



SEXUAL AND REPRODUCTIVE HEALTH IN INDIA: OBSERVATIONAL STUDY

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Abstract

India has demonstrated a commitment to improving the sexual and reproductive health of its population. Its policy and program environment has moved from a narrow focus on family planning to a broader focus emphasizing sexual and reproductive health and the exercise of rights. Great progress has been made. The total fertility rate is 2.2 (2015-2016), reaching substitution levels in 18 of her 29 states. The country's age structure is well positioned to enjoy the demographic dividend. Maternal, neonatal and perinatal mortality rates have declined, child marriage has declined sharply, contraceptive use and skilled labor care during childbirth have increased, and estimates of HIV prevalence are higher than the situation before. suggesting that it is not as dire as had been assumed. But there is still a long way to go. Despite impressive improvements, pregnancy-related outcomes remain unacceptably high in terms of both maternal and neonatal mortality and morbidity. Many women do not have access to care after giving birth. Patterns of contraceptive practice reflect a continued focus on female sterilization, limited use of male methods, limited use of endless methods, and ongoing unmet needs. The vast majority of abortions are performed outside the structure of legally licensed providers and facilities. More than a quarter of young women remain married during childhood. Few young people have access to comprehensive sex education, and their information needs to promote sexual and reproductive health are generally unmet. Access to and quality of services and making informed choices are far from optimal. Injustice is pervasive and places the poor, rural residents, young people and marginalized groups at particular disadvantage, not just in certain areas. To move

forward, and in particular to achieve the national goals and her SDGs 3 and 5, multi-faceted efforts are needed to accelerate the pace of change in all these aspects of health and rights.

Keywords : [sexual and reproductive health](#);; [sexual and reproductive rights](#); [pregnancy and maternal health](#); [family planning and contraception](#); [induced abortion](#); [adolescent and youth health](#); [gynaecological morbidity and RTI and STI](#); [policies and programs](#)

Introduction

During the 21st century, India has undergone profound and multifaceted changes in its population and sexual and reproductive health (SRH) situation. India's 2011 census put the population at 1.21 billion, and the decade-long growth rate in the 2001-2011 decade was sharper than in previous decades (Office of the Registrar General and Census Commissioner, India, 2013). Currently, the total fertility rate is 2.2, reaching substitution levels in 18 out of 29 states (IIPS & ICF, 2017), and the age structure puts the country in a favorable position to enjoy the demographic dividend. Yes (Kulkarni, 2014). The policy and program environment has moved from a narrow focus on family planning to a broader focus emphasizing SRH and the exercise of reproductive rights. Sexual and reproductive health has improved in many ways. Still, India may fall short of some of the milestones set by Sustainable Development Goals (SDG) 3 and 5.

A Brief Overview of Key Policies and Programs Addressing Sexual and Reproductive Health

Several SRH policies, laws and programs have been introduced throughout the 21st century. Table 1 briefly describes selected key policies and programs and provides an overview of regulations specifically relevant to SRH.

Table A. Key Policies and Programs Addressing Sexual and Reproductive Health

Policy and Programs	Vision	SRH-Related Goals and Objectives	Key Strategies
National Health Policy (NHP) 2017 (MOHFW, 2017a)	Attain the highest possible level of health and wellbeing for all at all ages, and universal access to good-quality health care services	<u>Reach by 2025</u> Total fertility rate of 2.1 Neonatal mortality rate of 16 Under 5 mortality rate of 23 Infant mortality rate of 28 Single digit stillbirth rate Maternal mortality rate of 100 Antenatal care for >90% of pregnant women >90% skilled attendance at delivery >90% full immunization for infants >90% met need for family planning 90:90:90 for HIV/AIDS by 2020 (90% of all people living with HIV know their HIV status, 90% of all	Strengthen health system Increase health expenditure from 1.15% to 2.5% of Gross Domestic Product (GDP) Direct 2/3 of health expenditure to primary health care Upgrade primary health centers and sub-centers to Health and Wellness Centers (HWCs) to provide comprehensive

Policy and Programs	Vision	SRH-Related Goals and Objectives	Key Strategies
		<p>people diagnosed with HIV infection receive sustained antiretroviral therapy, and 90% of all people receiving antiretroviral therapy will have viral suppression.)</p>	<p>primary health care including SRH</p>
<p>Ayushman Bharat (Healthy India) initiative 2018 (MOHFW, n.d.a)</p>	<p>Translate NHP 2017 into action</p>	<p>Goals and objectives articulated for NHP 2017</p>	<p>Transform and upgrade 1,50,000 existing health sub-centers into HWCs</p> <p>Strengthen outreach services</p> <p>Expand access to referral, essential drugs, and diagnostic services</p> <p>Upgrade the skills of health care providers, including ASHAs</p> <p>Provide financial protection for secondary and tertiary care for about 40% of the households</p>
<p>National Health Mission 2013 (Amalgamated National Rural Health Mission and National Urban Health Mission) (MOHFW, n.d.b)</p>	<p>Achieve universal access to equitable, affordable, and quality health care services accountable and responsive to people's needs</p>	<p><u>Reach by 2017</u></p> <p>MMR of 100/100,000 live births</p> <p>IMR of 25/1,000 live births</p> <p>TFR of 2.1</p> <p>Prevention/reduction of anemia in women aged 15–49 years</p>	<p>Strengthen reproductive, maternal, newborn, child health, and adolescent services</p> <p>Establish a new cadre of frontline workers, ASHAs</p> <p>Introduce social protection schemes: conditional cash transfers for institutional delivery; in-kind support for women and their</p>



Policy and Programs	Vision	SRH-Related Goals and Objectives	Key Strategies
National Youth Policy 2014 (Ministry of Youth Affairs and Sports, 2014)	Empower youth aged 15–29 to reach its full potential	Develop a strong and healthy generation	<p>newborns</p> <p>Improve access to health services</p> <p>Targeted health awareness program</p> <p>Targeted disease control program for youth</p>
Rashtriya Kishor Swasthya Karyakram 2014 (MOHFW, 2014)	Enable all adolescents to realize their full potential by making informed and responsible decisions related to their health and wellbeing, and by accessing the services and support they need to do so	<p>Improve health-promoting knowledge, attitudes, and behavior related to SRH</p> <p>Reduce adolescent pregnancy</p> <p>Improve birth preparedness and a safe transition into pregnancy and parenthood</p> <p>Prevent gender-based violence (GBV)</p>	<p>Establish or strengthen adolescent-friendly health clinics</p> <p>Community-based peer education program</p> <p>Supply commodities—weekly iron and folic supplements, sanitary napkins</p> <p>Sensitize parents</p> <p>Building the capacity of frontline workers and other health care providers to address the needs of adolescents</p>
National Policy on Women (Draft) 2016 (Ministry of Women and Child Development, 2016)	Allow women to attain their full potential and participate as equal partners in all spheres of life	<p>Reduce maternal and infant mortality rates</p> <p>Recognize women’s reproductive rights and reduce the reliance on sterilization as a key method of family planning</p> <p>Improve adolescent sexual and reproductive health</p> <p>Provide health coverage to surrogate mothers</p>	Strategies yet to be formulated

Policy and Programs	Vision	SRH-Related Goals and Objectives	Key Strategies
		Address all forms of violence against women	
The Assisted Reproductive Technology (ART) Bill, 2017 (MOHFW, 2017b)	Prevent misuse of ART and ensure safe and ethical practice of ART services	Oversee the implementation of ART	Establish national and state boards to regulate ART services Develop standards, regulations and guidelines on ART clinics and services
The Surrogacy (Regulation) Bill, 2019 (MOHFW, 2019)	Ensure that surrogacy does not violate rights	Regulate eligibility criteria for surrogacy clients, as well as surrogates	Establish eligibility criteria Require stringent reporting

Note: Many other policies, laws, and programs launched prior to 2010, relating to population, child marriage, AIDS, abortion, and more, are not described in the table.

In short, India has a wealth of policies, laws and programs aimed at directly or indirectly affecting sexual and reproductive health and rights. Unfortunately, gaps exist and the limited scope and quality of program delivery, combined with many demand-side barriers and limited allocation of resources, are slowing the pace of improvement in the sexual and reproductive health situation in India. Goals are set and strategies defined, often without proper political commitment or a clear plan of action. Priorities tend to shift, and sexual and reproductive health and rights are replaced by currently established priorities, such as health insurance, cleanliness and public defecation campaigns, national feeding campaigns, and even a renewed resurgence of sexual concerns. You run the risk of being overshadowed by the matter. 'Population explosion' and the need to discourage people with more than her two children.

The Sexual and Reproductive Health Situation

Maternal and Newborn Health

Maternal Mortality and Morbidity

Maternal mortality has declined in the 21st century, from 301 per 100,000 live births in 2001-2003 to 130 per 100,000 live births in 2014-2016 (Registry, India, 2006, 2018). This ratio has fallen significantly nationally during her 21st century, but will need to drop further to 70 by 2030 if India is to meet her SDG3 commitments (Niti Aayog, 2018).

Maternal Mortality Ratio: India, EAG1 & Assam, Southern States and Other States (per 100000 live births)

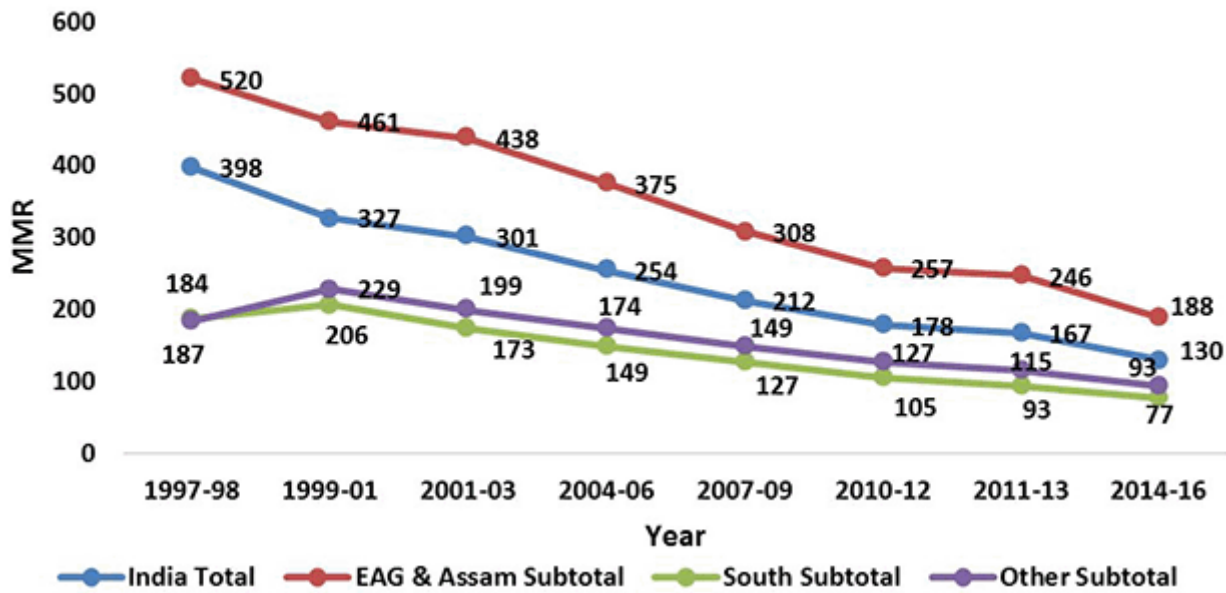


Figure . Maternal mortality ratio: India, EAG*, Assam, southern states, and other states (Office of the Registrar General, India, 2006, 2011, 2013, 2018, n.d.).

Note: *Empowered Action Group (EAG), comprises eight lesser developed states (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand)

Unfortunately, data on maternal mortality are outdated. Available data from the early 2000s show that the most common causes of maternal death are common in most low- and middle-income countries (hemorrhage, sepsis, unsafe abortion, labor, hypertension), It has been suggested that most are preventable (Registrar General of India, 2006) The true burden of maternal morbidity is poorly understood, but it is estimated that 20–30 people experience pregnancy-related morbidity for every maternal death (Firoz et al., 2013).). Although self-reported morbidity data are less reliable than medical records, 1 in 5 women aged 15 to 49 who gave birth in the 5 years prior to the National Family Health Survey (NFHS) had a large number of children. experienced vaginal bleeding and 15% reported very high fever within 2 months of their last delivery (IIPS & ICF, 2017). Estimates of morbidity using provider-assessed methods are typically lower than: B. NFHS survey based on women's own prevalence reports. For example, in rural Rajasthan, Iyengar (2012) followed approximately 5,000 women in the first week after giving birth and used a structured checklist to measure the prevalence, which was 7%. were found to suffer from severe anemia, 4% had fever, and 5% suffered from perineal disorders. A total of 7.6% were assessed as having a life-threatening condition (severe anemia, postpartum sepsis, severe hypertension, secondary postpartum hemorrhage).

Perinatal and Neonatal Mortality and Morbidity

Both neonatal and perinatal mortality are the result of inadequate or inadequate care during pregnancy, childbirth or the first critical period after childbirth, and both have declined significantly in India. I'm here. Neonatal mortality increased from 49 per 1,000 live births in the five years before NFHS-1 in 1992–1993 to 30 per 1,000 live births in the five years before NFHS-4 in 2015–2016. decreased to almost three-quarters of the total in 2015-2016. infant mortality during this period (IIPS & ICF, 2017). A similar trend was observed for perinatal mortality, with 36 per 1,000 pregnancies over 7 months of age in 2015-2016, compared with 48.5 per 1,000 of pregnancies over 7 months of age in 2005-2006. (IIPS & ICF, 2017; IIPS & Macro International, 2007).

Table B. Neonatal and Perinatal Mortality Rates, 1992–1993 to 2015–2016, India

Perinatal Mortality Rate	Neonatal Mortality Rate (NNMR)	Infant Mortality Rate	
1992–1993 (NFHS1)	Not available	48.6	78.5
1998–1999 (NFHS2)	Not available	43.4	67.6
2005–2006 (NFHS3)	48.5	39.0	57.0
2015–2016 (NFHS4)	36.0	29.5.1	40.7

Sources: IIPS (1995); IIPS & ORC Macro (2000); IIPS & Macro International (2007); IIPS & ICF (2017).

The major identifiable causes of neonatal mortality include neonatal infections (pneumonia, tetanus, sepsis, and diarrhea), prematurity, and asphyxiation at birth (Paul, Sachdev, Mavalankar, Ramachandran, and Kirkwood, 2011). Results from the 2000-2015 Million Deaths Study show that while these illnesses were severe from 2000 to 2015, they declined sharply each year from 2000 to 2015. is shown. Neonatal mortality from infectious diseases (primarily pneumonia and sepsis) declined from 11.9 per 1,000 live births in 2000 to 4.0 in 2015, and postnatal asphyxiation and trauma from 9.0 to 2.2. In contrast, the mortality rate for preterm or low birth weight infants increased from 12.3 to 14.3 deaths per 1,000 live births. Both rural and urban areas, and both poor and wealthy states, reduced mortality from infectious diseases and birth asphyxia or trauma, while mortality from premature or low birth weight infants decreased in rural areas. increased in rural areas and poorer states, but decreased in urban areas and richer states. suggesting large interstate differences in modifiable factors such as prenatal care, education, and diet (Million Death Study Collaborators, 2017).

Maternal and Newborn Health Care Utilization

Pregnancy-related health care utilization increased slightly in the 1990s and has increased sharply since then (Table C). There was a notable increase from 2005-2006 to 2015-2016. H. In the aftermath of the launch of the Safe Motherhood Initiative, namely Janani Suraksha Yojana (JSY). The proportion of pregnant women who received 4 or more screening tests increased from 37 in 2005–2006 to 51 in 2015–16, and the proportion of pregnant women who received 2 or more doses of tetanus toxoid was It increased from 76 over the same period to 76 in 2016. 84. Care is more comprehensive, with 88-93% of those who used antenatal services reported having their weight, blood pressure, urine sample tested and abdominal examined in 2015-2016. reported (2000s). Facility births and skilled birth care increased significantly from 39% to 79% and 47% to 81%, respectively. Fewer women still received postnatal care in 2015–2016, but much more women received postnatal care in 2015–2016 than in the 2000s, due to an increase in institutional births. (41% to 69%). From 2015 to her 2016, far more women received red flag counseling than before, but the proportion was not universal.

Table C. Pregnancy-Related Care: The Situation 1992–1993 to 2009

1992–1993 ¹	1998– 1999 ²	2005– 2006 ³	2015– 2016 ⁴	
Antenatal care				
Women receiving any antenatal check-ups	64.6	65.8	76.9	83.6
Pregnant women receiving at least four antenatal check-ups	26.9	29.5	37.0	51.2
Pregnant women receiving antenatal check-up in the first trimester	24.0	33.0	43.9	58.6
Pregnant women receiving two or more doses of tetanus-toxoid	53.8	66.8	76.3	83.0
Intrapartum care				
Women who delivered in a health facility or institution	26.1	33.6	38.7	78.9
Women who delivered in a public sector facility or institution	14.6	16.2	18.0	52.1
Women whose delivery was attended by trained health personnel	35.1	42.4	46.6	81.4
Postpartum care				
Women who received a postpartum check-up within two days of delivery	NA	NA	37.3	65.1
Pregnancy-related information provided				
Women who were told about specific signs of pregnancy complications (vaginal bleeding, convulsions, prolonged labor, severe abdominal pain, and high blood pressure)	NA	15–20	21–25	44– 52
Women who were told where to go if pregnancy complications experienced	NA	41.1	37.1	67.2

¹ Sources: IIPS (1995);

² IIPS & ORC Macro (2000);

³ IIPS & Macro International (2007);

⁴ IIPS % ICF (2017); refers to women aged 15–49 with a birth in the three to five years preceding the survey.

In addition to the increase in institutional offerings, there has also been a marked shift from private to public sector offerings after the launch of the JSY programme. In 1998-1999 and 2005-2006, less than half of all institutional births took place in the public sector, but in 2015-2016 the situation was reversed, with about 3% of institutional births. 2 of them were in the public sector (IIPS & ICF, 2017; IIPS & Macro International, 2007).

Family Planning Use and Method Mix

Contraceptive use increased by about 15% from 1992-1993 to 2005-2006 and remained fairly constant at 54-56% over the next decade (IIPS & ICF, 2017; IIPS & Macro International, 2007). Although there have been efforts to move India's family planning programs from a focus solely on sterilization to a more client-centred and rights-based approach that encourages informed choices and the use of non-stop methods, contraceptive patterns continue to be dominated by women. Sterilization. From 2015 to 2016, more than one-third of her current contraceptive users chose to undergo sterilization, and sterilization accounted for three-quarters of all modern methods used. (Table 4). The use of non-end-of-life methods remains limited and has only increased slightly over the past 25 years. The proportion of women using oral contraceptives increased from 1% to 4%, while those reporting condom use increased from 2% to 6%, while intrauterine contraceptives increased from 2% to 6%. reported using . Device (IUD) use is stagnant at 2% of her.

Table 4. Trends in Current Contraceptive Use, 1992–1993 to 2015–2016

	1992– 1993	1998– 1999	2005– 2006	2015– 2016
Any method	40.7	48.2	56.3	53.5
Any traditional method	4.2	5.4	7.8	5.8
Any modern method	36.5	42.8	48.5	47.7
Female sterilization	27.4	34.2	37.3	36.0
Male sterilization	3.5	1.9	1.0	0.3
Oral contraceptives	1.2	2.1	3.1	4.1
IUD	1.9	1.6	1.7	1.5
Injectables	0.0	NA	0.1	0.2
Condoms	2.4	3.1	5.2	5.6
Other	NA	NA	0.0	0.1
Percentage of non-terminal modern of all modern method use	15.1	15.9	21.0	23.9

Sources: IIPS (1995); IIPS & ICF (2017); IIPS & Macro International (2007); IIPS & ORC Macro (2000)

The use of male methods is limited. Taken together, male sterilization and condom use reported only 6% from He in 2015 to He in 2016, and has stagnated since the mid-1990s.

Contraceptive prevalence continues to vary widely from state to state. The percentage of women who reported using some form of contraception in 2015-2016 ranged from 23% of her in Bihar to 70% of her in Andhra

Pradesh. Female sterilization remained the leading modus operandi in all states, but the mix of methods also varied considerably from state to state. For example, in Andhra Pradesh, only 1% of women used modern and traditional methods. In contrast, in West Bengal, 28% of all women used modern non-end-of-life methods and 13% used traditional methods. Among male methods, vasectomy was rarely reported (<2%), and condom use varied from 1% in Tamil Nadu to 19% in Punjab. There were differences in contraceptive use with respect to various sociodemographic factors. Use of modern methods systematically rose from 36% of the poorest women to 53% of the richest women. 1% and 27% for no children and 1 living child, respectively, increased to 67% for 3 children. In any event, those without sons were much less likely to practice contraception than those with one or more sons. In addition, contraceptive use ranged from 38% of Muslim women to 49% of Hindu women. There were no differences by caste or educational background of women.

Timing of contraceptive initiation reflects a mixed pattern of methods. About 40% of women had never used contraception, and only 5% of them started using it before their first pregnancy. And, consistent with the promotion of sterilization, another 40% started contraception after the birth of two surviving children (and 20 to 3).

There is a clear division between public and private sector provision of contraceptive services. Sterilization services are mainly provided in the public sector.

Of the women who reported having had their husband's tubal ligation or vasectomy, 82% and 90%, respectively, said the procedure was performed in the public service, played a much larger role in providing reversible contraceptive methods such as condoms and oral pills (83% and 72% respectively; IIPS & ICF, 2017).

Abortion

A landmark national study on the frequency of abortions and unwanted pregnancies found a total of 15.6 million abortions per year, equivalent to a rate of 47 abortions per 1,000 women aged 15-49. (Singh et al., 2018). Exceeding previous estimates based on data from a small sample (6.4 million, 26 abortions per 1,000 women; Duggal & Ramachandran, 2004).

The abortion scenario in India has changed significantly in the 21st century with the availability of medical abortion. There has been a radical shift from surgical methods of abortion to medical methods of abortion. A 2015 estimate suggests that the overwhelming majority of abortions (81% or nearly 13 million) are achieved through medical abortion (Singh et al., 2018).

According to the slightly older data available, abortion-related deaths contributed to 8% of maternal deaths (Montgomery et al., 2014; Registrar General of India, 2006). Using recent data from annual health surveys conducted in EAG countries (2010–2013), Yokoe et al. (2019) found that risk factors for abortion-related death included adolescent abortion, being rural and belonging to a socially excluded planned tribe.

Data on abortion-related complications are not generally available. As of 2015, the number of post-abortion complications due to induced abortions ranged from 51,000 in Assam to 1,100,000 in Uttar Pradesh, according to the results of a national survey, with 1,000 per 1,000 women aged 15-49. Treatment rates for induced abortion complications ranged from 4-7 in Assam, Gujarat and Tamil Nadu to 21 in Uttar Pradesh and 26 in Madhya Pradesh. That abortion has become much safer is evidenced by the fact that the majority of women who seek help may have false signals about the normal process of medical abortion: B. Medical abortion or incomplete abortion due to bleeding. Severe complications, many overlapping, have also been observed in treated patients. 4-16% for infections. 2-9% for bodily injury. 3-7% for sepsis. 1-4% for shock (Singh et al., 2018)

Infertility and Surrogacy

Evidence on the prevalence of infertility in India is scant, and in its absence, the percentage of women aged 40-49 who are childless or have never given birth to live babies is used as a proxy. According to NFHS-4, 3% of

women aged 40–49 who are currently married are childless (IIPS & ICF, 2017). Higher rates were observed in studies that included specific infertility modules.

Her current infertility prevalence was 5% (percentage of childless people who had difficulty conceiving for the first time). Patra and Yunisa (2017) found that socially disadvantaged women were higher than other women. And seeking care has been jeopardized for many. Infertility outcomes in the form of stigma, violence and marital abandonment are commonly observed (Sama, 2018).

Nevertheless, infertility treatment and management is not a public health priority. Inadequate infrastructure and capacity of public sector facilities is well documented (Chauhan et al., 2018). At the same time, there is a growing trend to use options such as ART and surrogacy (Malhotra et al., 2003; Nadimpally & Venkatachalam, 2016). Efforts are underway to regulate eligibility criteria for both clients and surrogates to ensure surrogate mothers' rights are protected. The Surrogacy Act (Regulation), 2019 has been introduced by the House of Representatives of the Indian Parliament but has not yet passed.

Sexually Transmitted Infections, Reproductive Tract Infections, and Other Gynecological Morbidities

Self-reported prevalence of sexually transmitted infections (STIs) and symptoms such as abnormal genital discharge and genital sores or ulcers in the 12 months preceding the interview stood at 11% and 8% among sexually experienced women and men aged 15–49 years, respectively, in 2015–2016 (IIPS & ICF, 2017). A similar proportion of women (11%) but fewer men (5%) had so reported a decade earlier (IIPS & Macro International, 2007). Percentages reporting an STI, genital discharge, or a sore or ulcer ranged from a low 5% or less in Andhra Pradesh, Telangana, Sikkim, and Dadra & Nagar Haveli, to over 20% in states such as Haryana, Jammu and Kashmir, Meghalaya, and Mizoram (IIPS & ICF, 2017).

Smaller studies, using clinical or lab-detected findings rather than self-reports, also report considerable reproductive tract infections (RTIs) and STIs. Vasireddy (2017) interviewed 520 randomly selected women in the slums of Guntur and found that the prevalence of infection using the syndromic approach was 33%, with the majority reporting vaginal discharge. Clinical confirmation noted that of those reporting a symptom, almost three in five (58%) were diagnosed with bacterial vaginosis, that adolescent girls were over-represented, as were the poor, the poorly educated, and the socially excluded (Vasireddy, 2017). Ghosh, Paul, Das, Bandyopadhyay, and Chakrabarti (2018) analyzed the cases of over 5,000 women who attended STI clinics in Orissa and found that one-third were diagnosed with trichomoniasis or bacterial vaginosis.

A strong and consistent association between RTI and poor menstrual hygiene practices was documented in a study of 558 women attending two hospitals in Orissa, of whom 62% had at least one infection. 41% were diagnosed with bacterial vaginosis and 34% with bacterial vaginosis. Candida infection. Trondell et al. (2018) found that women diagnosed with these two infections were more likely than others to use reusable absorbent materials, wash their personal belongings more frequently, even after considering potential confounding factors. showed a high likelihood of reporting poor menstrual management practices such as low, unsanitary drying and storage of materials.

Cervical cancer affects many Indian women. India is estimated to account for one quarter of the global burden of cervical cancer. In India, it is estimated that 1 in 53 women will develop cervical cancer in her lifetime. The high burden of cervical cancer is due to risk factors such as poverty, early marriage, multiple sexual partners, multiple pregnancies, poor genital hygiene, malnutrition and lack of awareness. Despite this high burden, there is no federally sponsored national public health policy to prevent cervical cancer screening or human papillomavirus (HPV) vaccination (Bobdey, Jignasa, Jain, & Balasubramaniam 2016).

Treatment of symptoms of infections and gynecological diseases is limited. Additionally, public sector facilities are much less likely to be visited for treatment of symptoms of sexually transmitted infections than for symptoms of other health conditions. For example, Mitchell et al. (2011) Nearly all

women in rural areas of two districts of Andhra Pradesh use public sector antenatal services (96%), but few do because of sexually transmitted disease symptoms. only 4% of STI-related services used primary services (16%). health center services. The findings of Gawande, Srivastaba, and Kumar (2018) in rural areas near Mumbai city confirm that: Her prevalence of RTI in women who were always married was found to be 21% of hers. However, only 14% of her received treatment from a qualified provider. Jayapalan (2016) found that of his 85 men and women infected with her STI in Kerala, 60% of men and 82% of women sought appropriate treatment at first point of contact, many of whom It was discovered that the point of contact had received inappropriate treatment. (30% of men and 37% of women) cited poor quality of care at the facility where they were first treated.

Sexual and Reproductive Health of the Young

Almost one-third (30%) of India's population (365 million in 2011) are young people between the ages of 10 and 24 (Registry and Census Board, India, 2014). Whether India will reap the benefits of its demographic dividend, achieve its Sustainable Development Goals, and achieve its national aspirations for development all depend on investing in the health, education and skills of this cohort. increase. Despite significant progress, many young Indians fail to make the successful transition into adulthood.

Entry into Sexual Life Before Marriage

Although there are strict norms prohibiting premarital sexual relations, even prohibiting the social mixing of boys and girls, premarital sex is said to begin at puberty, especially between boys and young men. Evidence is mounting. For example, a 2006-2007 local survey of young people found that 9% of unmarried boys aged 15-19 and 3-4% of unmarried and married girls aged 15-19 had had premarital sex. (IIPS & Population Council, 2010). A subsequent nationally representative survey in three federal states found slightly higher percentages after 10 years.

14-20% for unmarried boys, 6-9% for unmarried girls, and 6-16% for married girls (Table D).

Table D. Pre-Marital Sexual Relations Among the Young, Selected States, 2015–2018

Bihar (2015–2016)¹	Uttar Pradesh (2015–2016)²	Jharkhand (2018)³	Journal
Ages	15–19	15–19	15–21
Pre-marital sexual experience			
Unmarried boys	14.1	19.7	17.6
Unmarried girls	6.3	6.5	8.5
Married girls	5.8	9.3	15.5
Consistent condom use*			
Unmarried boys	20.3	14.1	6
Unmarried girls	8.2	5.3	6

Bihar (2015–2016) ¹	Uttar Pradesh (2015–2016) ²	Jharkhand (2018) ³	
Married girls	0.8	8.4	4
Forced sex*			
Unmarried boys (perpetrated)	4.5	4.9	2.0
Unmarried girls (experienced)	4.0	3.8	2.7
Married girls (experienced)	3.4	5.2	5.2
Pre-marital pregnancy*			
Unmarried boys	1.7	5.9	2.1
Unmarried girls	6.7	0.8	2.6
Married girls	14.3	5.0	8.7

Note: * among those who reported pre-marital sexual experiences.

1 Sources: Santhya et al. (2017a);

2 Santhya et al. (2017b);

3 Jejeebhoy et al. (2019).

Individual-, Family-, and Community-Level Challenges

Multiple challenges at the individual, family and community levels continue to hamper India's efforts to achieve the SRH-related goals set out in SDG 3. Issues such as lack of awareness of health-promoting behaviors, limited female ownership, adherence to traditional notions of masculinity and femininity, inadequate male participation, and limited marital communication are often associated with SRH. undermine the rights of many.

Limited Awareness

Actions to promote SRH, the need for SRH services and awareness of women's and men's rights to these services are far from universal in India. In some parts of the country, awareness of good practices in the care of women during pregnancy, childbirth, the postpartum period and the newborn is low to moderate (Gupta, Shora, Verma & Jan, 2015; Laishram, Thounaojam, Panmei, Mukhia & Devi, 2013; Mangulikar, Howal & Kagne, 2016; O'Neil, Naeve & Ved, 2017; Patel et al., 2016; Santhya et al., 2017a, 2017b). For example, Santhya et al. (2017a, 2017b) In her two major states of India (Bihar and Uttar Pradesh), 26-32% of unmarried girls, 28-32% of married girls and 22-25% of unmarried boys indicated that only 15-19 years old). Pregnant women should undergo at least four tests. Red flag recognition is also limited (Chandhiok, Dhillon, Kambo & Saxena, 2006; Goyal & Bhandari, 2008). Goyal and Bhandari (2008) investigated childbirth and postnatal morbidity in the slums of Delhi and found that even women with profuse bleeding and high fever rated their condition as severe morbidity at 28% and 28%,

respectively. We found that it was only 13%. Subha Sri and Khanna (2014) report that of her 124 maternal deaths nationwide from 2012 to her 2014, lack of awareness of timely care was the primary cause.

In the field of contraception, awareness of at least one method of contraception is virtually universal among currently married men and women (99%), but awareness of endless contraception is not universal. Only 69% and 48% of women and men, respectively, were aware of the IUCD, condoms, and oral pills (IIPS & ICF, 2017). In addition, cognitive levels of specific methods increased slightly over time.

For example, condom awareness among married women increased from 76% in 2005-2006 to 82% in 2015-2016. At the same time, awareness of the emergency contraceptive pill increased dramatically.

For married women she is 12% to 42% and for married men she is 23% to 48%. Moreover, awareness of contraceptive methods is rather superficial. Awareness of contraceptive methods was nearly universal among young people and adolescents, but specific knowledge of at least one method was limited (IIPS & Population Council, 2010; Jejeebhoy et al., 2019).; Santhya et al., 2017a, 2017b).

Misconceptions about HIV transmission routes and measures to protect against HIV are clear. Comparison of overall awareness levels of HIV between 2005–2006 and 2015–2016, i.e., rejecting common misconceptions about transmission and favoring consistent condom use and single Acknowledgment of the importance of the partner relationship shows little change (17 21% for women and 33% to 32% for men (IIPS and ICF, 2017; IIPS and Macro International, 2007).

Limited consciousness also permeates the realm of rights and entitlements. Women and the wider community are unaware of women's rights and the programs they are entitled to. For example, they are underinformed about all the benefits they can enjoy under JSY (Santhya et al., 2011). Furthermore, many women are poorly informed about the legality of abortion and their rights under abortion law (Banerjee et al., 2013; Jejeebhoy et al., 2011a, 2011b). For example, in one community-based survey, three-quarters of her rural women knew that abortion was legal in at least one of her circumstances, but about half were unmarried women or I believed it was illegal in case of contraceptive failure. A person wishing to have an abortion must obtain her husband's consent (Jejeebhoy, Zavier & Kalyanwala, 2010). The perception that abortion is illegal in India has been fueled in part by conflicting statements about the illegality of prenatal sex-determined abortion and the legality of abortion for other reasons (Nidadavolu & Bracken, 2006).

Limited Female Agency, Compromised Exercise of Reproductive Rights, and Wide Gender Power Imbalances

India has a prevalent family system stratified by age and gender, and women's ability to act is very limited. There is substantial evidence about the extent to which restricted agency undermines health-promoting behavior and seeking timely care in terms of decision-making, freedom of movement, control of economic resources, and experience of violence (Bloom, Wypij, & Gupta 2001; Jejeebhoy & Santhya, 2014; Leon, Lundgren, Sinai, Sinha & Jennings, 2014). Women's participation in decisions related to their own health care has increased over time. (62% in 2005-2006 to 75% in 2015-2016), women's freedom to attend health care facilities unaccompanied has remained unchanged (48% to 50%; IIPS). & ICF, 2017; IIPS & Macro International, 2007). Between 2005 and 2006, the proportion of women with a savings account tripled (from 15% to 53%), but the number of The proportion of women who have it has remained the same (45% to 42%).

Women's limited mobility is also reflected in their limited exercise of reproductive rights. A sub-national study of youth in India observed that 51% of young women expressed a desire to have postponed first pregnancy, but of those with demand, only 10% had practiced contraception (Jejeebhoy, Santhya, & Zavier, 2014). Also reflecting young women's compromised exercise of reproductive rights were their reported reasons for not using a contraceptive despite a desire to postpone the first birth, as revealed in the recent stat-representative studies in Bihar, Uttar Pradesh, and Jharkhand: the leading reason, expressed by 18% of girls in Jharkhand, 20% of girls in Bihar, and 33% of girls in Uttar Pradesh was their husband's objection to doing so, and 11–16% to other family

members' objections to doing so (Jejeebhoy et al., 2019; Santhya et al., 2017a, 2017b). Similarly, about a fifth of women aged 15–49 who had a live birth in the five years preceding the survey who did not go for an institutional delivery cited objections from husband and other family members for doing so nationally (IIPS & ICF, 2017).

Gender power imbalances are evident in the persistence of marital violence. Women's inability to refuse marital sex, even if they suspect their husband has engaged in extra-marital relations, and gendered attitudes that condone pre- and extra-marital sex for men but not women also have the potential to compromise women's health. As a result, several studies have found that many women, including newlyweds, are at risk of transmission from their husbands (Santhya & Jejeebhoy, 2007).

Limited Male Involvement and Traditional Notions of Masculinity

Men's attitudes and behaviors influence not only their own SRH outcomes but also those of their wife or partner. Just 6% of couples practicing contraception were using a male method, even as recently as 2015–2016. Condom use among men reporting high-risk behaviors has also been found to be limited:

41% of men who had engaged in high-risk sexual behaviors in the year preceding the interview used a condom at last high-risk sex and 48% of men who had engaged in paid sex in the year preceding the interview used a condom during their last paid sexual intercourse (IIPS & ICF, 2017). Furthermore, the percentage of men who perceive that contraception is women's business rather than a man's concern has increased from 22% to 37% and that women who use contraception may become promiscuous from 16% to 20% over the period 2005–2006 to 2015–2016.

Male involvement in their wife's pregnancy-related care has increased only marginally over time: of the men whose youngest living child was less than three years old at the time of the survey, and whose wife had received antenatal care, 79% had accompanied their wife for an antenatal check-up in 2015–2016 (increased from 74% in 2005–2006). Furthermore, the main reason for men not receiving antenatal care for their wives was against the husbands themselves, although the percentage of receiving decreased over the decade (40% to 26%; IIPS & ICF, 2017; IIPS & Macro International, 2007)

Limited Spousal Communication

Spousal communication on sexual and reproductive issues is limited. Mishra and Ramanathan (2002) found that 45% of her husband's whose pregnant wives attended an obstetric clinic in Delhi reported having discussed family planning with their wives. Char, Saavala, and Kulmala (2009) reported that her one-third of men in Madhya Pradesh who responded to a questionnaire and most participants in focus group discussions were sole decision-makers on reproductive health. I observed what you did. There is also a lack of communication among young people.

For example, the Youth Study found that only one-third (34%) of married men under the age of 30 and half (54%) of married women between the ages of 15 and 24 had discussed contraception with their spouses. We found that there is (IIPS & Population Council, 2010). Wherever communication takes place, it is also selective.

Surveys of young men and women in Guntur (Andhra Pradesh) districts and Dhar and Guna (Madhya Pradesh) districts found that the topic of seeking prenatal care was frequently discussed, but contraception was rarely mentioned. No (Santhya, Jejeebhoy & Ghosh, 2008). Spousal communication regarding reproductive diseases, especially sexually transmitted diseases, is also limited. Santhya and Dasvarma (2002) found that in rural Tamil Nadu, only 37% of her and 20% of her married women and men, respectively, with probable symptoms of RTI experienced their own illness. indicated that you had informed your spouse about Malphatia et al. (2000) also found that he only 18% of married and unmarried men attending clinics in Gujarat had informed their wives or partners about their illness. On the other hand, Mishra and Ramanathan (2002) noted that less than one-third of women's husbands visited a maternity hospital. in Delhi, and Sahasrabuddhe et al. (2002) mentions her two-fifths of married men in clinics in Maharashtra.

Program Challenges

Although many programmatic innovations have been implemented to improve reproductive health care, gaps remain. Inadequate infrastructure and human resources, inadequate attention to provider capacity and training, poor service quality, gaps in the delivery of various reproductive health services and the most vulnerable and in need of assistance Limited efforts to reach out to people seriously hinder the pace of improvement affected by SRH. result.

Inequitable Reach of Services and Failure to Reach the Most Vulnerable

National-level findings show that, despite some limitations, significant geographic and sociodemographic disparities remain in reproductive health indicators (e.g., geographical and social demographic characteristics). 2006 and 2015–2016) were compared between the most and least disadvantaged across the range of sociodemographic characteristics in the selected indicators. The results highlight the country's failure to reach the most excluded populations, but improvements have been observed over time.

As shown in Figure 2, neonatal mortality was significantly higher during adolescence (54/1,000, respectively). Differences by education and family economic status were significant, but differences by religion and caste were relatively small in 2015-2016 (IIPS & ICF, 2017). The results show that while perinatal and neonatal mortality rates have declined between the least and least disadvantaged, inequalities have narrowed over the past decade for most indicators, except education attainment. suggesting that it is not or slightly under-reduced.

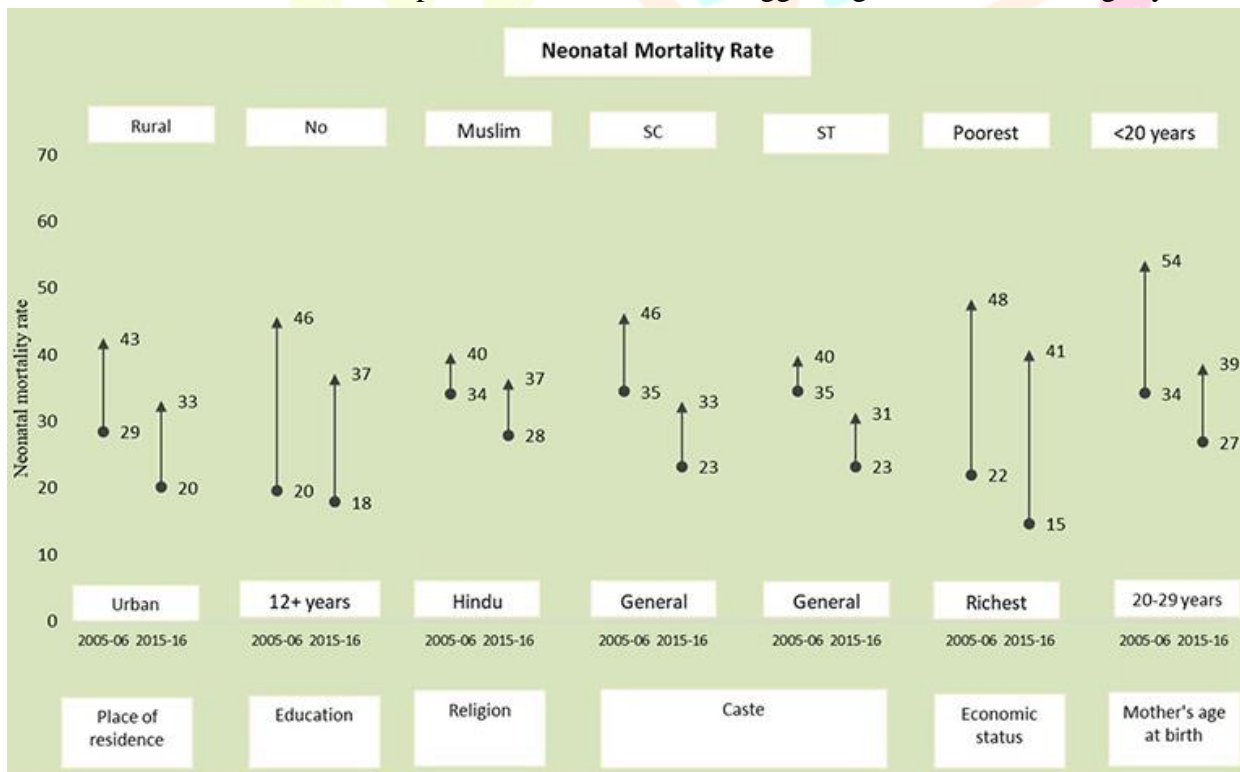


Figure B. Neonatal mortality by socio-demographic characteristics, 2005–2006 and 2015–2016 (IIPS & ICF, 2017; IIPS & Macro International, 2007).

Note. ● = Most advantaged group; → = Most disadvantaged group

The Constitution of India recognizes and provides special reservations to those belonging to socially disadvantaged castes and tribes in India, classifying them as belonging to Scheduled Castes (SC) and Fixed Tribes (ST).

Figure C shows the corresponding patterns for modern contraceptive use. There is no change in the levels or patterns of modern contraceptive use. In 2015–2016, the gap between the more and less privileged remained about the same as it was in 2005–2006. However, the urban-rural gap narrowed from 11% to 5%, and the gap between household wealth quintiles narrowed from 23% to 17%.

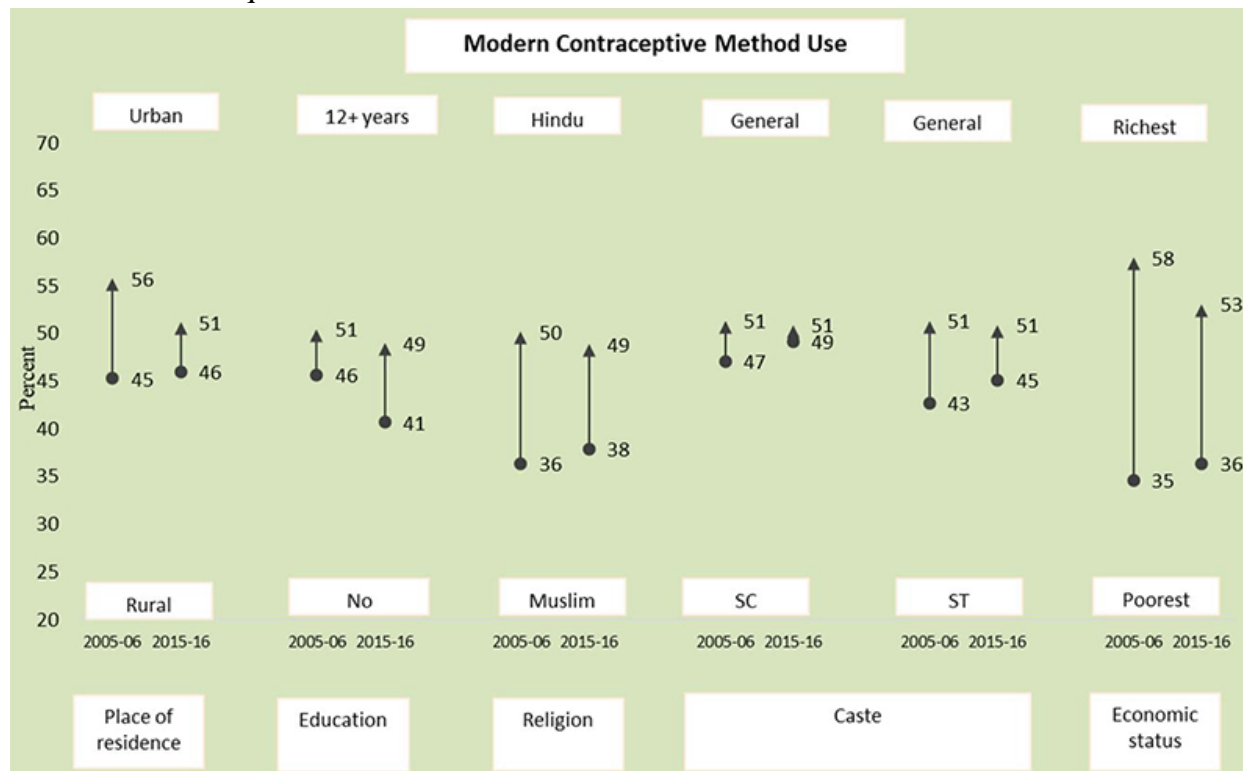


Figure C. Modern contraceptive method use at the time of interview by socio-demographic characteristics, 2005–2006 and 2015–2016 (IIPS & ICF, [2017](#); IIPS & Macro International, [2007](#)).

Note. ● = Most disadvantaged group; → = Most advantaged group.

The Constitution of India recognizes and gives special reservations to people belonging to socially disadvantaged castes and tribes in India, classifying them as belonging to Scheduled Castes (SC) and Fixed Tribes (ST).

The reach of frontline workers is also limited and remains unfair.

Only 24% of the women in the NFHS-4 interviews had contact with health care providers (ANM, AWW, ASHA, MPW, etc.) in the 3 months prior. Unmarried women were approximately one-third (11% and 28%, respectively) more likely to report contact with a health care provider than currently married women (IIPS & ICF, 2017).

Gaps in the Implementation of Policies and Laws

India has a range of rigorous laws, policies and programs aimed at promoting SRH and protecting the rights of women, men and young people to access appropriate services. Unfortunately, the implementation of these laws and policies has been lax in some respects. For example, despite pioneering laws outlawing child marriage, it persists and prosecution of offenders is rare. Abortion remains inaccessible, even though the law guarantees the right of women to have an abortion. Despite program commitments to ensure that contraceptive options are met, the unmet need for contraceptives is significant. Efforts to raise awareness of rights under these laws, policies and programs have been limited and thus undermined public perceptions of sexual and reproductive rights (e.g. Jejeebhoy et al., 2011a, 2011b; Santhya, 2019).

Moving Forward

India has demonstrated its commitment to improving the sexual and reproductive health of its population through a number of policies, laws and programmes. Major advances have been made in many aspects of sexual and reproductive health and rights. But there is still a long way to go.

Moving forward requires a multifaceted approach. The quality of infrastructure and equipment in public sector facilities should be improved. This requires a focus on building the capacity of frontline providers and other providers to ensure that services are delivered in a manner that respects the rights of customers. Women, men and young people need to be made aware of their rights to access quality services through health promotion practices and outreach activities, and young people through schools and community groups. Above all, to reduce persistent inequalities, programs need to target the most disadvantaged: the poor, rural people, the uneducated and young people.

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