

An Analysis of the Current Status of Contraceptive Services and the Treatment of Gynaecological Morbidities in India Through the Lens of Equality, Quality and Accountability.

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1. Introduction

As a signatory to the Programme of Action at the 1994 International Conference on Population and Development (ICPD) in Cairo (United Nations 1994), the Indian government made important commitments to the sexual and reproductive health and rights (SRHR) of its citizens. This was a turning point in India's ideological approach to population and development, which till then had been shaped by concerns around rapid population growth and comprised mostly of investments in family planning to the exclusion of other sexual and reproductive health (SRH) concerns. In the twenty-five years since ICPD, the country has witnessed economic and health sector reforms that have had mixed results on progress made towards the ICPD agenda. For instance, the country's public spending on health remains amongst the lowest in the world, contributing to the emergence of a large unregulated private sector (Balarajan et al. 2011). While policies have emphasised a comprehensive approach to reproductive health, deficiencies in health financing, alongside changes in the global health agenda in the early 2000s have guided investments in some (maternal health, HIV/AIDS, and to a lesser extent family planning) but not all of the "core" reproductive health services specified in the Cairo Programme of Action, leading to an imbalance in service provision. Therefore, while maternal mortality has fallen by nearly 50 per cent between 1990-2015, (Kassebaum et al. 2016) abortion service provision in the public sector remains inadequate, (Stillman et al. 2014) the contraceptive method mix is still heavily skewed towards female sterilisation (International Institute for Population Sciences - IIPS/India and ICF 2017), and gynaecological morbidities have received negligible programmatic attention (MoHFW 2018).

In this case study, we analyse two elements of SRH services—contraception and gynaecological morbidities—through the lens of equality, quality and accountability (EQA). While SRH is much broader, the focus on these two specific components is intentional. Contraceptive/family planning services has been a policy and programmatic priority in India for at least six decades. However, the processes and pathways through which fertility has been reduced have neither explicitly protected nor promoted human rights, nor till recently paid adequate attention to quality of service delivery (Koenig et al. 2000). In 2012, India committed to achieving a target of an additional 48 million contraceptive users by 2020 at the London Family Planning Summit (Government of India 2014). This commitment has been translated into action through new programmatic initiatives such as scaling up post-partum IUD services, and the addition of injectables within the public-sector delivery system. Such a renewed focus provides an opportunity for a critical assessment of contraceptive services using a lens of EQA, with a view to providing recommendations that can help make progress towards a rights-based approach to care.

While maternal health and birth control occupy a central place in wider development discourse, there is little recognition of the health needs of women outside of reproduction or beyond their reproductive years. In India, gynaecological morbidity causes considerable burden on women's health. For example, women have a similar lifetime risk of dying of cervical cancer (in the absence of any other disease) as in pregnancy (Dikshit et al 2012). A range of research over the past two decades indicates a considerable burden of gynaecological morbidity, but policy has largely addressed such concerns on the fringe of programmes for maternal health or family planning. As a result, services are largely unavailable at the primary level, despite the Cairo consensus on the inclusion of diagnosis and treatment of reproductive tract infections as an essential service for women. In this case study, these morbidities are defined to include three groups of symptoms and/or ailments: reproductive tract infections/sexually transmitted infections (RTI/STIs); menstruation-related morbidities and irregularities; and cervical cancer, including its precursor symptoms. This case study takes the view, aligned with the ICPD consensus, that women's gynaecological morbidities are a critical part of reproductive health services that must be provided and monitored as an indicator of progress towards sexual and reproductive health and rights.

1.1. Approach

This case study aims to provide an overview of the current status of these two aspects of SRHR in India, followed by an analysis of service provision and fulfilment of sexual and reproductive rights through the lens of EQA and concluding synthesis. Equality is operationalised across demographic characteristics such as location, socioeconomic status, education and other available data. Empirical data on status of family planning use and gynaecological morbidities is drawn primarily from the fourth round of India's National Family Health Survey (2015-16). We focus on national data and some state-level variation in this case study as a first step, while noting (i) the importance of state-level analysis to account for wide variation in epidemiologic burden and health systems across India (Dandona et al 2017); and (ii) that health is a state subject in India's federated structure; advocacy requires both national and state-level evidence to influence changes in policy and service provision. Throughout this case study, we present a birds-eye view of the quality of services—inclusive of availability/comprehensiveness; accessibility and affordability—through synthesis of available community-based/facility-level research and monitoring reports. Lastly, we examine accountability through an overview of existing legal and institutional frameworks, along with the role of civil society actors. The case study concludes with observations on advances, challenges and opportunities with respect to SRHR and the SDGs in India.

2. Benchmark Status

2.1. Laws, Policies and Programs

In the 65 years since India introduced its first National Family Planning Program, its rationale and approach to population policy has evolved from a focus on achieving demographic goals, to a recognition of the need for an integrated approach to reproductive health. This shift in policy was initiated in 1996 with the removal of contraceptive method-specific targets under Phase 1 of the Reproductive and Child Health (RCH) Programme (Donaldson 2002). This

change was largely influenced by (1) data and assessments that exposed inadequacies of the family welfare program in achieving its stated goals and improving reproductive health; (2) concerns raised by women's health advocates regarding substandard service quality and coercive practices; and (3) country commitments made at the ICPD 1994 and the World Conference on Women in Beijing in 1995 to respect, protect and promote human rights in national population and health policies and programs (Visaria et al. 1999).

The National Population Policy (NPP) 2000 formalised this paradigm change in numerous ways (Ministry of Health and Family Welfare 2000). It underscored the government's responsibility to make reproductive healthcare accessible and affordable to all, while affirming its commitment to voluntary, informed choice, and target-free family planning programming. It recognised the role of men in planned parenthood; the need to simultaneously address social determinants of poor reproductive health including gender discrimination; and differential access to clean water, sanitation, housing, education and employment. Adolescents were acknowledged as a key under-served population, specifically in terms of their sexual and reproductive health needs, including their requirements for contraceptive information, counselling and services. Despite this broad framework, the policy included "promotional and motivational" incentives for program implementers to "universalise the small family norm" and incentives for program beneficiaries who adopted permanent contraceptive methods such as sterilisation. Therefore, while the policy supported a target-free approach on the one hand, the creation of performance-based incentives undermined this claim, contributing to the promotion of informal acceptor targets by implementers on-the-ground.

In line with its commitments to achieve the health-related Millennium Development Goals (MDGs), the Indian government, in 2005, simultaneously introduced its flagship health program, the National Rural Health Mission (NRHM), (Nandan 2010), alongside Phase II of the RCH programme. The NRHM was conceived to facilitate universal access to affordable, equitable and quality healthcare services, and an increase in public expenditure on health was directed towards investments in and expansion of rural healthcare infrastructure, personnel and programs. Of note, the Mission introduced a new cadre of health workers at the community/village level, the Accredited Social Health Activist (ASHAs). It sought to integrate community participation in the planning, implementation and evaluation of services and programs and incorporate a community monitoring framework for accountability. The Indian Public Health Standards (IPHS), norms against which quality assessments could be benchmarked, were developed under the Mission (Satpathy 2005).

Both NRHM and RCH-II shared the twin goals of maternal mortality reduction and achievement of replacement fertility by 2012. While the provision of a constellation of reproductive health services, including abortion and management of reproductive tract and sexually transmitted infections were included as service guarantees, a programmatic focus on maternal health and contraception, particularly sterilisation, was prioritized. For instance, the government introduced Janani Suraksha Yojana, a conditional cash transfer program for institutional childbirth, as well as a sterilisation compensation scheme for health system personnel and sterilisation acceptors, ostensibly for "loss of wages". Client incentives differed based on procedure type (vasectomy vs tubectomy), and in non-high focus states, were targeted

specifically to women living below the poverty line and/or those having scheduled caste/scheduled tribe (SC/ST) status. Financial incentives were also extended to staff, motivating and providing sterilisation services in contracted private/NGO facilities.

In 2008, the Ministry of Labour introduced the Rashtriya Swasthya Bima Yojana (RSBY), a national health insurance scheme for families who hold below poverty line cards. RSBY, in exchange for nominal membership payments from beneficiaries, provided coverage for hospitalisation for a range of health conditions that require 24-hour admission. Vaginal and caesarean delivery, tubal ligation, vasectomy, copper-T/IUD insertion and post-abortion care are covered procedures related to pregnancy and contraception. Several (invasive) gynaecological procedures, such as ovarian cystectomy, myomectomy and hysterectomy are available under the scheme. However, preventive care and outpatient treatment are not covered under the scheme at present, although experiments in some states have considered the inclusion of basic outpatient care. In 2018, the government introduced the Prime Minister's Jan Arogya Yojana (PM-JAY), a new insurance scheme that expands coverage while altering management structures of government-sponsored health insurance. It continues to cover a range of inpatient gynaecological procedures.

In 2013, the NRHM was integrated into a National Health Mission (NHM), and an urban (NUHM) component added-on. Under the NHM, the framework of the RCH programme has been expanded in scope (RMNCH+A) to include a continuum of reproductive health services through the life-course and across all levels of the health system. Keeping in line with a commitment at the London Family Planning Summit in 2012 to increase contraceptive use amongst 48 million new users, family planning services has received renewed attention, with a focus on spacing methods, specifically the IUCD. This expansion of birth control services (FP + safe abortion) is seen as a strategy to make progress on the dual objectives of (1) achieving population stabilisation, and (2) improving women's and children's health and survival. The strong and growing network of ASHAs have been tasked with delivering contraceptive pills and condoms in homes, and to refer women for contraceptive services that require clinical care. The substantial increase in institutional deliveries through the NRHM is also being leveraged to promote and motivate women for the uptake of the postpartum IUD.

The NHM also defines the management of sexually transmitted and reproductive tract infections (RTI and STI) as a priority area in its strategy for RMNCH+A. The policy indicates that services should be provided at all CHCs and FRUs (community health centres and first referral units) and at PHCs that provide 24X7 care. Mandated services for the diagnosis and treatment of RTI/STIs includes availability of laboratory facilities and service providers trained in syndromic management. It notes the need for convergence with the National AIDS Control Program to provide laboratory facilities. The strategy establishes that services should be made available to all age groups, with special measures taken to provide adolescent friendly services.

Two recent national policy initiatives provide a renewed national framework for integrated delivery and steps to achieve the sustainable development goals. The National Health Policy (2017) and Ayushman Bharat scheme (2018) focus on provision of primary health care and universal health coverage through a range of initiatives such as: Health and Wellness Centres at the community level, an additional cadre of mid-level providers and expanded insurance

coverage to provide essential health services at the community level, including those defined under the National Health Policy.

2.2. The Sustainable Development Goals

The sustainable development goals (SDGs) 2030 lay down the framework for national and international targets to improve human development (UN General Assembly 2015). SRHR is addressed within the goals of ensuring healthy lives (Goal 3) and gender equality (Goal 5). Three separate but inter-related targets relate to family planning: (1) ensure universal access to sexual and reproductive health services, including family planning (target 3.7), (2) achieve universal health coverage (target 3.8), and (3) universal access to sexual and reproductive health and reproductive rights (target 5.6). The indicators for these targets relevant to tracking progress in FP access are:

3.7.1: The proportion of women of reproductive age who have their need for FP satisfied by modern methods

3.7.2: Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1000 women in that age group

3.8.1 Coverage of essential health services (including reproductive health services)

5.6.1: The proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care.

Current indicators for the SDGs do not directly address gynaecological ailments or their treatment. Goal 3.4 includes an indicator to monitor mortality due to cancer, although it is unclear whether mortality would be disaggregated by type or sex. Goal 3.7, ensuring universal access to SRH care services including integration of RH into national strategies, is monitored by coverage of family planning services; there is no indicator to address universal access to gynaecological care in particular. Goal 3.8 for universal health coverage, while broader, makes clear that reproductive health is part of essential health services: indicator 3.8.1 calls for monitoring coverage of these services amongst both the general and disadvantaged populations. The spectrum of issues covered in the SDG indicators suggests that reproductive health care is on the larger agenda but monitoring falls short of comprehensive reproductive health care. In particular, indicators related to reproductive health focus on family planning/contraception and maternal health, with no specific recognition of gynaecological morbidities.

2.3. India and the SDGs

India has signalled its partnership in the global SDG process through political and policy-level commitments, as well as programmatic investments in line with national priorities. In 2018, the NITI Aayog, India's national-level planning body, released a national framework for the SDGs and a specially developed 'SDG India Index'. The NITI Aayog developed the index to track progress of all states and union territories (UTs) according to 62 priority indicators. The indicators were chosen based on alignment between the global SDG framework and India's policies and priorities; availability and coverage of data; and in partnership with respective

ministries. In 2018, the SDG Index Score ranged between 42 and 69 for States and between 57 and 68 for UTs: Kerala and Himachal Pradesh led states and Chandigarh the UTs as of 2018.

Several indicators chosen for the SDG India index, relate directly to sexual and reproductive health, specifically maternal mortality, family planning, intimate partner violence and broader access to health care. Table 1 lists health-related goals in the global targets and India’s choice of indicators to monitor these within the India index. The India index also includes a wider range of indicators that address social determinants such as education, access to sanitation, the sex ratio at birth and female labour force participation.

India’s publicly available tracking and monitoring report marks an important step towards integrating SDGs into multisectoral policy initiatives. Specific to SRH, the sub-set of indicators chosen are aligned with major health programs, such as PM-JAY (health insurance) and JSY (maternity benefits). They also reflect persistent challenges that require a response across sectors, such as addressing intimate partner violence and increased investment, such as improving health worker availability. Accordingly, the indicators provide a mechanism to track progress specific to India’s policy priorities in SRH.

However, the choice of indicators reflects an outcomes focused approach, providing no information on the processes that underpin it. For instance, the percentage of reproductive aged women using modern family planning methods is a longstanding population-based, demographic indicator, which if used in isolation, neglects pressing concerns around the quality of care rendered in reaching an aggregate-level target that measures program performance. Further, aggregate gains can mask stark inequalities in availability and access to services by sub-groups such as adolescents, economically disadvantaged women or women living in rural areas. It will be critical to ensure consistent measurement of process-level information relevant to quality (e.g., details on method selection for contraception), alongside disaggregated data by various sub-groups to help strengthen health system accountability for reduction in inequalities and improved quality of services. Further, indicators to track progress in health systems strengthening required to ensure affordable, accessible SRH care, such as for gynaecological morbidities, will be needed to assess progress more critically at the national and state level.

Table 1: SDG India Index related to SRH

SDG Global Target	SDG India Index Indicator
1.3 Implement nationally appropriate social protection by 2030 to achieve substantial coverage of the poor and the vulnerable	Percentage of households with any usual member covered by any health scheme or health insurance
	Proportion of eligible population receiving maternity benefit
2. 2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional	Percentage of women (15-49) who are anemic (11.0 g/dl %)

needs of adolescent girls, pregnant and lactating women and older persons	
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	Maternal mortality ratio
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases	Annual notification of tuberculosis cases per 1 lakh population (no AIDS indicator)
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	Number of governmental physicians, nurses and midwives per 1,00,000 population
5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences	Percentage of women in the age group of 15-49 years using modern methods of family planning
5.2 Eliminate all forms of violence against all women and girls, sexual and other types of exploitation	Proportion of ever-married women aged 15-49 who have ever experienced spousal violence

Source: SDG India Index, Baseline report 2018

http://niti.gov.in/writereaddata/files/SDX_Index_India_21.12.2018.pdf

3. Analysis of the Provision of Contraception and Gynaecological Morbidities using a framework of Equality, Quality and Accountability

3.1. Contraception Equality

Nationally, India has been experiencing a steady decline in total fertility rate (TFR) from 2.7 (NFHS-III, 2005-06) to 2.2 (NFHS-IV, 2014-15), nearly reaching replacement fertility. In this decade-long period, the unmet need for family planning has decreased only marginally, from 13.9% to 12.9% of married women 15-49 years of age. While this is likely indicative of an increasing aspiration for smaller families, the modern contraceptive prevalence rate (mCPR) has remained stagnant, showing a 0.7 percentage point decrease from 48.5% to 47.8% (International Institute for Population Sciences - IIPS/India and ICF 2017). Despite policy directives emphasising contraceptive method choice and mix, in line with women's changing needs over their reproductive life course, the overwhelming majority of modern contraceptive users still rely on female sterilisation (75%), with very low/non-use of temporary contraceptive

methods in the intervening childbearing period. Comparing the two recent rounds of demographic and health survey data, temporary method use increased by 0.5 percentage points from 11.0% (2005-06) to 11.5% (2015-16). This is despite the program's stated intention to provide oral contraceptive pills, condoms, IUCDs, emergency contraception, and male and female sterilisation, with the addition of injectables in late 2016.

Aggregate national data mask the substantial variations in the availability and use of family planning services by age, state of residence, caste and wealth groups. For instance, in the most recent NFHS survey round (2015-16), only 10% of married girls between the ages of 15-19 reported using a modern method of contraception compared to 41.8% of women aged 25-29. (International Institute for Population Sciences - IIPS/India and ICF 2017) This sharp increase in contraceptive prevalence in the 25-29 age group can be attributed to the preponderance of female sterilisation. This trend is particularly problematic for girls and women in the younger age groups who want to delay or space childbearing. As is expected, unmet need for family planning in the most recent NFHS round was highest (over 1 in 5 women) amongst married teenage and young adult women ages 15 to 24. In a study on adolescents in Bihar, over half (51 per cent) of married girls in the age-group of 15-19 had an unmet need for family planning, compared to only 7 per cent who had their demand for contraception satisfied (Santhya et al. 2017). The NFHS data also show substantial wealth differentials in modern contraceptive use, with a 17-percentage point difference in contraceptive prevalence between the wealthiest quintile of married women (53.1 per cent) and the poorest quintile of married women (36.4 per cent).

The considerable regional variation in unmet need is indicative of the substantial health system investments that are needed to reduce the gap in the availability, distribution and accessibility of contraceptive supplies and services across states. In the southern state of Tamil Nadu, contraceptive unmet need was 10.1 per cent, compared to 18.1 per cent in the northern state of Uttar Pradesh, and 21.7 per cent in the north-east state of Sikkim (NFHS-4). In a separate analysis, the difference in modern contraceptive use between non-tribal and tribal married women in the states of Madhya Pradesh, Chhattisgarh and Jharkhand ranged from 9-21.6 percentage points (Prusty 2014). Non-use was frequently attributed to personal or family opposition, indicating the need for more sensitive and responsive client and community engagement and education to address concerns, social norms, beliefs and practices that impede access and use.

Reports of the Common Review (CRMs) and Annual Joint Review Missions, monitoring mechanisms set up under the NRHM and RCH programme, point to a number of management implementation and quality gaps. The most recent CRM (2016) (National Health Systems Resource Centre 2016) noted inadequate supplies of temporary contraceptive commodities, poor adherence to systems and protocols for contraceptive counselling, and absence of patient follow-up in certain states. The variability in the extent of program rollout across states is evident. Whereas in Uttar Pradesh, door-to-door delivery of oral contraceptive pills (OCPs), emergency contraceptive pills (ECPs) and condoms by ASHAs were found to be well-functioning, this system was entirely absent in other states. Comparative program evaluations

across states with variation in program performance may shed light on the facilitators and barriers to implementation and state-level investments.

The review also highlighted the role of human resource deficits, particularly in rural and hard-to-reach areas in inhibiting availability and delivery of services. Persistent vacancies in clinical posts, including amongst specialists, are being compensated for through task shifting/sharing for services such as non-scalpel vasectomies and mini-laparoscopic tubectomies by trained medical officers, and accreditation of private providers and non-governmental organisations. With the scale-up of PPIUCD and interval IUCD services, practitioners of alternative systems of medicine (AYUSH doctors) are being trained on insertions. In theory, task shifting as a solution to a human resources deficit works on the assumption that transferring tasks to be in the scope of practice of mid-level providers can expand service provision and minimize delays in service delivery, improving efficiency.

For task shifting to be successful in the long term, there needs to be adequate commitment of resources —both human and financial— for training and mentorship, supervision, and monitoring and evaluation of processes and health outcomes. Inadequate regulatory frameworks, poor quality training and punitive approaches to supervision may contribute to poor quality of care in the context of task shifting. Deficits in non-clinical personnel, such as family planning counsellors, a position that has largely remained unfulfilled in community health centres across many states continues to hamper service quality.

Family planning services within public facilities are free at the point of care. However, given existing public infrastructure and human resource constraints, the NHM calls for public-private partnerships via social franchising of family planning services and contracting-in of private providers. To improve access in the private sector, beneficiaries of the National Health Insurance Scheme (RSBY) are entitled to receive family planning from empanelled private hospitals. However, a study by the Population Council examining utilisation of RSBY in the state of Uttar Pradesh found that less than one in five women and a minority (30 per cent) of men were aware of this coverage (Mozumdar et al. 2016). Moreover, the actual use of this scheme for FP services was negligible.

Differences in the type of FP service provision between the public and private sectors are also evident. Given the focus of the FP program on sterilisation, the majority of clients (85 per cent) report receiving this service in the public sector, whereas the private sector plays a larger role in the provision of temporary contraception. The ongoing expansion of social franchising networks also raises questions of equity, as it is likely that user fees, no matter how small, are a barrier to service utilisation, particularly amongst disadvantaged groups (Ravindran and Fonn 2011). The greater role of fee-charging private providers in the provision of temporary contraception, alongside the financial incentives for uptake of terminal methods in the public sector belies the principle of free choice, particularly for economically disadvantaged populations in the country.

3.1.1. Quality

Perhaps the biggest shortfall in FP service provision in India has been the program's lack of adherence to quality, ethical and human rights standards. A discussion of family planning

quality in India has to consider the long and chequered history of the national family planning program in the country. Malthusian concerns of rapid population growth in a newly independent India, and its negative impact on economic prosperity motivated the Indian government to establish the world's first National Family Planning Program in 1952 (Connelly 2006; *The Global Family Planning Revolution: Three Decades of Population Policies and Programs* 2007). Leading demographers in the United States successfully lobbied for foreign technical and financial assistance from the Rockefeller and Ford Foundations to curb population growth in India. Their involvement would continue through the next two decades. In the initial years, government and private funding and attention were devoted to generating empirical data on fertility levels, preferences and attitudes towards fertility control. The dissemination of information on the use of the rhythm method via health facility-based awareness activities complemented ongoing research activities. A "clinic-based" approach to family planning was gradually established with 4000 additional clinics built throughout the country in the latter half of the decade.

The 1961 Census however, indicated no change in the population growth rate (~2 per cent), despite such investments (Ledbetter 1984). The third five-year period (1961-65), marked a shift in approach with (1) the expansion of the program outside of facilities through an "extension approach" involving family planning educators visiting homes to motivate couples to adopt contraception; and (2) the introduction of modern methods – focusing on the intra-uterine device (IUD), and male and female sterilisation. In the late 1960s monetary incentives to providers and acceptors of these methods were introduced, alongside targets and quotas (proposed by the World Bank) as strategies to both motivate and address the shortage of trained medical personnel and the inadequate uptake of contraception by couples, particularly in rural areas (Connelly 2006). Private businesses were also encouraged to provide incentives to employees to adopt these methods. The family planning program was likened to waging war on unchecked population growth, such as in Deepa Dhanraj's documentary on sterilisation camps. The narrowly focused goal of fertility reduction motivated rapid expansion of the incentivised IUD program without appropriate systems in place for follow-up visits to assess side-effects, manage spontaneous expulsions, or remove IUDs for women wanting to discontinue using this method.

A lack of focus on quality was the primary contributor to the program's failure. Growing reports of prolonged bleeding and uterine perforations were linked to a public backlash against the program and a rapid decline in IUD acceptors. While sterilisations continued, reviews of the program indicated unusually high rates of sepsis, and surgeries performed on men in their old age, and on women who were no longer of childbearing age. The expansion of the sterilisation program, preferred due to their non-reliance on sustained motivation extended into the early 70s, culminating in the debacle of the "compulsory" sterilisation program during the Emergency in 1976-77 when 8.3 million male sterilisations were performed, the majority of them forced (Gwatkin 1979).

Such events led to the mobilisation of social and women's movements in the early 1980s, in response to the government's violations of individual dignity, wellbeing and rights in its pursuit of economic goals (Datta and Misra 2000). This was the beginning of what would grow to be

an international women's movement which, in 1994 at the International Conference on Population and Development in Cairo, successfully brought about a pivotal change in international population policy, from governments' focus on fertility control to policies promoting sexual and reproductive health and rights. The Indian Government announced two policy changes after Cairo: contraceptive targets were dropped, and the Family Welfare Programme with its singular focus on contraception was replaced by a broader Reproductive and Child Health Programme.

In the decades since Cairo, the articulation of commitments in policy documents to individual rights and choice in the provision of family planning services, have been met with limited action. Assessments by researchers and civil society groups have highlighted the poor quality of care along multiple dimensions. First, general health system constraints such as poor retention of trained human resources and irregular supply of family planning commodities and related logistics have hampered service availability. Recent data from public healthcare facilities in Rajasthan indicate that commodity stockouts vary by method (PMA2020 2018). While less than 10 per cent of health facilities had stockouts of pills and condoms in the previous three months, 20 per cent and 71 per cent reported stockouts of IUDs and injectables in the same time period. Having a wider range of methods that are suited to clientele who are at various stages of the reproductive life-course can promote accessibility of FP services (Germain et al. 2015). Using a standard of 5 minimum modern methods, namely the oral contraceptive pill, condoms, injectables, intra-uterine devices, and sterilisation (male or female), the percentage of public facilities in Rajasthan that provided this standard differed by facility type. While 100 per cent of tertiary care institutions provided this standard, only just over one quarter of primary health centres did so. Such variation in method availability across facility types is likely to most affect contraceptive access and choices of women who are economically disadvantaged or those living in rural areas due to financial and geographical inaccessibility of services located only in higher-level institutions.

When contraceptive products are available, the provision of accurate and complete information is essential to informed choice and appropriate use of a chosen method (Bruce 1990). An analysis of data from NFHS-3, found that only 16 per cent of women using contraception were told about other methods they could use, the potential side-effects of their current method, and what actions to take if they experienced these side effects (Jain 2016). Contraceptive discontinuation within the first year of use is a useful marker of satisfaction with a method. In NFHS-4, the one-year contraceptive discontinuation rate for modern spacing methods was 44 per cent, with the highest discontinuation rate for injectables (51 per cent), followed by condoms (47 per cent) and pills (42 per cent). Only 5 per cent of users who discontinued any method switched to a different one. Some women reported desire for pregnancy as their main reason for discontinuation; however, many reported dis-satisfaction with their method due to side effects, health concerns, inaccessibility, cost and inconvenience as reasons for stopping use (International Institute for Population Sciences - IIPS/India and ICF 2017).

The preponderance of female sterilisation, and the monetary incentives targeted to vulnerable population sub-groups is a reflection of the long-term impacts of constrained choices on norms and preferences related to method use. The poor quality of care in the provision of sterilisation

services became publicly evident in 2014, associated with the deaths of several women after undergoing tubectomies at a sterilisation camp in Bilaspur, Chhattisgarh (Sharma 2014). A civil society enquiry and fact-finding mission found egregious violations of the Standard Operating Procedures set by the Ministry of Health and Family Welfare (Sama Resource Group for Women and Health et al. 2014). Amongst other things, the camp was conducted in an abandoned private health facility, with no arrangements for counselling, pre- and post-operative care. A single surgeon conducted more than double the number of allowable sterilisations in a single session, with less than the minimum requirements for equipment. Accounts by family members also point to consent procedures being glossed over, with a focus on signature collections as proof of consent.

Such violations of norms and standards are not unique to this incident. The 2016 Common Review Mission (National Health Systems Resource Centre 2016) identified similar issues of poor adherence to counselling, infection control and consent-taking protocols and lack of privacy and emphasised an “urgent need to institutionalize a rights-based approach to terminal methods.” In 2016, the Indian Supreme Court banned sterilisation camps and directed the Indian government to phase out this practice over a three-year period. While this was a welcome move, the sub-standard quality of FP services and the poor adherence to a human-rights approach in care provision is an outcome of larger unaddressed systemic issues. These include (1) the continuation of target-setting for state program managers and implementers through “expected levels of achievement” (ELA) for various contraceptive method types in state NHM programme implementation plans (PIPs); (2) Monetary incentives to both FP clients and staff for the uptake of terminal contraceptive methods, and more recently, PPIUCDs; (3) Conditioning the eligibility of women for other government entitlements and participation in local politics on the basis of their adherence to the two-child norm in some states; and the (4) Lack of attention in staff training curriculums on respecting the rights of clients to informed choice, privacy, dignity and bodily integrity.

3.1.2. Accountability

Under the national health policy, numerous strategies have been outlined for monitoring (including community monitoring) of progress in health system reforms and quality of service provision. However, there is limited publicly available information on the implementation of these accountability systems, specifically as they relate to the tracking of FP service provision. The Ministry of Health and Family Welfare has drawn up and made publicly available, standard operating procedures, clinical and quality guidelines and monitoring checklists. However, whether and to what extent these standards are implemented and used as benchmarks to assess the quality of care in monitoring procedures is unknown. Civil society reports of fact-finding missions indicate that these standards and protocols are observed more in the breach, with little to no threat of consequence (Dasgupta et al. 2017). While the CRMs report on whether or not District Quality Assurance Committees (DQAC) are formed, there is little insight into what measures are taken by these bodies to monitor QOC and implement corrective measures. Reports suggest that formal grievance and redress mechanisms are non-functional, with attention brought to safety and rights abuses only in particularly egregious cases.

While FP data is available through nationally representative DHS surveys and district-level household surveys, summary indicators are limited to percentage of users by method type and levels of unmet need. This is supplemented by a few measures of service quality (e.g.: current users informed about side-effects). However, crucial information on rates and reasons for discontinuation, satisfaction with current method and service provision for method switching are data that are either not collected on a regular basis or not actively used for monitoring and improving care.

Citizen and women's advocacy groups and non-governmental organisations such as Medico Friend Circle, the People's Health Movement (Jan Swasthya Abhiyan) and Rural Women's Social Education Centre (RUWSEC) have drawn attention to policy and programmatic lapses related to a number of reproductive health issues (Dasgupta et al. 2017; Sama Resource Group for Women and Health et al. 2014; Sathyamala 2000). Such groups were critical to the movement in the 1980s that demanded a shift from coercive and directive population policies to ones centred on health, human rights and women's empowerment (Datta and Misra 2000). In the early 1990s women's groups successfully obtained stay orders from the Supreme Court to halt trials of Norplant and Net-Oen due to unethical research practices and poor transparency of findings and demanded withdrawal of unsafe contraception from the Indian market (Singh 1997).

These advocates continue to use multiple activities such as research, fact finding missions, public documentation and court action to draw attention to the neglect of women's reproductive health needs. More recently, the National Health Mission has included patient welfare committees (Rogi Kalyan Samitis) as a mechanism to integrate community-led monitoring of health services for accountability of the health system to the populations it serves. These committees are formed by members of the Panchayati Raj Institutions (local self-government), non-profit organisations, local elected and government officials. A multi-state project to improve community action for health has been implemented under the technical assistance and guidance of the Population Foundation of India. Activities include trainings on effective leadership through establishing grievance redressal systems, strategising about local priorities and associated utilisation of untied funds to support action (PFI 2017-18). Finally, public exposure or negative publicity by the media of actions that violate ethical, medical and human rights standards (such as the poor quality of sterilisation services) are a type of sanction that has been used successfully to identify failures in the provision of FP services.

3.2. Gynaecological morbidities

3.2.1. Equality

National data

Nationally representative data on treatment-seeking patterns related to gynaecological morbidities outside of pregnancy, as collected in the National Family Health Survey (NFHS), are limited to three primary areas: self-reported prevalence and treatment-seeking for symptoms of RTIs/STIs; hysterectomy; and cervical examination, the latter two introduced in the most recent NFHS round (2015-16).

In 2015-16, 8.7 per cent of women in ages 15-49 reported experiencing symptoms such as genital discharge or genital sore/ulcer in the past twelve months. While noting that these do not cover the range of symptoms associated with RTI/STIs, reported prevalence was similar to that in 2005-6 (8.9 per cent). Of women who reported symptoms, 39.2 per cent reported seeking treatment; notably, this figure has not changed from NFHS-3 estimates ten years ago (Bhasin et al 2019). About one-half of women utilised only private care, while 38 per cent sought public care alone and the remainder sought a combination. Variation by individual characteristics indicated inequitable utilisation by socioeconomic and demographic characteristics. An analysis indicated that higher education, wealth status and religion were associated with higher odds of seeking treatment (Bhasin et al 2019). State level variation in the proportion of women who sought treatment for symptoms was also wide, ranging from 7.6 per cent in Nagaland, 19.3 per cent in Assam to over 63 per cent in Kerala and Punjab. Notably, this data does not provide information on the cure rate or source of infection, such as if it is related to contraceptive use.

National data indicated that 22.3 per cent of reproductive-aged women had ever undergone a cervical exam. There was a marginal difference between urban and rural women, with a slightly lower proportion of rural (21.0 per cent) women compared to urban (25.3 per cent) who had been screened. Since the exam would have comprised either a pap test or visual inspection, this estimate may also be proxy for the reach of gynaecological services. Although not a direct measure of density or distance regarding services, utilisation may serve as a proxy for availability, accessibility and affordability – as well as knowledge amongst women. Lastly, mortality due to cervical cancer varies across demographic characteristics. According to the Million Deaths Study, a nationally representative analysis of mortality, cervical cancer is the leading cause of cancer deaths for women in both rural and urban areas, with a slightly higher rate in rural India (Dikshit et al 2012).

The NFHS-4 estimated a hysterectomy prevalence of 3.2 per cent of all women in the 15-49 age group. Estimates vary widely by age group, as expected, and by state (Desai et al 2019). For example, over one-fifth women in ages 40-49 in Andhra Pradesh and Telangana has had a hysterectomy, a prevalence comparable to women in high-income settings. The odds of hysterectomy were higher in women with lower education, who live in rural areas and with higher wealth status. While national prevalence is not high compared to other countries where data are available, the low age and state variations suggest hysterectomy is both a medical and health systems issue. Although lack of appropriate data precludes an analysis of factors such

as health insurance or density of gynaecologists, state-level variation may be associated health system factors such as common caesarean section and female illiteracy. As with most procedures, there is high use of the private sector for hysterectomy; only one-third of hysterectomies were conducted in the public sector. Over one-half of hysterectomies were conducted for excessive menstrual bleeding, as reported by women, followed by fibroids/cysts (19.5 per cent) and uterine prolapse (13.4 per cent) – which suggests its common use as treatment for gynaecological ailments amenable to other treatments.

Other studies

In the absence of other relevant national-level data, a range of community-based research studies provides insight on utilisation of treatment services for gynaecological morbidities. The definition of RTIs differs across research studies conducted in India, thereby limiting generalizable conclusions. The majority of studies refer to women's self-reported symptoms, while others focus on laboratory-confirmed diagnosis. In studies where women reported seeking treatment for symptoms of RTIs (such as white discharge), most women did not seek treatment from formal providers (Nagarkar et al 2015). In a large survey of 4,850 married and unmarried women, about two-fifths of married, and one-third of unmarried, women had sought formal treatment for RTI symptoms (Sabarwal and Santhya 2012). Despite variation in proportions who sought treatment, research has consistently indicated that the vast majority of women who do so utilize the private sector (Prasad et al 2005; Singh et al 2012). Women commonly cited not believing the issue was serious enough to warrant treatment, which may reflect either women's knowledge of RTIs or low priority accorded symptoms of reproductive tract infections. Research has also indicated that women treat symptoms differently: according to perceived seriousness, they utilize home-based, traditional, public and private facilities (Kielmann and Bentley 2003). Perceptions of the gravity of symptoms may be linked to lack of availability of specific education or knowledge on reproductive tract infections.

3.2.2. Quality

Appropriate and accessible services

Across most studies, common health system-related reasons for not seeking care include a lack of female doctor available at government facilities, distance and waiting times. These all point to availability of appropriate services as well as accessibility. According to the National Health Mission, the tertiary level of care, either the District hospital or a first referral unit, should be equipped to treat reproductive tract infections. For rural women in particular, these facilities may be far and require loss of time at work and childcare. Moreover, these facilities are large; require long waits and negotiation of complex systems of registration and paperwork that may intimidate women seeking care. Perceived seriousness, therefore, may be a function of how accessible facilities are as opposed to women's symptoms. The ASHA worker, for example, focuses on maternal and child health, with limited training or direction to provide women with information or advice regarding gynaecological complaints.

Qualitative research notes that the well-established notion of a “culture of silence” around gynaecological ailments, women's fear/ embarrassment and lack of provider sensitivity prevent women from seeking care (Barua and Kurz 2001; Oommen 2008; Santhya 2008). Another

barrier to utilisation of gynaecological services in the public sector relates to the integration of reproductive health and HIV/AIDS programs. Although an important intervention to provide comprehensive HIV/AIDS prevention, research suggests that integration must be delivered aligned with local need and prevalence (Church and Mayhew 2009). Otherwise, services provided in the same facility may result in increased barriers to women seeking care for reproductive tract infections. The National AIDS program established HIV/AIDS testing centres equipped with laboratory facilities or providers trained in syndromic management of RTIs/STIs at the district and in some states, block level. Research has largely focused on the opportunities provided at these centres (Patel 2014), but not from the perspective of women's barriers to seeking RTI/STI services. For example, largely because these centres are 'branded' as voluntary testing and counselling centres or HIV/AIDS treatment facilities, women may not feel comfortable utilizing them for RTI/STI symptoms. They report hesitation or fear of stigma as barriers to utilisation. Further, messaging tends to focus on HIV/AIDS prevention and care – which may limit awareness of RTI/STI facilities.

Private facilities, typically much closer and perceived to be more user-friendly, emerge as the more common option for women who seek care for symptoms of infection in most states. This pattern is not an exception for reproductive morbidities, as the majority of outpatient services in India are indeed sought in the private sector (Berman et al 2010). Notable in this case, however, is that the public sector provides the majority of care related to maternal health and family planning services (International Institute for Population Sciences - IIPS/India and ICF 2017). Accessibility does not emerge as a barrier for institutional delivery, for example, in light of increases across the country. Delivery of antenatal and postnatal services tends to be at the home or community level – which further suggests that gynaecological services are not accessible to the same degree in public sector services.

Even where services are available and accessible in the private sector, questions emerge on the quality and appropriateness of care. Research indicates that private facilities do not provide basic gynaecological care, as their focus is maternal health. Few facilities conduct pap tests, for example, or have the equipment to conduct a trans-vaginal ultrasound, for example. Evidence from Gujarat on the incidence of hysterectomy amongst rural women at a young age has suggested that women who present with reproductive tract infections or menstrual-related morbidities are typically offered hysterectomy as a first or second-line treatment (Desai 2016). Qualitative research amongst women in Gujarat and Maharashtra suggests that lack of appropriate services, such as cyst removal or hormonal treatment, emerged as a push towards hysterectomy, alongside providers' lack of skills or experience to conduct less invasive procedures (Sardeshpande 2014). Both women and service providers reported that hysterectomy seemed more 'efficient' in the long run, as travel time to facilities for a series of outpatient procedures and follow-up visits would be both costly and inconvenient. As above, the lack of gynaecological services at the community or even block level may lead women to seek more permanent 'solutions' for ailments rather than incremental care. While data are not yet available, anecdotal reports suggest that the availability of publicly funded health insurance may be associated with provider-induced moral hazard, i.e. providers prescribing unnecessary use of covered procedures such as hysterectomy for financial or practical benefit (Prayas 2019). In the absence of appropriate diagnosis and care, hysterectomy is emerging as an increasingly

common procedure to treat gynaecological morbidity such as cysts or severe irregular bleeding. The health ramifications of hysterectomy amongst women in their mid-thirties or younger are yet unknown but will likely include increased risk of cardiovascular disease and osteoporosis, amongst other conditions.

A further question regarding appropriate care concerns diagnostics: the national health policy, as well as facilities, promote syndromic management for RTIs/STIs. Despite a body of evidence indicating the need to refine such guidelines to be appropriate for women in the Indian context, syndromic management continues to dominate public sector services (Vishwanath 2000; Aggarwal 2004; Ray 2009). Microscopic examination or laboratory facilities are not available in public, or most private, facilities. Thus, even when women access care, the quality of treatment in both public and private facilities may not meet standards of care required for gynaecological treatment. Specifically, the use of microscopic and laboratory diagnosis is recommended to improve diagnosis and, importantly, reduce unnecessary medication.

Prevention

Prevention of cervical cancer through screening remains limited, as of the last round of the NFHS (2015-16). The national policy on cervical cancer screening, rolled out in 2017, provides for visual inspection and referral services for women at the population level. By choosing population screening over opportunistic services, the policy may reach more disadvantaged or hard-to-reach women. In private services, most providers do not perform pap tests, both due to lack of equipment and links to laboratory services. Screening at present is only available at higher level government facilities, and nurses are not trained or supported to perform visual inspection yet in most states. Introduction of the national policy should help overcome these barriers, and potentially will provide women with immediate screening and referral services. However, deeper understanding of barriers to screening, such as lack of awareness, service-level limitations and health worker performance will be required to improve outreach as programs expand (Krishnan et al 2013).

Affordability

Gynaecological ailments present a considerable burden on financial security and expenditure: for example, an analysis of women's health care expenditure indicated that reproductive ill-health contributed over one-half of total expenditure (Bhatia and Cleland 2001). Affordability of services varies by ailment, and sector and location influence women's choice of care (Bhanderi and Kannan 2010). Public services are intended to be free, with additional expenses incurred for diagnostics and drug purchases. Private services for outpatient care, while more expensive, may not be prohibitive for consultations. Medicines and costs incurred on travel and lost wages, however, may prohibit women from seeking regular care. In the case of hysterectomy, women prioritized quality and convenience over expenditure in choosing a provider— and thus willingly incurred debt to finance gynaecological care (Sardeshpande 2014; Desai 2016). Outpatient gynaecological care is not covered under the national health insurance scheme, leaving women to self-finance treatment in the private sector in the absence of public services.

3.2.3. *Accountability*

The greatest challenge for accountability with regards to gynaecological morbidity in India is in defining it as a priority within women's health care through the life cycle. Although policy initiatives for SRH services have gained traction, the specific prevention and treatment of women's gynaecological ailments, particularly infections and menstrual morbidity, have not been translated into a priority within primary health care. Estimation of the burden morbidity is one challenge: current measurement in the NFHS does not include menstrual morbidities, for example. Although small-scale epidemiological studies indicate a significant burden of reproductive tract infections and other gynaecological ailments, the lack of nationally representative data renders estimation of morbidity difficult. Moreover, ensuring the appropriate level of care at primary, secondary and tertiary services in the public sector requires a concerted focus on understanding women's barriers to seeking treatment.

Accountability for the availability and quality of care for gynaecological ailments is limited to guidelines for care, with virtually no oversight of the appropriateness or availability of prevention and treatment. Standard treatment protocols and procedures focus on syndromic management, which impedes holding doctors accountable for a higher standard of care for women's ailments. Audits of procedure performed, particularly surgical interventions such as hysterectomy, are not mandated for either the public or private sector. Most audits are conducted in government teaching hospitals, and typically for the purpose of research rather than regular monitoring.

Moreover, there is limited or no information on women's sexual and reproductive health through outreach or community-based programs. Although ASHA workers are trained on RTIs/STIs, neither their workload or support systems facilitate education programs or referral for women with symptoms. Information material provided through the national health system on women's health focuses on pregnancy and does not include gynaecological or menstrual care. Women advised hysterectomy for menstrual morbidities, for example, report not knowing what their options were or access to resources for guidance on treatment for their symptoms. At present, outside of HIV/AIDS and maternal and child health, there is little information available on gynaecological morbidities. The introduction of comprehensive primary health care in Health and Wellness Centres provides an opportunity to include gynaecological morbidities in community-based service delivery—and therefore accountability measures such as Common Review Missions and community-based monitoring—provided the issue receives greater attention in both policy and program implementation.

4. Advances, Challenges and Opportunities

This analysis of services for contraception and gynaecological morbidities in India indicates considerable progress in some areas towards India's commitment to the SDGs and continued commitment to ICPD, while raising areas for further monitoring and advocacy. The availability of data within the National Family Health Survey provides an opportunity to conduct quantitative analysis related to equality and to a lesser extent, accountability. This section synthesises advances, challenges and recommendations for further action in (i) monitoring EQA and (ii) service provision for family planning and gynaecological morbidities. We

conclude with overarching observations on areas for future action towards achieving EQA within SRHR in India.

Monitoring EQA

The SDG framework and India Index represent an opportunity to monitor broad progress towards service provision related to SRHR. Ideally, the expansion of an India Index could include additional indicators specific to SRH. As a first step, regular, disaggregated analysis of national data may help ensure these data inform national SDG monitoring. Nationally representative data on family planning and gynaecological morbidity provide disaggregated data by rural/urban status; wealth; marital status; religion; education; caste; and measures of empowerment such as exposure to violence and mobility. Analysis through the lens of equality with state-level analysis will provide more meaningful and precise estimates of progress.

The NFHS data do not, however, provide comprehensive indicators of quality. Quality of services can be monitored in a number of ways; we propose areas amenable to quantitative data collection and monitoring. Regarding family planning, discontinuation rates; satisfaction; and unmet need provide indicators of quality of services, all of which are available in nationally available data. The expansion of FP programme monitoring measures which, in addition to quantity, track specific dimensions of quality, for example, (1) availability and stockouts of specific methods, (2) the provision of information on a range of methods and counselling on side-effects, (3) whether clients obtain their method of choice, and (4) payments made for services, will provide data to address specific gaps in service provision.

In addition to whether women sought treatment for RTI/STI symptoms, cure rates can also be estimated if made available through national surveys. Data on hysterectomy may provide an indicator of quality or appropriateness of services: a high proportion of women who undergo the procedure at a young age suggests poor quality gynaecological services. Beyond national survey data, regular medical audits of public and private facilities on gynaecological morbidities such as adherence to treatment protocols, cure rate and appropriateness of services should be introduced. Overall, standardised quality monitoring protocols and data collection at both the facility and smaller population level may include survey data, facility audits and client exit interviews.

In addition, specific cross-sectional and longitudinal studies on SRHR will be critical to monitor needs and progress. For example, research on women's access to treatment of non-reproductive morbidities, such as for menstrual disorders and other infections, through the life cycle is very limited at present. Longitudinal data on women's utilisation of family planning methods will be critical to understand concerns with access and quality, side-effects, and provision for method-switching, particularly for newer contraceptive methods. Similarly, monitoring of new methods through continued follow-up in routine data collection through ASHA/ANMs and facility points of care is required.

Service Provision

Our analysis indicates several areas of progress in India regarding service provision for SRHR, as well as many challenges. The gradual expansion of the contraceptive method mix is a

promising step in family planning, albeit with limited change in reported use in 2015-16. Shifts may take time and will require additional investment in addressing preferences and norms that result from decades of a focus on female sterilisation. The Indian government is capitalising on the increasing numbers of women having institutional deliveries to promote birth spacing through the rapid scale up of the program post-partum insertion of intra-uterine devices. Such a program must be embarked upon with careful consideration to institutionalising practices and the delivering of information and services that meet public health, medical and human rights standards. Data is needed to answer key questions on the quality of care and effectiveness of the program. For instance, at what stage in the maternal period are women provided information on the PPIUCD and consented to have the device inserted? What proportion of women receive follow-up care for monitoring and management of side-effects, and discussion of method removal and switching based on women's preferences? What are the one-year discontinuation rates of PPIUCDs, and the reasons for removal? This data will be useful to improve efforts, including through in-service training, supportive supervision, facility audits and client exit interviews to institutionalise and monitor adherence to norms, standards and guidelines in the delivery of contraceptive services. Discontinuation of temporary methods, in general, also remains a challenge, one that requires both further research on acceptability as well as investment in medical/counselling support available to women. At the policy level, removal of informal targets and incentives is critical to changing the broader environment that continues to promote sterilisation in practice.

The introduction of national, primary health care-based screening for cervical cancer reflects an important step to addressing women's gynaecological health outside of reproduction. Although implementation will require both time and investment, introduction of training amongst frontline health workers and nurses in some states may provide promising lessons. The proportion of women who access treatment for gynaecological morbidities (as reported in NFHS, limited to symptoms of specific RTI/STIs) has not changed at the national level for over a decade—which reflects a challenge in priorities as well as service provision. One important step is to train and task ANMs in basic diagnosis and treatment of RTIs/STIs and gynaecological morbidities at primary level with referral guidelines for advanced diagnosis and treatment, as has been suggested in the new Health and Wellness Centres. A continued gap, however, is the lack of information on gynaecological morbidities at community level and through mass media. Lastly, introduction of outpatient gynaecological care within health insurance may limit the use of unnecessary invasive procedures such as hysterectomy.

Moving women's health to an agenda beyond maternal health will require concerted advocacy by researchers, implementers and civil society. The recent development of an India strategy for Women, Adolescents and Children (I-WACH) is an encouraging step towards promoting a holistic approach in national policy. Further, the introduction of Ayushman Bharat provides another opportunity to expand services at the primary level. A continuing challenge, however, will be the balance between promoting tertiary care, funded by publicly funded insurance, at the expense of primary facilities.

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