

Knowledge Brief

Health, Nutrition and Population Global Practice

INDIA: MATERNAL AND REPRODUCTIVE HEALTH AT A GLANCE

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KEY MESSAGES:

- India is the third largest economy and has the second largest population in the world. It achieved MDG1 on poverty reduction; however, gender inequality still persists.
- Maternal mortality rate is 190 deaths per 100,000 live births, representing a 65 percent decline from 1990.
- Fertility fell to 2.5, while contraceptive prevalence rate increased to nearly 55 percent. Seventy-four percent of women sought ANC from a qualified provider and 52 percent of births were attended by qualified providers.
- Wide gaps in CPR and access to skilled-birth attendance remain by geography and wealth quintile.
- India would focus on preventing unwanted pregnancies especially among adolescents; improving demand-side strategies; strengthening access and quality in public and private sectors; improving antenatal, intranatal, and postnatal care; strengthening M&E systems and reducing inequities; and improving nutrition.

Country Context

India includes 28 states and 7 union territories. It has the second largest population in the world (1.2 billion people) and is the third largest economy in the world in purchasing power parity. On average, real GDP expanded 7.9 percent annually between FY2003-04 and FY2012-13.^{1,2}

India achieved MDG 1 by halving the proportion of people earning less than \$1.25 a day. Nonetheless, one-third of the world's poor live there. Structural inequalities by gender, caste, and tribe persist in spite of accelerated growth and social mobility. India's large youth population could provide a demographic dividend through high growth and poverty reduction; 29 percent are younger than 15.^{1,2}

The country has progressed on most MDG targets, investing resources from growth into programs to deliver services to the poor. Access to primary education is largely universal: net primary school enrollment is 93 percent and the completion rate is 96 percent for boys and girls. Child survival rates are improving: U5MR and IMR were 56.3 and 43.8 per 1,000 live births in 2012, compared with 84.7 and 62.2 in 2002. However, malnutrition has declined little during the past decade.^{1,2}

Gender equality and women's empowerment are important for improving reproductive health. The ratio of females to males has slightly improved to 940 from 933 in 2001, with a wide variation from 818 in Chandigarh to 1,084 in Kerala (2011 census). The ratio of girls to boys in primary and secondary education is nearly equal.^{1,2} India ranks 132 of 148 countries in the Gender Inequality Index (2012).³

INDIA: MDG 5 STATUS**MDG 5A indicators**

Maternal mortality ratio (MMR; maternal deaths per 100,000 live births) – *UN estimate* **190**

Births attended by skilled health personnel (percent) **52.3**

MDG 5B indicators

Contraceptive prevalence rate, any method (percent) **54.8**

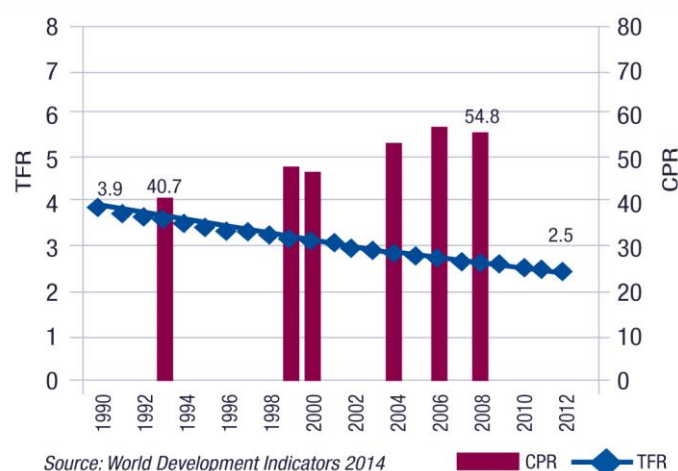
Adolescent fertility rate (births per 1,000 women ages 15–19) – *WDI* **32.8**

Antenatal care with health personnel (percent) **75.2**

Unmet need for family planning (percent) **12.8**

Source: 2014 WHO/UNICEF/UNFPA/World Bank MMR report, 2005–06 India DHS, 2014 World Development Indicators (WDI)

choice and are used by 48.5 percent of currently married women. Female sterilization (37.3 percent) and condoms (5.2 percent) are the most commonly used form of modern methods. Traditional methods are used by 7.8 percent of currently married women. But 12.8 percent of married women still have an unmet need for contraception.⁵

FIGURE 2: TRENDS IN CONTRACEPTIVE PREVALENCE RATE (CPR) AND TOTAL FERTILITY RATE (TFR)

Birth intervals of less than 24 months are considered too short: 27.7 percent of children are born within 24 months of the previous birth in India. The median number of months since the preceding birth is 31.1 months.⁵

The median age at first marriage among women age 20–49 is 17.2 years and the median age at first birth among the same cohort is 20 years. The share of women age 15–19 that have begun childbearing is 16 percent.⁵ The adolescent fertility rate is 32.8 births per 1,000 women age 15–19.¹

Pregnancy Outcomes

Complete and timely antenatal care (ANC) is a necessary component for positive pregnancy outcomes. As of 2006, 74.2 percent of women sought ANC from a qualified provider; 37 percent of women received the recommended four or more ANC visits; 59.5 percent of women had their blood pressure measured (a component in a package of ANC services).⁵

Skilled birth attendance (SBA) is critical reducing maternal deaths. SBA by a qualified provider increased from 34.2 percent in 1993 to 52.3 percent in 2008 (figure 3).¹ The majority of births are delivered at home with institutional delivery for 38.7 percent of all births (18 percent in public sector facilities, 0.4 percent in NGO/trust facilities and 20.2 percent in private sector facilities).⁵

MDG Target 5a: Reduce the MMR by three-quarters, between 1990 and 2015

India has made solid gains over the past two decades on maternal health. The MMR declined from 560 deaths per 100,000 live births in 1990 to 190 in 2013 (figure 1). According to the latest Interagency estimates, India is “making progress” toward achieving MDG5.i Maternal mortality declined 65 percent with an average annual decline of 4.5 percent between 1990 and 2013.⁴

FIGURE 1: MATERNAL MORTALITY RATIO 1990–2010 AND 2015 TARGET

Source: 2014 WHO/UNICEF/UNFPA/World Bank MMR report
 i “Making progress” is defined as a 2%–5.5% average annual decline between 1990 and 2013.

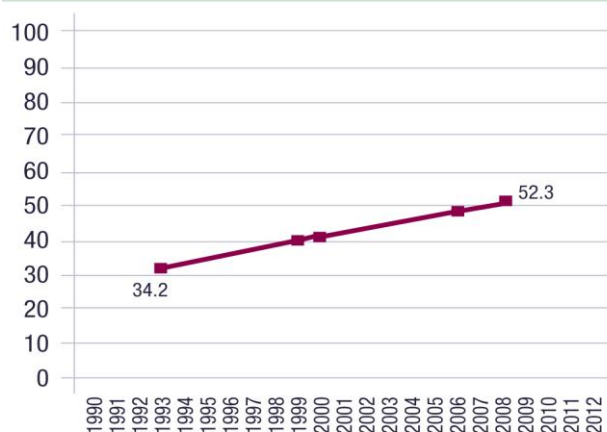
Fertility

Fertility has been declining in India. Between 1990 and 2012, the total fertility rate (TFR) declined from 3.9 to 2.5 (figure 2).¹

The contraceptive prevalence rate (CPR) has been increasing over the past 20 years.¹ The CPR (any method) increased from 40.7 percent in 1993 to 54.8 percent in 2008 (figure 2). Modern methods are the main

The main reason for not delivering in a facility is the belief that it is unnecessary (71.8 percent). Other reasons include: costs too much (26.2 percent), too far/no transport (11 percent), not customary (6.3 percent), and husband/family do not allow (5.9 percent).⁵

FIGURE 3: TRENDS IN SKILLED BIRTH ATTENDANCE



Source: World Development Indicators 2014

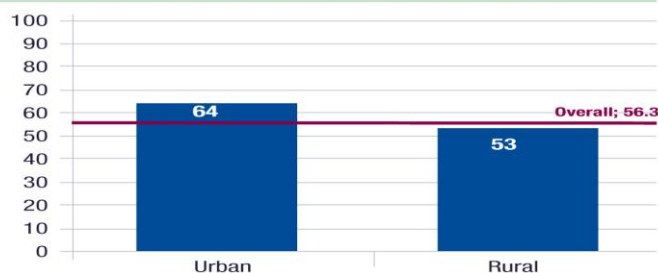
Postnatal care is another important component for maternal health, especially for managing post-delivery complications. It is recommended that postnatal care for mothers occur within the first two days of delivery. Of women, 37.3 percent sought this type of care from a qualified provider within the first two days of delivery.⁵

Equity in Access to Maternal Health Services

Inequity in access to maternal health services is a barrier in the progress toward achieving MDG 5. While contraceptive use and SBA has been increasing throughout the years, disparities remain.

The gap between the CPR in urban and rural areas is fairly small. The CPR in urban areas is 64 percent and 53 percent in rural areas (figure 4).⁵

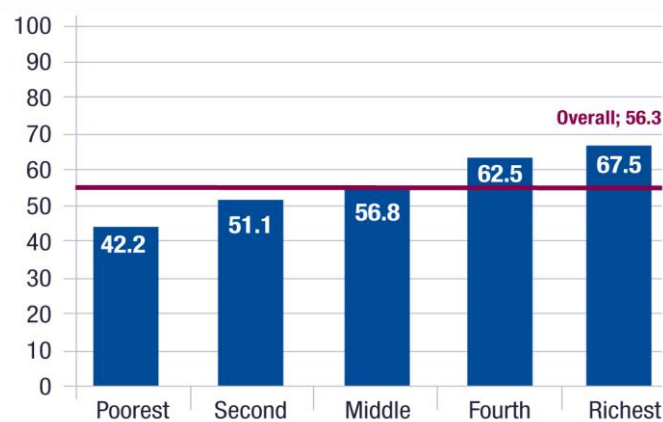
FIGURE 4: CPR (ANY METHOD) BY RESIDENCE



Source: 2005-06 India DHS

There is wider variation in wealth quintiles for the CPR. The CPR in the richest quintile is 67.5 percent but only 42.2 percent in the poorest quintile (figure 5).⁵

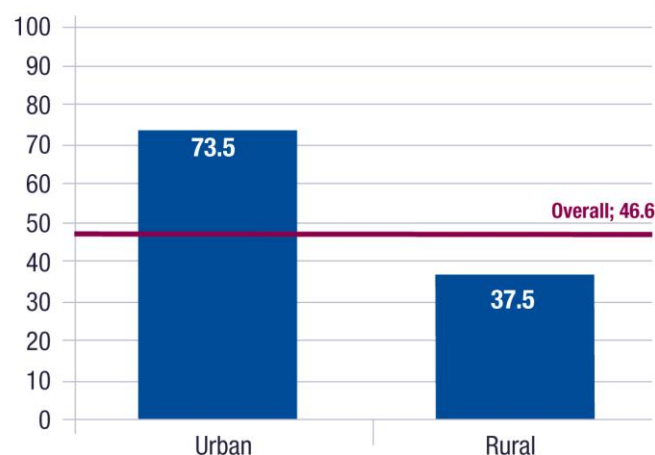
FIGURE 5: CPR (ANY METHOD) BY WEALTH QUINTILE



Source: 2005-06 India DHS

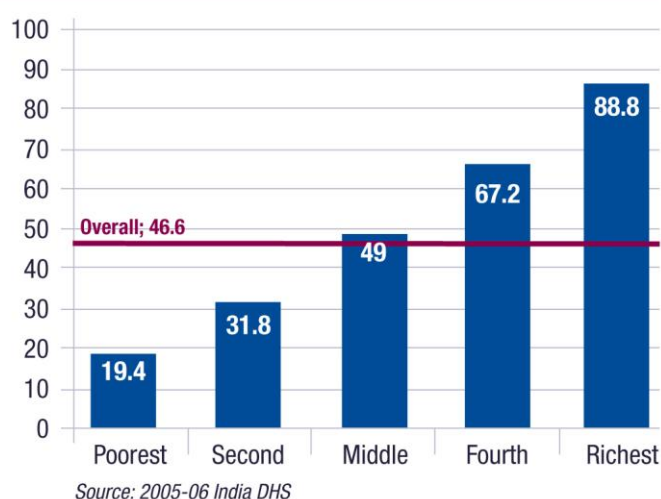
Disparities across residence and wealth quintiles are also found in SBA: More than two thirds (73.5 percent) of urban women are assisted during delivery by a qualified provider but only half that rate (37.5 percent) among rural women (figure 6).⁵

FIGURE 6: SKILLED BIRTH ATTENDANCE BY RESIDENCE



Source: 2005-06 India DHS

Considerable variations in SBA also exist among wealth quintiles. Women in the richest quintile are more likely than women in the poorest quintile to have SBA. Only 19.4 percent of women in the poorest quintile receive SBA but 88.8 percent in the richest (figure 7).⁵

FIGURE 7: SKILLED BIRTH ATTENDANCE BY WEALTH QUINTILE

One program that aims to improve institutional delivery and postnatal care among the poor is the Janani Suraksha Yojana (JSY) Safe Motherhood Program. JSY provides incentives on both the supply and demand sides and has been credited with increasing service utilization.

HIV/AIDS

As of 2012, there were about 2.4 million people living with HIV in India. The adult prevalence rate for HIV was 0.3 percent. Women's share of HIV infections is 39 percent. HIV infections are mainly transmitted through unprotected heterosexual intercourse and are largely driven by sex workers and their clients. India's response to HIV/AIDS is delivered through more than 1000 nongovernmental and community-based organizations.⁶

Key Strategies to Improve Maternal and Reproductive Health Outcomes

Preventing unwanted pregnancies with a focus on adolescents by providing safe abortion and FP services; doorstep delivery of FP products; delaying age at marriage; delaying first pregnancy; creating adolescent friendly clinics; expanding the basket of FP products; increasing the uptake of male contraception—considering the very low participation of men; continuing education of girls—perhaps through CCTs building on JSY; and providing post-partum counseling for FP.

Improve use of demand side strategies, including financing and behavior change communication.

Strengthening the supply side response (access and quality) using public and private sector by increasing the number of delivery points; mapping of public and private facilities to provide comprehensive EmONC services within 30 minutes; promoting institutional deliveries; and ensuring an effective referral system.

Improving antenatal, intranatal, and postnatal care by identifying complications and high-risk pregnancies early, for example, anemia, line listing, screening for NCDs; ensuring timely referral and treatment of high-risk pregnancies; ensuring post-natal visits; and building capacity for service providers to ensure quality of care.

Strengthening M&E systems, including focus on reducing inequities, by registering all pregnant women early; and conducting maternal death audits.

Improving nutritional status by addressing maternal nutrition, for example, IFA supplementation; and post-partum counseling for child nutrition.

References:

- 1 World Bank. World Development Indicators 2014: Accessed 19 May 2014
- 2 India:Country Program Snapshot. March 2014, the World Bank
- 3 UNDP. 2013 Human Development Report Gender Inequality Index
- 4 WHO, UNICEF, UNFPA and The World Bank. 2014. Trends in Maternal Mortality: 1990 to 2013: World Health Organization
- 5 International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS.
- 6 World Bank. 2012. "HIV/AIDS in India". <http://www.worldbank.org/en/news/feature/2012/07/10/hiv-aids-india>

The Health, Nutrition and Population Knowledge Briefs of the World Bank are quick reference on the essentials of specific HNP-related topics summarizing new findings and information. These may highlight an issue and key interventions proven to be effective in improving health, or disseminate new findings and lessons learned from the regions.

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