is higher in rural areas (10%) (NFHS 4 2015-16: India, 2017). Twenty-seven percent of births occur less than 24 months apart, which increases risk of infant and neonatal mortality (NFHS 4 2015-16: India, 2017). Women who are wealthy, more educated, and living in urban areas often space their births farther apart and are older at their first pregnancy. Thus, women living in rural regions, who are poor, and have little education have higher health risks and problems associated with maternal health. In terms of antenatal care (ANC), 84% of pregnant women received care, 59% had their first ANC during their first trimester, and 51% had four or more visits (NFHS 4 2015-16: India, 2017). At these visits, pregnant women had their weight checked (91%), blood pressure taken (89%), urine sample taken (88%), abdomen examined (89%) and a blood sample taken (87%); only 30% of patients took iron and folic acid tablets and only 18% took an intestinal parasite drug (NFHS 4 2015-16: India, 2017). Although some of these numbers are high, they should be at 100%. Improving quality of care at ANC visits should be a focus of the Indian government to ensure pregnant women are getting the appropriate and necessary care during and after pregnancy.

Gender-based violence

Gender-based violence is an issue that has been plaguing India for decades due to a variety of reasons such as religion, customs, traditions, and gender prejudices. Women in India have historically played a subservient role in all aspects of life and have not been treated as an equal to their male counterpart. Women are often dependent on men, especially their husband, due to a lack of education, financial responsibility, and a career. India remains a male-dominated society, however more women are starting to fight for their rights, freedom and independence. With that being said, domestic violence in the form of physical, emotional and verbal abuse is still an issue. Fifty-two percent of women and 42% of men agree that a husband is justified in beating his wife if she neglects chores and taking care of the children, leaves the house without telling him, argues with him, refuses to have sex, doesn't cook food properly, he thinks she is cheating, or she is disrespectful to her in-laws (NFHS 4 2015-16: India, 2017). Additionally, 15% of men do not agree that a wife can refuse sex with him (NFHS 4 2015-16: India, 2017). There are 33% of married women who have suffered from spousal physical, sexual or emotional violence and 25% of these women experienced injuries due to spousal violence (NFHS 4 2015-16: India, 2017). Unfortunately, only 14% of women who experienced these forms of violence sought help (NFHS 4 2015-16: India, 2017). Although gender-based violence has been recognized since 1983 as a criminal offence, it was not until the Protection of Women from Domestic Violence Act of 2005 came into effect that women of domestic violence could be protected (NFHS 4 2015-16: India, 2017). Gender-based violence is a violation of a woman's basic right. Although India remains a patriarchal society, involving key stakeholders to fight for female independence and equality, equal gender pay, and diminishing the rates of domestic violence could change the way men in India treat women.

Impact

India has an escalating burden of non-communicable diseases on top of an already existing burden of communicable diseases, which results in a double burden of disease. There are millions of people living in poverty and dying from preventable infectious diseases, and now there are millions of people suffering from chronic diseases. This has caused significant challenges and posed many problems to the public health system in India, one that is already fragile. In 2017, the disability-adjusted life years (DALYs) was a mixture of both noncommunicable and communicable diseases: neonatal disorders, ischemic heart disease, COPD, and diarrheal diseases (IHME, 2018). This problem is further exacerbated by individuals suffering from multiple chronic diseases that remain undiagnosed due to insufficient healthcare facilities and lack of awareness (Arokiasamy, 2018).

In 2013-2014 the total health expenditures was 4.02% of GDP and the government expenditures was 1.15% of GDP, which is considered below-average for low-income countries (Gupta & Bhatia, 2016). Household out-of-pocket spending was 69.1% of total health expenditures and due to the high costs, this was often a deterrent to seek help for low-income individuals (Gupta & Bhatia, 2016). All citizens of India can access government health services under a taxed-financed public health system, however due to poor quality of care, long-wait times, and long distances to get to the center, individuals tend to seek private healthcare. This increases out-of-pocket spending substantially. In fact, only 45% of households seek healthcare from the public sector (NFHS-4 2015-16: India, 2017). This becomes an issue for women age 15-49 because 25% do not have the money to afford services, 30% cannot obtain care due to the distance of the health facility, and 37% report having concerns that a female health practitioner is not available (NFHS-4 2015-16: India, 2017). This in turn limits access to much

needed sexual and reproductive healthcare, education, resources and services needed for these women of reproductive age. The most vulnerable women with higher risks of health problems and poorer quality of life live in rural areas, are less educated, and have low socioeconomic standing due, in part, to the inability to afford private sector health services.

Opportunities for Intervention

It is important that changes are made to improve the quality and availability of safe, abortion services in public health facilities. For example, more doctors could be trained and certified to perform surgical abortions and the government of India could allow nurses and midwives to administer MMA. Therefore, this would increase the number of practitioners able to perform abortions and administer MMA, increase the number of health facilities offering these services, and increase the number of women seeking care in public health facilities. Additionally, it is important that public health facilities have the necessary equipment to perform surgical abortions along with adequate and continuous supplies of MMA. Millions of women are choosing MMA and thus, it is imperative that there are campaigns providing women with easy-to-understand educational information about using MMA effectively and safely. Lastly, it is important that contraceptive services provided to women are improved. The public health facilities can offer numerous modern contraceptive methods at their facilities and provide services to women to help identify which contraceptive method would be best for them. This would decrease the number of women choosing sterilization, an irreversible method, and instead increase the number of women turning to modern, reversible and long-acting contraceptives that decrease risk of unwanted pregnancies.

India has been trying hard to improve its sexual and reproductive health situation for decades. The National Rural Health Mission (NARHM) was created in 2005 aiming to improve the public healthcare delivery system along with providing accessible, affordable, safe and quality healthcare to people in rural environments (Nandan, 2010). Additionally, the introduction of the JSSK Intervention helped decrease the MMR and continues to offer free services to pregnant women. However, more must be done in order to improve the lives of the most vulnerable women. They continue to be at higher risks for health problems relating to sexual and reproductive health, specifically contraception, abortion, maternal health, and gender-based violence. Public health facilities can play a bigger role in providing safe, legal abortion services by increasing the number of trained practitioners, ensuring adequate and continuous supplies of abortion equipment and medication, offering a variety of long-acting, reversible modern contraceptives, and providing women with accurate, reliable information about MMA.