**Country Context**

India has experienced remarkable growth over the past decade and now has the fourth largest economy in purchasing power parity terms. It is home to 15 percent of the world’s population—a population of great diversity in culture, language and religion. India has also made progress on most of the Millennium Development Goals (MDGs) and has invested resources generated from growth into programs to deliver services to the poor. Poverty is widespread in India with 42 percent of the population, or 456 million people, subsisting on less than US $1.25 per day.

India’s large share of youth population (32 percent of the country population is younger than 15 years old) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. But for this opportunity to result in accelerated growth, the government needs to invest in the human capital formation of its youth.

Gender equality and women’s empowerment are important for improving reproductive health. Higher levels of women’s autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes. The ratio of females to males ages 0-6 is 91.4 to 100 which is the lowest since 1947. This a result of the natural sex ratio at birth, combined with sex-selective abortions and discrimination against girls resulting in higher mortality for females than males.

In India, the literacy rate among females ages 15 and above has increased from 65 percent in 2001 to 74 percent in 2011. Fewer girls are enrolled in secondary schools compared to boys with a ratio of female to male secondary enrollment of 86 percent. 36 percent of adult women participate in the labor force that mostly involves work in agriculture. Gender inequalities are reflected in the country’s human development ranking; India ranks 113 of 157 countries in the Gender-related Development Index.

Economic progress and greater investment in human capital of women will not necessarily translate into better reproductive outcomes if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.

**India: MDG 5 Status**

<table>
<thead>
<tr>
<th>MDG 5A indicators</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Mortality Ratio (maternal deaths per 100,000 live births) UN estimate</td>
<td>230</td>
</tr>
<tr>
<td>Births attended by skilled health personnel (percent)</td>
<td>52.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MDG 5B indicators</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive Prevalence Rate (percent)</td>
<td>54.0</td>
</tr>
<tr>
<td>Adolescent Fertility Rate (births per 1,000 women ages 15–19)</td>
<td>67.1</td>
</tr>
<tr>
<td>Antenatal care with health personnel (percent)</td>
<td>75.2</td>
</tr>
<tr>
<td>Unmet need for family planning (percent)</td>
<td>12.8</td>
</tr>
</tbody>
</table>

Source: Table compiled from multiple sources.

*Sample Registration System estimate for the period 2004–06 is 254.*

**MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio**

India has been making progress over the past two decades on maternal health but it is not yet on track to achieve its 2015 targets.

**Figure 1 - Maternal mortality ratio 1990–2008 and 2015 target**


**World Bank Support for Health in India**

The Bank’s new *Country Assistance Strategy Progress Report* under preparation (P121340) was approved by the Bank’s executive Board on November 30, 2010.

**Current Projects:**
- P071160 Karnataka Health Systems ($119.14m)
- P078538 Third National HIV/AIDS Control Project ($180m)
- P094360 National VBD Control & Polio Eradication ($521m)
- P118830 Tamil Nadu Health Additional Financing ($109.46)
- P078539 TB II ($141.1)

**Pipeline Projects:**
- P10004 SECOND UTTAR PRADESH HEALTH SYSTEMS STRE Appraisal date 3/15/2011
Key Challenges

Fertility is declining

Fertility has been declining over time but remains high among the poorest. Total fertility rate (TFR) decreased from 3.4 births per woman in 1990–92 to 2.9 births per woman in 1996–98 to 2.7 in 2005–06. Fertility remains higher among the poorest Indians at 3.9 in contrast to 1.8 among the wealthiest (Figure 2). Similarly, TFR is 1.8 among women with secondary education or higher compared to 3.6 among women with no formal education. It is also lower among urban women at 2.1, compared to rural women at 3.0 births per woman.

Adolescent fertility adversely affects not only young women’s health, education and employment prospects but also that of their children. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother. In India, adolescent fertility rate is moderate at 67 reported births per 1,000 women aged 15–19 years.

Early childbearing is more prevalent among the poor. While 50 percent of the poorest 20–24 years old women have had a child before reaching 18, only 9 percent of their richer counterparts did (Figure 3). The rich-poor gap in prevalence of early childbearing has increased across cohorts.

Use of modern contraception is increasing. Use of contraception among married women was 54 percent in 2007-08, up from 48 percent in 1998-99 and 41 percent in 1992–93. More married women use modern contraceptive methods than traditional methods (47 percent and 7 percent, respectively). Sterilisation is the most commonly used method (34 percent), followed by the pill (4 percent). There are socioeconomic differences in the use of modern contraception among women: modern contraceptive use is 58 percent among women in the wealthiest quintile and 35 percent among those in the poorest quintile (Figure 4). There is less difference by education level, but a similar trend can be seen: 46 percent of women with no education use modern contraception as compared to 50 percent of women with secondary education or higher.

Unmet need for contraception is moderate at 21 percent indicating that women may not be achieving their desired family size.

Although it is illegal to opt for an abortion based on the gender of the fetus, prosecution is uncommon. Unsafe abortion accounts for about 9 percent of maternal deaths each year, approximately 15,000. Further, estimates suggest that in 2002 and 2003, 3.6 million abortions, or 50 percent of the total number performed, were unsafe.

Opposition to use, health concerns or fear of side effects are the predominant reasons women do not intend to use modern contraceptives in future, not including fertility related reasons (such as menopause and infecundity). Nine percent not intending to use contraception cited health concerns or fear of side effects as the main reason while 15 percent expressed opposition to use, primarily by themselves, their husband, or due to their religion. Cost and access are lesser concerns, indicating further need to strengthen demand for family planning services.

Poor Pregnancy Outcomes

While the majority of pregnant women use antenatal care, institutional deliveries are less common. Seventy-five percent of pregnant women receive antenatal care from skilled medical personnel (Doctor/Nurse/midwife/Lady Health Visitor/Auxiliary nurse Midwife/Other health personnel) with 50 percent having three or more antenatal visits. However, a smaller proportion, 52 percent deliver with the assistance of skilled
medical personnel.11 While 89 percent of women in the wealthiest quintile delivered with skilled health personnel, only 19 percent of women in the poorest quintile obtained such assistance (Figure 5). Further, half of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.14

Figure 5 = Birth assisted by health personnel (percentage) by wealth quintile

Source: DHS Final Report, India 2005–06. The overall contraceptive use was 56.3% in 2005–06

Among all women ages 15–49 years who had given birth, 59 percent had no postnatal care within 6 weeks of delivery while 4 percent received postnatal check-up from a traditional birth attendant.9

Janani Suraksha Yojana (JSY) scheme
Introduction of Janani Suraksha Yojana (JSY) scheme (Conditional Cash Transfers to poor pregnant women for institutional delivery) resulted in a surge in demand for obstetric services. JSY beneficiaries availing public sector facilities have increased about 110 times from 0.704 million in 2005–06 to 7.841 million in 2009–10.15 The number of institutional deliveries reported by public sector facilities has increased from 10.841 million to 13.356 million during the same period. However, successive Joint Review Mission (JRM) reports indicate that provision of quality services on the supply side has not kept pace. The provision of cost effective evidence based services are critical to translation of this increased demand into the desired outcome of an accelerated decline in maternal mortality.

Human resources for maternal health are limited with only 0.6 physicians per 1,000 population but nurses and midwives are slightly more common, at 1.27 per 1,000 population.3

HIV prevalence is low in India although knowledge of risk reduction is poor
HIV prevalence is low in India at 0.3 percent of the population ages 15–49 years.3

Knowledge of HIV and HIV prevention methods is generally low. Sixty-one percent of women and 83 percent of men in India have heard of AIDS. Thirty-six percent of Indian women and 70 percent of men know that condoms can help reduce risk of transmission. The proportion of Indians who know that the risk of transmission from mother-to-child can be reduced by using medication is 19 percent for females and 20 percent for males.9

There is a large knowledge-behavior gap regarding condom use for HIV prevention. While most young women are aware that using a condom in every intercourse prevents HIV, only 5 percent of 15–19 year olds report having used condom at last intercourse (Figure 6). This gap widens among older aged women likely due to the fact that the chances of using condoms as a form of contraception diminishes with marriage.

Figure 5 = Knowledge behavior gap in HIV prevention among young women


Technical Notes:
Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs. The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3. These countries are also a sub-group of the Countdown to 2015 countries. Details of the RHAP are available at www.worldbank.org/population.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.
Key Actions to Improve RH Outcomes

Strengthen gender equality

- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women’s health and wellbeing.

Reducing high fertility

- Address the issue of opposition to use of contraception and promote the benefits of small family sizes. Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women’s groups.
- Leverage the increasing number of women coming to institutions for delivery under JSY scheme by providing postpartum counseling and voluntary services for family planning.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including long-term methods, through proper counseling which may entail training/re-training health care personnel.
- Secure reproductive health commodities and strengthen supply chain management to further increase contraceptive use as demand is generated.
- Strengthen post-abortion care (treatment of abortion complications with manual vacuum aspiration, post-abortion family planning counseling, and appropriate referral where necessary) and link it with family planning services.
- Expand the use of private sector capacity for provision of various services

Reducing maternal mortality

- Strengthen the referral system by instituting emergency transport systems training health personnel in appropriate referral procedures (referral protocols and recording of transfers).
- Improve quality of services (basic and comprehensive obstetric care) by introducing and using standard treatment protocols and guidelines to be used by skilled attendants at birth at all levels
- Utilize services of newly introduced village level workers (ASHA) for improving access to quality antenatal services, nutrition and management of anemia among pregnant women and improving access to home level postnatal and neonatal care.
- Build capacity in public sector and engage with the private sector to provide quality services.
- Address the inadequate human resources for health by training more skilled birth attendants and deploying them to the poorest or hard-to-reach areas. Multiskilling of health professionals at all levels including training of general physicians in anesthesia and cesarean sections for providing comprehensive emergency obstetric care
- Promote institutional delivery through provider incentives and implement risk-pooling schemes. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.

Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Focus HIV/AIDS providing information, education and communication efforts on adolescents, youth, married women, and other high risk groups including IDUs, sex workers and their clients, and migrant workers.

References:

5. Preliminary findings of the 2011 India Census.
12. Samuel Mills, Eduard Bos, and Emi Suzuki. Unmet need for contraception and opposition to use of contraceptives in the United States and Districts, Mumbai: IIPS.
**Development Partners Support for Reproductive Health in India**

The Reproductive and Child Health II program is led by the Ministry of Health and Family Welfare, Government of India and is supported by various partners through pooled financial assistance or technical assistance to the program. All assistance is coordinated towards this program with a common results framework and strategies to address RCH related issues in India.

The pooling partners providing financial assistance through the common pooled fund are: UNFPA, DFID (till 2010) and the World Bank. Other partners providing technical assistance include USAID, UNICEF, WHO, GTZ, JICA, SIDA, EC and BMGF. The EC is also providing budget support to the MOHFW supporting some of the goals of the RCH II program. In addition, there are several NOGs (international and national) that work on several RCH related issues in India.
National Policies and Strategies that have Influenced Reproductive Health

The Government of India has been focusing on improving reproductive health through a series of programs over the last two decades, including the Child Survival and Safe Motherhood Program (CSSM 1992–97), the Reproductive and Child Health (RCH) Phase I (1997–2004) and more recently through the RCH II Program, which is part of the flagship National Rural Health Mission (NRHM 2005–12). During this period India has made a perceptible shift from the high risk approach prior to CSSM Program to essential care for all pregnant women during CSSM and to ‘skilled attendance for all births’ during RCH II. The National Program Implementation Plan (NPIP) outlines the technical strategies, the goals, implementation plan and the results framework.

Under the current programs (RCH II/NRHM), there are interventions to improve demand for overall RCH services, including obstetric services and also to strengthen and expand the supply side to provide quality RCH services. The demand side interventions include use of Conditional Cash Transfers to poor pregnant women for institutional delivery (JSY – Janani Suraksha Yojana) and use of community health workers (ASHAs – Accredited Social Health Activist). The supply side interventions include preparing standards of care at various levels, upgrading public sector hospitals, entering into partnerships with the private sector, provision of emergency referral transport and strengthening program management systems.

National Policies

**National Population Policy – 2000** The NPP 2000 provides a policy framework for advancing goals and prioritizing strategies to meet the reproductive and child health needs of the people of India, and to achieve net replacement levels (TFR) by 2010. It is based upon the need to simultaneously address issues of child survival, maternal health, and contraception, while increasing outreach and coverage of a comprehensive package of reproductive and child health services by government, industry and the voluntary non-government sector, working in partnership.

**National Health Policy 1983 – Revised and Updated in 2002.**

**Facilitating LAWS/ACTS**

**Medical Termination of Pregnancy ACT – 1974, amended 2004** – Act permits MTPs under predefined circumstances – Purpose was to reduce/control unsafe abortions for reducing MMR.

**Maternity Benefit ACT 1961** – For providing maternity leave and benefit to women employees.

**Child Marriage Restraint Act – 1929**

**The Registration of Births and Deaths Act – 1969**