



Development
Alternatives with
Women for a
New Era

Equality, Quality and Accountability

Advancing SRHR
in China, India and Indonesia

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Title: Equality, Quality and Accountability in Advancing SRHR in China, India and Indonesia

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Foreword

Ever since the United Nations International Conference on Population and Development (ICPD) was held in Cairo in 1994, governments, agencies, and civil society have been addressing the challenge of implementing the sweeping changes to population-related policies and programmes it had envisioned. The situation of sexual and reproductive health and rights (SRHR) varied greatly within and between countries then and has continued to do so in the following years. Some countries and regions faced shortages in supplies of contraceptives and programme capacity; others had to address and redress the consequences of coercive practices; while yet others have had to face the onslaught of conservative forces opposed to gender equality and women's human rights, especially sexual and reproductive rights.

In the lead-up to the twentieth-year review of ICPD, there was growing evidence that challenges in implementing SRHR through policies and programmes could be crystallized as three interlinked issues – inequality, poor quality services, and absence of transparency or accountability. The DAWN project on Equality, Quality and Accountability (EQA) grew out of these debates, and it was decided to focus on a few countries in one region for more in-depth analysis. The choice of Asia's largest countries was challenging but also exciting because of their scope and diversity of concerns. The EQA case studies on China, India and Indonesia in this collection are a complement to previous DAWN work that produced Regional Advocacy Tools on SRHR. But EQA are also the most pressing concerns today and for the foreseeable future of SRHR policies and programmes, including in the context of universal health care.

DAWN is happy to bring these case studies together as a contribution to the public discourse on the implementation of ICPD and the fulfilment of the SRHR agenda.

DAWN wishes to thank many people who have contributed to this project – the authors of the case studies and the introduction, Seona Smiles – our smiling editor, the SRHR team, and all the secretariat staff who supported the project. Without you, this could not have been completed.

Gita Sen & Maria Graciela Cuervo

General Co-coordinators

DAWN



INTRODUCTION

*By
Vanita Mukherjee
and Cai Yiping*

Background and Objective

“Equality, Quality and Accountability in Advancing SRHR in China, India and Indonesia” is a research project coordinated by DAWN as a contribution to advancing the sexual and reproductive health and rights (SRHR) agenda. Through concrete case studies for the three most populous countries of Asia, we examine what policies and programs have worked, what have not, and what are the continuing challenges that need to be addressed in order to move the SRHR agenda forward, 25 years after the International Conference on Population and Development (ICPD) conference in Cairo. The project originated from an intense phase of analysis, advocacy and activism during the regional and global negotiations for the twentieth-year reviews of ICPD and the Fourth World Conference on Women in Beijing, as well as the Post 2015 Development Agenda.

This research is built on DAWN’s prior work on SRHR, which included both an assessment of the MDGs in relation to SRHR in Mexico, India and Nigeria (DAWN 2012), a review of key SRHR issues in terms of what has been achieved and what lies ahead (Sen et al 2015), a set of regional advocacy tools across six regions for use in the ICPD beyond 2014 review process (<https://dawnnet.org/publication/dawn-regional-advocacy-tools-on-srhr-for-cairo20>), and a paper written for the human rights conference organized by UNFPA in the Netherlands in 2013 (<http://dawnnet.org/wp-content/uploads/2018/12/Sexual-and-Reproductive-Health-and-Rights-in-the-Post-2015-Development-Gita-Sen.pdf>). Our advocacy during recent regional and global processes, together with our key partners, focused on the challenges in providing SRH services to all, in protecting, promoting and fulfilling sexual and reproductive rights, and in addressing the particular needs and rights of adolescents, especially adolescent girls.

In this project, we focus on the three largest Asian countries – China, India and Indonesia. In doing so we have chosen countries of great size and diversity, as well as similarities in being anti-natalist in their policy thrust. A multiplicity of issues and challenges surface through these case studies. The differences by region, age, ethnicity, religion, and other features, as well as significant variations in legal and policy-making processes, provide rich variation for the study of challenges and advances. We hope this research offers insights for a study of other countries and regions.

Methodology and Framework

This research analyses equality, quality and accountability (EQA) in the provision of sexual and reproductive health services and related legal and policy frameworks in three countries. The EQA framework was developed by Gita Sen and Adrienne Germain.¹ There is considerable evidence to suggest that the three main gaps in both SRHR and MDGs implementation was the absence of quality in service provision; the fact of large and growing

¹ Discussion Paper for “ICPD Beyond 2014 International Conference on Human Rights” July7-10, 2013, Netherlands.

inequality; and the need for accountability (Sen, 2014). These three major gaps continue to require priority attention:

- Inequalities in access to SRH services, education and information have left women and adolescents in the lowest two wealth quintiles, living in rural and other hard-to-reach areas, far behind (Santhya & Jejeebhoy, 2015; Snow et al., 2015).
- The quality of SRH services falls far short of human rights and public health standards, and often, medical ethics standards as well (Kismodi et al. 2014; Sen and Govender, 2015).
- Accountability mechanisms do not exist or are not used to track progress, or to prevent and redress inequalities and poor quality of services in most countries (Kismodi et al., 2015).

“These three gaps reflect fundamental failures by governments and their development partners to understand and act in accordance with the human rights foundation of the ICPD Programme of Action (PoA). Successfully integrating SRHR into the post-2015 development agenda requires attention to remedying these gaps and re-positioning SRHR within a framework of human rights as articulated in the PoA” (Germain et al, 2015; op cit. p 139).

An approach based on criteria of quality, equality and accountability would advance SRHR laws, policies and programs towards respecting, protecting and fulfilling the human rights of the most disadvantaged women and young people, especially adolescent girls. Our attention is given to Equality, Quality and Accountability in the provision of sexual and reproductive health services, and protection, promotion and fulfilment of sexual and reproductive rights in each country. Equality is viewed along multiple dimensions: age, location, economic class, gender, caste, ethnicity, religion, minority status, SOGI, disability and any other relevant variable. Quality of services includes four dimensions: availability / comprehensiveness, accessibility, affordability, and quality. Accountability addresses legal and institutional frameworks, as well as the presence and role of media, NGOs and social movements.

Applying the EQA framework, the research team of each country identifies the progress made to date since ICPD, as well as key laws, policies, programs and actions to address the most critical issues in their countries. Both quantitative data and qualitative reports and information are used, especially the most updated national census, survey and health statistics. Each country study has the following components: (i) a status benchmark using both quantitative data and qualitative information; (ii) in-depth analysis of major laws, policies, programs and action from the perspective of EQA; (iii) a synthesis analysis that identifies critical advances and challenges; (iv) recommendations on next steps needed. In addition to the approaches and actions of national governments, the research also examines the roles of other stakeholders – international agencies, private foundations and philanthropists, non-governmental organisations and social movements, as well as of regional and local governments and other bodies where possible and relevant to the country context.

Rooted in human development and human rights, the EQA framework has the potential to loop in human rights to the development of targets and indicators and solidify the support of many countries for SRHR as part of the larger SDGs implementation. In all three countries, SDGs

have been tailored to their specific contexts, and integrated into the national development program and policies. The authors work with two sustainable development goals, and their targets and indicators, that have particular relevance in this research -- Goal 3: Ensure healthy lives and promote well-being for all at all ages; and Goal 5: Achieve gender equality and empower all women and girls (noting a number of other SDGs also have relevance, such as Goal 1: End poverty in all its forms everywhere; Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; and Goal 17: Strengthen the means of implementation and revitalize the global partnership for sustainable development).

Target	Indicators
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1 Maternal mortality ratio 3.1.2 Proportion of births attended by skilled health personnel
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	3.2.1 Under-five mortality rate 3.2.2 Neonatal mortality rate
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs	3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods 3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group
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	3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population) 3.8.2 Number of people covered by health insurance or a public health system per 1,000 population

<p>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</p>	<p>5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care</p> <p>5.6.2 Number of countries with laws and regulations that guarantee women aged 15-49 years access to sexual and reproductive health care, information and education</p>
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Pegging the analysis through an EQA lens on key SRHR issues, helps to shed light on progress toward the SDGs. The China and Indonesia case studies focus on maternal and child health and family planning, while the India case study uses family planning/ provision of contraception and gynaecological morbidities as a way to assess progress and highlight gaps and challenges. The choice of the selected issues was guided by availability of data for in-depth analysis, and the fact that family planning policies and maternal and child health remain a priority for all countries. The focus of the India case-study on gynaecological morbidity was spurred by choosing an issue that is an important health need of women that continues beyond their reproductive years. Yet, while gynaecological morbidity finds a place in policy documents, it seldom garners attention and resources like MCH or family planning. Using the EQA lens to assess SRH services for gynaecological morbidity helps to examine what would be required to strengthen the services to respond to women’s needs.

Target 3.8 of the SDGs, on universal health coverage (UHC), has gained increasing importance and attention. It is viewed as a powerful tool for providing health services to all, especially the poorest and most vulnerable people in the country. Governments in the three countries have launched different UHC-related schemes, such as the New Cooperative Medical Scheme (NCMS) and System of Equalisation of Basic Public Health Services in China, National Health Insurance Scheme (Jaminan Kesehatan Nasional/JKN) in Indonesia, and Rashtriya Swasthya Bima Yojana (RSBY), the National Health Policy and recently, the Ayushman Bharat scheme in India. The country cases offer useful insights on how UHC is being implemented at national and community levels and its implications for SRH services, whether or not it creates growing momentum for advancing SRHR, and how it can be further improved by integrating EQA into both provision and monitoring.

Main findings and Recommendations

From an EQA perspective, the research provides a worm’s eye-view of how well-intended policy plays out on the ground to highlight the problems of last-mile delivery. Admittedly, the large size of the populations in these countries, the vastness of their geographies and existing regional disparities make it challenging and complex. But all case studies foreground human rights through the Equality, Quality and Accountability lens and the ways in which these could be built into the SRHR agenda at the country level policies and programs to enable the

operationalization and fulfilment of ICPD PoA, BPfA, SDGs and UHC commitments and other international guidelines on human rights standards for quality of care, and in the provision of contraceptive information and services (WHO, 2014, 2017; WHO and UNFPA, 2015), to overcome the ongoing lacunae and barriers.

All three cases demonstrate once again the importance of an enabling legal and policy framework that the international commitments on SRHR (ICPD PoA, SDGs, UHC, for example) emphasise, and the ways these could be translated and integrated into the national legal framework, policies and programs, with monitoring and indicators. After ICPD, China, India and Indonesia have passed several laws, crafted key policies, and have shifted their policy thrust from a pure demographic imperative to a recognition of the need for an integrated approach to reproductive health. China continued with the one-child norm till 2015 when the policy allowed for two children. India removed its “method-specific target” approach soon after Cairo, but the persistence of a system of incentives and disincentives that framed a targeted approach continued to guide the actions of health-workers on the ground. Several ground-breaking initiatives in China point to a commitment towards equality – especially the focus on underdeveloped regions. However, when a strict imposition of one-child and later two-child norm in China overarches the family planning program, they bring into sharp relief the contradictions inherent in efforts towards equality and accountability in a coercive environment. The Indonesia case study also shows how the controversy over abortion in the health law and regulations potentially prevent making safe abortion services accessible.

While aligning with global and regional policy framework and standards, targets and indicators that are appropriate to the respective country context and specificities need to be developed in the process of implementation. Following the 2030 Agenda for Sustainable Development, China adopted the Outline of Healthy China 2030 Plan, which reiterates its commitments to universal access to affordable and quality medical health services for all throughout the life course. Moreover, vulnerable groups such as adolescents, women of reproductive age, and rural–urban migrants were singled out as the focus of interventions. Current SDGs indicators do not directly address gynaecological ailments or their treatment, which is one of the primary issues the India case study analysis. Several indicators chosen for the SDG India index released in 2018 relate directly to sexual and reproductive health, specifically maternal mortality, family planning, intimate partner violence and broader access to health care. 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. As the India case study points out, the choice of indicators reflects an outcome-focused approach without providing information on processes that underpin it. Elements of equality and quality also have process-oriented outcomes that aggregate number mask.

To close the EQA gaps between the laws/policies and implementation on the ground remains the predominant challenge that each country faces. The studies suggest that these three gaps are interlinked and inseparable from each other. The goal of addressing one gap cannot be achieved without efforts to address the other two. Failure in improving performance of any of the three will cause the efforts on the other two to become futile. To address multi-dimensional

disadvantage and marginalisation requires a multi-pronged approach that pays attention to both equality and quality. In China, so far, the efforts targeting other sexually active groups, such as rural migrants, sex workers and college students who are at a particular disadvantage in access to reproductive health services, have been fragmented and unsystematic. Meanwhile, realising accountability would entail efforts to be made by those most marginalised by gender and other hierarchies to claim their rights and disrupt the system that gives rise to unacceptable inequities (Boydell et al. 2019). India and Indonesia's health insurance programs were purportedly introduced to address inequalities in access to health services. With a wide national coverage from the primary to the tertiary level, there is potential for equalising access. In Indonesia, the introduction of a deep network of Skilled Birth Attendants (SBAs) in remote islands, and access to "institutional" delivery was expected to significantly reduce maternal deaths. However, the reductions were marginal and quite disproportionate to the investment made in human resource and insurance coverage. Wide regional variations, a shortfall due to the rudimentary skills of SBAs who are recruited through a crash course, indicate that achieving equality requires painstaking attention to several factors simultaneously. The India case study points to the quality of services in the family planning program, and how and why the program continues to be skewed to permanent methods (sterilisation) despite investments in promoting temporary methods.

The experience of the three countries clearly shows that public financing is key to improve EQA in SRH services. In India and China, an increase in public expenditure on health was directed towards investments in and expansion of rural healthcare infrastructure, personnel and programs. In China, there has been a steady decrease in the disparities of MMR between rural and urban areas, 19.5 and 20.0 per 100,000 live births respectively in urban and rural areas in 2016, with the urban-rural difference being almost negligible. This is largely attributable to a significant increase in government's financial investments for SRH services, particularly for maternal health in rural areas of the least developed central and western regions. Health insurance schemes are a major investment by all three countries. However, there is a major risk that they will further exacerbate the already severe imbalance of health financing towards hospitals and curative services, particularly among the poor or those who are living in remote areas where availability of health facilities is limited and cost for reaching health facilities are higher.

Data and statistics, and their availability, accuracy, timeliness and transparency, are prerequisites for monitoring and evaluation and an important component of accountability. For example, in India, crucial information on rates and reasons for discontinuation, satisfaction with current family planning method and service provision for method switching are data that are either not collected or not actively used for monitoring and improving care. Most of the data used in the three case studies are from national surveys, or national in scope. But other sampling data and evidence are also utilised, because of the lack of available data on specific issues regarding accountability, for instance the role and participation of civil societies to measure EQA. It is also noted that 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.

There are many emerging issues and challenges that need to be further interrogated, including the role of private sector in service delivery, and initiatives such as Family Planning 2020 (FP2020) to renew family planning services (India and Indonesia are among countries committed to FP2020), among others. Other elements of inequality – ethnicities, disabilities, gender identity and sexual orientation could not be investigated in-depth in this research due to lack of statistics and reliable data.

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CHINA

*By Hu Yukun
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Equality, Quality and Accountability in Sexual and Reproductive Health and Rights: China Case Study

1. Introduction

After the founding of the People's Republic of China in 1949, maternal and child health (MCH) was within a few years put on the agenda of the Chinese Government. In the early 1970s, family planning programs were launched throughout the country. Since the early 1980s, "to implement family planning, control population growth and improve the life quality of the population" became a basic state policy, which was enshrined in the Constitution promulgated in 1982. Since the 1970s, the two national networks of MCH and Family Planning have long addressed sexual and reproductive health services, through joint or complementary actions, in collaboration with other agencies (Information Office of the State Council, 1995).

Prior to the mid-1990s, China harshly implemented a strict population control policy. A top-down approach focused on controlling the birth-rate and emphasised the quantitative demographic goals and birth quotes. A system of "one-vote veto" was initiated and the performance of the local 'head' of the Party and the government would be voted against if they failed to meet their population control targets. During the high tides of the family planning campaign, local family planning staff resorted to violence, coercion and other abuses, including forced abortions, sterilisation, IUD insertion, and even tearing down houses or confiscations in some places in the countryside (Xie and Tang, 2008:6).

Not surprisingly, equality, quality and accountability (EQA) in sexual and reproductive health and rights (SRHR) has seldom been considered seriously. For instance, every expectant mother needed a birth permit, otherwise her child was not entitled to state preferential medical, food, housing and educational benefits, and extra allocations of land in rural areas (Conly and Camp, 1992:23). In rural areas, married women were regularly inspected to check if they were pregnant, even well into their 40s and 50s. To achieve demographic targets, local family planning staff developed some measures such as to insert IUDs for couples who had had their first child and to perform sterilisation for those who had had a second child. A woman who had given birth to unlicensed children might suffer forced abortions, even late-term abortions, and sterilisations as well as escalating financial penalties known as the "social compensation/upbringing fee" (Conly and Camp, 1992: 8-9; Xie, 2011: 6). The priority of population control apparently often overrode respect for women's and men's needs, rights, and dignity (Xie and Tang, 2008: 2-3).

Following the International Conference on Population and Development (ICPD) in 1994 and its path-breaking outcome document, Program of Action (PoA), which was described as a "paradigm shift" in population policy because of its overarching human rights frame and emphasis on the interconnections of sexual and reproductive health, gender equality, women's empowerment, and poverty reduction; China gradually started to reform population and development polices. Led by the State Family Planning Commission established in 1984, a

holistic approach to addressing SRHR was strengthened. The quality of care (QOC) campaign became a catalyst to translate some new international concepts into practices.

Despite great progress over the past 25 years, gaps in SRHR between the most advantaged and least advantaged populations remain. The convergence of globalisation, urbanisation, large-scale migration, along with the influences of mass media, have reshaped the demographic landscape, as well as opportunities and perils for sexual and reproductive health among Chinese people, particularly marginalised groups.² So far, a large percentage of the population remains vulnerable and excluded from access to quality sexual and reproductive health services. They include the left-behind women in poor rural areas, rural-urban migrants, and particularly sexually active young people.³

Since the early 1990s, China has actively engaged in global health governance. The Chinese Government has aligned its 13th Five-Year Plan with the 2030 Sustainable Development Goals (SDGs). Health has become an explicit priority with the approval of the Healthy China 2030 Planning Outline launched in October 2016. This strategic plan, with its focus on social equity and justice, offers a rare opportunity to make a difference in promoting a healthy life for all. It demonstrates the Government's tremendous political will in investing in health and fulfilling the SDGs.

Meanwhile, the Chinese Government kicked off the two-child policy nationwide at the end of 2015. More women of advanced age have been seeking to have their second child, which is associated with a range of adverse pregnancy outcomes. As indicated by official data, there was an increase in the maternal mortality rate in rural areas, which rose from 20 per 100,000 live births in 2016 to 21.1 per 100,000 live births in 2017 (National Bureau of Statistics, 2018). In 2017, the number of live births born in the hospital was 17.58 million, and the percentage of second child accounted for 51% (National Health Commission, 2018). In 2016, pregnant women with high risks accounted for 24.7% (National Commission on Health and Family Planning and China Population and Development Research Center, 2018:253). Safe motherhood and postpartum contraception thus became a new challenge for improving availability, accessibility and quality of reproductive health care.

It is timely to take account of EQA in monitoring the progress, identifying gaps and improving the delivery of services. However, there has been little scholarly literature linking these three dimensions in SRHR. We know even less about their intersections in the real world.

² Since the 1980s China has experienced rapid urbanisation, with the proportion of urban residents increasing from 21.1 per cent in 1982 to 59.6 percent in 2018 (National Bureau of Statistics, 2019). Along with urbanisation, China has witnessed a large-scale internal migration from rural to urban areas, from the western and central to the eastern regions over the past four decades. By end of 2017, there were a total of 287 million rural migrants, accounting for more than one-fifth of the total population, with migrant women accounting for more than one third (34.4%) of them. Notably, more than half of them (50.5%) were the new generation of migrant workers born after 1980 (National Bureau of Statistics, 2018a)

³ According to China's sixth census in 2010, China has approximately 300 million young people aged 10-24, more than one fifth of the total population. An increasing number of vulnerable youth population is exposed to a variety of reproductive health risks, including unsafe sex, unplanned pregnancies, sexually transmitted infections including HIV/AIDS, and gender-based violence. Severe inequalities have been embedded also in the shortage and unequal distribution of human and financial resources for their reproductive health.

Reproductive health policies and practices urgently require a thorough analysis of these key factors.

This case study seeks to fill the gap by examining the state of EQA in SRHR in China. It tries to answer the following three questions applying EQA framework: (1) What have been the changes in SRHR related laws and policies over time? (2) What has been achieved and what are the major challenges? and (3) How can China deal with the gaps? Drawing on available official statistics, population-based studies and academic work, this case study scrutinises the realities of EQA in China since the mid-1990s beyond the political rhetoric.

This case study primarily focuses on maternal and child health and family planning policies and practice in China, the two priority issues that have topped the government agenda. There is adequate data and evidence for the in-depth analysis.

2. The Key Trend of Law and Policy Development – Benchmark Status

Over the past two decades, the Chinese Government has made significant strides towards putting in place a framework of laws and policies in accordance with international frameworks on SRHR. This evolution is mainly due to two driving forces: (1) to meet the commitments made at ICPD, Beijing Platform for Action at 4th World Conference on Women and other internationally agreed standards; and (2) to respond to the emerging challenges in population and social development.

2.1. Legislative Frameworks

Immediately after the ICPD, the Law on Maternal and Infant Health Care was issued in October 1994 (revised in 2009 and 2017). Ever since then, promoting SRHR has been put at the centre of China's vigorous efforts.

At the start of the 21st century, a host of new laws and regulations were promulgated. In December 2001, the Population and Family Planning Law was passed. For the first time, a national law adopted key ICPD principles. It addressed the topics of women's status, male participation, sexual health education and the establishment of a social-support system, etc. Its Article 3 reads: "the population and family planning programs shall be combined with the efforts to offer more opportunities for women to access to education and employment, improve their health and promote their status." Article 13 provides: "schools shall conduct education on physiological health, puberty or sexual health among pupils in a planned way appropriate to the characteristics of the receivers" and Article 17 stipulates: "both husband and wife bear equal responsibility for family planning."

It defines eight legitimate rights and interests, including the rights of access to family planning and reproductive health information and education, the right of access to contraceptive methods and reproductive health care services and the right of informed choice of safe, effective and appropriate contraceptive services. For example, Article 19 provides that: "the State creates the conditions to ensure individual citizens knowingly choose safe, effective, and appropriate contraceptive methods" and Article 34 states: "persons providing family planning technical services shall give guidance to citizens who practice family planning in choosing the safe, effective and appropriate contraceptive methods."

Other laws and regulations also play a pivotal role in shaping reproductive health and rights policy and practices. For instance, the Regulation on Administration of Technical Services for Family Planning was passed in 2001, with the improvement of reproductive health being stressed. The Law on the Protection of the Rights and Interests of Women promulgated in 1992 was amended in 2005 and 2018. It strengthens the commitments to promoting maternal and child health care and improving women's reproductive health. At the end of 2015, the Anti-domestic Violence Law was passed prohibiting any form of domestic violence.

In response to the challenges of swift demographic shifts, the amended Population and Family Planning Law passed in December 2015 allows for all married couples to have two children. The law reaffirms promoting informed choice, providing safe, effective and appropriate contraceptive services to people of reproductive years and improving equity and accessibility.

Another notable challenge in the Chinese Government's agenda for health and development is how to equalise basic public services to meet the needs of marginalised and disadvantaged groups. Given that the segmented urban-rural hukou registration system prevented migrants from accessing the same basic public services as urban residents in terms of reproductive health services, in 2009 the State Council promulgated the Regulations on the Work of Family Planning among the Migrant Population. This regulation promises to guide reproductive-aged couples among migrants to choose safe, effective and appropriate contraceptive methods and to provide basic family planning technical services to them free of charge. This regulation is of particular importance for targeting the large, vulnerable group of rural-urban migrants.

The above frameworks, along with some special laws and regulations, seem to lay the legal foundations for improving related policies on SRHR.

2.2. Policy Trajectories

Prior to the promulgation of Population and Family Planning Law in 2001, the Central Committee of the Communist Party of China (CPC) and State Council issued A Decision on Strengthening Population and Family Planning Work and Stabilising a Low Fertility Rate in 2000. It reiterates the stringent target of stabilising a low fertility rate, meanwhile promises to promote quality of care universally, focusing on technical services and informed choice of contraceptive methods. It also emphasises prohibition of all forms of coercion and to uphold citizens' reproductive health and rights. In 2006, two institutions again jointly issued A Decision on Fully Strengthening Population and Family Planning Work and Addressing Population Issues in an Integrated Manner. Both regulations make clear that it is essential to deal with the population issue in an integrated way, highlighting people-centred development.

Universal access to essential health services has been continuously stressed in policy framework on health (China Institute of Reform and Development and UNDP China, 2008; Deng et al., 2014). To narrow the gaps in public services between rural and urban, rich and poor areas, and among different social groups, the Opinion on Promoting Gradual Equalisation of Basic Public Services was enacted in 2009, which underscored maternal and child health care. Its key principles were again echoed in the Outline of Healthy China 2030 Plan approved in 2016. This strategic plan reiterates its commitments to universal access to affordable and quality medical health services for all throughout the life course. Vulnerable groups, such as

adolescents, women of reproductive years and rural–urban migrants, were singled out as the focus of interventions. In response to the Outline, the Action Plan of Maternal and Child Safety (2018-2020) was released by the National Health Commission in 2018.

Sexual and reproductive health has also become one of the national priorities of women’s policies. To implement the Beijing Platform for Action adopted in 1995, the Chinese Government has successively released three versions of the Program for the Development of Chinese Women (1996-2000, 2001-2010, and 2011-2020). Taking the latest one as an example, the program aims to promote gender equality in seven areas, including health. The program sets some ambitious goals for SRHR such as increasing women’s access to quality essential medical services throughout the life cycle; reducing the maternal mortality ratio (MMR) to less than 20 per 100,000 live births; closing the MMR gap between urban and rural areas; controlling HIV/AIDS and STD infections among women, and protecting women’s rights for making informed contraceptive choices, etc.

In sum, the milestone conference of ICPD in 1994 and 4th World Conference on Women in 1995 ushered in a raft of progressive legislation and policies related to SRHR in China. Since then, the Chinese Government has made tremendous political commitments to invest in reproductive health, fight against inequality and inequity and leave no one behind. More recently, reproductive health has been emphasised in the chief national development strategies, such as the Thirtieth Five-Year Plan for National Economic and Social Development (2016-2020). The legal and policy frameworks, in turn, provide a solid foundation for continuous progress in the field. Although it is too early to assess the outcomes of the recent policy shift, it has, undoubtedly, paved the way towards achieving the 2030 Sustainable Development Goals.

3. EQA in SRHR: Progress and Challenges

Despite positive legal and policy frameworks that enable EQA, great challenges and gaps remain. Based upon the available data, we will examine how the laws and policies have been implemented and the evolution of EQA on the ground. We will also identify challenges and opportunities of addressing EQA in the SRH services and policies.

3.1. Equality Profile

Since the early 1990s, China has achieved remarkable progress in advancing equality and equity in SRHR. The Chinese Government has made great efforts in achieving the MDG and SDG targets to increase access to reproductive health services by all throughout their life cycle, and to reduce urban-rural, regional and subgroup health inequalities (Ministry of Foreign Affairs and United Nations System in China, 2015; United Nations Children’s Fund, National Working Committee on Children and Women and National Bureau of Statistics, 2018). The improvement of maternal health is just one of the telling stories.

China’s MMR has decreased significantly over the past quarter of a century. As illustrated in Figure 1, the MMR dropped from 88.9 maternal deaths per 100,000 live births in 1990 to 22 maternal deaths per 100,000 live births in 2014, down by more than 60 percent, thereby attaining the MDGs of “reducing maternal mortality rate by three quarters from the 1990 level by 2015” ahead of schedule. China has also basically achieved the target of universal access to

reproductive health (Ministry of Foreign Affairs and United Nations System in China, 2015). By the end of 2017, the MMR further dropped to 19.6 per 100,000 live births.

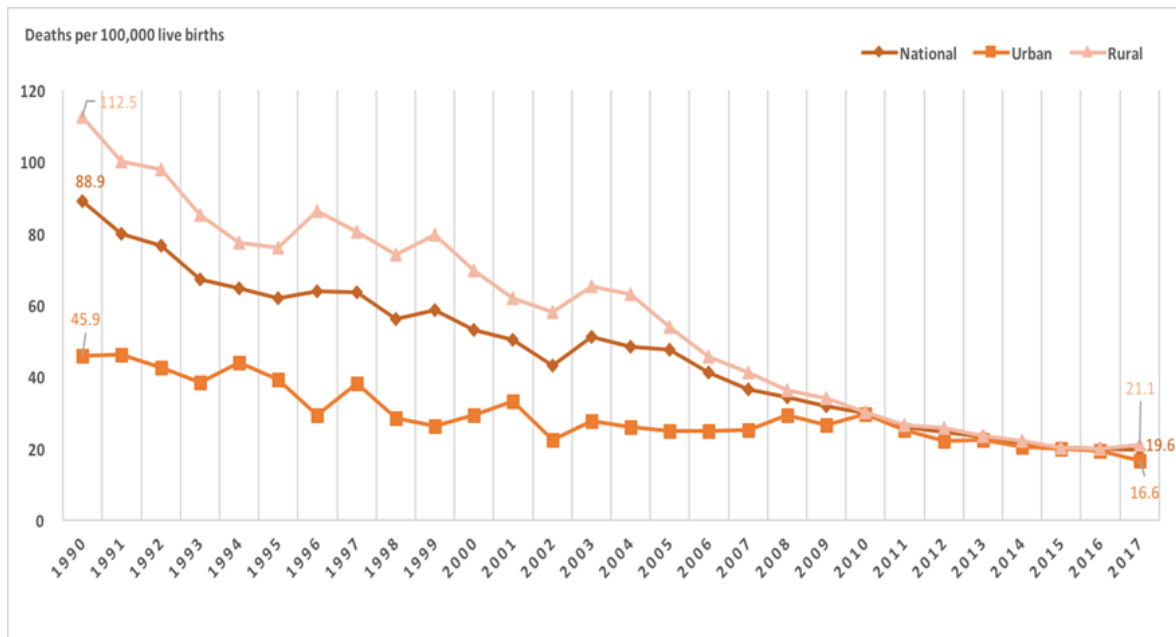


Figure 1: Trends in Maternal Mortality Rate by Urban/Rural Division 1990-2017
Source: National Commission on Health and Family Planning and China Population and Development Research Centre (2018: 250) and National Health Commission (2018:217)

Meanwhile, there has been a steady decrease in the disparities of MMR between rural and urban areas. In 1990, women living in rural areas had a much higher maternal mortality ratio (112.5), compared with their urban counterpart (45.9). Even in 2005, the MMR in rural areas was almost 2.15 times that of urban areas. Since then, urban-rural disparities have been narrowing and the gap between the two has almost disappeared. This was due primarily to a dramatic drop in rural maternal mortality and simultaneously a surprising lack of improvement in urban maternal mortality (You, 2014). The MMR was, respectively, 19.5 and 20.0 per 100,000 live births in urban and rural areas in 2016, with the urban-rural difference being almost negligible.

Similarly, the MMR in under-developed provinces in western China show greater and more rapid progress than that in more developed eastern provinces. As shown in Figure 2, the MMR fell from 21.2, 52.1 and 114.9 per 100,000 live births in 2000, respectively, to 13.5, 21.2 and 26.9 per 100,000 live births in 2016 in Eastern, Central and Western China.

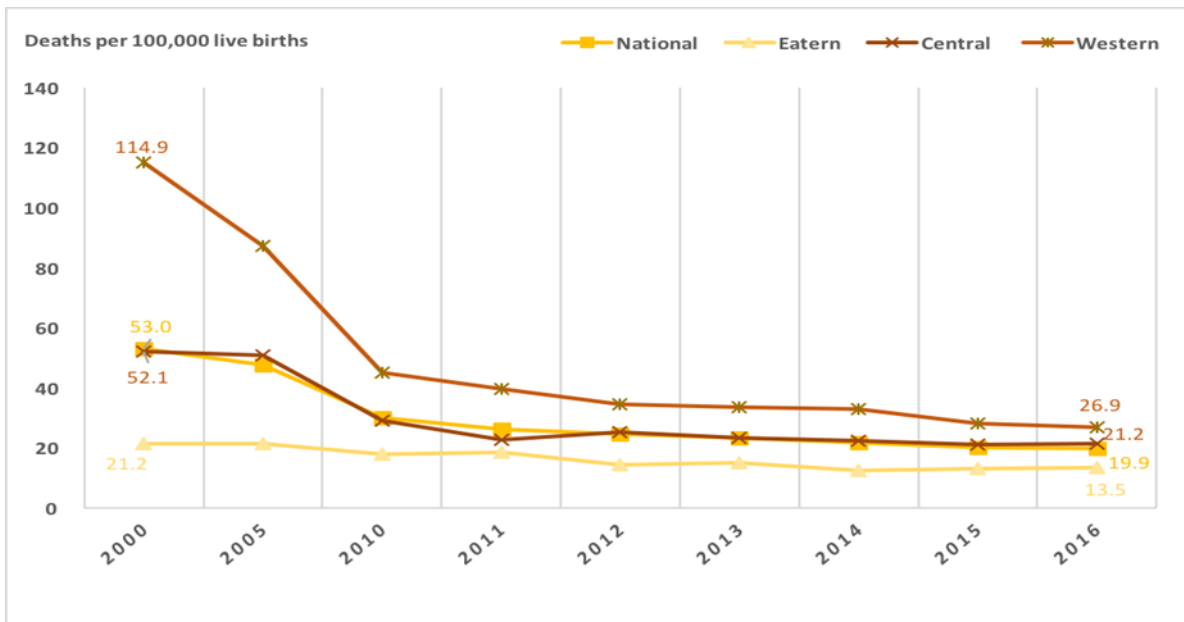


Figure 2: Trends in Maternal Mortality by Region 2000-2016

Source: National Bureau of Statistics (2017:26)

How did this happen and what has been done to address the gaps and tackle the inequality in SRHR? We will only outline some key drivers behind the continuous progress.

Firstly, the declining trend of MMR has resulted largely from China’s societal and economic development over the past four decades with rapid economic growth performance and impressive progress in rural poverty reduction. By 2015, China had achieved the MDG targets of halving the proportion of people in poverty. Meanwhile, we also witness the demographic shift, such as rural-urban migration and decreased fertility rate. Some preferential public policies, such as the strict implementation of one-child policy from the 1980s to 2015, with increasing contraceptive use, contributed to the dramatic drop of MMR. The total fertility rate (TFR) fell below the replacement level of 2.1 between 1990 and 1995 as a consequence and has remained at a low level ever since, making China one of the low-fertility countries of the world.

Secondly, universal health coverage (UHC) has become a powerful tool of providing basic health services for all, especially to the poorest and most vulnerable people. By 2015, basic medical insurances for urban employees and residents and the New Cooperative Medical Scheme (NCMS) launched in 2003 for rural residents, have covered almost all Chinese citizens. In the context of a new round of reform of the medical and healthcare system launched in 2009, the System of Equalisation of Basic Public Health Services has been implemented involving two kinds of schemes: basic public health programs and major public health programs. MCH was incorporated into the former, including five antenatal check-ups and two postnatal visits for all pregnant women free of charge. Other maternity care, such as hospital delivery for rural pregnant women, screening and treating breast cancers and cervical cancers among rural women, and prevention of mother-to-infant transmission of HIV/AIDS, was integrated into the latter. The types of services covered have expanded from the original nine categories to

fourteen in 2017, including free contraception. These interventions have greatly reduced out-of-pocket expenditure for impoverished families.

Thirdly, focused interventions have played a pivotal role, which will be elaborated in detail in the accountability section of in this case study.

Fourthly, as shown in the following section of quality, a three-tier network of maternal and child healthcare, established gradually since the 1950s, has been consistently improved throughout the country.

Fifthly, ongoing progress in gender equality and women's empowerment enables women to have greater control over their reproductive lives. Since the economic reform, rural women have performed an increasing share of on-farm and off-farm work in the countryside. Currently, more than one third of rural migrants are women.

Despite this great progress in China as a whole, significant disparities in MMR remain in different regions and provinces, with a similar pattern observed in rural and urban areas. As shown in Figure 3, the MMR in 2017 ranged from less than 10 per 100,000 live births in coastal provinces, about 15 per 100,000 live births in central provinces to above 25 per 100,000 live births in some western provinces. Additionally, there has been a consistently high MMR among migrant women, who often have limited access to high-quality health care.

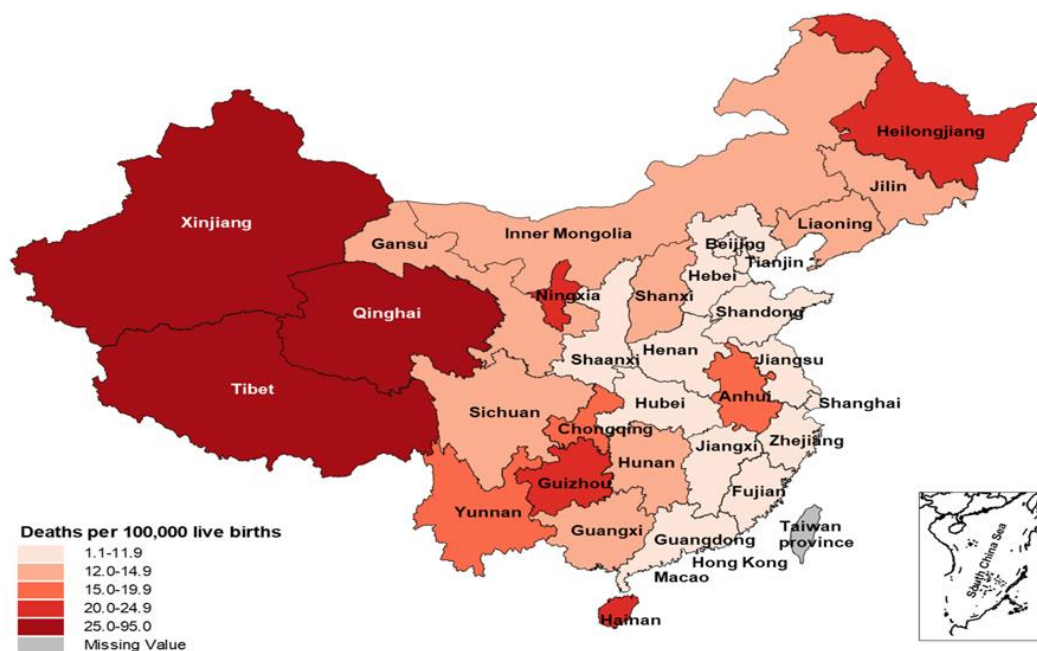


Figure 3: Maternal Mortality Ratio by Province in 2017

Source: United Nations Children's Fund, National Working Committee on Children and Women and National Bureau of Statistics (2018: 49)

The patterns of maternal mortality differ greatly between high- and low-income provinces and regions and across different groups. In 1990, there were 15.3 maternal deaths per 100,000 live births in Shanghai, whereas this figure was as high as 715.8 maternal deaths per 100,000 live births in Tibet. The corresponding figures in 2000 were, respectively, 9.6 and 466.3 maternal deaths per 100,000 live births in Shanghai and Tibet (Zhuang and Zhang, 2003: 136). In 2016 the gap between the province with the lowest rate, Jiangsu (2.2) and the one with the highest, Tibet (109.9) was nearly 50 times greater (National Commission on Health and Family Planning and China Population and Development Research Centre, 2018:258). As seen from Figure 2, in 2016, MMR in western China was almost twice that of eastern China.

The disparities in maternal survival and health undoubtedly reflect the wide urban-rural and the east-centre-west divide of income and wealth and corresponding human development. China's reform and opening up to the outside world policy have led to serious socio-economic inequalities between rural and urban residents and among residents living in eastern, central and western regions. For example, the ratio between per capita income of urban and rural residents remained high at 2.7 across country in 2017 (United Nations Children's Fund, National Working Committee on Children and Women and National Bureau of Statistics, 2018:28). At the same time, with the reduction and privatisation of public health services, access to reproductive health care has largely depended on the levels of individual income and wealth. The out-of-pocket expenditure once reached a peak of 60 per cent in 2001. It dropped to below 30 per cent in 2015 for the first time and to 28.8 per cent in 2017 (United Nations Children's Fund, National Working Committee on Children and Women and National Bureau of Statistics, 2018: 48).

3.2. Quality Profile

After the ICPD, the concept and practices of quality of care (QOC) were introduced to China. The six fundamental elements of QOC landmark framework in family planning proposed by Judith Bruce (1990), have been incorporated in the provision of sexual and reproductive health services ever since. The six components include: choice of methods, information given to clients, technical competence, interpersonal relations, follow-up and continuity mechanisms and the appropriate constellation of services. Both MCH and family planning systems began to be involved in improving access and quality of reproductive services.

In the field of MCH, a three-tier network of maternal and child healthcare initiated in the 1950s has continuously been improved across the country. By the end of 2016, there were 3,063 MCH institutions, 757 maternity hospitals, and 370,000 gynaecologists, obstetricians, paediatricians, and assistants. In 2016, the Chinese Government invested RMB 2.9 billion to support the construction of 247 city-and county-level maternal and child healthcare institutions. Full-time and part-time maternal and child health workers were available in 34,000 community health centres (stations), 37,000 town and township health centres and 640,000 village clinics (State Council Information Office, 2017). As a result, the coverage of MCH services has steadily increased.

Since the early 1990s, a continuum of care, from pre-pregnancy to postnatal stages, has been implemented on a large scale. Antenatal care, the hospital delivery, emergency obstetric

services and postnatal visits, among others, remarkably improved (see Figure 4). For instance, prenatal checkup rate rose markedly from 69.7% in 1990 to 95% in 2010, and 96.5% in 2017. The hospital delivery rate substantially increased from 50.6 % in 1990 to 99.2% in 2010, and 99.9 % in 2017. Between 2009 and 2013, on average, pregnant women took up 6.3 antenatal visits (7.4 visits for urban women and 5.4 visits for rural ones), vis-à-vis five minimal antenatal visits required by the systematic maternal care management (United Nations Children’s Fund, National Working Committee on Children and Women and National Bureau of Statistics, 2018: 46).

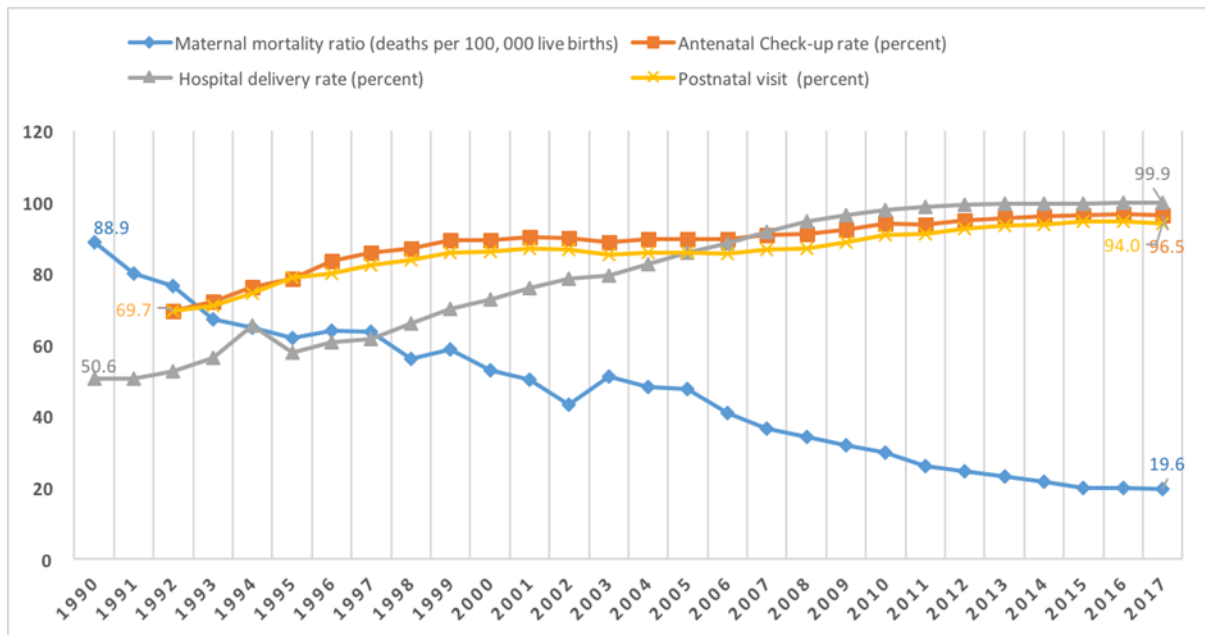


Figure 4: Maternal Mortality Ratio and Maternal Health Interventions
Source: National Commission on Health and Family Planning and China Population and Development Research Center (2018: 250) and National Health Commission (2018:219; 220)

Meanwhile, a wide variety of maternal and newborn interventions have been promoted, with QOC being emphasised. For instance, China immediately responded to the Baby-Friendly Hospital Initiative (BFHI) launched in 1991 by UNICEF and WHO the same year. By 1994, approximately three thousand facilities had been awarded Baby-Friendly status (Yan, 1996:8). Not only are numbers of mothers breastfeeding their infants growing, but privacy, informed choices and user-friendliness are considered seriously in maternity services. Notably, a demonstration project of QOC in Maternal and Child Health began to be implemented in 2013. In order to improve the quality and level of maternal and child health services, the National Health Commission released the Action Plan of Maternal and Child Safety (2018-2020) in 2018, which focuses on the following five areas: to prevent the risks during pregnancy, to treat and cure emergency and severe cases, to improve quality and safety, to enhance professional capacity building and to deliver convenient and high quality services.

In spite of significant improvements, coverage of maternal care interventions varies within and between provinces and across the continuum of prenatal to postnatal care. For instance, China has achieved a near-universal coverage of hospital delivery at the national level, yet the disaggregating data shows that less than 80 percent of pregnant women delivered in hospital in

39 counties in the western areas in 2015 (United Nations Children’s Fund, National Working Committee on Children and Women and National Bureau of Statistics, 2018: 48). Limited access to the continuum of basic care reflects different levels of socioeconomic development current in China, which is also an issue of equality.

Following the ICPD, a comprehensive reform on the family planning work was launched. The State Family Planning Commission (SFPC) announced “two reorientations” in family planning work in October 1995. One reorientation was the shift from treating family planning in isolation to linking it closely with economic and social development, dealing with population issues via comprehensive measures. Another one was the shift from a social control-oriented approach to a combination of interventions targeting social control and incentives, which integrate publicity and education with services and management (Xie, 2011: 1; Peng, 1996).

The “san wei zhu” (three priorities) and “san jie he” (three combinations) launched at the end of the 1980s became two powerful instruments. The former refers to the practice of pursuing family planning primarily through administrative means and campaigns that must be replaced by efforts of publicity and education, contraception and regular work. The latter means that family planning in rural areas should combine with “developing economy, helping peasants to become better off through hard work, and building progressive and happy families” (Information Office of the State Council, 2015). The scope of family planning has gradually expanded to include QOC, clients’ informed choice of contraceptive methods, and some new priorities such as birth defects, RTIs and the HIV/AIDS epidemic (Zhang, 2008; Xie and Tang, 2008).

Since the mid-1990s, the improvement of the QOC in family planning services has become one of the key priorities. In order to attain the “two reorientations”, the SFPC decided in 1995 to initiate QOC projects in five counties, in five provinces and one of the districts in Shanghai. These aimed at exploring best practices to ensure family planning goals were met with high quality care. In 1997, the pilot project was scaled up to eleven counties and districts (Xie and Tang, 2008: 13-17). In 2002, the SFPC launched a campaign of Constructing National Advanced Units of Quality of Care in Family Planning, with the intention of scaling up the successful experiences and working pattern of the pilot project to the whole country. By 2013, 1,818 national advanced units have been established, accounting for over 63.7 percent of the units at the county level (2,853) across the nation while eastern China has basically achieved full coverage of high-quality services (Xie, 2016). In the context of the two-child policy, a new campaign around Constructing National Advanced Units of Quality of Care in Family Planning was initiated in 2016.

Since the QOC project started, a comprehensive package of interventions has been launched. The SFPC initially defined the QOC in reproductive health services as “people-centred, need-based and contraception-focused”. The initial QOC project set a powerful example for subsequent movement. The quality of care approach has reframed the reform of family planning from population quota-centric to the clients’ need-driven. The core of QOC in family planning service has long targeted the standardised technical services, including the improvement of provider motivation and equipment, as well as quality IUD and sterilisation contraceptive services. Consequently, the QOC movement enhanced the communication

capability of service providers, offered more choices of contraceptives to the married population of childbearing age and allowed them to make informed choice of contraceptives.

Moreover, the QOC project has emphasised clients’ rights, empowerment and the quality of client-provider interactions. The users’ rights promoted by the International Planned Parenthood Federation were introduced into China (Gu, et al., 1996). It is underscored by the clients’ satisfaction with “ten rights” in family planning.⁴

As Kaufman pointed out, the QOC became a symbol of advanced family planning work (Kaufman, 2012). The incremental changes in the QOC movement consequently led to a silent revolution in population policy. The contraceptive prevalence rate among married women of reproductive age was over 88% in 1990 and 88.6% in 2011. With the relaxation of the family planning policy, it dropped gradually from 87.9% in 2012 to 80.6% in 2017 (Zhuang and Zhang, 2003:154; Zhuang and Han, 2012: 208-209; National Health Commission, 2018:223).

The QOC in family planning services have contributed to people’s choice of the most appropriate contraceptive method in terms of its safety, effectiveness, availability (including accessibility and affordability), and acceptability. A variety of contraceptive options are now available in China and all of the major contraceptive methods are available without cost for married people. Due primarily to the QOC interventions, as shown in Table 1, condom use increased significantly from 3.68 in 1990 to 18.04 in 2017. At the same time, male and female fertilisation dropped from 11.79 and 37.45 percent to 3.32 (male) and 24.93 (female) percent. Dual protection from the simultaneous risk for HIV and other STDs was considered by contraception users. Since the mid-1990s, informed choice of contraceptive methods, as an essential guiding principle in family planning services might be an important contributor to the rise of condom use. In Beijing, condom use accounted for 80.77% of all contraceptive methods. Its impacts will become more pronounced over time.

Table 1: Contraceptive Methods Used by Married People of Childbearing Age (1990-2017) (%)

Year	Vasectomy	Tubal Ligation	IUDs	Implant	Pill	Condom	Drug	Others
1990	11.79	37.45	40.61	--	5.0	3.68	0.85	0.62
1995	10.57	39.92	41.65	0.31	2.92	3.76	0.52	0.34
2000	8.88	37.60	46.32	0.36	2.14	4.23	0.30	0.17
2005	6.98	33.84	50.57	0.35	1.54	6.31	0.24	0.17
2010	5.19	30.78	53.50	0.29	0.96	8.89	0.18	0.22
2017	3.32	24.93	52.18	0.19	0.82	18.04	0.15	0.37

Source: Zhuang and Zhang (2003:154); Zhuang and Han (2012: 208-209); National Health Commission (2018:223)

Although QOC itself is a means to reduce inequality, notable gaps and challenges remain. For example, because of gender norms and bias, the burden of birth control has long fallen largely on women. Since its inception in the early 1970s, the use of modern contraception was much

⁴ The ten user’s rights include the right to information, choice, safety, comfort, privacy, confidentiality, access, continual use, respect and expression.

higher among women than that among men. As shown in Table1, in 2017, IUD use still represented 52.2 percent of total contraceptive use and female sterilisation 24.9 percent. Despite an increasing proportion of controllable and reversible contraceptives, long-term contraceptives used by women remain the most popular ones in most parts of China, perpetuating a long-discredited concept that family planning is merely the business of women of childbearing years. Notably, in 2017, there were 181,000 cases of male sterilisation surgery, in contrast to 1.68 million cases of female sterilisation and 8.48 million cases of IUD insertions throughout the year (National Commission on Health and Family Planning and China Population and Development Center 2018:214). The feminisation of contraception places a huge burden of birth control, along with its risks, on women.

Method-specific contraceptive prevalence varies substantially by provinces. As seen below, the four contraceptive methods of male and female sterilisation, IUD and condom use account for 98.47% of all methods used. IUDs are the most prevalent method of contraception for women, with the highest percentage being 82.37% in Jilin province and lowest 16.82% in Beijing in 2017. Tubal ligation, a permanent type of female sterilisation, was the second most popular type of birth control method in China. After assessment indicators for long-acting reversible contraception (IUDs) were cancelled, increasing numbers of women have stopped using this contraceptive method. Variation in condom use between provinces was even greater, ranging from 80.99 percent in Beijing to 3.18 percent in Shanxi. Although sterilisation and IUD are highly effective at preventing pregnancy, they do not protect against STDs, including HIV.

In addition, increasing condom use leads to a high rate of contraceptive failure and unwanted pregnancies. China has one of the world's most liberal abortion laws. Women, married or unmarried, have legal access to early termination of pregnancy. It is widely reported that there are more than 1,300 million cases of induced abortions annually in China and approximately half of the abortions occur among youth under the age of 25 (Hu, 2015). The lack of post-abortion contraceptive counselling in abortion services is common. All of the above, shed light on the lack of adequate protection mechanisms and on the existing gaps in policies and programs to address this challenge.

Table 2: Five Provinces with the Highest and Lowest Percentage of the Four Most Popular Contraceptive Methods Used by Married People of Childbearing Age in 2017 (%)

Tubal Ligation		IUDs		Vasectomy		Condom	
Highest	Lowest	Highest	Lowest	Highest	Lowest	Highest	Lowest
Gansu (53.61)	Beijing (0.44)	Jilin (82.37)	Beijing (16.82)	Henan (11.27)	Liaoning (0.00)	Beijing (80.77)	Shanxi (3.18)
Guizhou (50.72)	Chongqing (1.27)	Heilongjiang (80.97)	Guangdong (23.10)	Guizhou (10.58)	Jilin (0.01)	Tianjin (52.60)	Henan (5.21)
Jiangxi (43.78)	Liaoning (1.77)	Liaoning (79.59)	Tibet (24.33)	Guangxi (7.63)	Ningxia (0.01)	Shanghai (51.19)	Gansu (5.54)
Fujian (39.58)	Sichuan (2.24)	Xinjiang (75.76)	Guizhou (32.29)	Guangdong (5.88)	Beijing (0.02)	Zhejiang (35.93)	Guizhou (6.00)
Henan (39.37)	Shanghai (2.70)	Sichuan (75.64)	Jiangxi (33.68)	Shandong (5.56)	Tibet (0.02)	Guangdong (34.75)	Yunnan (7.03)

Source: National Commission on Health and Family Planning and China Population and Development Research Center (2018: 217-218)

Serious challenges persist in delivering quality services, sustainably and fairly, to some social groups most in need. For example, there are considerable challenges in meeting the SRHR needs of unmarried young people (Hu, 2015). A national survey unveils there was a significant gap in meeting the needs of unmarried people. 22.4 percent of youth aged 15-24 had sexual intercourse, and 9.4 percent for those aged 15-19. Only 4.4 percent of youth were well-informed about reproductive health and merely 14.4% percent had the accurate HIV prevention knowledge. More than half (53.9%) did not use any contraceptive methods when they had their first sexual intercourse. In addition, among sexually active female youth, 21.3 percent had experienced unplanned pregnancies, with 86 percent resorting to abortion and 4.9% of this group of youth undergoing multiple abortions. Notably, 59 per cent of counselling needs and 54 per cent of service needs in reproductive health were not met. The major reasons include: “feel embarrassed”, “perceived it is not serious” and “afraid of being humiliated”. In terms of the choice of health facilities, they cited the “level of quality of medical service”, followed by “protection of privacy” (Zheng and Chen et al., 2010).

To address the multi-dimensional disadvantages and marginalisation, requires the multi-pronged approach that pays attention to both equality and quality. So far, the efforts targeting other sexually active groups, such as rural migrants, sex workers and college students, who are at a particular disadvantage to access reproductive health services, have been fragmented and unsystematic. Even sexually active college students may have limited knowledge of and access to reproductive health information and services, let alone the marginalised youth group. Indeed, there is a great deal of heterogeneity in offering sexual education across China. Some current sexual education programs have tended to focus too narrowly and have missed the opportunities to deliver a broader set of interventions at the primarily and secondary levels (Hu, 2015; UNESCO & Shanghai Institute on Planned Parenthood Research, et al., 2018). All these reflect the inequality and inadequacies in the availability or delivery of care, or structural barriers that prevent marginalised people from utilizing the care they need.

3.3. Accountability

The following analysis focuses on some core elements of accountability for SRHR, including government's commitments at the global and domestic level, the mechanism of implementing domestic laws and policies, the financing for SRH services and the collaboration with multiple partners, among others.

(1) China has actively participated in global governance and in particular global health governance. In response to the Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s adopted at the World Summit for Children in 1990, the State Council approved the Program for the Development of Chinese Children in 1992. One of the seven major goals of the Plan of Action is by year 2000 to have reduced maternal mortality rates to half that of the 1990 rate. As mentioned above, the two landmark international conferences held in the mid-1990s, marked an obvious shift from a vigorous pursuit of birth control towards a people-centred approach to population and development. China is a signatory to the Program of Action of the International Conference on Population and Development (ICPD) held in Cairo in 1994. The hosting of the Fourth World Conference on Women in Beijing the following year further promoted a broader development agenda.

Since 2000, the Millennium Development Goals (MDGs) became a critical mechanism for accountability at the national level. It provided unparalleled opportunities for the Chinese government to build commitments. By 2015, a total of six of China's progress reports towards the Millennium Development Goals were released. These reports review the implementation of the MDG agenda, its structural obstacles and challenges, including many facets of reproductive health. Since reproductive health was identified as one of the most critical unfulfilled challenges, China's national strategy recently responded to its endorsed Sustainable Development Goals (SDGs), accelerating progress on meeting the needs of the most vulnerable and least reached marginalised population. The SDGs provide further impetus to accelerate action towards reproductive health goals.

(2) Updating and amending laws and policies is an important mechanism to translate high-level aspirations and commitments into measurable actions. For instance, the Outline of Healthy China 2030 Plan was approved in October 2016 to implement the country's commitment to the UN 2030 Agenda for Sustainable Development. The Plan set an ambitious national goal of reducing MMR to 18.0 per 100,000 live births in 2020 and 12.0 in 2030.

In order to improve the maternal health over the years, the Chinese Government has launched some powerful and innovative programs and invested resources to implement the prenatal check-ups and postnatal care services and provide emergency obstetric care and family planning services. It demonstrates that putting in place the right policies can make striking differences in reducing the gaps, improving accessibility for the poorest and marginalised populations.

In 2000, the National Working Committee on Women and Children, Ministry of Finance and Ministry of Health jointly launched a widely noted program entitled Reducing Maternal Mortality and Eliminating Neonatal Tetanus that initially covered only 378 poverty-stricken

counties in 12 provinces, autonomous regions and municipalities in central and western China. By 2008, it had expanded to 1,200 poor counties in 22 provinces in central and western China for the benefit of 460 million people (Ministry of Foreign Affairs and United Nations System in China, 2015:46).

Notably, there are some life-saving interventions. A *Green Channel* system to ensure timely referral and first-aid was formulated. By the end of 2014, 2191 *Healthy Fast Vehicles for Mothers*⁵ had been sent out to more than 1000 counties/districts all over the country, benefiting over 39 million persons (Ministry of Foreign Affairs and United Nations System in China, 2015: 51). The MCH monitoring and emergency response capability has continuously strengthened. In 2015, the monitoring network covered 140 million people in 334 districts and counties, which has become the largest MCH monitoring network in the world (Ministry of Foreign Affairs and United Nations System in China, 2015: 51). In rural areas in western China, numerous preventable deaths of mothers and newborns at home have been averted with improved transportation and infrastructure.

However, the progress is slow and uneven, facing new gaps and challenge. Some of the national legal provisions are not sufficiently concrete to provide a cause for action, resulting in a lack of accountability. The package of incentives and disincentives relating to childbirth remain. The fine still applies for breaching the new two child policy. In addition, whilst laws were passed by the National People's Congress' Standing Committee, the formulation of actionable guidelines has been left to the provinces. Each province and administrative region formulate its own family planning and MCH regulations as well as other supporting policies. The implementation of national and sectorial policies thus often depends on or is determined locally. The diffusion of responsibility may lead to a lack of action around creating new programs to improve quality and equality. It would seem that the implementation of the law and policy frameworks rely heavily on the local authority, its initiative, financing and capacity. This is probably one of the major reasons for significant variations in the MMR among provinces. A coherent and coordinated monitoring and evaluation mechanism is needed. This shows once again that equality, quality and accountability are interdependent, and the accountability problem cannot be solved without improving equality and quality.

(3) There have been tremendous increases in government's financial investments for sexual and reproductive health services, particularly for maternal health in rural areas of central and western regions. From 2009 to 2013 only, a total of RMB 2.52 billion Chinese yuan (about 360 million US dollars) was invested in the program of Reducing Maternal Mortality and Eliminating Neonatal Tetanus initiated in 2000, covering 2,297 counties and benefiting 830 million people. In addition, a subsidised hospital delivery program was launched for rural

⁵ *Healthy Fast Vehicles for Mothers* is a program initiated by the China Women's Development Foundation in July 2003. It raises funds to purchase medical vehicles and donate them to county-level maternal and child health centres in poor, remote and ethnic minority areas. This program is jointly implemented by local women's federations and local hospital. The mobile medical vehicles offer the health services such as screening and physical examination, as well as used as ambulance and transportation bringing women to hospitals. It also plays the role of health and service platform for training of health personnel.

pregnant women in 2009, which by 2015 had benefited 47.278 million people (Ministry of Foreign Affairs and United Nations System in China, 2015:50-51).

Usually, the central government provides funds for these programs and local governments provide matching funds. For instance, the rising hospital delivery rates were financially supported not only by NCMS, but also by specific local or regional programs.

In 2008 the Ministry of Health launched a Subsidy Program on Maternal Hospital Delivery in Central and Western China, which provided a subsidy for pregnant women who delivered in hospitals in 2,297 counties in central and western China and by 2009 it had covered the whole area. In 2014, 9.74 million rural women benefitted from this subsidy program and delivered in hospital. All these efforts reflect strong political commitments and willingness to invest in the SRHR for vulnerable and hard to reach populations.

(4) The merging of the health and family planning department can help to enhance accessibility and quality of reproductive health services, particularly at the grassroots level. For a long time, family planning and MCH belonged to two different sectors. The SFPC established in 1981 was renamed the National Population and Family Planning Commission (NPFPC) in 2003. The NPFPC and the former Ministry of Health (MOH) merged into the National Health and Family Planning Commission (NHFPC) in March 2013 and was renamed the National Health Commission (NHC) in March 2018.

Further optimising and integrating the resources of maternal and child health care and family planning technical services is urgently needed. There were previously about 3,000 women and children healthcare facilities with 500,000 workers and 35,300 family planning service outlets nationwide. The family planning programs were enforced through its five-tier administrative network; including central, provincial, prefecture, county, township and village levels, with a wide service management network. It had the advantages of health communication, education and consulting. The work of family planning in China has emphasised birth control and management of fertility, focusing on married couples of childbearing age rather than improving the services. Therefore, the human resource allocation cannot fully meet the service needs. While health sectors have strong technical strength: health examination, diagnoses and treatment, it has been predominantly focusing on clinical treatment. This disease-centred medical system disadvantages prevention in health care, for instance, prioritising treatment over prevention, emphasising the successful outcome of pregnancy (i.e. maternal health care and delivery services) and neglecting abortion care and contraceptive services after abortion. The merging of the two agencies had provided the potential to better deliver comprehensive services.

(5) Multi-sectoral collaboration of government departments, international organisations and domestic NGOs and academia have played an important role in SRHR-related issues. Since UNFPA began to work in China in 1979, it has contributed substantially to improving SRHR by providing technical and funding support. For example, its fourth Country Program (1998-2003) focused on reproductive health and family planning services in 32 counties of 22 provinces in the less developed regions in central and western China. The fifth Country Program (2003-2005) extended the RH/FP program to 30 counties in 30 provinces. The sixth

Country Program (2006-2010) sought to further enhance the capacity of the pilot counties in providing quality client-centred reproductive health/family planning integrated services, as well as advocacy and services of HIV prevention among migrants and adolescents (Xie and Tang, 2008: 19-20). Under the seventh Country Program (2011-2015), UNFPA China cooperated with the related authorities to strengthen monitoring and evaluation of national reproductive health-related policies and worked with the national and provincial authorities to develop policy recommendations. It made efforts to advocate for the integration of sexual and reproductive health and prevention of gender-based violence issues into the national public health policy. UNFPA also focused on policy development on youth sexual and reproductive health.

Some international and domestic NGOs have also played a key role. Since 1998, the China Family Planning Association has been working with the UNFPA and PATH to implement a Youth Health Project. In the philanthropy sector, the Ford Foundation provides funding support for government agencies, academia and civil society groups to conduct research, capacity building and pilot projects in the areas of SRHR in promoting equality, including gender equality, and quality services. Marie Stopes International China has often been at the forefront of attempts to promote youth friendly services. China Family Planning Association, founded in 1980, is the largest non-profit, non-governmental organisation in the field of reproductive health and family planning (RH/FP), with its extensive network of over one million branches and 94 million members and volunteers all over the country.

4. Conclusion and Recommendations

In summary, from the perspective of EQA, reproductive health intervention in China has been both promising and disappointing. On the one hand, SRHR was making its way onto the broader legislative and policy agendas after ICPD 1994, with inequalities in some fields being narrowed and quality improved; whilst on the other hand, much effort still needs to be made to bridge the remaining gaps and to address the crucial issues as outlined below in this case study.

4.1. The Remaining Gaps

Although the State has taken a range of actions on some fronts, the laws and policies have been generally slow therefore unable to respond to the rights and needs of people's SRHR, especially those beyond reproductive age. For example, according to family planning law and policy, married women who are eligible for family planning can enjoy four free family planning technical services, including free removal of IUD, but the needs of women beyond childbearing age are neglected, such as comprehensive sexuality education for adolescents and young people, sexual and reproductive health services for elderly women, etc. There is also lack of clarity in policy on whether it is family planning technical service (meaning free of charge), or it is a general medical treatment, which should be covered by out-of-pocket expenses. According to a research by Professor Sun Xiaoming, the cost for removal of IUD ranges from 100 to 3000 yuan (about 15 to 430 US dollars). The research concludes that whether women beyond childbearing age can have access to this service or not would actually depend on "who pays the bill."

Laws and policies sometimes have biases built into them that advantage some groups while disadvantaging others. For instance, most policies do not contain any explicit reference to the rights of adolescents and youth. Article 21 of the new Population and Family Planning Law provides that married couples of reproductive ages who practice family planning shall receive, free of charge, the basic items of technical services specified by the State. Access to these basic items of technical services remain a privilege that has not yet been extended to adolescents and unmarried youth. In addition, older women were almost entirely missing from the SRHR related policy debate and consideration.

Progress in increasing access to the services that could make a difference to people's reproductive health is patchy and uneven. Some services, such as antenatal care and hospital delivery are more likely to be put in place than others, such as youth friendly services or eliminating sexual violence. Up to now, many facets of quality services are lacking. At the local level, the family planning programs have long been dominated by a narrow perspective that prioritises regulating rather than service delivery. Gender has not sufficiently been taken into consideration in policies and programs related to reproductive health including HIV/AIDS. Inter-sectoral coordination among implementing agencies is weak. In terms of improving EQA, much work needs to be done to respond to the long neglected and increasingly complex reproductive health challenges facing marginalised groups such as migrant women and adolescents.

The new two-child policy which was officially launched in January 2016 does not go far enough in terms of SRHR and gender equality. Rather than giving women and individuals the reproductive rights aligned with principle of ICPD, the amendment of Law on Population and Family Planning retains the article on punishment of couples for having more than two children. As long as the quotas and system of surveillance remain, women still could not fully enjoy their reproductive rights and bodily integrity. Furthermore, the policy does not integrate the gender perspective in a comprehensive manner. For example, there are special incentives and subsidies for families and households with only daughters. However, how effective this kind of policy would be in changing the attitude and behaviour of families in regard to son preference remains in doubt due to the lack of empirical evidence.

The obvious implication of this policy is labelling these families as weak and vulnerable and separating them from society, which may result in further exacerbating the gender-based bias, stigma and discrimination and reinforce the discriminatory son preference culture and patriarchal ideology. The original motivation for the adjustment of the family planning policy was not for advancing SRHR. Its rationale is to address the striking, imperative issues of demographic shift and disappearing population dividend, especially low fertility rates and aging. The new policy introduces tremendous new challenges in SRHR and gender equality, such as high-risk pregnancies and delivery, exclusion and discrimination against women in the job market, as well as the backlash discourse on gender and women's role. The implementation of the new family planning policy and its consequences for women, the health system and society yet need to be reviewed comprehensively to make it truly work for SRHR and gender equality.

Complicating the scenario is the lack of proper oversight and measurement of the quality and outcomes of reproductive health services. One of the striking findings of the case study is the paucity of statistics and data on key issues that affect SRHR. The available data and evidence are too patchy and incomplete. Proper indicators and improved data collection systems at different levels would be needed for monitoring progress and ensuring accountability.

4.2. Recommendations

In light of the above findings, the following policy recommendations related to equality, quality and accountability should be considered in the process of implementing national policies, such as the Outline of Healthy China 2030 Plan, National Population Development Plan (2016-2030), the Program for the Development of Chinese Women (2011-2020) and achieving SDGs.

Firstly, equality and equity should be at the forefront of updated national health and development policy and strategies. Some social groups who are economically or socially disadvantaged face multiple threats to their reproductive health. Further, policy improvements are thus needed in order to achieve universal access to reproductive health, especially for hard-to-reach, vulnerable populations, including those living in remote rural areas, migrants and young people. For instance, high-quality and integrated sexual and reproductive health services, including modern contraceptives, should be expanded from married couples of reproductive ages to the whole population, regardless of age or marriage status. The vulnerable people who are at risk of HIV/AIDS and other sexually transmitted infections should have access to prevention services including male and female condoms.

Secondly, applying a life-cycle approach and making health systems work for all people, especially for the vulnerable people and disadvantaged groups, is required. SRHR should be addressed through the integrated provision of an array of sexual and reproductive health-care services, including family planning, maternal health, testing and treatment for HIV/AIDS and other sexually transmitted infections, and services for victims of violence. For instance, the prevention of HIV/AIDS and STIs should be integrated to sexual and reproductive health services. It is essential to build capacity among service providers for integrated delivery of maternal health, family planning and HIV/AIDS services. Under the new two-child policy, family planning reform needs to shift focus from regulating and administrative management to supplying high-quality reproductive health services.

Thirdly, in order to deal with the unfinished business in SRHR, more collaboration across multiple sectors is needed to develop accountability mechanisms. The government should seriously implement the related laws and policies, optimise the supervision mechanism and improve the supervision system. It is thus essential to establish long-term mechanisms to enhance law enforcement, strengthen reproductive health services supervision, improve capacity to collect and use age- and sex-disaggregated data on service utilisation, and to evaluate the quality of care. This also requires commitment and investment in collection, analysis, and utilisation of data on women and men beyond reproductive age and regardless of their marital status.

Fourthly, health systems need reorienting so that they are better geared to meet the special needs of some marginalised people – in terms of accessibility, comprehensiveness and

responsiveness. Migrants, people with disabilities, people living with HIV/AIDS, elderly people and other marginalised groups should be given priority in this effort. Comprehensive sexual education could be a potential entry point for a broader package of interventions that take into consideration young people's overall health needs. Financial barriers and discriminatory attitudes that hinder young people's access to contraceptive and abortion services and other SRHR services must be removed. The involvement and full participation of young people and their organisations are essential.

Fifthly, inter-sectoral collaboration is required to identify and promote actions outside the health sector. For instance, the sheer size of China's young and migrant population, combined with their tremendous challenges, requires a comprehensive, multi-sectoral response. It is of concern that during the process of merging health and family planning sectors at local levels, family planning services and reproductive health services are neglected and marginalised due to the lack of coordination and consolidation and shift of managers and service personnel. To strengthen the capacity of health service providers and medical personnel and improve the quality, services should be prioritized in this process.

Finally, policy intervention and service provision require a gender sensitive and rights-based approach that harnesses the energy and contribution of civil society. It is essential to raise awareness on gender equality in the policy making process and in society to encourage men to share equal responsibility in unpaid care work and for contraception and family planning.

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INDIA

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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.

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 purposed 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.

Accountability: integrating EQA into the SDG framework

The India Index, while aligned with India's data availability, will require expansion or additional efforts in order to capture progress towards SRHR in general, and specifically through an EQA lens. At the service level, formal grievance and redress mechanisms are critical to ensure accountability and a forum to address quality concerns. At the policy level, implementation of service guidelines along with greater emphasis on quality have become an important area of discussion, and eventually, investment. We propose three actions to improve monitoring and accountability for SRHR within the SDG framework.

Firstly, the development of a civil society monitoring report to track equality and quality of SRH services within India, using disaggregated data and compilation of evidence on quality. Such a tool can include a broad set of SRH indicators related to, for example, contraceptive mix, gynaecological morbidity and access to treatment. State-level analysis will be key to influencing policy in India, as well as comparing trends and achievements across states. A network of researchers, activists and implementers focused on SRHR, building on existing civil society initiatives may provide the consolidated evidence required to influence policy and, most importantly, its implementation at the level of service provision.

Secondly, improve the dissemination of information to empower women and men to choose appropriate and quality services. At present, there is limited and/or ineffective coverage of information and health education on SRH in general. While community-based channels such as ASHA workers provide some education, wide potential exists to improve information through use of mass media, community media, school education and digital technology.

Thirdly, continue to advocate for SRHR within existing health care movements in India, particularly the growing momentum for universal health coverage and primary health care. As investment continues to build towards ensuring equal and accessible health care through flagship programs such as Ayushman Bharat, it is critical that service provision, targets and monitoring frameworks reflect a nuanced understanding of SRHR beyond maternal health. Improved use of available evidence, at both the national and state level, will be an important start to integrate equality, quality and accountability into both provision and monitoring.

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INDONESIA

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Sexual and Reproductive Health Services in Indonesia: An Analysis of Equality, Quality and Accountability

1. Introduction

It has been nearly 25 years since the United Nations International Conference on Population and Development (ICPD) with its Programme of Action (PoA) that was agreed by consensus in Cairo in 1994. ICPD set key goals to be achieved by 2015, including reduction of infant, child and maternal mortality; provision of universal access to education, particularly for girls; and provision of universal access to a full range of reproductive health services, including family planning (UNFPA, 1994). Following the ICPD in 1994, there have been advances in various aspects of sexual and reproductive health services in Indonesia.

In the four years after Cairo, Indonesia went through significant political changes. The fall of the New Order in 1998 (ending Suharto's 30-year regime) brought a dramatic transformation to Indonesian society. Two years later, in 2000, Indonesia implemented a decentralisation policy and the law on local government was enacted to establish financial balance between central and local governments. Decentralization added more complexity to the institutional arrangements of program deliveries and brought about a dramatic change in the administration arrangement in districts, whereby authority for planning and development was transferred to district government. Decentralisation to district level gives significant authority to district administrations in program funding and implementation, while at the same time districts have limited capacity and experience in managing programs.

The fall of the New Order in 1998 also witnessed an increase in the influence of conservative Islamic values in the community (Rinaldo 2008). A growing trend to root ideas for change in religious discourse and making Islam a more central aspect of life in Indonesia was observed. This in many ways posed new challenges to sensitive issues such as promotion of a sexual and reproductive health program. The rise of conservatism was accompanied by the emergence of symbols representing Islamic piety, appearing in the form of increasing use of veiling among Muslim women and the practice of polygamy that usually involves Siri marriage. This form of informal marriage is not usually registered, which increases vulnerability of both women and children in this situation. A rise of conservative forces has also led to a call for "strengthening of family values" to make the country more "civilized". One of these groups has requested a judicial review to outlaw any consensual sexual relationship outside marriage, including same-sex relationships. To what extent conservative groups influence decisions on the number of children and, therefore, family planning is currently not documented.

The two main Sexual and Reproductive Health and Rights (SRHR) programs implemented by the government in Indonesia are family planning and maternal health. The maternal health program was introduced during the pre-independence period (early 1940s) as a key community health program, at a time in Indonesia when high maternal deaths were identified as a pressing community health problem. After independence in 1945, maternal and child health got special

attention, with the establishment of centres for Mother-and-Child Welfare (Balai Kesejahteraan Ibu dan Anak, BKIA) at district level from 1952. These centres were then merged with polyclinics at community health centres and became the health centres (Puskesmas), the precursors of the primary health care system in Indonesia (Cholil, Iskandar & Sciortino, 1998). In successive decades there was a rapid expansion of health care facilities that significantly increased access to care.

The family planning program was introduced later, with some reservation at first (Hull, 2007). In the late 1950s a group of doctors established Perkumpulan Keluarga Berencana Indonesia/PKBI (Indonesian affiliation of the International Planned Parenthood Federation/IPPF). The family planning program was later promoted mainly as a response to internal and external concerns of rapid population growth, especially in major cities (Hull, 2006). The National Institute for Family Planning (Lembaga Keluarga Berencana Nasional/LKBN) was established in 1968 and then transformed into the National Family Planning Coordinating Board (Badan Koordinasi Keluarga Berencana Nasional/BKKBN) in 1970. The family planning program has since expanded, increasing contraceptive use from 0 to more than 60 per cent within four decades. The program is internationally renowned for rapidly expanding access to and use of modern contraceptives, and BKKBN got credit for much of this success.

A major recent advance in provision of health services in Indonesia is the enactment of the National Health Insurance Scheme (Jaminan Kesehatan Nasional/JKN⁶) since 2014. The JKN aims to achieve universal health coverage for all by the end of 2019. At the end of the first-year implementation of JKN, 133.4 million people were covered. By mid-2019, 222 million people were covered by JKN, equal to 84.1 per cent of the population. With JKN, the cost for health services, including SRHR such as family planning services, antenatal care, delivery, post-partum and treatment of sexually transmitted diseases, can be obtained free of charge or at a minimal cost. In the other words, implementation of JKN offers a great opportunity to address the continuing problem of high maternal mortality as it removes the user fee. Financial constraints are dominant factors causing maternal deaths in Indonesia (D'ambruso, Byass, & Qomariyah, 2010).

This case study aims to describe the progress in achieving ICPD PoA goals in Indonesia. It describes the law and policy context of SRHR development in Indonesia and progress to date, emphasising the two main components of SRHR, maternal health and family planning programs. Data and information were gathered from the latest survey reports, focused group discussions and interviews with key informants. The case study applies a framework of quality, equality and accountability to assess laws, policies and programs towards respecting, protecting and fulfilling the human rights of the most disadvantaged women (Sen, 2013).

2. Laws and Policies on Maternal Health and Family Planning

We argue in this and the next section of the case study that, regardless of a number of new laws that were enacted in Indonesia bringing new perspectives to maternal and family planning

⁶ JKN: Jaminan Kesehatan nasional (Public Health Insurance) is a national-based insurance that covers all communities and is applied nation-wide.

programs, there are various barriers and challenges affecting equality, quality and accountability of the programs.

The first law that explicitly concerned maternal health is the Health Law introduced in 1992. The law focuses on family health and refers to a period before, during and after pregnancy and other periods outside pregnancy and delivery. The law is also the first regulation on abortion in Indonesia, although the word abortion itself is not used in this law, indicating continuing sensitivity towards the issue. “A certain medical procedure” is used to replace the word ‘abortion’. While the law was expected to provide better protection to reproductive rights, according to women’s rights activists inconsistency within its articles and their differing explanations led to more controversy rather than clarifying debates (Djohan, Indrawasih, Adenan, Yudomustopo & Tan, 1993; Hull, Sarsanto & Widyantoro, 1993), particularly on statements related to abortion.

Parallel to the amendment process of the Health Law, an amendment of the Population Law was also on-going in the Parliament. Both laws have articles on Family Planning. During the process there was an effort to pull all family planning articles into the Health Law. Towards the end of the amendment process, however, family planning articles were stated in both laws. The old Law on Population and Family Development stated only that family planning services were for married couples. This excludes unmarried adolescents and young people from government family planning programs.⁷

After a long amendment process that covered two legislative cycles, the two important laws related to SRHR were passed. The Health Law and Population Law were both enacted in October 2009. The Health Law uses the terminology of Reproductive Health for the first time and has nine articles on the topic, including provision of abortion for medical indications of effects on women’s health, and congenital defects. While the Population Law brings up family planning as a means of population control, there is no significant change in the new population law regarding the family planning program’s beneficiaries, and unmarried people are still excluded. Five years after enactment of the Health Law, a Government Regulation on Reproductive Health was enacted in 2014 followed by a ministerial decree on training and implementation of abortion services when medically indicated and rape cases in 2016. The process of development of the ministerial decree was heavily influenced by the interests of various stakeholders. However, implementation of the law is far below expectations.

The Health Law and the Government Regulation state that abortion should be conducted with pre- and post-abortion counselling by competent and authorised counsellors. The law further states that abortion should be performed before the pregnancy is six weeks from the first day of the last menstrual period and provided by health personnel with the skills and authority as certified by the Minister. The Government Regulation in 2014 and Ministerial Decree in 2016 following the Health Law give further explanation on how abortion should be provided and highlight the dominant role of doctors in abortion. The requirement that pre- and post-abortion

⁷ This limits access for the unmarried (particularly young adolescents) to the services. People in general and health personnel tend to be judgmental about young persons trying to get contraceptives, although it is true that condoms are widely available at many stores.

counselling should be provided by competent and authorized counsellors does not, however, define who these counsellors should be.

The law on Local Government governs the structure of district institutions and offices. The law states that health is a compulsory basic service that should be provided at the district level. This means each district should have a dedicated office for health. Meanwhile family planning is categorised as a compulsory function but is not related to basic services. Consequently, the law strengthens the importance of health institutions at the district level, but it does not have implications for the maternal health program that has been running in a decentralised manner for more than a decade. However, the arrangement of the family planning program, which tends to be centralised, is affected. The new law requires that a family planning district office should be established, but since family planning is not categorised as a basic service, the office is often combined with other programs. The most common structure for family planning found in the districts is where they are jointly run with child protection and women's empowerment programs. Consequently, the amount of resources allocated for the family planning program tends to be limited, as it is spread thinly among the other divisions in the office.

3. Equality, Quality & Accountability for Maternal Health and Family

Planning

Indonesia is among the countries with considerable experience in expanding the family planning program as signified by the improvement of contraceptive use from non-existent in the early 1970s to 63 per cent in 2017; and a reduction in the average number of children per woman during the same period, from 5.6 in the early 1970s to 2.4. Since the early 1990s, Indonesia has invested tremendously in creating a cadre of midwives to increase coverage of delivery by skilled birth attendants (SBAs). A significant reduction in infant and child mortality has occurred since then. However, the maternal death problem in Indonesia shows a paradox. Despite a high proportion of deliveries by SBAs (91 per cent - IDHS 2017), the MMR continues to be high (305 per 100,000 live births according to the most recent estimates).

Disparities within geographic and socio-economic areas remain challenging. Comprehensive sexual and reproductive health services and unsafe abortion practices remain neglected. Most of the program has also experienced a slowing down and reduction in intensity, particularly after the decentralization system was introduced in 2000. Nevertheless, the maternal and child health program continues to gain more attention following the declaration of the Millennium Development Goals (MDGs) in 2000 with a projected target of achieving an 'MMR of 102 per 100,000 by 2015 (Bappenas, 2010). A health-focused strategy called 'Making Pregnancy Safer' was launched in 2000 (Departemen Kesehatan R.I., 2001) followed by various maternal health-focused projects supported by different donors.

3.1. Maternal Health Program

In the late 1980s, maternal health problems started to become a major concern and were highlighted in the international discourse as the global burden of maternal mortality became more evident. The world gained an understanding of high maternal deaths due to pregnancy and delivery-related causes. Indonesia participated in several conferences from the late 1980s

into the 1990s that influenced program direction in the country. The Safe Motherhood Conference in Nairobi in 1987 led to the Safe Motherhood Initiatives of 1988.

The International Conference on Population and Development (ICPD) in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995 also influenced program direction as well. After the conferences, the ICPD Program of Action (PoA) commitment was translated into action mainly to promote maternal health and family planning programs in the country. The data of the Indonesian Demographic and Health Survey that reported a high level of maternal mortality ratio, estimated at 390 maternal deaths per 100,000 live births during the period 1990-1994 and 334 per 100,000 live births during the period 1993-1997, provided a ground for the focus (Statistics Indonesia, National Family Planning Coordination Board, Ministry of Health Indonesia, & ORC Macro, 2003) on the Mother Friendly Movement in 1998.

One of the most important programs during this period focused on the deployment of midwives at village level in 1990s by the Ministry of Health, aimed at bringing maternal health closer to women in the community. This effort was initiated in a move to ensure equity in accessing the family planning program.

The maternal health program relies heavily on the community health centre (Pusat Kesehatan Masyarakat/Puskesmas), the cornerstone of the public health system in Indonesia, and remains one of the program priorities of Puskesmas since its inception. Early initiatives in maternal and child health focused on the provision of care. However, a significant change was Puskesmas substituting the extensive network of TBAs, Traditional Birth Attendants (dukun) with a 'Community Midwives' program. With a local area monitoring concept, a Puskesmas is responsible for various programs provided in its catchment area, usually at the sub-district level. The service of Puskesmas can be provided either at the Puskesmas facilities, by Puskesmas pembantu (sub-health centres), at a village maternity post by the midwives in the community, or through an outreach program.

The community midwives' program deployed midwives at village level as part of the effort to reduce maternal deaths. This was a strategic step to reduce the domination of traditional birth attendants close to the community in providing delivery assistance at the village level (Widayatun, Hull, Raharto, & Setiawan, 1999). The community midwives programme was dramatically successful in increasing the coverage of maternal health care, particularly antenatal care and skilled birth attendance. The coverage of home delivery was around 80 percent in the early 1990s. It dramatically decreased in the following years with implementation of the community midwives programme and introduction of delivery at the Puskesmas facilities.

However, after running for several years, there were various concerns about the quality of the midwives training program. The short period crash course for midwives without follow-up training did not provide adequate knowledge and skills to perform standardised care. Several studies have indicated that many village and Puskesmas-based midwives, who are intended to provide delivery care, do not qualify as Skilled Birth Attendants as per the international definition. Thus, increasing the number of midwives at the community level did not impact on

the incidence of maternal deaths, which remains high in Indonesia. This contrasts to the situation in other countries where skilled birth attendance is a good predictor of quality of maternal health care and contributes to reduction of the maternal mortality ratio. However, deployment of the community midwives reduced home deliveries. By 2017, the percentage of home deliveries was 20.5 as people shifted to deliveries at facilities (BKKBN, BPS, Kemenkes R.I. & USAID, 2018).

Table 1 shows the progress of selected maternal and family planning indicators. It shows that during the past decades, the level of maternal deaths remains high at 200-300 per 100,000 live births. Similarly, family planning programs have stagnated, with modern contraceptive use remaining steady at around 57 per cent in the past two decades. Indonesia was not successful in achieving the MDG 5 on reduction of maternal deaths or 5b to achieve universal access to reproductive health.

Table 1: Selected Indicators on MMR and Family Planning

Selected Indicators	1994	1997	2002	2007	2012	2017
Total Fertility Rate (TFR)	2.9	2.8	2.6	2.6	2.6	2.4
Maternal Mortality Ratio (MMR): maternal deaths per 100,000 live births	390	334	307	228	359	305*
Delivery by skilled health personnel (%)	36.5	43.2	66.3	79.4	83.1	90.9
Delivery in health facilities (%)	17.5	20.7	40.1	46.6	63.2	79.0
Contraceptive use (all methods)	52.1	54.7	56.7	57.4	57.9	57.2
Unmet needs for contraception	15.3	13.6	13.2	13.1	11.4	10.6

Source: Indonesian Demographic and Health Survey 1994, 1997, 2002, 2007, 2012

* Based on Intercensal Population Survey since IDHS 2017 does not calculate MMR

Measurement of maternal mortality could not be easily done in Indonesia where vital statistics and civil registration are not fully in place. Therefore, the MMR measurement relies mostly on

survey data where calculations of MMR are often based on a very small number of cases and the validity of the MMR levels were often questioned and debated. After 2000, the government of Indonesia has recommended using census or intercensal data for calculating MMR and special questions to investigate maternal deaths were added to the Census questionnaire. The Census of 2010 reported a maternal mortality ratio of 278 per 100,000 livebirths, although this number was not widely quoted. Table 2 shows the results of a Census 2010 follow up study on causes of maternal mortality and level of maternal mortality by region.

Table 2: Level and Causes of Maternal Deaths by Region in Indonesia in 2010

Selected indicators	Region					Indonesia
	Sumatera	Java-Bali	Kalimantan	Sulawesi	Eastern Indonesia	
Maternal mortality ratio	262	227	340	459	434	278
Postpartum hemorrhage	16.4	16.8	28.1	26.3	29.8	20.3
Hypertensive disorders	33.3	33.1	34.9	32.6	25.8	32.4
Placenta previa, premature separation of placenta and Antepartum hemorrhage	4.4	2.7	4.3	2.3	3.6	3.3
Other maternal care related to fetus and amniotic cavity and possible delivery problems	3.0	1.7	0.0	0.8	0.1	1.6
Pregnancy with abortive outcome	3.7	4.2	2.7	5.6	4.2	4.1
Obstructed labor	0.5	1.1	0.0	0.6	1.0	0.8
Others	38.7	40.3	30.0	31.8	35.6	37.4

Source: Review of Maternal Mortality in 5 Regions in Indonesia, 2012

As indicated above, there is regional variation. The main causes of maternal death are dominated by direct obstetric reasons with hypertensive disorders as the leading causes, followed by postpartum haemorrhage. This indicates that there has been a shift in the main cause of maternal deaths in the past decades from haemorrhage to hypertensive disorders. The indirect causes of maternal deaths as indicated in the other cases are varied among the regions.

In Java and Bali, the main indirect causes are cardiovascular and cardiomyopathy diseases, whereas in Eastern Indonesia the indirect causes are non-puerperal infections such as malaria and tuberculosis.

The maternal death phenomenon in Indonesia continues to be a paradox where, despite a high proportion of deliveries by SBAs (91% in IDHS 2017), the MMR continues to be high according to the most recent estimates. The disparities in MMR occur across regions, sub-groups and socio-demographic variables. Various problems underlying under-performance in the health system may be the reason behind this situation. Many projects were implemented vertically, focusing on a disease or health problems-specific approach that often overlooked the systemic health factors that determine quality of care. Hospitals are the main facilities where maternal complications are treated. However, the median scores of compliance to standards for complications treatments are below 80 per cent as shown in Table 3.

Table 3: Compliance to Standards for Management of Maternal Complications

Components for management of complications*	Hospital		
	Median	Min - Max	
Postpartum hemorrhage	74.2	25.0	- 93.0
Preeclampsia/eclampsia	69.5	21.8	- 92.7
Postpartum infection	71.7	13.0	- 93.5
Early pregnancy hemorrhage (before 20 weeks gestation)	66.4	17.2	- 91.4
Preterm labor	67.0	22.7	- 93.2
Prolonged labor	68.6	13.6	- 90.0

Source: Ministry of Health, Pelayanan Kesehatan Ibu di 100 Fasilitas Kesehatan dan 10 Provinsi di Indonesia tahun 2012.

*Scores on compliance in percentage shows in median with minimum and maximum scores

There are also disparities between coverage of maternal health indicators. Figure 1 shows the disparity of selected maternal health indicators, antenatal care by health providers, percentage delivery in health facilities and percentage delivery by Caesarean section by wealth quintile. In general, all indicators show increasing trends from 2007 to 2012 and 2017. Antenatal care has the highest coverage among the three indicators by wealth quintile, while delivery in health facilities and delivery by Caesarean Section show an increasing trend, but also wider gaps among the wealth quintile categories.

The Jaminan Kesehatan Nasional (JKN/national health insurance) is supposed to eliminate financial barriers and was expected to cover all citizens by 2019. The three indicators reflect the conditions in which barriers remain for poor people accessing care, despite introduction of JKN. One critique regarding JKN is that the scheme seems to benefit people who are living in urban areas or areas where health facilities' availability is high. In remote areas or areas with

geographic challenges where health facilities are dispersed over a wide geographical area, the scheme cannot be used by the poor who cannot afford the cost of transport to access health services.

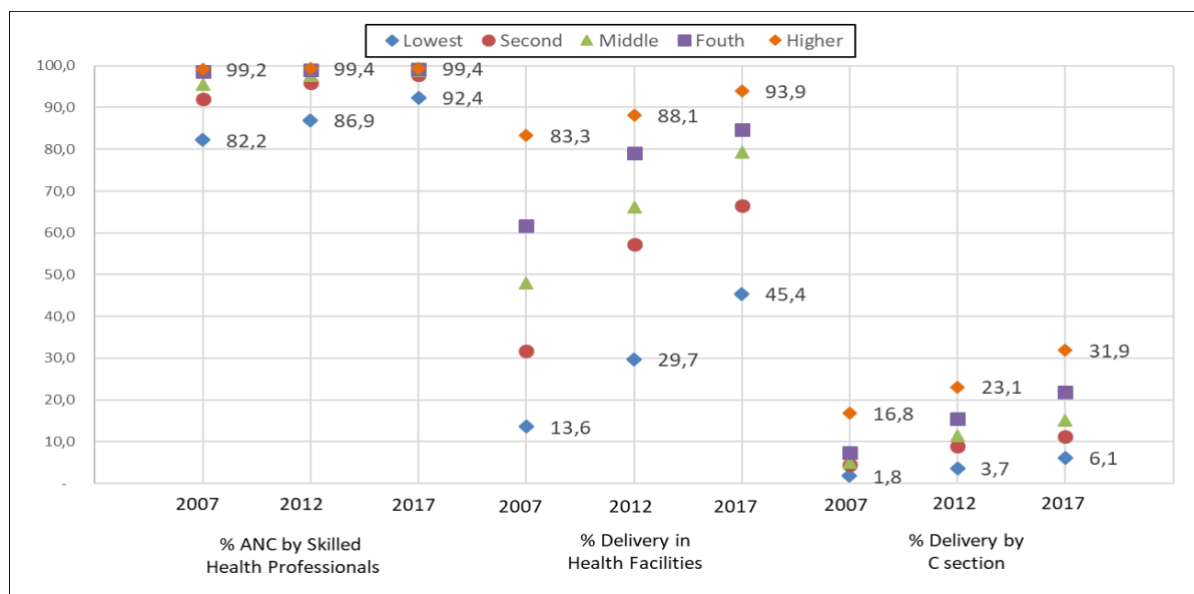


Figure 1. Distribution of selected maternal health indicators by wealth quintile
Source: Indonesian Demographic and Health Survey 2007,2012 and 2017.

3.2. Family Planning Program

Despite the globally acknowledged success in expanding family planning, the program has its adverse side. The family planning program was initiated in a highly centralised system with a strong program aiming to recruit many women as family planning acceptors. The word “acceptors” for family planning users that was used for a lengthy period very much represents the nature of the program, in which women were considered passive recipients. Problems such as poor service quality and limited choice of contraceptives, with emphasis on those that are provider-dependent and long-acting such as IUDs and implants, were reported. Clients are rarely provided with full and accurate information about contraceptives, especially side effects, nor have they been encouraged to switch contraceptive methods if they do not like the one they have. Often, services have been delivered in ways that do not protect privacy and may also impose inappropriate social pressure to accept a particular method. Implementation and service delivery of the program does not seem to provide women with the means of regulating their fertility autonomously through access to freely chosen contraceptives. Therefore, the program’s principles and practices do not focus on safeguarding women’s reproductive health (Smyth, 1991).

Deployment of midwives at village level is expected to increase family planning uptake, as there are more providers for contraceptives. However, the program only slightly affects overall prevalence of contraceptive use although it did affect method choice. In early 1990s when the community midwives’ program was introduced, the level of contraceptive use reached 50 per cent. The family planning agency was very strong then, with huge campaigns promoting ‘two children is enough’ and long-term contraceptives being encouraged through mobile clinics. In

the decades afterward contraceptive use only slightly increased. The presence of midwives at community level was associated with increased use of injectable contraceptives and decreased use of IUDs and implants. The women’s “switching behaviour” indicates that the program succeeded in providing additional outlets for promoting the use of injectable contraceptives and data shows an increased uptake of short-term contraceptive methods. With deployment of midwives at village level, there are more providers for contraceptives. However, the midwives gain benefit from promoting injectables (with a regular need to retake the injectable, thus requiring payment of a fee for services) rather than the long-term methods.

The contraceptive prevalence rate for all contraceptive methods was 63.6 per cent in 2017, with an increase in the use of traditional methods but a slight decrease in modern contraceptive methods in the previous five years, from 57.9 per cent to 57.2 per cent. Overall, most provinces experienced a decrease in the use of modern contraception. The disparity in the use of modern contraception between provinces is also considerable. The highest use is found in Central Kalimantan at 69.4 per cent while the lowest is in Papua at 35.9 per cent (Figure 2).

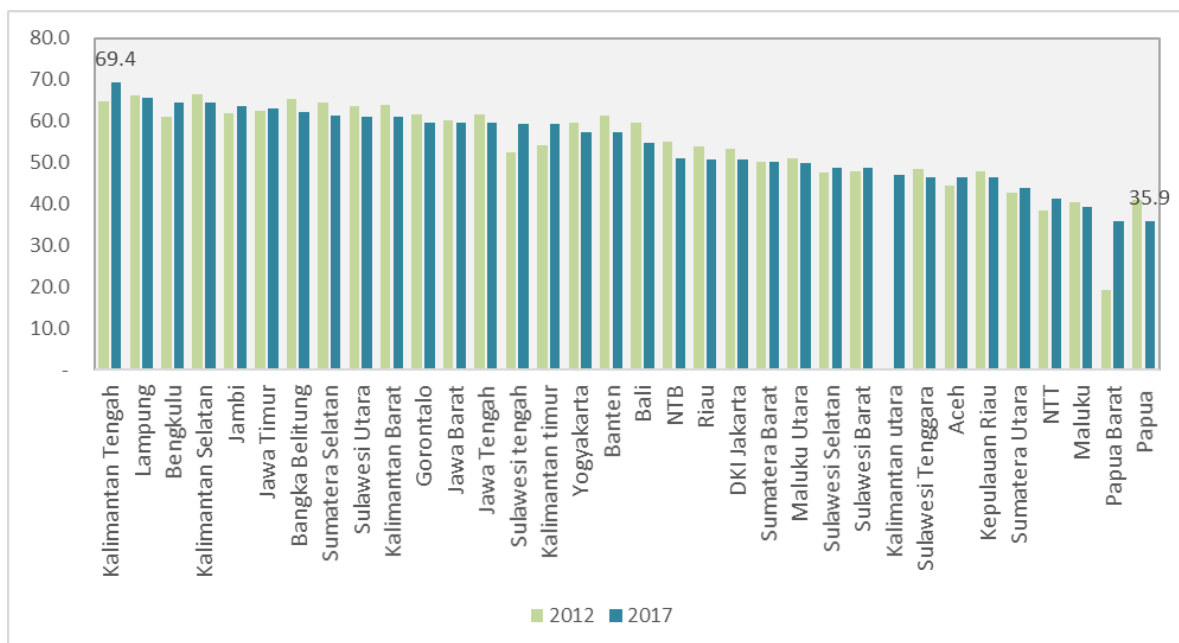


Figure 2: Modern Contraceptive Use by Province, 2012 and 2017
Source: Indonesia Demographic and Health Survey 2012 and 2017

As discussed above, contraceptive use in Indonesia has experienced a major shift over the decades, from long-term contraceptive methods to the short-term as can be seen in Figure 3. The proportion of women using injectables has dramatically increased, while the use of the long-term contraception method of IUDs has declined. The different methods of contraception have different effectiveness. The use of short-term methods has a higher risk of family planning failures. It is also important to note that the shift in contraceptive use has been argued to be health-provider-driven as described above.

Male contraception (male sterilisation and condom) use in Indonesia is very low, less than 3 per cent. This level is lower than the use of traditional methods. In the past three decades, male

sterilisation is stable at 0.2 per cent, while male condom use has increased from 1.3 per cent (1997) to 2.5 per cent (2017). The family planning program in Indonesia has always been focused on women since its introduction, and education programs for men are extremely limited. In many communities, men play important roles in decision making, including those related to reproductive health such as using contraceptive. Therefore, serious efforts are needed to educate men on reproductive health issues.

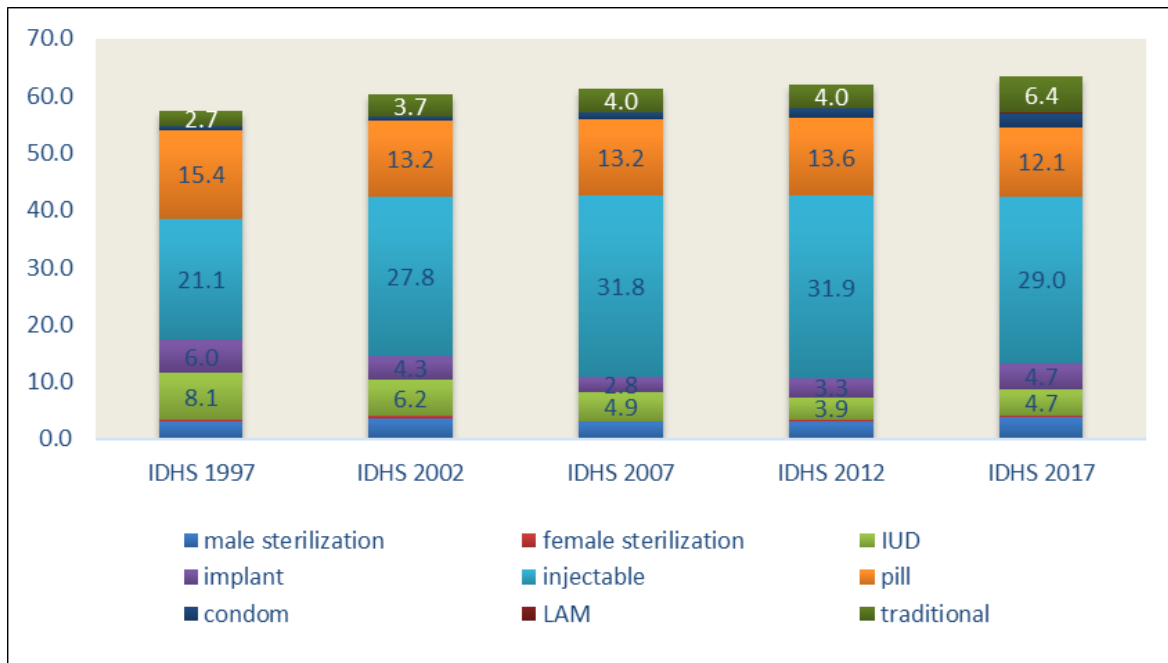


Figure 3: Chart on the shift of contraceptive methods mix
Source: Indonesian Demographic and Health Survey 1994, 1997, 2002, 2007, 2012

Figure 3 shows the shift of contraceptive methods in the past three decades. In the 1990s, the use of long-term methods (IUD, implant and sterilisation) was the highest. There were reported issues of violating rights, for instance women being forced to use methods such as IUDs. Gradually there was a switch to short term methods. But other issues of rights emerged since women were not well informed and educated about the choices of contraceptive methods. Even older women who did not want any more children still used short term injectables. So, there are issues of rights and inadequate information on the choices in both situations that raise concerns on equality, quality and accountability.

Contraceptive use does not vary significantly by socio-economic group. Unmet needs for contraceptives remain high over the years with past decades showing unmet needs of around 11 per cent. The unmet needs are particularly high among the lowest wealth quintile. The discontinuation rate is also high at 29 per cent, with the most common reason for discontinuation being fear of side effects (BKKBN, BPS, Kemenkes R.I., et al., 2018). High discontinuation rates reflect the problem in quality that affects the sustainability of the program, and lack of attention to educating and counselling on reproductive health. Despite understanding the need to respect women’s reproductive rights, the program still applies a conventional approach to achieve demographic targets.

Table 3: Contraceptive Use and Unmet Needs by Wealth Quintile

Wealth Quintile	% Modern Contraceptive Use		% Unmet Needs	
	2012	2017	2012	2017
Lowest	53.0	56.3	13.5	11.0
Second	61.4	61.4	10.2	10.2
Middle	60.2	59.6	10.3	10.0
Fourth	58.7	56.3	10.9	10.2
Higher	55.4	52.3	12.3	11.7
Total	57.9	57.2	11,4	10.6

Source: Indonesian Demographic and Health Survey 2012 and 2017.

Efforts to revitalise the family planning program have been discussed since the realisation that the program achievements were stagnating. There were efforts to strengthen the program to return to the era of family planning's glory days, but they have not been successful in bringing the program up to the expected level. The lack of attention and low priority given to the family planning program, particularly at the sub-national level, has become one of the major challenges.

In July 2012, the Summit for Family Planning was held in London where the FP2020 program was launched. It called for voluntary family planning services to reach an additional 120 million women and girls in the world's poorest countries by 2020. An Indonesian delegation attended the summit led by the Coordinating Minister of People's Welfare. Following the commitment at the summit, BKKBN, UNFPA, USAID and Canada established a FP2020 country committee forum that held regular meetings. It is expected that the forum could be used to share experiences and lessons learned as well as discussing and addressing various challenges in family planning programs. A rights-based family planning strategy that aims to provide a guide for all family planning stakeholders has been developed through the FP2020 committee. Several other programs were supported and implemented by the main stakeholders of family planning in Indonesia following the FP2020 commitments. In January 2016, BKKBN hosted the fourth International Conference on Family Planning that gathered over 3100 participants from more than 80 countries. The conference was officially opened by the President of the Republic of Indonesia. The commitment to revitalise the family planning program currently seems to be reaching a new high and the FP2020 initiative provides a platform and momentum to promote the program.

However there seems to be limited visible improvement in the family planning program on the ground. Unclear roles and responsibilities between the Ministry of Health that is responsible for family planning service providers and BKKBN as the main institution responsible for family planning demand continue to exist. The Law on Local Government added more

complexity by requiring local government to establish a family planning office, while a similar body as an extension of BKKBN already existed, particularly at the provincial level. This creates potential conflict due to unclear roles and responsibilities of these institutions. BKKBN also promoted the focus on generating demand for long-term methods. This resulted in several district family offices having a tendency to reintroduce the old methods of generating demand with incentives such as providing gifts or money to new long-term methods users, rather than ensuring clients received family planning education. Rights issues have not been fully addressed and the issue of unwanted pregnancy, especially among the unmarried, has never really been addressed.

The continuation of early and child marriages means that roughly 10 per cent of girls have their first child between 15 and 19 years of age. The government has made efforts to expand reproductive and sex education through a school program. This, however, is strongly rejected by some segments of the population who consider the teaching of reproductive and sexual health to be vulgar, inappropriate and not in line with culture, and claim that it will promote “free sex”. While the government maintains its firm position to exclude unmarried adolescents from the family planning program, it turns a blind eye to non-government organisations that deal with these issues. This situation has been seen by non-government organisations as an opportunity to provide SRHR services to unmarried individuals. However, since this is not formally approved, there is no legal protection for NGOs that provide such services.

The JKN scheme provides a great opportunity for improving access and equality in health care including SRHR care for all Indonesian citizens. Nevertheless, there are various problems with its implementation, mostly because the benefit packages of the scheme related to family planning have not yet been fully understood by both the clients and the providers. Another challenge is related to the role of midwives within the JKN system of health providers. Private midwives have been the main providers of the maternal health and family planning program in Indonesia. With JKN policy, midwives cannot be registered as an ‘individual provider’ but have to be a part of the primary health care network. One of the implications of this policy is related to the reimbursement process that should be done through the primary health care clinics where the midwives are registered. Anecdotal data from first few years of JKN implementation indicates a reluctance by midwives to use the JKN scheme for matters that are relatively inexpensive, such as pills, because of the long and complicated reimbursement process. This resulted in low interest on both provider and patient sides in using JKN, thus the cost is covered by ‘out of pocket’ payments. The long reimbursement process that takes months has also created difficulties for midwives who usually have limited financial capacities. Covering operational costs for months in advance can disrupt their ability to provide maternal or family planning services.

Another important challenge with regard to utilisation of JKN is related to disparities in health facility availability across Indonesia. Their availability in the eastern part is much lower compared to Java. Access to the JKN scheme should be accompanied by an improvement in availability of health facilities to ensure access to health services for every individual.

4. Conclusions and Recommendations

More than two decades after ICPD, the SRHR concept with rights and choices has never been fully adopted in Indonesia. The programmes are delivered in a vertical manner, mostly targeted towards married women of reproductive age, with an emphasis on pregnant and delivering mothers and consequently leaving the unmarried people and adolescents excluded from the programme. Despite higher commitment on the issues during the MDGs era, Indonesia has failed to achieve the goals. These indicate that the underlying problems i.e. poor health sector performance and disparities among sub-populations, have not been fully addressed and remain among the main challenges. These are also important aspects to address in achieving SDGs targets, particularly Goal 3.1. to reduce the MMR to 70 per 100,000 live births, Goal 3.7 to ensure universal access to reproductive health and Goal 5.6 on ensuring universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Program of Action of the ICPD and the Beijing Platform for Action.

There is persistent inequity in access to family planning and reproductive health information and services, particularly among the poor and marginalised, as well as to those who live in underdeveloped areas, border regions and islands. Expansion of services and access to contraceptive methods based on need at all levels of services remains challenging, requiring serious attention as well efforts to improve the quality of family planning and reproductive health services.

Although there are new initiatives in Indonesia that provide a platform for revitalising the family planning program, on the ground the implementation of the family planning program remains the same, with lack of coordination between the BKKBN and the MOH. The commitment is considered a BKKBN initiative rather than a comprehensive effort to revitalise the family planning program in Indonesia. The revitalisation's focus on increasing new acceptors, with emphasis on long-term contraceptive methods, has tended to reintroduce the old methods of demand generation that potentially also neglects the client's rights. There seems to be a lack of serious attention to ensure a rights perspective in the programme, and therefore there is a diminishing of accountability.

The new health law has provided better regulation for maternal health service provision before, during and after pregnancy. The health law is the first that used reproductive health terminology and has provisions on abortion for medical indications, severe congenital defects and rape cases. Despite the positive development on efforts in providing access to abortion services as per the law, the process leading to the ministerial decree was heavily influenced by the interests of various parties. There are also tendencies to rely on provision of care treatment to be only that provided by physicians. The ministerial decree has only one paragraph mentioning counselling.

Other SRHR issues such as violence against women and the girl child and adolescent reproductive health remain neglected. In the era of rising conservatism, it is likely that there will be more stigmatisation, violation and discrimination on these issues. Government and the civil society movements should take serious action to address the problem.

There is also an urgent need for male participation in SRHR programs. Men play an important role in decision making in the family. The fact that the low rate of use of male contraception of less than 3 per cent up until now shows that the program heavily targets women. Male participation is also important in promoting maternal health status to avoid the unnecessary disaster of maternal deaths. It is unfortunate that Indonesia still has a very high maternal mortality ratio regardless of the increasing availability of health facilities and personnel, and advancement of technology. The rigid values and norms as well as increasing conservatism have also contributed to failure in respecting women's rights.

Actions have been taken to improve and ensure the monitoring of SDGs and additional national SRHR indicators. For instance, at the national level, the transition process from MDGs to SDGs is quite inclusive, with various government institutions and non-government organisations involved in developing the national SDG indicators. Learning from previous MDG experience and the slow adaptation of MDGs in the field, the government should be able to shortcut the process to promote faster adaptation and monitoring of the indicators.

However, despite various efforts and resources put into the maternal health program, Indonesia has had limited success in achieving its goals in maternal health. Furthermore, as discussed in the case study, the focus on maternal health has consequently resulted in a lack of attention and resources for other components of reproductive health. Even more troubling is the fact that decentralisation occurs at the juncture of various social changes in society, including rising conservatism. This phenomenon has significantly influenced the political process in the government system and has had harmful effects on the SRHR discourse in the country.

The new health insurance program, JKN, is fundamentally changing the structure and incentives in the health system, including how health providers are paid, relationships between public and private sectors and a decentralisation of funding for health. However, there is a major risk that the national health insurance scheme will further exacerbate the already severe imbalance of health financing towards hospitals and curative services, which are concentrated in major cities, for reimbursement of treatment of chronic diseases. Membership in JKN is not always accompanied by knowledge on entitlements of benefit packages, which has led to low utilisation of the scheme, particularly among the poor or those who are living in remote areas where availability of health facilities is limited and costs of reaching facilities are higher. Implementation of Universal Health Coverage under the JKN scheme provides a great opportunity to address financial barriers on SRHR care, and for ensuring equality.

However, there are several challenges to be overcome including the lack of knowledge of both clients and personnel about the benefit packages of JKN, and unavailability of a specific coverage for contraceptives in post-delivery and post-abortion periods. Without specific coverage or a service fee for post-partum contraception, whether or not it is offered depends on the willingness of health providers to make it available. Other barriers that need to be removed include clarifying the role of midwives as the main providers of SRHR services in the JKN scheme and differential access to health facilities across various geographical settings in Indonesia, affecting equality and accountability of the health services.

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Sapna Desai is an epidemiologist and public health practitioner whose areas of interest are women's health and sexual and reproductive health and rights, implementation and evaluation of community-based programs and health systems research. She currently works with the Population Council in New Delhi, where she generates evidence on the implementation and effect of women's groups interventions, the epidemiology and utilisation of services for gynaecological morbidity and women's engagement with the health system. She holds a PhD in Epidemiology and Population Health from the London School of Hygiene and Tropical Medicine and a MS in International Health from the Harvard School of Public Health. Dr Desai previously spent several years working with the Self-Employed Women's Association, an organisation of women workers in the informal economy, where she implemented community-based health interventions and conducted research on primary health care and health insurance.

Yukun Hu is an associate professor at the Institute of Population Research at the Peking University, a Research Fellow of the Centre for Urban Development and Land Policy at the Peking University-Lincoln Institute, and an adjunct associate professor at Griffith University of Australia. She was a Fulbright Scholar at the Columbia University in the City of New York (2013-2014). Her main areas of interest include: Population, Environment and Development in Rural China; Reproductive Health of Women; Gender and Development, and Gerontological Social Work. Her recent publications include: *Gender and Ecological Civilization* (Social Sciences Academic Press, 2014); *Population, Health and Development: Global Perspectives and Local Experiences* (Social Sciences Academic Press, 2016); *From "Man Can Conquer Nature" to "Rebuild Beautiful Landscapes": Gender, Natural Resources Management and the Chinese State in an Inner Mongolia Village* (In English) (China Social Science Press, 2017). Her academic website is available at: <http://www.aisixiang.com/thinktank/huyukun.html>

Mridula Shankar is a doctoral student at the Johns Hopkins Bloomberg School of Public Health. Her current work focuses on investigating the community and individual-level factors that influence abortion care pathways and the measurement of quality of medication abortion provision through the informal health sector in Nigeria and India. Mridula has previously conducted research in the areas of maternal health and safety with the Gender and Health

Equity Project in Southern India, and on medication abortion accessibility in Australia. Her work is driven by a keen interest to identify the social and structural factors that create inequities in access to quality reproductive health services. She earned her Masters in Public Health from the University of California at Berkeley.

Ninuk Widiantoro is a psychologist. She is among the most respected women and health activists in Indonesia. She started her career as a Family Planning Counselor in one of the Indonesian Planned Parenthood Association's clinics and soon she became a Counseling Trainer, and wrote a counseling manual, guideline and book. In 1993, she became an independent consultant and trainer for Family Planning/Reproductive Health counseling, working in several countries such as Vietnam, Bangladesh, Iran, Azerbaijan, and Kazakhstan. In the year 2000, together with other activists in Indonesia, she began an initiative to amend the Health Law - 1992, which includes women and adolescents' reproductive health rights and services. She is one of the Founders of the Women's Health Foundation.

About the DAWN SRHR Team

Maria Graciela Cuervo shares the role of General Co-coordinator jointly with Gita Sen. She is a law graduate from the Pontificia Universidad Catolica Madre y Maestra (PUCMM) and has a Master's in Labour Policies and Globalisation from the Berlin School of Economics and Law. She is an alumna of the 4th DAWN Training Institute held in Siem Reap in 2011. Maria Graciela has worked on women's human rights, labour rights and education. She has been on the staff at CIPAF (2007-2011), one of the oldest feminists' organisations in the Dominican Republic, where she took part in research and advocacy on women's labour rights and sexual and reproductive rights. She was Head of International Relations at the Dominican Labour Ministry (2011-2012); and Programs and Advocacy Officer at the International Council for Adult Education Secretariat (2012-2017). Maria Graciela has been engaged in international advocacy processes in the United Nations system, including at UNESCO, ILO, CSW and the 2030 Sustainable Agenda. At local level she is a member of the Feminist Forum Magaly Pineda and a collaborator for CIMTRA (the Dominican Inter-Union Committee for Women Workers).

Vanita Nayak Mukherjee prior to re-joining DAWN, Vanita was a Program Officer at the Ford Foundation's New Delhi office (2006-2017), and a Senior Advisor (2017-2018). She was responsible for developing two portfolios at the Foundation – the Civil Society and Social Justice, and the Gender, Sexuality and Reproductive Justice through program development and grant-making towards building a strong field of work with policy and programmatic outcomes. Vanita started out as an activist in 1982, and has worked in several feminist groups, organisations and networks in various capacities contributing to advocacy, capacity building and action-research. She holds a Master's in Gender Studies from the Institute of Social Studies, Erasmus University, Holland and a Bachelor's degree in Biology from Kerala University, India.

Gita Sen is the General Co-coordinator of DAWN. She has over 35 years of experience working nationally and internationally as a researcher and advocate on gender equality and women's human rights. She holds a PhD in Economics from Stanford University, has been a professor of public policy at the Indian Institute of Management in Bangalore (IIMB), India, and is adjunct professor of global health and population at the Harvard School of Public Health. She is a co-founder of DAWN, and its General Coordinator since November 2014 and Co-coordinator since February 2017. Her combination of advocacy, practical experience, activism and analysis has resulted in a number of awards and honours, including the Volvo Environment Prize for her work on women, population and development, and honorary doctorates from the University of East Anglia, the Karolinska Institute (Stockholm), the Open University (UK), the University of Sussex, and the University of Edinburgh.

Cai Yiping co-leads DAWN's Sexual and Reproductive Health and Rights (SRHR) thematic analysis team together with Vanita Mukherjee. Yiping was an Associate Researcher at the Women's Studies Institute of China (2006 – 2008) and was a journalist for China Women's News (1995 - 2005), writing extensively on the issue of women's human rights. She participated in creating several vibrant women's NGOs in China after the Fourth World Conference on Women, held in Beijing in 1995. Her areas of focus include media and communications, gender-based violence, sexual and reproductive rights and health, and gender mainstreaming. Her current engagements cover the multiple processes in the national, regional and global levels on the post 2015 development agenda, ICPD beyond 2014, and Beijing+25 process. Cai holds a Master's Degree in History and LLM in International Human Rights Law from Peking University.