Monitoring the Progress of Sustainable Development Goals in Assam

Situation Analysis for Selected Targets from SDG3 and SDG5

Compiled by
SAHAJ and IDeA

Supported by
Equal Measures 2030

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List of abbreviations

AIDS	- Acquired Immunodeficiency Syndrome
ANC	- Antenatal Care
ANM	- Auxiliary Nurse Midwife
ASHA	- Accredited Social Health Activist
BMI	- Body Mass Index
CH	- CommonHealth
CHC	- Community Health Centre
CSO	- Civil Society Organization
DLHS	- District level Health Survey
EM 2030	- Equal Measures 2030
GSDP	- Gross State Domestic Product
HIV	- Human Immunodeficiency Virus
HMIS	- Health Monitoring Information System
ICPD	- International Conference on Population and Development
IHHL	- Individual Household Latrine
IPC	- Indian Penal Code
IPD	- In-patient Department
JSA	- Jan Swasthya Abhiyan
MDGs	- Millennium Development Goals
MMR	- Maternal Mortality Ratio
MoSPI	- Ministry of Statistics and Programme Implementation
NACO	- National AIDS Control Organization
NAMHHR	- National Alliance for Maternal Health and Human Rights
NCRB	- National Crime Records Bureau
NFHS	- National Family Health Survey
NHSRC	- National Health Systems Resource Centre
NHM	- National Health Mission
NSS	- National Sample Survey
NSSO	- National Sample Survey Organization
OPD	- Out Patient Department
PHC	- Primary Health Centre
PNC	- Postnatal Care
PP	- Post Partum
PWDVA	- Protection of Women against Domestic Violence Act
RTI	- Reproductive Tract Infections
SDGs	- Sustainable Development Goals
SLL	- Special Local Laws
SRH	- Sexual and Reproductive Health
SRHR	- Sexual and Reproductive Health Rights
STI	- Sexually Transmitted infections
UN	- United Nations
VAW	- Violence against Women

Preface

Government of India and national and international organizations in the development sector have conducted several studies and produced reports for mapping the demographic, economic, social profile and the status of health and education related services. In this report, SAHAJ has attempted to compile data from several such sources for the state of Assam with the objective of monitoring the development of sustainable development goals in the state.

SAHAJ has undertaken work related to 'Data Driven Dialogues for Gender Equality and SDGs', in select states of India and at the national level wherein we are trying to strengthen the efforts towards achieving the selected targets from two SDGs that revolve around women and girls- SDG 3 (Ensure healthy lives and promote well-being for all at all ages) and SDG 5 (Achieve gender equality and empower all women and girls). The SDG agenda of 'leave no one behind' reflects fair, equitable and inclusive development process. Thus, the analysis in this report builds on gender analysis and social equality.

Along with the data from secondary sources, SRH and gender equality related experiences of some grassroots organizations working in different parts of Assam are also compiled in order to depict women's health and gender equality situation for the state. We hope that this report will feed into the local efforts of dialogue with the state officials

SAHAJ and IDeA Team,

October 2018

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- Mr. Martin Rabha, Diya Foundation
- Ms. Nandita Deka, HRLN, Assam
- Ms. Nilanju Dutta, NEN
- Mr. Ronald Basumatary, IDeA

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Executive Summary

In 2015, the international agenda moved from MDGs to more detailed and comprehensive Sustainable Development Goals (SDGs) with 17 goals and 169 targets revolving around economic, social and environmental dimensions of development. India is one of the 193 signatories that accepted the SDGs agenda. In India, *NITI Aayog* is assigned the role to coordinate the SDGs whereas, MoSPI is involved in enlisting indicators for all the targets. Simultaneously, several civil society organizations and coalitions (such as, WNTA) are working for monitoring India's progress towards achieving SDGs. SAHAJ has undertaken work related to 'Data Driven Dialogues for Gender Equality and SDGs', wherein we are trying to strengthen the state and national level efforts towards achieving the selected targets from two SDGs that evolve around women and girls. In a diverse country like India, the processes required to achieve the targets in different contexts and with different communities will vary. The SDG agenda of 'leave no one behind' reflects fair, equitable and inclusive development processes to include all the marginalized communities in the process of development. Through this project SAHAJ is trying to contribute towards realizing this vision for the selected targets by acknowledging the presence of different social and economic groups that are on different levels in terms of development indicators and suggesting strategies for taking all of them towards achieving the set goals.

This report is based on state and national level data from secondary sources including Census of India 2011 and NFHS-4, 2015-16. Considering the differences in sampling methods and different sample sizes, this report does not compare the data but presents data from varied sources with gender and health equality perspective. First section of this report deals with socio demographic profile of Assam, health profile of the population of the state and a section on budgets for the state. A section on sexual and reproductive health includes indicators related to ANC, delivery care and PNC services received by women in Assam and indicators for women's access to information about SRH and the SRH services. Section on gender equality contains data on violence against women, women's empowerment related indicators and indicators on harmful practices against women and girls.

Assam, the largest state among the North Eastern States, is given special status by National Development Council (NDC) because of which the state gets preferential treatment in getting central funds assistance. Assam is peculiar from SDGs point of view because it is the first Indian state to have a Vision document- 'Assam Vision- 2030' and to have established a state SDG cell. The state government is relying on strategic and action plans and inter departmental synergies. Assam has also formulated SDG oriented outcome budget for 2017-18. With all this on one hand, according to the Health Index developed by NITI Aayog, Assam is among the least performing states in the country.

Overall sex ratio for the state is better than the national average. The sex ratio for children born in the last 5 years stands at 794 (NFHS-4, 2015-16) in urban Assam which raises alarm bells and points to the violation and poor implementation of the PCPNDT Act. In education, the average annual dropout rate at secondary level for girls is 27.8 percent which is very high compared to the national average of 14.5 (NUEPA, 2013-14). Even with implementation of many schemes by the government of Assam for education of girl children, the dropout rate at secondary level still remains high.

According to NFHS-4 (2015-16), access to piped water into their dwelling, yard or plot is reported by only 9 percent of the households in Assam. Nearly 84 percent households of the state reported access to improved drinking water source. The use of solid fuel for cooking has been seen to be associated with several adverse health outcomes among women. Three fourth of the households in Assam surveyed for NFHS-4 use solid fuel for cooking.

The shortfall in health infrastructure in the state has resulted in extra pressure on existing infrastructure and human power. Statistics also point to a deficit in specialists in DHs, SDHs and CHCs (Rural health statistics, 2014-15 and CAG report, 2017). The reporting of ailments by both men and women is significantly lower for Assam as compared to the national average (NSSO, 2014). Nearly half of the women in the state (both rural and urban areas) are anemic. At the same time, there is a newer phenomenon of rise in overweight/obese women especially in urban areas (NFHS-4, 2015-16).

Poor budgetary expenditure is one of the contributing factors for Assam's poor health and nutrition indicators. Low levels of allocation and spending on children's and women's health like immunization, ANC, JSSK, RBSK, RKSK etc. are reflected in the very high mortality rates and low levels of utilization of these services.

Even what is allocated is underspent on many of the programs and over the years there are huge fluctuations in allocations and expenditures.

Maternal mortality ratio (MMR) for Assam (237 maternal deaths per 100000 live births) is the highest among all the states and is nearly double the national average of 130 (SRS 2014-16). Apart from differences in the percentage of women from rural and urban areas receiving ANC and PNC services from a skilled provider, there are large differences in percentage of institutional deliveries among groups of women based on level of education and religion. Only 35.6 percent pregnant women in urban areas and 60 percent of pregnant women in rural areas received any benefits under ICDS (NFHS-4, 2015-16).

Sexual and reproductive health (SRH) is still a taboo topic. As per NFHS- 4, of all women who were already mothers or pregnant at the time of the survey, 13.6 percent were aged 15 to 19 years. Early pregnancy and no discussion on SRH could lead to more health issues for girls. There are cultural taboos around menstruation which compromise hygiene and adoption of safe methods of protection during menstrual periods. The use of modern contraceptives is also low (37 percent).

In NFHS-4 (2015-16), one fourth of interviewed women reported to have ever faced either physical or sexual violence. Only 7 percent of those women have sought help (NFHS-4, 2015-16). Even with such low reporting, Assam ranks 2nd among the states and UTs on the rate of total cognizable crimes against women (NCRB, 2015). Workforce participation rate for women in the state is low with less than 15 percent urban females and 24 percent of rural females participating in the workforce (Census of India, 2011).

Mean age at marriage for girls in the state is 21.5 years. For those girls who have been married before the legal age of 18 years, the mean age at marriage is 16.3 years (Census of India, 2011). Although, some percentage of women from each social category have begun child bearing at an early age, women residing in rural areas, women with no schooling and women belonging to Muslim community have more chances to do so compared to women belonging to other religions (NFHS-4, 2015-16). A more stringent implementation of The Prohibition of Child Marriage Act, 2006 could provide better outcomes.

Some of the vulnerable groups for health and gender issues identified during the process are- 1. Tea garden workers, 2. People residing in the extensive flood plains, 3. People from Char areas (sandbars occupied by people), 4. People from conflict affected areas and 5. Women with disabilities. These communities face peculiar issues because of their specific conditions and many times are deprived of basic health and other social services. High MMR among the tea estate workers is indicative of poor reach to reproductive health services. Geographical inaccessibility and overall underdevelopment in Char areas result in poor health outcomes. Women as well as men in these areas do not have access to clinics or health services. Though Boat Clinics are a proud innovation of the Assam health services, they have many deficiencies and are unable to provide adequate health care to Char inhabitants in the hour of need (CAG report, 2017). Women and girls from flood affected areas face several reproductive health related issues while staying in the camps.

In order to have accelerated progress towards achieving the SDGs in Assam, following steps need to be taken:

- Improvement in the infrastructure and staff availability in the health facilities across the state, most importantly at primary and secondary levels.
- Periodic mandatory trainings of the health staff at all levels with a mandatory component of respectful maternity care.
- Concentrated efforts towards reducing maternal mortality incidence, with a special focus on women from vulnerable groups.
- Community based programmes on information and counselling for addressing women's and girls' reproductive and sexual health needs in a comprehensive manner.
- Regular dialogues with civil society organisations to see who is being 'left behind' and joint planning for improvements.
- Community participation through monitoring processes at the local level involving PRI members.
- Strict implementation of laws such as PWDVA, Child marriage Act, MTP Act and PCPNDT Act for improving the status of girls and women in the state.
- Sensitization of health service providers and persons from law enforcing agencies towards the survivors of violence through thorough recurrent trainings.
- Special provisions for the vulnerable groups so that they are integrated in the development process.
- Understanding that equality breeds inequity and hence the services, the communication and the strategies must be specially developed to empower those who were hitherto left behind.

Introduction

Background- MDGs to SDGs

Millennium Development Goals (MDGs), set in the year 2000 by the countries and development partners across the globe, attempted to combine economic, social and environmental spheres of development in achieving eight broad, time bound (till the year 2015) and measurable goals. These goals shaped the international discourse and debate on development in intervening years. Three of these eight goals focused directly on health. Other goals on nutrition, water and sanitation were indirectly related to health. A strong critique of women's health advocates across the globe was that the MDGs had gone back on the commitments made at the ICPD, Cairo (1994) and the Beijing UN Conference for Women (1995). From the previous comprehensive Sexual and Reproductive Health (SRH) approach, the MDGs reduced women's health to maternal health.

With reference to India, under the goal of improving maternal health and achieving universal access to reproductive health (MDG-5), the Government decided to monitor only two targets, viz., the maternal mortality ratio (MMR) and proportion of births attended by skilled birth attendants. Other targets such as contraceptive prevalence rate, adolescent birth rate, ANC and unmet need for family planning were dropped from the agenda.

Building upon the MDGs and extending those for better results, the new international agenda, in 2015, moved to more detailed and comprehensive Sustainable Development Goals (SDGs). This agenda consists of 17 goals and 169 targets, revolving around three dimensions of development - economic, social and environmental development. The SDGs are universal, integrated and interrelated in nature. A fundamental assumption of the SDGs is that health is both a major contributor and a beneficiary of sustainable development policies. Women's health component that previously focused on one indicator, i.e. maternal mortality, is broadened to include other indicators related to SRH. Also, elimination of violence against women and practices such as child marriage and female genital mutilation are included in the new agenda.

India is one of the 193 signatories that accepted the Sustainable Development Goals (SDGs) agenda in the year 2015. SDGs are monitored at three different levels- Global, Regional and National. The global indicators are modified by each country as per their own setting. In India, *NITI Aayog* is assigned the role to coordinate the SDGs. At the same time, Ministry of Statistics and Programme Implementation (MoSPI) is involved in evolving indicators for each of the targets under the 17 SDGs. Simultaneously, several civil society organizations and coalitions (such as, WNTA) are working for monitoring India's progress towards achieving SDGs.

With all these efforts by the Government of India as well as the civil society organizations (CSOs), there is progress in popularizing SDGs at the national and sub national (state) levels. *NITI Aayog* has come up with first draft of the set of indicators which would be monitored by India. CSOs have submitted their recommendations on this draft of indicators that need to be monitored. Several states have set up their own SDG Cells. The National Health Policy 2017 also addresses the goals and targets of SDGs.

At this juncture there is a need to reiterate that development affects different social groups differently. India is a diverse country - geographically, economically, culturally and socially - and the processes required to achieve these targets in different contexts, will vary. With the SDGs in place and the Government of India's commitment to align its policies with the SDG targets, this is the right time for CSOs to effectively communicate their concerns to ensure that recommendations are incorporated in the official plans.

SAHAJ has undertaken work related to 'Data Driven Dialogues for Gender Equality and SDGs', wherein we are trying to strengthen the state and national level efforts towards achieving the selected targets from two SDGs that revolve around women and girls. The SDG agenda of 'leave no one behind' reflects fair, equitable and inclusive development process. Gender equality is one of the important aspects of equitable and inclusive development.

About SAHAJ

SAHAJ (Society for Health Alternatives), registered in 1984, envisions a society with social justice, peace and equal opportunities for all. We focus on children, adolescents and women in two specific sectors- health and education. We strive to make a practical difference in lives of marginalized women and girls through direct action in the communities and through action research and policy advocacy work. We believe in developing programs based on the expressed needs of the communities that we work with, i.e. being led by the people. For greater impact, we collaborate with likeminded organizations to form coalitions at state and national level. The present report is a part of SAHAJ's project 'Data driven dialogues for gender equality and SDGs' ongoing since October 2017.

About the project

This project is supported by Equal Measures[1] (EM) 2030 . Through this project, SAHAJ has set out to generate a policy dialogue for more encompassing, holistic and realistic state and national level plans for better implementation towards achieving the selected targets for girls and women. This work is going on in six selected states, viz., Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Punjab and at the national level.

One of the important objectives of the project is to increase political will and dialogue amongst key stakeholders, particularly government, on the importance of data and evidence-based implementation around selected SDG targets. Keeping in mind the necessity for reviewing the systems that are in place and the current status around the indicators, a desk review was carried out first. This was followed by preparation of state specific reports monitoring the progress of selected Targets from-

- 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)

The selected targets are -

- Reducing maternal mortality (3.1)
- Ensuring universal access to sexual and reproductive health (SRH) services (3.7)
- Eliminating Violence against Women (VAW) in public and private spheres (5.2)
- Eliminating harmful practices such as child, early and forced marriage and female genital mutilation (5.3)
- Ensuring universal access to SRH rights (5.6)

Activities of the project

- **Preparing State reports**

State Reports are based on review of secondary data. They analyze data pertaining to current situation of states for selected indicators depicting social, demographic and economic conditions of the states, general health of the population, SRH, SRHR and gender related indicators. They also capture state level progress towards achieving selected targets as per SDG Plans.

- **State level meetings**

State specific policy dialogue is based on analysis from the state reports. In three states out of the six- Assam, Gujarat and Madhya Pradesh, state level meetings were conducted with CSOs active in the state to share the findings of the report, add the local level opportunities and challenges and plan for the policy dialogue with concerned state officials. In Punjab and Bihar, the state reports were shared and discussed with the local CSOs. Further processes will be done along with their state specific agenda.

- **Training of State partners in using data / evidence for advocacy on SDGs**

SAHAJ conducted a three day training on data driven advocacy for the state level teams in July 2018. 25 participants from five states, viz., Assam, Bihar, Gujarat, Madhya Pradesh and Punjab, participated in this training.

- **State level policy dialogue**

State level policy dialogues were conducted in three states- Assam, Punjab and Madhya Pradesh. This involved representatives of CSOs working in the states and concerned government officials. Media campaign was also a part of the state level dialogue.

1 Equal Measures (EM) 2030 (http://www.equalmeasures2030.org/) is a partnership convened by nine civil society and private sector organizations with a Secretariat hosted in the UK. EM 2030 is facilitating the access to easy-to-use data and evidence to guide efforts to reach the SDGs for women's movements' and rights advocates in six countries - Colombia, India, Indonesia, Kenya, El Salvador and Senegal. SAHAJ is their partner for India.

- **National level policy dialogue**

A national level meeting will be held with the representatives of different coalitions such as *Jan Swasthya Abhiyaan (JSA), Wada Na Todo abhiyaan (WNTA)* as well as government officials, members from *NITI Aayog* and Ministry of Statistics and Programme Implementation (MoSPI) on importance of gender data for successful implementation of the SDGs.

- **Launch of EM 2030 SDG Gender Index**

As part of this project, SAHAJ would host the national event to launch EM2030 SDG Gender Index. The findings of this index would be presented in a form of a country briefing paper. This launch event will also be an important opportunity to publicize about this index through media.

This report is an attempt to compile the state level information pertaining to selected Sustainable Development Goals (SDGs) - SDG 3 (Ensure healthy lives and promote well-being for all at all ages) and SDG 5 (Achieve gender equality and empower all women and girls) for Assam with the objective of monitoring the development of sustainable development goals in the state.

Conceptual Framework

We attempt to describe below the conceptual framework that informs our decisions of what we have decided to include in our analysis, and how we have tried to analyse the available data

Gender and Social Equity Analysis

The UN General Assembly recognizes sex as an important stratifier in its resolution (68/261) that states, 'the indicators should be disaggregated … by income, sex, age, race, ethnicity, migratory status, disability and geographic location…' The data tables generated through census or surveys show us the differences and inequalities across male and female categories (i.e. sex), whereas gender analysis looks at the reasons behind these differences or inequalities. Though, the term gender is sometimes used loosely and interchangeably with sex, it has a deeper meaning and understanding. While sex is used to represent the biological differences, gender, which is a sociological construct, gives us a context. Thus, while sex disaggregation will merely tell us whether or not there is a difference, a gender analysis will tell us whether gender-power inequalities cause or contribute to the observed difference. Further, there are gender dimensions even to 'women only' indicators such as maternal mortality ratio.

We also recognize the existence of other gender categories, such as transgender, bisexual or intersex. But, as data on these groups are not available – they are by and large invisible. Thus our report is limited to analysis of Male / Female differences.

Gender analysis is a social analysis that distinguishes the resources, activities, potentials and constraints of women relative to men in a specific socio-economic group and context (March C. et al., 1999). A gender analysis looks at both-the Practical Gender Needs (PGNs) of women and men, and the Strategic Gender Interests (SGIs), which arise from their social status. PGNs are the physical things that women or men need in order to carry out their socially prescribed tasks and meet the daily requirements of life. Women's SGIs result from women's subordinate position and men's privilege and working on these is expected to result in transformation of gender power relations.

Also all women (and all men) are not one homogenous category. A Social Equity lens also factors in the differences based on caste, class, location, ability, sexuality and such like, into the analysis. Thus we will be particularly looking at the data related to social groups like groups based on religion, women's education levels and residence (Rural-Urban).

Health Equity perspective

The World Health Organization (WHO) defines equity as the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are based on geographical or other means of stratification. "Health equity" implies that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.

In the current analysis of women's health, health equity perspective plays an important role because women's health is influenced by their social status, gender roles, control over resources and decision making powers through their knowledge about health issues and access to health services. It becomes particularly important to see if the differences in health status or access to services among male and female are because of their social advantage or disadvantage. Health Equity perspective also guides us to look at the health status and outcomes' gaps and differences in health needs that exist among different social groups.

To summarise, Gender and Health Equity analysis helps in analyzing data from different sources to understand the factors behind differences among

women and men and also intra group differences (based on caste, class etc.).

In addition we are also attempting a gender-analysis of accepted SRHR indicators (wherever possible) and working with them further to better capture the gender and equity dimensions of the issue under scrutiny

Features of the report

Equity is the central concern of SDGs as seen in the tag line 'Leaving no one behind'. We attempt in this report to look at the progress towards SDGs from the perspectives of gender and equity. Other features of this report are:

- The government policy making and strategic course corrections with respect to SDGs is based on reports published by the government, government records or national surveys conducted by reputed organizations such as IIPS. Our report relies on the same sources of data.
- Along with these sources, this report is appended with documented case studies, material from small surveys, research studies done by local civil society organizations, to give the local context and to show the diversity of issues faced by people in different settings and also different communities in the same setting.
- This report is compiled through an in-depth involvement of local civil society organizations since the beginning. The report thus is not owned only by SAHAJ but also by the network of civil society organizations working on women's health, women's empowerment, women's rights and gender issues in different parts of the state.
- We hope that this report will be a technical and structural input for dialogue around gender equality keeping the SDG framework in mind within the network of CSOs and with the government officials.

Methodology

This report is based on state and national level data from secondary sources such as Census and several surveys. The data sources included in this report are- Census of India 2011, National Family Health Survey-4 (NFHS-4, 2015-16), Annual Health Survey (2011-12 and 2012-13), Crime in India report by National Crime Records Bureau (NCRB, 2015-16), HMIS report published by NHSRC (2015-16), Rural Health Statistics report (2015), Several NHM reports published by Government of Assam, Health in India report of 71st round of National Sample Survey (NSSO, 2014) etc. The data are compared with the previous rounds of surveys for the state or with the national level data wherever possible.

The use of data from secondary sources has a few disadvantages. All these sources use varied techniques (census, household survey, facility survey, cases records etc.). They differ in their sampling methods and sample sizes. In surveys such as NFHS and AHS, the responses are the perceptions of household respondents whereas in datasets such as HMIS or NCRB, the calculations are based on number of cases registered with clinics and police respectively. This report does not compare the data but compiles data from different datasets and analyses using with gender and health equality perspective. For the analysis of data pertaining to early marriage among girls, the age groups should be such that, the girls below 18 years of age should be considered a separate category. This is not true for data sources such as Census of India and NFHS that group women of the ages 15 to 19 years together. This makes analysis difficult.

Structure of the report:

The first section of this report is about Assam State profile and includes information about demographic indicators, household characteristics, health infrastructure, health status of the population and nutrition related indicators among women in Assam along with the details of current civil society campaigns active in the state on the issues related to the topics under consideration. Household characteristics such as access to drinking water sources, availability of latrines and type of cooking fuel used are also presented considering the health consequences of these particularly for women. Health infrastructure in the state, health status of the population and nutrition related indicators especially for the women are incorporated in this report to have a clear picture of health situation in the state. Implementation data for schemes like JSY and JSSK are considered too. A section on budgets for the state of Assam is an essential part of this report.

The section on women's health includes indicators related to ANC, care during delivery and PNC services received by women in Assam and indicators for women's access to information about SRH and access to select SRH services. The section on gender equality contains data on violence against women that includes percentage of women experiencing different types of violence, data on reported cases and the redressal mechanisms. This section also

ponders upon women's work participation, property rights and participation in household decisions that tells us about the status of women's empowerment in the society. The section on eliminating harmful practices against women and girls concentrates on the percentage of reported child marriages in the state and percentage of women in the age group of 15-19 years who have already begun child bearing as a proxy indicator for child marriage.

Civil Society participation in the process

Under the project, a meeting was held on the 19th to 21st March 2018 with civil society organizations in Assam to understand the issues related to SRHR and build a data driven plan for policy dialogue in regard to SDG 3 and SDG 5. Participants from 20 NGOs from different districts of Assam joined the meeting. The spectrum included people from the UN bodies in Assam, people from state government particularly the health department, and state and district level organizations and academic institutes. The list of participants is given in Annexure. During this meeting, a preliminary analysis of available data from secondary sources was presented and discussed. Based on the discussions and experiences of the participants of this consultation, the preliminary report was modified.

This modified report was further discussed with around 30 NGO participants from Assam during a one day consultation on 23rd August, 2018. Based on further suggestions by the participants in this meeting, some information has been added to this report. This final report is a culmination of work based on all the feedback we have received on several drafts of this report.

Section 1: State Profile - Assam

Assam is the largest among the North Eastern States in terms of its size as well as the population. It is bordering seven states viz. Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Tripura and West Bengal and two countries viz. Bangladesh & Bhutan.

Assam is given special status by the National Development Council (NDC) based on certain criteria. These are- 1. Low resource base, 2. Hilly and difficult terrain, 3. Low population density, 4. Sizable share of tribal population and 5. Hostile location. The benefits received because of the special status include preferential treatment in getting Central funds assistance and concession on excise duty to attract industries to the state.

Assam is peculiar from SDGs point of view because it is the first Indian state to have a Vision document- 'Assam Vision- 2030' and to have established a state SDG cell. The state has prepared a seven-year strategy plan and three-year action plan to achieve the targets under SDGs at the state level. The state is using cross-sectoral synergies and goal wise and department wise clustering to move towards the targets. Assam also came up with an SDG oriented outcome budget for 2017-18. The state has identified 59 core indicators for monitoring the SDGs and has constituted a semi-formal body called SDGs Strategy Support Group (SSSG).

According to the Health Index[2] developed by *NITI Aayog*, Assam stands 16th among the 21 large states in terms of overall performance and ranks 11th in terms of annual incremental performance with 0.6 incremental change between Base Year (2014-15) and Reference Year (2015-16). According to this performance, Assam is among the least improved states along with Madhya Pradesh and Odisha (NITI Aayog, 2018).

2 Health Index is a weighted composite index based on indicators related to health outcomes, governance and information and key inputs/processes.

Civil Society Campaigns in Assam

The civil society groups in Assam have time and again come together to address the issues of the state in a coherent and concerted manner. The civil society groups in Assam are vibrant and often organize themselves into collectives and campaigns to address the issues. There are forums which have organized themselves for policy dialogue, sharing and collective learning in a sustained manner. Some of the key forums and campaigns of civil society of the state are listed below [3].

Peoples Rights Forum

The policy of Targeted Public Distribution System under the Right to Food Act helps in provisioning of food grains, oil and pulses to citizen of India based on their socio-economic categories. With a view to provide a guaranteed minimum of 100 days employment to rural population, the Government of India has implemented the National Rural Employment Guaranteed Act (NREGA) since 2005 to ensure a minimum of hundred days of work along with many other benefits.

In the year 2008, it was disheartening to see that the rural inhabitants in Assam were far away from receiving both these benefits. With a lot of corruption in the system, TPDS was pushing people to the edge, NREGA was yet to deliver as desired. The effects of non-implementation of well-designed development schemes had manifested in the form of increasing violence, rising unsafe migration, deterioration of rural infrastructure, declining health status and tightening vicious cycle of poverty.

Thus, civil society groups in Assam came together and formed a body called 'People's Rights Forum' to campaign around these issues in alliance with the National Civil Society Movement. After extensive community mobilization by NGOs in their own

3 The details of the various Civil Society Groups have been taken from their respective Charter of Association.

territories, forum members realized that it is also vital to advocate for a larger systemic change at the State level. The forum organized conventions on TPDS and NREGA involving higher officials from the government, eminent national level activists and academicians. It provided a platform to poorest of the poor people of rural Assam so that their testimonies can be presented directly, to pressurize the bureaucrats. Civil society organizations from other states were also involved at a later stage. Media actively supported the campaign and also involved national level activists.

Inter-Agency Group

Floods are an annual phenomenon in Assam. The recurring floods devastate on an average 20 percent of the area of the plain districts of Assam and in the high floods years the devastation has been recorded to be as high as 67 percent (Assam Disaster Management Authority, n.d.). In recent times, maximum losses were recorded in 1998, 2000 and 2004 floods. These floods virtually destroyed the entire rural economy. In 2004, more than 12 million people (close to half of the population of Assam and just under one-third of the entire region) were displaced or otherwise affected by high water, four times the 'normal' figure, suffering immense loss of property, crop and livestock, often a major source of livelihood and income (Hazarika, S., 2005).

The Inter-Agency Group (IAG), started functioning in Assam in 2004, it has so far been a loosely formed collective of civil society partners, and national and international agencies.[4] The primary focus of the IAG has been on emergency response and information sharing. The IAG meetings focus on reviewing the information and Situation Assessments carried out by the different participating agencies and field level NGOs, review the requirements relating to relief supplies, vis-a-vis the provision of relief from the State Government/District Administrations, and coordinate relief/supplies distribution, to avoid duplication of effort and to share resources for better coverage and collective learning.

All Assam Forum for Child Rights

The national study on child abuse done by the central Ministry of Women and Child Development in 2007 brought to light the alarming data that 99.6 percent children of Assam are subjected to corporal punishment in school against a national average of 65 percent putting Assam on top of the list of States where physical abuse is rampant. 53.5 percent of boys and 46.5 percent girls in Assam reported that they were sexually abused moreover, 71.3 percent children in Assam reported that they were emotionally abused in one or more forms (Ministry of Women and Child Development Government of India). These findings pointed to the need for effective and affirmative action and sustained interventions for reducing child abuse in Assam. Organization working with children across the state came together for interventions in the field of Advocacy for child rights. In November 2008, a two-day All Assam Consultation on Child Rights was organized and the participating organizations formed themselves into an All Assam Forum for Child Rights. This was preceded by the observance of the 19th anniversary of UNCRC with child participation as the major component. Subsequently, various other activities like advocacy by children with the legislators etc. have been going on.

There are other forums. For example, Lower Assam NGO Forum (LANF), engaging within themselves, with the community and the government primarily for policy influence. The Forum for the Voluntary Sector of Assam is a group of community based organizations. These organizations strengthen each other and build a momentum of community voluntary institutions working for their own communities in the state. These groups have played a key role in reviewing and monitoring the implementation of the government schemes and programs in the remote corners and inaccessible geographical locations of Assam.

Socio- Demographic indicators

Total population of Assam is 3,12,05,576 as per 2011 census and the area covered by the state is 78,438 sq. km. (2.4 percent of the country's total geographical area). The population density is 398 persons per sq. km. The decadal population growth (2001-2011) is 17 percent. 86 percent of the population resides in rural areas of the state. The proportion of working age population (15-59 years) is 62.8 percent (Census of India, 2011). The household size for the state is 4.6 (AHS, 2012-13).

Assam has a heterogeneous population with socio-cultural & ethnic diversity. Though Hindu is the majority religion of the state (61.5 percent), Muslim population contributes to more than one-third (34.2 percent) of the total population. Tribal population constitutes 12.4 percent of the state population with the Bodo tribe (40 percent of total tribal population) being the dominant one. Two districts of Assam have tribal population of more than 50 percent and five districts have 25-50 percent tribal population.

4 As per Inter Agency Group Charter of Association

Per capita NSDP at current price for the year 2016-17 was Rs.65698. GSDP of Assam at current price was Rs.2.49 lakh crore during 2016-17 with a growth of 10.55 percent from the previous year. The per capita income of the State in terms of NSDP at constant prices (2011-12) was estimated to be Rs.51040 for the year 2016-17.

Sex ratio

In terms of sex ratio of the total population, child sex ratio and sex ratio at birth, Assam performs better than the national average. Sex ratio for Assam is depicted in the table below.

Table 1: Sex ratio, Assam and India

Assam	Total	Rural	Urban	Source
Sex ratio (Total population)	958	960	946	Census of India, 2011
Child (0-6 years) sex ratio	962	964	944	
Sex ratio at birth	929	945	794	NFHS 4, 2015-16
	922			HMIS- NHSRC, 2015-16
India				
Sex ratio (Total population)	940	947	926	Census of India, 2011
Sex ratio at birth	919	927	899	NFHS 4, 2015-16
	922			HMIS- NHSRC, 2015-16

Education

Literacy rate for the state is 72.2 percent with female literacy rate (Ages 7 years and above) of 66.3 percent. Female literacy rate for urban areas (84.9 percent) is much higher than rural areas (63 percent) (Census of India, 2011). According to NFHS-4, 23 percent of women (15-49 years) have never been to school. Though school attendance is marginally high for girls (92 percent) as compared to boys (88 percent) in the age groups 6-14 years, in the later age group, i.e., 15-17 years, the percentage of girls attending school (57 percent) is little less than boys (58 percent). Ratio of girls to boys enrolment is better than the national average at all levels. The ratio of girls to boys enrolment is above one for upper primary, elementary and secondary levels (National University of Education Planning and Action (NUEPA), 2013-14).

Median number of years of schooling completed for women in Assam was 4.6 years with 8.1 years for women from urban areas and 3.9 years for women in rural areas (NFHS-4, 2015-16).

At elementary, secondary as well as higher secondary level, girls from all the caste groups in the state showed higher participation compared to the national average. Average annual dropout rate for secondary level for girls is 27.8 which is very high compared to the national average of 14.5 (NUEPA, 2013-14).

Following table gives the differences in school attendance for girls across age groups. The dropout rate is very high between 14-15 years (secondary level) and 16-17 years (higher secondary level). There are differences in school attendance by girls residing in rural and urban areas, in favour of urban areas.

Table 2: Age group wise differences in school attendance by girls (6-17 years) in Urban and Rural areas of Assam, NFHS-4, 2015-16

Age groups (Level of schooling)	Female	
	Urban	Rural
6-13 years (Elementary level)	97.3	93.4
14-15 years (Secondary level)	85.0	68.6
16-17 years (Higher secondary level)	41.1	26.9

Following are the girls' education related schemes of Government of Assam.

Table 3: Schemes of Government of Assam related to education

Scheme	Objectives / Provisions	Who is eligible?
Free Bicycle for Girl Students	The scheme is to provide free bicycles to all BPL girl students up to Class X to discourage them from dropping out of school.	All BPL girl students
Free Two Wheeler for Girl Students	Scheme for Providing Two-wheeler to Top 1000 Girls Students who pass H.S. Examination	All girl students
Scholarship to Girl Children of Minority Communities	This scheme proposes an annual scholarship for girl students belonging to minority communities from Class X to post graduation. It aims to support all girls belonging to minority communities to keep pursuing higher education.	Girl students belonging to Minority Communities
Women University	Set up a Women's University to promote higher education of women and girls.	Graduate Girls
Women ITI	Enhancing skills of girls and women towards better livelihood option and empowerment	

Even with all these schemes for higher education of women, the percentages of women opting for higher education look discouraging.

There is not much difference in the school attendance by girls for social groups based on religion and caste groups (NFHS-4, 2015-16).

Household characteristics

Household characteristics such as access to drinking water sources, availability of latrines and type of cooking fuel used are important indicators that have health consequences particularly for women. Women and girls are mainly involved in fetching water for drinking as well as other household chores. Type of fuel for cooking is also an important indicator impacting women's health. The use of solid fuel[5] for cooking has been seen to be associated with several adverse health and birth outcomes among women (Mohapatra, Das & Samantaray, 2018). Availability of latrines is important for women as they face both safety and health risks because of its lack (Anand, 2014). Some of the selected indicators for Assam are given below.

Access to drinking water

Access to piped water into their dwelling, yard or plot is reported by only 9 percent of the households in Assam. Only 4 percent of the rural households and 31 percent of the urban households reported access to piped water into their dwelling, yard or plot. Nearly 84 percent households of the state reported access to improved drinking water source[6]. The percentage is little higher for urban households (89 percent) compared to rural households (83 percent) (NFHS-4, 2015-16).

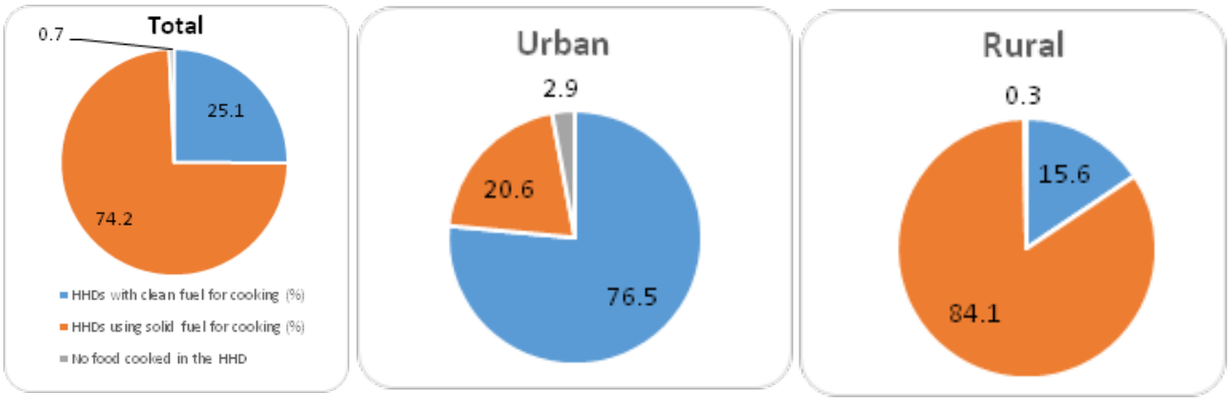
5 Solid fuel includes coal/lignite, charcoal, wood, straw/ shrubs/grass, agricultural crop waste, and dung cakes.

6 Improved water source in this case includes all the sources including- piped water in the household, public taps, tube well/ borehole, Protected dug well, protected spring, rainwater, community RO plant etc.

Fuel for cooking

Solid fuel includes coal/lignite, charcoal, wood, straw/shrubs/grass, agricultural crop waste, and dung cakes. Women are not only exclusively responsible for cooking but also for gathering fuel for cooking. The use of solid fuel for cooking has been seen to be associated with several adverse health and birth outcomes among women. The type of fuel used for cooking is exemplified in the following figure.

Figure 1: Type of fuel used for cooking, Assam (NFHS-4, 2015-16)



Access to latrines

Table 4: Access to sanitation facilities, Assam

Percent households reporting-	Sources			
No latrine	35.1	Census of India, 2011		
Improved sanitation facility	47.7	NFHS 4, 2015-16		
	Total	**Rural**	**Urban**	
No sanitation facility	11.1	12.9	1.0	NFHS 4, 2015-16

The table shows huge gaps in access to sanitation facilities, but indented according to the Swachh Bharat dashboard, the coverage of Individual Household Latrine (IHHL) has seen an improvement. 91 percent households in rural areas of the state now have access to IHHL (Ministry of drinking water and Sanitation, GoI). Assam is one the few states, that have not yet reported full coverage of IHHL.

Health and nutrition

Health infrastructure

A total of 98 percent of ASHAs had been selected in the state till July 2013 and the density of ASHAs[7] was 1:918 (NHM, 2013).

7 Number of ASHAs selected: Total Rural Population

According to the Rural Health Statistics report (Ministry of Health and Family Welfare (MoHFW), 2014-15), Assam has 4621 subcentres, 1014 PHCs and 151 CHCs functioning in the state. The availability of health centres against requirement and shortfall is given in the below table.

Table 5: Shortfall in health facilities in Assam (CAG report, 2017)

	Requirement (Number of health facilities required as against the population as on 31st March 2016)	Availability (Number of health facilities available as on 31st March 2016)	Shortfall (in percent)
Subcentre	6,817	4,621	2,196 (32.2)
PHC	1,112	1,014	98 (8.8)
CHC	278	151	127 (45.7)

The shortfall in infrastructure results in extra pressure on existing infrastructure and human power. This also raises the issue of access for the population. Out of 25800 habitations from seven select districts, 78 percent habitations were within a distance of 3 kms from subcentres. 14 percent of habitations were within the distance of 3 kms and 5 kms (CAG report, 2017).

According to the CAG report (2017), there were surplus gynaecologists in the district hospitals and sub district hospitals in the state whereas there was a deficit in other categories of specialists and other health staff as in these two types of health centres as of March 2016. 55 PHCs (6.3 percent) out of 878 considered under the survey, did not have any doctor (CAG report, 2017). 1230 subcentres (26.6 percent) didn't have a male health worker whereas 40 subcentres functioned without both ANM and male health worker (MoHFW, 2014-15).

Health status of the population

3.1 percent rural and 4.7 percent urban population in the state reported an ailment during a 15 day reference period. This percentage is very low compared to the national average of 9 percent in rural and 12 percent in urban population. 2.8 percent of the rural and 3.6 percent of the urban population was hospitalized (excluding childbirth) during a reference period of 365 days. The rates of hospitalization are also low compared to the national average (4.4 for rural and 4.9 for urban population) (NSSO, 2014). The lower reporting can be attributed to barriers such as availability, affordability, acceptability and geographical access to health services which point to systemic issues as well as lower level of economic development in the state (Bart Jacobs et al., 2011).

Health management information system (HMIS) data are gathered by National Health System Resource Centre (NHSRC) every year. These data are gathered for all the public health facilities and registered private health facilities. Health facility related services data for Assam are shown in the table below.

Table 6: : Health facility related services (NHSRC, 2015-16)

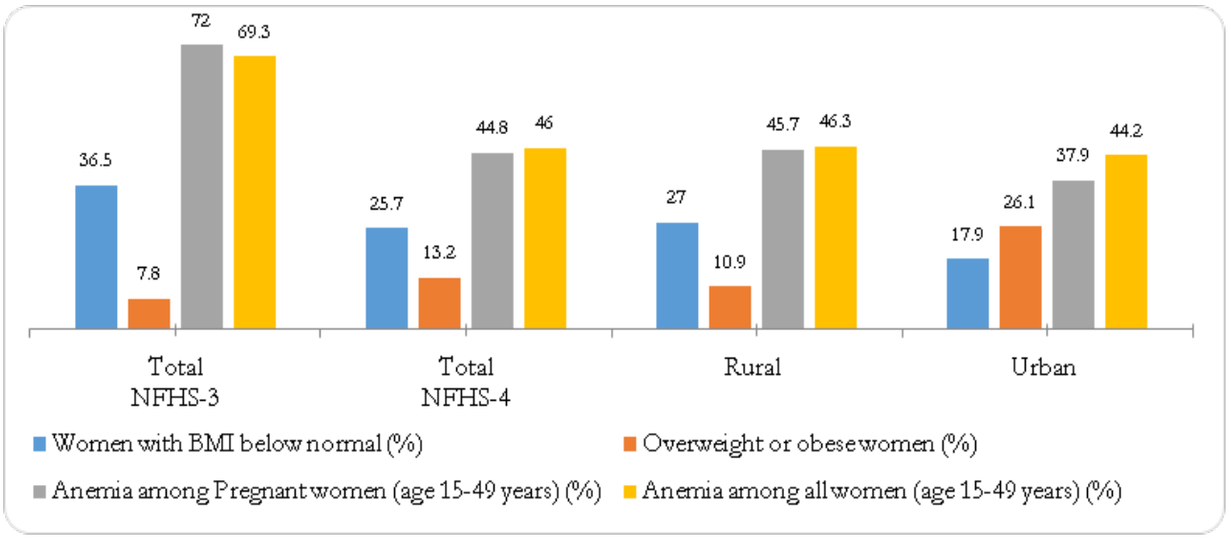
Indicator	Assam	India
OPD per 1000 population	849.0	1033.0
IPD per 1000 population	34.0	48.5
Major surgeries per lakh population	145.5	363.0

Nutrition indicators among women

India is experiencing a demographic transition with double burden where both undernourished and obese population are on the rise. Assam also shows a rise in overweight / obese women especially among urban population. There is a decrease in percentage of women with BMI below the normal range from NFHS-3 (36.5 percent) to NFHS-4 (25.7 percent).

Nearly half of the women in the state (both rural and urban areas) are still anemic even with a steep decrease from 69.3 percent (NFHS-3) to 46 percent (NFHS-4).

Figure 2: : Nutrition related indicators among women in Assam



Anemia levels among women are high irrespective of the social group to which they belong with small differences within different categories. Anemia levels are very high among women (15-49 years) (46 percent) as compared to men belonging to same age group (25.4 percent).

Highlights

- The sex ratio for children born in the last 5 years stands at 794 (NFHS-4, 2015-16) in urban Assam which raises alarm bells and is a clear indicator of the violation and poor implementation of the PCPNDT Act.
- Median years of schooling for women from rural areas of Assam (3.9 years) are low compared to the urban areas (8.1 years) (NFHS-4, 2015-16).
- Even with implementation of many schemes by the government of Assam for education of girl children, the dropout rate at secondary level still remain high (NUEPA, 2013-14).
- Clean fuel has a direct impact on women's health preventing respiratory infections amongst them. Nearly three fourth women in Assam are at risk of respiratory and eye infections due to biomass fuels (NFHS-4, 2015-16).
- Shortfall in infrastructure, availability of staff in existing health facilities and distances of health facilities from the habitations are important issues for Assam (MoHFW, 2014-15 and CAG report, 2017). These barriers might have also resulted in lower levels of reporting of illnesses (NSSO, 2014).
- The decrease in levels of anaemia is quite striking but the levels are still very high. At the same time, there is a newer phenomenon of rise in overweight/obese women especially in urban areas (NFHS-4, 2015-16).

Section 2: Policy and Program Environment in the State

Health indicators for Assam are generally below the National average, reflecting the relative poorer socio-economic condition of the state to the rest of the country. However, some of the priority health outcomes targeted for improvement by 2015 have been bridged and now are close to the National average.

Health programs

The Government of Assam has initiated programs and policies in Line with SDG 3 (Ensure healthy lives and promote well-being for all at all ages). In the Budget for the financial year 2017 -2018 the SDG 4 received the fourth highest allocation Rs. 4635 crores. In the current financial year (2018-19) Health has been given second highest allocation with Rs. 3336 crores.

In this section, we have tried to list the programs in relation with Reducing maternal mortality (3.1) and Ensuring universal access to sexual and reproductive health (SRH) services (3.7), being implemented in the state currently.

The Government of Assam is implementing the National Health Mission and the national flagship programs. The key objectives and schemes are detailed below.

National Health Mission

The National Health Mission is an umbrella programme of all essential health related services in the country which caters to reproductive and child health, control of communicable and non-communicable diseases as well as building necessary health infrastructure. Its major objective is to provide effective health care to citizens, especially disadvantaged groups including women and children by improving access to health services, enabling community ownership & demand for services, strengthening public health systems for efficient service delivery, enhancing equity, accountability and promoting decentralization. National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM) are the 2 sub missions under the overarching programme (MoHFW, Government of India).

Goals of the National Health Mission:

1. Reduce MMR to 1/1000 live births
2. Reduce IMR to 25/1000 live births
3. Reduce TFR to 2.1
4. Prevention and reduction of anaemia in women aged 15–49 years
5. Prevent and reduce mortality & morbidity from communicable, non-communicable; injuries and emerging diseases
6. Reduce household out-of-pocket expenditure on total health care expenditure

One of the major components of NHM is Reproductive, Maternal, Newborn, Child & Adolescent Health (RMNCH+A) of which maternal health is a part. The objective is to have improved maternal health through easier access to skilled care achieved by health facility infrastructure development, increased coverage and quality of Antenatal Care and Postnatal Care, access to skilled birth attendants, institutional deliveries . Following are the major interventions addressing maternal health-

- Essential obstetric care - Quality antenatal care including prevention and treatment of anemia, institutional / safe delivery services and post-natal care. To provide essential obstetric care services, GoI is operationalizing the PHCs for 24 X 7 services and also training the SNs/LHVs/ ANMs in Skilled Attendance at Birth.
- Quality Antenatal Care - Quality ANC includes minimum 4 ANCs including early registration and 1st ANC in first trimester along with physical and abdominal examinations, Hb estimation and urine investigation. 2 doses of TT Immunization and consumption of IFA tablets (6 months during ANC & 6 months during PNC).

- Post-natal care - Ensuring post-natal care within first 24 hours of delivery and subsequent home visits on 3rd, 7th and 42nd day are important components for identification and management of emergencies occurring during post-natal period.
- Janani Shishu Suraksha Karyakram – Scheme that entitles all pregnant women delivering in public health institutions to a free delivery including Caesarean section. The initiative stipulates free drugs, diagnostics, blood and diet, besides free transport from home to institution, between facilities in case of a referral and drop back home. Similar entitlements have been put in place for all sick newborns accessing public health institutions for treatment till 30 days after birth. In 2013 this has been expanded to sick infants and antenatal and postnatal complications.
- Janani Suraksha Yojana – This is a major scheme under NHM to promote institutional delivery by entitling the mother with a cash transfer of Rs 1400 (rural areas) and Rs 1000 (urban areas) to be facilitated by the ASHA who is incentivized for each safe delivery.

Other components include child health and adolescent health. To address the issues of high early neonatal and neonatal mortality, several steps are taken. A new scheme, Home-Based Newborn Care has been launched by incentivising ASHAs to provide newborn care. ASHAs will make visits to all newborns according to a specified schedule for first 42 days. Apart from the regular vaccination schedule, Rashtriya Bal Suraksha Karyakaram (RBSK), an initiative aimed at (a) early identification and intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, Deficiencies, Diseases and Development delays including disability and (b) the provision of need based comprehensive care at appropriate levels of health facilities, is also implemented (MoHFW, Government of India).

Adolescent Health related interventions include Weekly Iron Folic Acid Supplementation (WIFS) with a blue 100 mg Iron pill, facility-based adolescent health services, community based health promotion activities, information and counselling on sexual and reproductive health (including menstrual hygiene) among many others. These interventions are operationalized through various platforms at the village as well as health facility level (MoHFW, Government of India).

Some of the key flagship schemes that address maternal mortality and sexual and reproductive health implemented by the Government of Assam in the financial year 2018 -2019 are listed below.

Table 7: Maternal health related schemes, Government of Assam

Scheme	Objectives / Provisions	Who is eligible?
Janani Suraksha Yojana (JSY)	Promote institutional delivery by entitling the mother with a cash transfer of Rs 1400 (rural areas) and Rs 1000 (urban areas)	All pregnant women delivering in Government health centres
Janani Shishu Suraksha Karyakram (JSSK)	To provide free and cashless services to pregnant women for normal deliveries / caesarean operations and sick new born(up to 30 days after birth) in Government health institutions in both rural & urban areas.	All pregnant women delivering in public health institutions
Compensation of wages to pregnant women tea garden workers	In order to reduce IMR & MMR in the Tea-Garden, all temporary tea-garden women workers would be provided a sum of Rs.12000 as wage compensation during their period of maternity	All temporary women Tea garden workers
Annual Grants for Sanitary Napkins	Promotion of menstrual hygiene among adolescent (12-20 years) girls in rural areas and reduction of school dropout among girls cash transfer of Rs. 600/- Annual Grant to girls.	Girls in the age of 12 to 20 with family income less than 5 lakhs per annum

Box 1: Implementation of JSY

From among six out of seven selected districts selected for the audit, JSY incentive was reported to have been paid to 82.7 percent beneficiaries registered during 2011-16. 1,181 cheques (issued during April 2011 to February 2016) though shown to have been paid to the beneficiaries by nine health centres, were found retained by the health centres. The cheques had however, lost their validity being time barred. Further, delay ranging from 11 to 1085 days in making payment of JSY money was noticed in seven selected health centres of the four districts. Some beneficiaries left without collecting the cheques and many of them did not have bank accounts (CAG report, 2017).

Box 2: Implementation of JSSK

In Assam, Adarani scheme aims at the safe conveyance of mother and child after delivery from hospital to their residence under the JSSK. In March 2016, 235 vehicles had been operating under the scheme throughout the State. During CAG audit, it was revealed that 13 out of 26 health centres did not have Adarani service. In case of the remaining 13 health centres, 'Adarani' service was available but the free services were not provided to 45 percent mothers during 2011-16.

Out of pocket expenditure per delivery under JSSK

JSSK entitles all women delivering in public health institutions to free delivery including in the case of a C-section. According to NFHS-4, out of pocket expenditure per delivery in public health centres (rural areas) in Assam was Rs. 3054.

During CAG audits of health centres, instances of shortage of medicines, insufficiency of transportation facility, lack of functional equipment, diagnostic services etc., were noticed. As a result, free and cashless health care services were not feasible. The patients had to spend their own money ranging from Rs. 950 to Rs. 8100 for purchasing medicines, diagnostic test, transportation etc. Thus, the intended objective of providing free delivery service under NRHM was not fulfilled (CAG report, 2017).

Apart from these programs, there are a few policy documents drafted by the government of Assam in regard to Health. In 2010, Assam enacted the Assam Public Health Act that seeks to guarantee people's right to appropriate and efficacious health care, especially towards effective measures of prevention, treatment, and control of epidemic and endemic diseases. The Act came into effect from January 2011.

The Health & Family Welfare Department, Government of Assam has prepared the State Population Policy, Assam with an objective of incentivizing families to optimize family size and thus allows them the freedom to aspire for a higher standard of living and thereby keep the state's fast growing population within the critical limit and achieve a stable population size by 2045. The goal of the policy is that every family in Assam should have access to quality education, healthcare and employment opportunities. The draft State Population Policy is in the public domain with a request for comments/observations since March 2017. On 15th September 2017, Assam Legislative Assembly passed a resolution adopting the 'Population and Women Empowerment Policy of Assam'. This policy is a big shift from a medically led policy to positive social reform. The policy document talks about encouraging behavioral change and promoting informed choice and participation for long term sustainability and acceptance.

Targets of the Policy to be achieved by 2030 are as follows-

- Free and compulsory education for children under-fourteen; Reducing the school dropout rate between boys and girls to less than 25 percent;
- Bringing IMR < 30 and MMR <100
- Full immunization
- Strict enforcement of the legal age at marriage for boys and girls and encouraging the increase in average age at marriage of girls. Strict and complete enforcement of laws that prohibit child marriage.

- 95 percent institutional deliveries
- 100 percent deliveries by trained personnel
- 100 percent availability of contraceptive of choice
- 100 percent IEC coverage for RTI/STI/AIDS
- Integration of Allopathic and Indigenous Systems of Medicine for betterment of RCH services. All PHC's to provide comprehensive family planning services.
- Encouraging the two children norm to substantially reduce TFR
- Full coverage of education for all girls
- Introduction of appropriate educational methods in all schools to ensure children have exposure to gender equality and sensitization

The following Goals constitute the Population & Women's Empowerment Policy of the Government. The strategies for achieving the Goals will be implemented through specific programmes which will be developed by the Task Force mandated to formulate the Action Plan on Population and Reproductive Health. In the Action Plan the roles and responsibilities of the Administrations, NGOs and the Private Sector will be identified.

GOAL I: Maintain current declining trends in fertility so as to achieve a stable population size at least by the middle of the 21st Century.

GOAL II: Ensure safe motherhood and reduce reproductive health system related morbidity and mortality. Maternal mortality levels are the highest in Assam amongst Indian states. Moreover, morbidity levels related to reproductive health still cause concern. Among the problems connected with reproductive health which will need to be addressed are- Anaemia, Sub-fertility, Unwanted pregnancy, Induced abortion, Reproductive tract infections, Sexually transmitted diseases including HIV/AIDS, Reproductive system cancers

GOAL III: Achieve gender equality in the truest sense; although Assam is one of the states with a perceived improved situation for women in society, this is not enough.

GOAL IV: Promote responsible adolescent and youth behavior.

GOAL V: Provide adequate health care and welfare services for the elderly.

GOAL VI: Promote the economic benefits of migration and urbanization while controlling their adverse social and health effects.

GOAL VII: Increase public awareness of population and reproductive health issues.

The state government says the state population policy bill proposes confining family size to two children but has shifted the focus from enforcement by the government to getting the job done by empowering them. However, there have been controversies and opposition to the bill on the grounds that the policy is communally motivated and that it infringes upon the reproductive rights of women.

Women's policies

The key challenges faced by women in Assam, like in most other states are poverty, inequality and violence against women. Women's education and health are of primary concern for the government. The government is working at ensuring good sexual and reproductive health services for every woman and also towards increasing enrolment and higher education of the girl child. The increase in providing two wheelers for the top 5000 Girl Students, who pass the Higher Secondary Examination in 2018, from the previous year's allocation of only 1000 Girl Students who passed in 2017, is a step in this direction. However, in the outcome budget, SDG 5 received the third lowest allocation of Rs. 490 crores for the financial year 2017-18. Allocations seem to have been enhanced in the current financial year. Key schemes related to education are given in table 3 above. Some of the key schemes in the financial year 2018-19 related to social security, livelihood and protection of women are listed in the following table.

Table 8: Key schemes related to social security/ empowerment, livelihood and protection, Government of Assam

Scheme	Objectives / Provisions	Who is eligible?
Social Security /Empowerment		
Scholarship to Girl Children of Minority Communities	Annual scholarship for girl students belonging to minority communities from Class X to post graduation. It aims to support all girls belonging to minority communities to keep pursuing higher education.	Girl students belonging to Minority Communities
Financial Incentive for SC Meritorious Girls Student	Annual scholarship for girl students belonging to SC communities. It aims to support all girls belonging to minority communities to keep pursuing higher education.	Girl Student from SC communities
Women SHG Support for Tea Tribes	Grants @ 25000/- to 1000 women SHG of tea tribes	SHG of Tea Tribe Women
Livelihood		
Kanaklata Mahila Sabalikaran Yojana (KAMS)	This scheme is about helping women move out of poverty through strengthening of SHGs and their network, financial inclusion, Skill development and marketing support. Financial Assistance to one lakh Women SHG	Women SHGs
Training Programme	Encouraging women to become entrepreneurs and help them in financial inclusion, Skill development and marketing support	
Radhika Woman Empowerment	Skill Development training programme for unemployed women	
Rengoni	Provide skill development training and loan of Rs. 2,00,000/- per group with subsidy of 10percent i.e. 20,000/- to felicitate the women for self-employment.	
Welfare of Transgender Community (HIJRA)	Provide skill development training on any one of the selected trades to transgender people according to their choice, so that they may avail the opportunities to become independent and bring about a transformative change in their lifestyle and livelihood activities.	Transgender
Schemes for Weavers	Distribution of Yarn and Blankets and schemes for economic development of weavers	
Surakhya	Intended to support women affected by violence, in private and public spaces, within the family, community and at the work place. Women facing any kind of violence due to attempted sexual harassment, sexual assault , domestic violence , honour related crime, acid attacks or witch hunting by organizing massive awareness among the women as well as in the society and also organizing self-defense training camps among the school/college students	All women
Bhorosha	Is meant for prevention of trafficking of women for commercial exploitation by organizing massive awareness among the women as well as in the society in influential manner and also organizing self-defense training camps among the school/college students	All women
Protection from Domestic Violence	Scheme for protection of woman from domestic Violence	All women
One Stop Crisis Centers	Will provide support and assistance to women affected by violence, both in private and public spaces.	All women
Women Police	Objective is to ensure their sustainable functioning by facilitating the minimal needs of the Women Police Force	All women
Women's Commission	Apex body with the mandate to protect and promote the interest of women in the state.	All women

Budgets for SGD3 and SDG5

Assam is one of the poorer performers for health and nutrition related indicators. These performances are largely a consequence of budgetary expenditures. Low levels of allocation and spending on children's and women's health like immunization, ANC, JSSK, RBSK, RKSK etc. are reflected in very high mortality rates and low levels of utilization of these services.

Following table looks deeper into budget allocations/expenditures of specific schemes of the WCD and Health departments of Assam and the pattern of spending that emerges more or less corroborates the above observations.

Table 9: : Budget Allocation and Expenditures of Selected WCD and Health Schemes in Assam (Rs. in Lakhs) (Demand for Grants of respective Ministry and respective years; For NHM – PIP and ROPs respective years)

	2015-16 (BE)	2015-16 (Ac)	2016-17 (BE)	2016-17 (Ac)	2017-18 RE	2018-19 (BE)
WCD Total (Rev+Capital)	**165821**	**141839**	**119350**	**95733**	**186470**	**209872**
ICDS Total	**84366**	**79121**	**62858**	**49293**	**81193**	**75209**
Anganwadi services	9037	3982	5172	8213	13164	26223
Special Nutrition Programme	35678	37493	36077	29082	40275	30300
Nutritional Support to Pregnant Women (MAMONI) @Rs.2000/-	0	0	0	0	0	0
National Mission For Empowerment Of Women Including IGMSY (Maternity Benefit)	2879	65	2058	914	5113	2225
Rajiv Gandhi scheme for empowerment of Adolescent Girls (SABLA)	4521	1221	1111	119	1517	333
Empowerment & Protection of Women Total	**15227**	**8377**	**4126**	**1394**	**11233**	**35699**
Beti Bachao Padhao	0	0	432	45	150	200
One Stop Centres	0	0	749	0	432	433
Scheme for protection of woman from domestic Violence	30	14	14	14	15	20
Financial Assistance & support services to victim of rape	0	0	5	0	5	300
Home for Destitute Women and Helpless widows	29	33	79	57	93	112
Compensation of Wages to Pregnant Women Workers of Tea Gardens	0	0	0	0	1800	5593

	2015-16 (BE)	2015-16 (Ac)	2016-17 (BE)	2016-17 (Ac)	2017-18 RE	2018-19 (BE)
Implementation of Integrated Child Protection Scheme (ICPS)	**751**	**874**	**1776**	**2030**	**3333**	**3207**
Welfare of Children in need of Care and Protection	11	15	18	17	21	22
Vocational Training and Rehabilitation Centre For Women, Guwahati	76	35	45	41	55	54
Women Welfare and Children Condition	13	22	68	20	38	46
Health &FW Dept. Total (Rev+Capital)	**291484**	**266924**	**376126**	**297835**	**545106**	**508217**
NRHM Total				**105170**	**268439**	**251524**
RCH Flexipool &Immunization &IDD				79104	237844	
Health Systems strengthening				12924	16801	20879
NUHM				**1425**	**3715**	**3532**
NHM Total				**100380**	**272154**	**255056**
Maternity and Child Health	1557	1295	1554	1317	2243	2585
Rural & Urban Family Welfare Services	12004	16156	19812	19086	28677	32071
School Health Scheme (under 01-urban health services -allopathy)	542	426	570	447	773	795
Total 01-Urban Health Services-Allopathy	27113	20488	27944	22296	60224	29828
Total 03-Rural Health Services - Allopathy	168383	161182	219051	148296	286129	257624
Primary Health Centres (103) under Rural Health Services - Allopathy	**32276**	**26611**	**33927**	**29842**	**42861**	**12951**
Community Health Centres(104) under Rural Health Services - Allopathy	7979	5842	8431	6461	10755	11914
Hospital and Dispensaries - total	**46119**	**35827**	**50572**	**40044**	**82245**	**53240**
Prevention and control of diseases (101) under 06	16416	13943	13815	11296	15468	16432
Assam Bikash Yojana (Mamoni, Majoni1, Moromi)	6000	1500	1350	1350	0	0

[1] **Majoni** -fixed deposit of Rs. 5,000/- for 18 years. On her 18th Birthday, the girl will be able to encash the fixed deposit. In case she is married before attaining 18 years of age, the fixed deposit will be forfeited.

In terms of benchmarks like 2.5 percent of GDP for health spending by governments, allocations for maternity benefit and supplementary nutrition as per the NFSA law, allocations for primary healthcare and NHM as per IPHS standards and the mandate in the National Health Policy etc., the WCD and Health department budgets are grossly inadequate to meet the objectives of the various specific programs and schemes listed in the above table as well as the targets defined for SDGs.

Apart from the overall low levels of allocation and spending, even what is allocated is underspent on many of these programs and over the years we see huge fluctuations in allocations and expenditures. ICDS, SNP. Maternity benefits, SABLA all show ups and downs in program allocations and spending reflecting lack of consolidation efforts within the program. Most programs under Women's Empowerment and Child Protection also suffer a similar fate. While the Health department programs have generally seen an upward momentum in allocations some critical programs like Primary Healthcare and NHM too have witnessed fluctuations in allocations. However underspending is huge across the board. In the table for years 2015-16 and 2016-17, we have both Budget Estimates and Actual Expenditures and for each program/scheme we see huge underspending from the budgeted amounts, with exception of ICPS and the Family Welfare program. So what clearly emerges is that like elsewhere across the country in Assam too we see inadequate allocations for key programs that could impact gender equity and even what is allocated is underspent rendering the programs ineffective in reaching their intended objectives.

Highlights

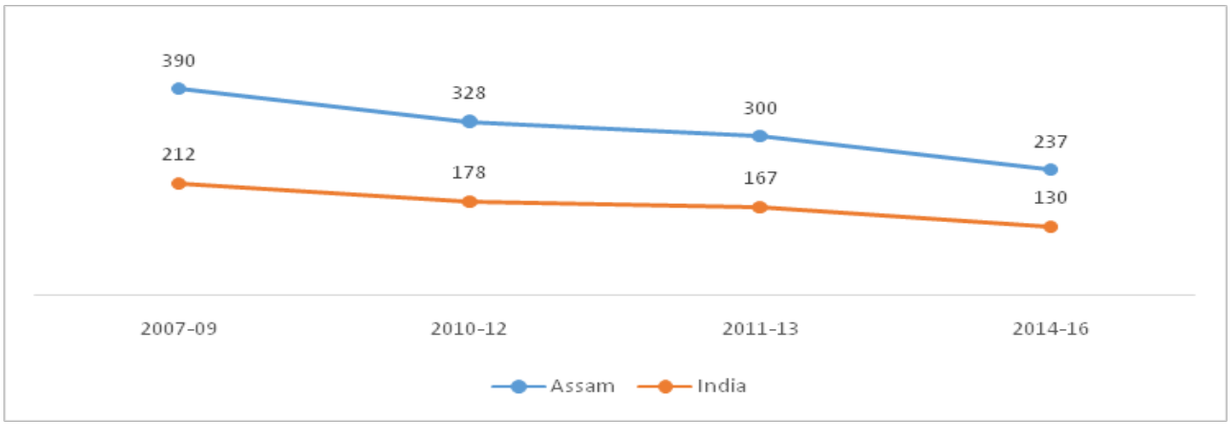
- Assam's poor health and nutrition indicators are largely a consequence of budgetary expenditures.
- Low levels of allocation and spending on children's and women's health like immunization, ANC, JSSK, RBSK, RKSK etc. are reflected in the very high mortality rates and low levels of utilization of these services.
- The WCD and Health department budgets are grossly inadequate to meet the objectives of the various specific programs and schemes, as well as the targets defined for SDGs

Section 3: Maternal Mortality and other SRH Issues

This section delves into analysis of select targets from SDG 3 that revolve around sexual and reproductive health services- SDG 3.1 (Reducing maternal mortality) and SDG 3.7 (Ensuring universal access to sexual and reproductive health (SRH) services). First part deals with maternal mortality.

Maternal mortality ratio (MMR) for Assam has historically been higher compared to other states in India. The documented reasons for this include lack of health care services especially in inaccessible rural areas of the state resulting in higher number of deliveries carried out by untrained birth attendants at home. Non availability of emergency obstetric care for complicated cases worsens the situation (Ahmed et al, 2016). During the last few rounds of SRS, Assam has shown highest maternal mortality rates among the states. Following figure shows trend in MMR for Assam during a decade (Special SRS Bulletins on MMR).

Figure 3: Trend in MMR for Assam and India (Special SRS Bulletins on MMR)



Even though the state has shown some decrease in MMR over the years, MMR of 237 is nearly double the national average (130) (SRS, 2014-16). In the meanwhile, the neighboring country of Bangladesh, which has even larger floodplains compared to Assam, has been able to reduce the MMR to 176 (World Development Indicators, The World Bank, 2015) from 399 in the year 2000 (BMMS, 2001).

Annual Health Survey (2012-13) shows region wise MMR for Assam.

Table 10: Assam region wise MMR (AHS, 2012-13)

Region	Districts	MMR
Hills and Barak Valley Division	Karbi Anglong, North Cachar Hills, Cachar, Karimganj, Hailakandi	281
Lower Assam Division	Kokrajhar, Dhubri, Goalpara, Darrang, Bongaigaon, Barpeta, Kamrup, Nalbari	254
North Assam Division	Marigaon, Nagaon, Sonitpur, Lakhimpur, Dhemaji	251
Upper Assam Division	Tinsukia, Dibrugarh, Sibsagar, Jorhat, Golaghat	404
Assam		301

Although data presented in the table are old, the table shows the vast difference in MMR in different regions. Upper Assam Division, which has majority of tea estates in Assam and the attendant tea tribe population (which is 23.9 percent of the state population), has highest MMR among regions. This region also has two out of the six medical colleges in the state. Despite the availability of such health services, anaemia and hypertension are among the major reasons of maternal morbidity resulting in high maternal deaths in this region.

As per Survey Report of 2014-15 conducted by Regional Resource Centre for North Eastern States (RRC-NE), MoHFW, 85.6 percent Tea Estates (TE) had hospitals run by the TE management. The health care in Tea Garden hospitals had following issues:

- 'In Patient Department' (IPD) service were not available in 45 percent tea garden hospitals and functional labour rooms were not available in 54 percent tea garden hospitals.
- Functional New Born Care Corner (NBCC), laboratory service and doctors were not available in 82, 78 and 38 percent of Tea Garden hospitals respectively.
- NHM, Assam, covered only 150 TE hospitals as of 2015-16 under Public-Private Partnership (PPP) mode and thus, women from remaining 643 TEs (81 percent) were deprived of benefit of health care under NRHM.

NRHM, Assam, needs to ensure adequacy of health care system in all the TEs by providing required infrastructural, logistic and manpower support under the Mission on priority basis to reduce the mortality rates in tea garden areas with consequential reduction in State MMR (CAG report, 2017).

Maternal mortality is caused by many biological and social factors acting together but, it is directly related to factors around pregnancy and obstetric phase. Thus, access to Antenatal Care (ANC), delivery services and immediate Postnatal Care (PNC) become important indicators for MMR. Following table gives an account of some ANC, delivery and PNC related indicators.

Table 11: Select ANC, delivery and PNC related indicators, Assam

Indicator	NFHS-3	NFHS-4			
	Total (%)	Total (%)	Rural (%)	Urban (%)	India Total (%)
Full ANC	6.7	18.1	16.6	30.4	21
Four ANCs during pregnancy	23.5	46.5	44.8	60.4	51.2
Institutional delivery	22.4	70.6	68.2	92.9	78.9
PNC during 48 hrs. of delivery	13.2	54	51.9	79.5	62.4
Births attended by skilled health personnel	31	74.3	72.1	94.1	81.4
C-section	5.3	13.4	10.8	36.9	17.2
C-section (Public Health Facilities)	21	12.9	11.4	26.6	11.9
C-section (Private Health Facilities)	26.7	53.3	48.3	65.6	40.9

82.5 percent women in Assam received ANC from a skilled health care provider. Women belonging to social groups based on residence, level of education and religion in Assam have differential access to ANC, delivery and PNC related services (NFHS-4, 2015-16). These differences are given in the table below.

Table 12: Percentage of women for select maternal health indicators according to the background characteristics

Background characteristics		Percentage receiving ANC from a skilled provider	Percentage institutional deliveries	Percentage receiving PNC
Residence	Urban	90.2	92.9	79.3
	Rural	81.6	68.2	63.6
Level of education	No schooling	68.8	50.0	52.4
	<5 years of schooling	80.3	58.6	58.4
	5-9 years of schooling	84.6	75.3	66.2
	10-11 years of schooling	92.4	90.1	77.4
	12 or more years of schooling	93.8	94.0	81.5
Religon	Hindu	89.1	84.7	76.0
	Muslim	73.4	53.6	50.1
	Christian	83.3	69.6	75.0

The HMIS data produced by NHSRC shows higher proportion of home deliveries as well as C-section deliveries compared to the national average. In terms of ANC registrations, ANC checkups and institutional deliveries, Assam shows higher percentages compared to India.

Table 13: Select ANC, delivery and PNC related indicators, Assam (NHSRC, 2015-16)

Indicator	Percent	
	Assam	India
ANC registration against estimated pregnancies	91.0	94.0
ANC registration in first trimester against reported ANC registration	81.0	62.0
Women with 3 ANC Checkups against reported ANC registration	87.0	79.0
Home deliveries against estimated deliveries	12	9
Institutional Deliveries against estimated deliveries	73	66
C-Section Deliveries	18.5	16.7
PNC Visits within 48 hours of delivery against total deliveries	72	71.0

According to the 2015-16 data, 14 percent of the deliveries were home deliveries. In case of home deliveries, only 15 percent were attended by SBA. Four ANC visits were provided to 69.6 percent women registered during the period 2012-16. There was a shortfall in provision of other ANC services such as provision of TT injections and IFA tablets. Maternal Death Review (MDR) reports of the selected districts disclosed that in case of 29 deaths (11 percent) during 2013-16, no ANC was provided. Hypertension, eclampsia and anaemia were reported as the major reasons of maternal deaths in the MDR reports. 20 percent mothers died of anaemia during 2013-16 (CAG report, 2017).

ICDS works closely with the pregnant and lactating mothers by providing them with different services such as supplementary food, health checkups and health and nutrition education during pregnancy as well as during breast feeding. Only 35.6 percent pregnant women in urban areas and 60 percent of pregnant women in rural areas received any benefits under this scheme. Health checkups were received by 22.7 percent pregnant women in urban areas and 40.9 percent pregnant women in rural areas. The benefits received during the breastfeeding phase were even lower compared to the pregnancy phase (NFHS-4, 2015-16).

The NGOs from different districts of Assam who participated in the SRHR Consultation shared a lot of concern over the poor state of affairs in terms of safe motherhood and respectful maternity care. There is also a huge cost burden on patients, which was shared as an area of concern. It was stated that the cost for a C-section delivery at the civil hospital in the district of Bongaigaon is often Rs. 20,000 and so for the private hospital it is obvious that the cost will be even higher. It was also highlighted that the C- Section rate in both public and private health facilities in Assam is higher than the national rate (NFHS-4, 2015-16). Average total medical expenditures for delivery in rural and urban areas of Assam (NSSO, 2014) are depicted in the following figure-

Table 14: Table 14: Average total medical expenditure incurred for delivery in rural and urban areas of Assam (NSSO, 2014)

	Public health facilities (in Rs.)	Private health facilities (in Rs.)	All facilities (in Rs.)
Rural	3599	12502	4158
Urban	6949	30031	11219

It was also shared that due to the poor services at the government health system women tend to go back home soon after delivery thereby reducing the chances of availing the PNC within 48 hours of institutional delivery. As per NFHS 4, only 54 percent mothers received postnatal care from a doctor/nurse/LHV/ANM/midwife/other health personnel within 2 days of delivery.

Maternal Death Reviews are not being conducted and recorded in most cases HRLN has been filing PILs on maternal deaths but the problem is with finding out the exact cause of death as the hospitals give various excuses for the deaths, while the medical histories are not recorded properly by the hospitals dealing with the concerned patient. In most cases in Assam the pregnant woman is not aware of the results of her ANC as the reports and records are kept by the ASHA.

Following are some of the case studies shared by the participants of consultation.

Box 3: Findings from survey on Safe Motherhood (PAJHRA)

PAJHRA, an organization based in Sonitpur and working with the Adivasi community, conducted a survey on safe motherhood (May to November 2014). They have collected 70 cases of violation primarily in terms of maternal mortality and/or infant mortality in Tea Gardens and Rural areas in Sonitpur district. The 3 major findings of the study are-

- Lack of Medical Care- 29 percent of the clinics were without a doctor or a nurse
- Ambulance unavailability- 28 percent patients hired a private taxi to reach to the clinic/ hospital.
- Undue hospital referral- 25 percent cases referred to four different hospitals while in labour.

Box 4: Experiences of women with respect to maternal health services in five districts of Assam (Diya Foundation)

Diya Foundation conducted a study in 5 districts of Assam on the experiences of women with maternity care services in collaboration with White Ribbon Alliance (2016). The data for the study was collected through in-depth interviews of 92 women. The key findings of the study are given below-

- Detention of patients- 69 percent respondents said that they were aware that the doctor would not deliver the baby if they don't pay for the health services.
- Denial of care- 27 percent respondents said that even the bare minimum care during childbirth was not provided to the patients. A case was cited in which the woman who had delivered a baby was asked to clean her own room and prepare her own bed. She told the interviewer that during that time she felt that she was being treated like an animal.
- Discrimination- 7.6 percent respondents said that they felt discriminated based on their class, community or their appearance.
- Non- confidential care- 35 percent women said that the delivery did not take place at a private and safe place. They said that people could see the delivery taking place from the outside.
- Non-consented care- 16 percent women said that the doctors or nurses did not take consent from them while dealing with her and touching her private body parts.
- Undignified care- 35 percent respondents said that they were treated in an undignified manner by the health providers. One of the respondents had told the interviewer that when she had asked for water during childbirth at the hospital, she was scolded by the nurse and told that a hospital is not a restaurant. In another case a patient who had been taken to a hospital in Guwahati and was crying because of pain was hit by a doctor with scissors and asked to keep quiet, which injured her.

This study goes to say the least about the apathy towards Respectful Maternity Care in the state of Assam.

Sexual and Reproductive Health (SRH)

Comprehensive definition of reproductive health includes several components, viz., family-planning counselling, information, education, communication and services; education and services for ANC, safe delivery and PNC; prevention and appropriate treatment of infertility; abortion, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood; referral for family-planning services; further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS which should always be available, as required; and active discouragement of harmful practices, such as female genital mutilation (ARROW).

This section deals with selected indicators related to SRH. The components of ANC, delivery care and PNC are covered in maternal mortality part of the section. Some of the other components are discussed here.

Table 15: SRH service related indicators, Assam (NFHS-4, 2015-16)

Indicator		NFHS-4			NFHS-3
		Total (%)	Rural (%)	Urban (%)	Total (%)
Access to information	Women having comprehensive knowledge of HIV/AIDS	9.4	8.0	16.0	8.2
	Women age 15-24 years using hygienic methods of protection during menstrual period	44.8	40.9	62.4	25.9
	Health workers ever talked to female contraceptive non users about family planning	17.2	17.6	14.8	4.1
	Current contraceptive users ever told about side effects of current methods	55.1	55.0	55.8	44.3
Access to contraception services	Use of contraceptive method (currently married, 15–49 years) (%)	52.4	52.0	54.9	56.5
	Use of modern contraceptive method (currently married, 15–49 years) (%)	37.0	36.8	38.4	27.0
	Unmet Need- spacing (currently married, 15–49 years) (%)	5.8	5.9	4.9	3.6
	Unmet Need- Total (currently married, 15–49 years) (%)	14.2	14.4	12.9	12.2

Contraceptive use is slightly higher in urban areas (55 percent) than in rural areas (52 percent). Unlike other indicators, contraceptive prevalence is not much affected by level of education. The rate among Muslim women (50 percent) is slightly lower than Christian and Hindu women (54 percent).

23.7 percent of male respondents (15-49 years) reported that contraception is women's business and a man should not have to worry about it. This explains the higher number of sterilizations being female sterilizations. 91 percent of total sterilizations during 2014-15 were female sterilizations. 16.4 percent of these sterilizations were postpartum (PP) sterilizations. 103 women (0.2 percent) faced complications following the procedure. 35 sterilizations failed as the women who underwent the procedure, became pregnant afterwards. Four women died because of the complications of sterilization procedure (NHSRC, 2014-15).

A total of 23 training centers in the state conduct training of service providers for providing abortion related services. 317 service providers (MBBS Medical Officers) have been trained at district level till March 2017. 46 percent delivery points from PHC upwards provide MTP Services. 11 clinical mentors are identified in the state to provide technical support. A "Model CAC Centre" at Assam Medical College & Hospitals, Dibrugarh is built which will be a model site for all NE States. Abortion rate against estimated pregnancies for the state is 2.3 percent (NHSRC, 2014-15). NFHS-4 shows 5.5 percent pregnancies in abortions. Out of the total abortions reported, 27.8 percent abortions were performed by the women themselves (by taking an abortion pill on their own). 12 percent women reported complications after abortion.

Box 5: SRH related discussions during the consultation

SRH is still a not to be discussed topic with a lot of taboo and hesitation attached to it. Many of the participants of the consultation expressed that it was for the first time that they were invited for a consultation on SRH issues. They stated even the sexuality related chapters in the school syllabus are usually not taught and children are asked to read those chapters by themselves at home. This is very well highlighted in the fact that only 9.7 percent women have information on HIV and AIDS (NFHS-4, 2015-16).

As per NFHS- 4, percentage of Women (age 15-19 years) who were already mothers or pregnant at the time of the survey was 13.6 percent. The early pregnancy and no discussion on SRHR with adolescents could lead to more health issues for girls as they progress into womanhood. Some participants of the consultation also reported that Adolescent Reproductive Sexual Health (ARSH) Clinics are not functional in most areas.

The state also has cultural taboos around menstruation, which compromise menstrual hygiene and adoption of safe methods of protection during menstrual period. With long duration of the monsoon season, high level of humidity and floods leading to communities living in relief camps menstrual hygiene, drying of cloths or disposal of sanitary pads are great issues and often lead to unhygienic practices. Women often do not dry the cloth in the sun, rather in relief camps there are reported cases of women tying the cloths to themselves to dry it with the body heat.

NFHS-4 reports only 103 cases of complications because of sterilization. The consultation participants thought this number to be too less. According to the participants, women who experience problems do not necessarily report them to the hospital. HRLN has also conducted a study on sterilization in Kamrup (Rural) district of Assam where they found that women were not informed that they had been implanted with copper T after delivery.

Highlights

- High MMR of 237 in Assam (SRS, 2014-16) can be attributed to several medical and non-medical factors.
- There was a lack of awareness amongst women of the importance of check-up during and after pregnancy and taking of IFA tablets during pregnancy that resulted in Lower levels of access to ANC, safe delivery and PNC services. Also, respectful maternity care is lacking which further pushes women away from receiving services.
- Access to maternal health services shows inequities across social groups formed on the basis of residence, level of education and religion (NFHS-4, 2015-16). Women workers from tea estates are far from receiving adequate maternity care (CAG report, 2017)
- Women's access to information about SRH is poor (NFHS-4, 2015-16).
- 23.7percent of male respondents (15-49 years) reported that contraception is women's business and a man should not have to worry about it (NFHS-4, 2015-16). This explains the higher number of female sterilizations (91percent of total sterilizations during 2014-15, NHSRC, 2015).
- Higher proportion of early pregnancy (15-19 years) and no discussion on SRHR could lead to more health issues for girls (NFHS-4, 2015-16).

Section 4: Gender Equality

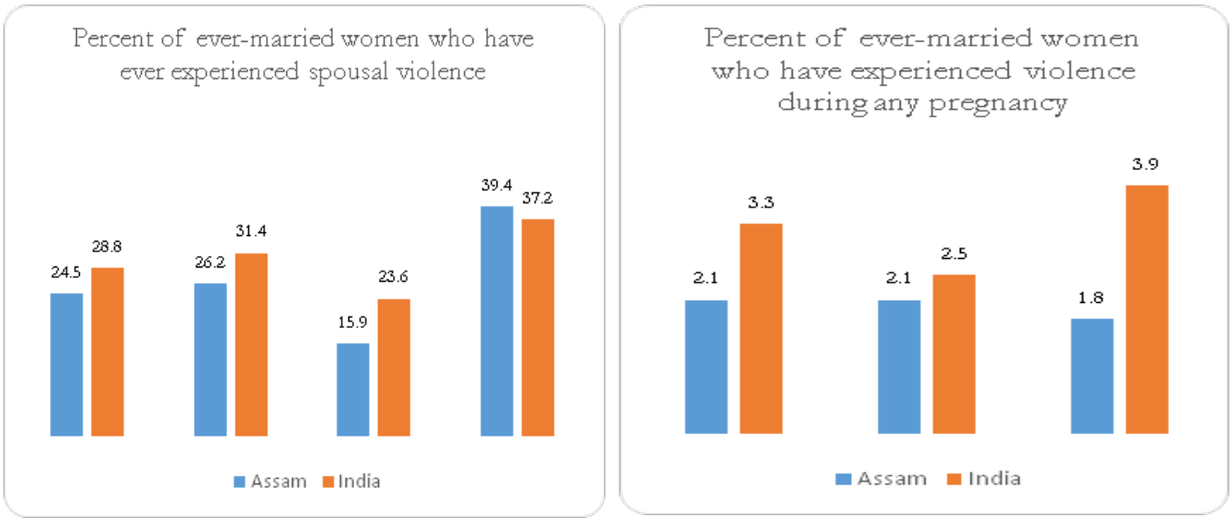
This section describes the situation of Assam for violence against women, child marriages and other harmful practices prevalent against women and girls in the state with the help of selected indicators. It also gives some information on selected indicators for analyzing women's empowerment levels in the state.

Violence against Women (VAW)

The World Report on Violence and Health (WHO, 2002) defines violence as 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation.' According to victim perpetrator relationship, there are three types of violence- Self-directed violence, interpersonal violence and collective violence. In this section, we will talk about interpersonal violence which refers to violence between individuals, that includes domestic violence, intimate partner violence, as well as assault by strangers. It could be of four types- physical violence, sexual violence, psychological violence and deprivation or neglect.

Proportion of spousal violence as reported by ever married women in the age group of 15-49 years is as follows-

Figure 4: Percent of ever married women who have ever experienced violence



Some more indicators regarding spousal violence are given in the table below.

Table 16: Various forms of violence committed against women by their husbands (NFHS-4, 2015-16)

Indicator	In past 12 months			Ever
	Often (%)	Sometimes (%)	Often or sometimes (%)	Total (%)
Any form of physical violence	2.1	14.2	16.3	23.6
Any form of sexual violence	0.5	3.9	4.4	5.5
Any form of emotional violence	1.2	7.6	8.8	11.4
Either physical or sexual violence	2.3	15.0	17.3	24.5
Both physical and sexual violence	0.3	3.1	3.4	4.6

Only 7 percent of women who have ever experienced physical or sexual violence by anyone have sought help. 57 percent women who have sought help, have spoken to their own families. Only 9 percent sought help from the police and 1 percent from social service organization (NFHS-4, 2015-16). From the proceedings of the consultation, it was noted that the domestic violence cases were under reported as women do not normally register and at many times, these cases are settled by organizations like Students Union or traditional community bodies, and do not get reported with the law enforcement authorities.

Box 6: Implementation of Protection of Women from Domestic Violence Act (PWDVA), 2005 in Assam (Carpenter & Vauquline, 2016)

The PWDVA is implemented through a Nodal Agency and Protection Officers (PO). The protection officers act as a 'go-between' between the aggrieved woman and the court. The nodal agency in Assam is the Social Welfare Department, Government of Assam and the District Social Welfare officers, numbering 26, have been notified as POs. Sensitization programmes for these Protection Officers who looks at the process of filing a case under PWDVA, 2005 (are lacking). No special training is imparted to the Protection Officers as service providers. This problem is compounded when people who are freshly appointed as District Social Welfare Officers and as Protection Officers, are not trained for this dual responsibility. The increasing number of domestic violence cases in the state also burdens the service providers, who have other responsibilities, leading to implementation challenges.

Apart from the violence faced at home, there are other types of crimes against women like rapes and kidnapping. A report on crime in India (NCRB, 2016) shows that Assam ranks 2nd among the states and UTs in India on rate of total cognizable crimes (IPC+SLL) against women and is only preceded by Delhi UT. Following table shows some of the important crime rates against women in the state of Assam.

Table 17: Crime rate for different crimes against women, Assam (NCRB, 2016)

Indicator	Crime rate (crimes per one lakh population)
Rate of total cognizable crimes against women (IPC+SLL)	131.3
Cruelty by Husband or his relatives (Sec. 498 A)	58.7
Kidnapping & Abduction of Women	33.6
Rape	11.2
Assault on women with intent to outrage her modesty	21.3
Rate of IPC crimes	128.7

Empowerment related indicators

While working towards reducing violence against women, along with the indicators related to the actual instances of violence, it is equally important to look at the social positioning of women. Certain indicators such as work participation, property rights and participation in household decisions tell us about the status of women's empowerment in the society. Some indicators from NFHS-4 are related to women's empowerment. These are tabulated below.

Table 18: Select indicators regarding women's empowerment, Assam

		NFHS-4 Total	Rural	Urban	NFHS-3 Total
Currently married women who usually participate in household decisions (%)	A	87.4	86.2	93.7	88.1
	I	84.0	83.0	85.8	76.5
Women who worked in the last 12 months who were paid in cash (%)	A	17.0	16.7	18.6	25.8
	I	24.6	25.4	23.2	28.6
Women owning a house and/or land (alone or jointly with others) (%)	A	52.3	53.7	45.9	NA
	I	38.4	40.1	35.2	NA

The records of 52 percent women owning a house or land did not seem to be realistic to the participants of the consultation as most assets are owned by the husbands and sons within families in most cases in the state. However, this could not be verified and could be checked through the review of land records of the state. Workforce participation rate for women in the state is low with less than 15 percent urban female population and 24 percent of rural female population participating in Workforce (Census of India, 2011). Labour force participation rate for females in Assam was 9.7 percent for urban areas and 12.9 percent for rural areas (AHS, 2012-13).

Child marriage

Mean age at marriage for girls in the state is 21.5 years. For those girls who have been married before the legal age of 18 years, the mean age at marriage is 16.3 years (Census of India, 2011). The table gives details of early marriage among girls in Assam.

Table 19: Child marriage related indicators, Assam (NFHS-4, 2015-16)

Assam	Total	Rural	Urban
Percentage of women (20-24 years) married before the age of 18 years	30.8	31.9	24.3
Percentage of women age 15-19 years who were already mothers or pregnant	13.6	14.4	8.1

61.4 percent of currently married women in the age group of 15-19 years were already mothers or were pregnant at the time of the survey. Percentage of women in the age group 15-19 years, who have already begun child bearing is as high as 33 percent for women with no education. As the education levels of women increase, this percentage gradually decrease to 4 percent for women with 12 or more years of education. The percentage of women (15-19 years) who have already begun child bearing is more than double for Muslim women (20.8 percent) as compared to Hindu women (9.5 percent) (NFHS-4, 2015-16).

Although more stringent implementation of The Prohibition of Child Marriage Act, 2006 could provide better outcomes in general, in a state like Assam, with hundreds of smaller community groups having their own cultural norms about marriage and elopement, the implementation becomes an issue. Among some tribes and communities in Assam, early marriage and elopement are culturally accepted traditions. Women elope and get married or in other case are given off in marriage by the parents at a very early age.

Box 7: Witch hunting in Assam

Among other harmful practice prevalent in Assam is witch hunting or *daayna hatya.* Though both men and women are affected by it but it is largely against women. Witch hunting involves the branding of victims, especially women as witches, either after an observation made by an *'ojha'* or *'bej'* or a witch doctor. The victim who is branded as a witch is subjected to numerous forms of torture, beatings, burns, paraded naked through the village, forced to eat human excreta and sometimes even raped. In some cases their hair is cut off and the victim and their children are socially ostracised and even put to death. Lack of education and health services have contributed to the continuation of this antiquated practice of witch hunting. As per records available with Mission Birubala and NGOs, more than 400 persons have been killed in Assam during the period from 2007 to 2014 in cases of witch-hunting.

Assam Witch Hunting (Prohibition, prevention and protection) Bill has been passed in the year 2015, however, deaths and killing on the suspicion of witch continue to happen (Das, Personal communication, March 21, 2018).

Highlights

- Even with the under reporting of violence cases, the percentage of women who have ever faced physical or sexual violence is high. Spousal violence data also show high levels (NFHS-4, 2015-16).
- Although, some percentage of women from each social category have begun child bearing at an early age, women residing in rural areas, women with no schooling and women belonging to Muslim community have more chances to do so compared to their respective counterparts (NFHS-4, 2015-16).
- A more stringent implementation of The Prohibition of Child Marriage Act, 2006 could provide better outcomes.

Section 5:
Leave No One Behind

Although Assam has the highest maternal mortality rate, its distribution between different groups and communities within the state is skewed and can't be generalized for the entire state. It is thus, very important to identify and understand these contours of maternal health among different groups and communities in the state to address the issue effectively. When we go deeper into the identification of vulnerable groups in the state it shows startling disparities among different population. For example- MMR among the Tea Tribe population which forms 20 percent of the state population is a startling 400 which is comparable to that of Sub-Saharan Africa (Ghoshal, 2016). Similarly among the 9 percent population residing in the Char areas of Assam, 67 percent fall below the poverty line and more than 50 percent are illiterate. Floods, a regular natural calamity for the state affects the 17 highly flood prone districts of the state frequently bringing a disaster induced vulnerability to women residing in these areas. All these dimensions of vulnerability among the different social, religious and geographic groups have been explored and presented below-

Plight of the Adivasis (Tea-Tribes) of Assam

Assam, the largest tea producing region in the world is home to 800 large tea estates and around 1,00,000 smaller tea gardens which produce approximately over 600 million kg of tea annually- 50 percent of the annual tea production in the country (Kadavil, 2007). Though the tea industry is the most well-known industry of the state and contributes a substantial amount to the state economy, the labourers working in these tea estates are one of the most deprived and exploited communities of Assam. The tea estates of Assam employ an estimated 5,00,000 permanent labourers and an equal number of casual labourers, of which a majority are women. These labourers belong to Munda, Oraon, Santhal and Gond tribes and were brought as migrant workers from present day Jharkhand, Orissa, Chhattisgarh and West Bengal. The inflow of labourers from these regions started after the British discovered tea for the first time in Assam and started organised production and export of tea around the 1820s and 30s. Since then, most of the migrant labourers and their decendents continued to work in the tea estates and formed permanent settlements in and around the estates. Today, the people belonging to the Munda, Oraon, Santhal. Khadiya and Ho tribes residing in Assam are collectively known as 'Adivasis' or the 'Tea Tribe'. Besides the local languages, Assamese and Sadri, these people speak Santhali, Kuruk, Mundari, Ho as well as Odiya, Tamil and Telugu in some places. Their total population is estimated to be 6 million and constitute 17 percent of the total population of Assam. A total of 4 million tea tribe people still reside in the residential quarters built inside the tea estates and are concentrated mostly in the Upper Assam and Northern Brahmaputra belt districts of Dibrugarh, Jorhat, Tinsukia, Golaghat, Sibsagar, Udalguri, Sonitpur, Kokrajhar and Nagaon.

This particular group of population known collectively as the Tea Tribes or the Adivasis has arguably been the most marginalized and exploited community of Assam since the pre-independence era. The situation has not improved much for the community even after 70 years of independence as most of the population is illiterate, undernourished, underpaid and unaware their rights and entitlements due to lack of education. Although Assam has the highest MMR in the country, the MMR in the Upper Assam districts where a majority of the Adivasi community resides is an appalling 404, which is worse than the MMR of Sub-Saharan African countries such as Burkina Faso (389), Tongo (386) and Uganda (372).

The main reasons for the exceptionally high MMR among the Tea Tribe community are poor health and nutrition of population as well as lack of

adequate health facilities at the tea estates. Anaemia is believed to be the top killer of pregnant women from the tea gardens of Assam. The other crucial health factors which contribute to the high mortality of mothers from the tea gardens are hypertension and sepsis. Since malnutrition is rife among the Adivasis, anaemia turns out to be lethal for women. During cases of postpartum hemorrhage, it becomes increasingly difficult for doctors to save patients. A study conducted by Medhi et al. (2006) on health problems and nutritional status of tea garden workers of Assam found high incidence of under nutrition and infectious diseases among tea garden population. The study found prevalence of under nutrition among 59 percent children and widespread thinness among adults. Deb (2000) also found widespread prevalence of undernourishment and malnourishment among the labourers.

Another major reason for high MMR among the women from tea garden areas is hypertension. A study conducted by the Regional Medical Research Center in Dibrugarh (2002) estimated that 60 percent of the tea garden workers in Assam suffer from the ailment. The study found high consumption of locally prepared alcohol, intake of high qualities of salt and intake of tobacco increase the risk of hypertension. Alcohol and salt consumption lead to complication in pregnancy often characterized by high blood pressure and organ damage, which is one of the main reasons for high maternal mortality rate across the world. The British provided workers with tea that contained high quantities of salt to counter dehydration due to working in the sun, a practice which continues to this day (Ghoshal, 2016). Pregnant mothers in the tea gardens work into their 9th month to generate the necessary income, who end up consuming the beverage. A study conducted by Sahoo et al. (2011) in a tea garden in Tinsukia district found that 87 percent of the tea garden labourers, of whom a majority are women, consume alcohol on a daily basis, and 90 percent of the labourers consume tobacco.

The frail health conditions of the tea garden labourers and their families is exacerbated by the bare minimum wages provided to them by the tea estates. A worker in a tea garden in Upper Assam is paid a daily wage of no more than Rs. 126, which till 2014 was a meager Rs. 94. The income of casual tea garden labourers who constitute almost half of the total workforce is even lower than that. Due to the low income the families cannot afford nutritious food and basic healthcare. The meager income is further drained by the community through excessive use of alcohol and tobacco.

The lack of adequate health care facilities for the population residing in and around the tea gardens of Assam is a major contributing factor to the drastic health status of the Adivasis (Dutta, 2016). The governance of employment, wages and benefits such as education and health for the tea garden labourers is done in accordance with the Plantation Labour Act of 1951. Under this act clear guidance is given for the provision of health, education, accommodation and recreation among other facilities to the workers. In 2008, under NRHM the government began a public private partnership with the tea estates to improve the health care services at the tea gardens and made provisions to provide up to 15 lakh to a single tea garden to deliver basic health care to workers and their families. However this has not led to improvement of health care services at the tea garden health centers due to lack of doctors, lack of regular supply of medicines and corruption. This has led to limiting of this partnership to only a small proportion of tea gardens, due to which the health infrastructure at the lush tea gardens of Assam continue to languish amidst high morbidity and mortality among the workers.

Vulnerability of women during floods

Assam falls in the Brahmaputra river basin which is the most flood prone river basin in India. 17 of the 32 districts of the state are severely flood prone and perennially affected by flood. About 1.55 lakh hectares of land area of the state comes under the high flood risk category which constitutes 7 percent of the total land area of the state and 23 percent of the total land area of the state is classified as moderately prone to flood. In the year 2016, floods in Assam affected 1.8 million lives in 23 districts and displaced 1.25 lakh people. In the subsequent year of 2017, Assam witnessed the largest deluge in 3 decades which affected 2 million people in 21 districts. Although the fury of flood brings destruction and loss for all affected families, it is the women and children who are the most affected during and after the disaster. According to Duff and Cooper (1994) floods can have a significant impact on the physical and mental health of pregnant women and on their ability to access healthcare services. With specific reference to Assam, the following are the major reproductive health challenges faced by women during floods which make them and the children extremely vulnerable to adverse pregnancy outcomes-

Displacement

During a deluge, the affected households have to flee their homes and take refuge in a safe raise area; usually in government buildings, schools and community halls. Such places where the families take refuge are referred to as relief camps and hundreds of households are usually cramped together in a single relief camp, which are devoid of space and basic water and sanitation facilities. During such circumstance, the pregnant women particularly face severe challenge in moving to the relief camps as well as during the course their stay there.

Access to healthcare facilities

During floods, communication within and out of the affected areas are severely affected as roads and bridges are most often swept off. During such circumstances, it becomes very difficult for the pregnant women to access any form of medical help for weeks together. This hampers the antenatal care visit necessary for the women and even turns out to be life threatening in case of emergencies.

Health and hygiene at relief camps

Due to submergence of vast tracts of land for days and contamination of water sources, the flood affected areas turn into a feasting ground for waterborne diseases. According to Bunyavanich et al. (2003) temporary accommodation in refugee camps, shelters, and short-term housing may promote infectious diseases. To exacerbate the vulnerability to waterborne diseases and infections, there is severe lack of basic sanitation facilities at the relief camps. Complications due to diseases and infections during flood can lead to negative health outcomes for pregnant women.

Lack of nutrition

When a flood strikes, along with shelter the families also lose access to food and adequate nutrition. The pregnant women and children do not get the necessary food supplements to keep them healthy in the immediate aftermath of flood. Floods in developing countries have been associated with maternal and child malnutrition, food shortages, and decreased levels of breastfeeding in rural areas (Choudhury and Bhuiya, 1993). Even in the long run, the nutrition levels of the families are hit because of lack of food supply due to loss of crops and lack of purchasing power due to loss of livelihood.

Sexual and menstrual health of young women

While living at the relief camps along with hundreds of families, it becomes impossible for young women and adolescents to practice menstrual hygiene due to societal taboos. Most often the women use cloth as sanitary pads which they wash and reuse. Due to cramped surroundings, the women don't find spaces to dry the washed sanitary cloth and hence use damp cloth after washing it which leads to infections. Also, while at relief camps, the women and children face sexual abuse, rape and unsafe sex which leads to both psychological and physical trauma. This also results in unwanted pregnancies and unsafe abortions which is one of the prime causes of maternal deaths.

Life and Deprivation in the Char areas in Assam

The extremely braided channels of the river along with its unique gradient, suspended particles and bed load combine together during floods to give rise to 'almond' shaped alluvial formations known as chars (Bhagabati, 2001). Innumerable chars dot the 720 km stretch of the Brahmaputra in Assam. Although the formations of char areas are dynamic because due the river activities old chars are eroded away and new chars are composed, currently they are distributed across 23 sub-divisions of 14 districts of the state. An estimated 25 lakh people (9 percent) of the state's population live in the 2,251 villages in the char areas which form 4.6 percent of the total land area of the state. A majority, 85-90 percent of the population of the char areas are Bengali Muslims. In spite of holding 9 percent of the total state population, the char areas have only 4 percent of the cultivable land of the state. The population density in char areas is very high (at 690/ sq. km) and is double that of the state population density which is 340 persons/sq. km.

A study (2014) conducted by Monoj Goswami with 1000 char households in 4 developmental blocks in the districts of Barpeta and Kamrup looks into the micro details of the char areas. The study showed the Total Fertility Rate (TFR) of the population to be very high at 4.6 which is much higher than the desired replacement rate of 2.1. 9 percent of the households were found to have no access to safe drinking water and only 1.4 percent households have sanitary latrine within their premise. Under such circumstances the morbidity and mortality among the population is bound to be much higher.

In order to reflect this, the Crude Death Rate (CDR) was found to be 8.6 per thousand which is higher than the state average of 6.6 and Infant Mortality was found to be 136.9 which is more than double the state average.

With regard to factors affecting women's reproductive health it was found that 55.7 percent women were illiterate which has been seen to have a direct bearing on their maternal health outcomes. In addition, the mean age at marriage among the sample population has been found to be just 17 years. The Human Development Report for Assam published in the year 2014 showed that a quarter of the women get married between the age of 15-19 years, which is conservative yet still high. This results in higher fertility in the char areas and leads to a higher number of sexual and reproductive health issues. In terms of health care services, it could be seen that only 2 subcenters existed in a total of 23 char villages surveyed. All of these factors make the women in the char areas extremely vulnerable to adverse sexual and reproductive health outcomes.

No separate records for Char areas are maintained by NRHM, however, since 2005, NRHM arranged for health care provision in Char areas by operating Boat Clinics. 15 Boat Clinics were under operation in March 2016. These clinics covered only 19 percent of Char villages. Others still remain out of coverage under NRHM. Provision of quality health care for the villages covered by Boat Clinics was another issue. The issues that surfaced from verification of two Boat Clinics are given below:

- Boat Clinics have a staff of two doctors, two ANMs, one laboratory technician and one pharmacist and provide basic ANC and PNC services and immunisation. Other necessary services such as sterilization, insertion of Intra Uterine Contraceptive Device (IUCD), abortion etc. are not provided by the Boat Clinics.
- Boats were only the means of transport for the medical staff and did not have any provisions for treating patients on the boats. During the period 2011-16, no delivery was conducted by the Boat Clinics.
- No adequate visits by the Boat Clinics to Char villages.
- There was no facility of ERS/PTS available for transporting patients from the Char area to the mainland during the hour of emergency in the selected districts (CAG report, 2017).

Women from conflict areas

Assam, the most populous among the 8 North-Eastern states and home to a large number of ethnic communities with unique identities has been experiencing ethnic violence since the 1980s. The violence in Assam has been driven by presence of diverse communities such with diverse identities and interests. Adding to the presence of already diverse ethnic communities, the migration of Adivasis from central India and the alleged immigration of Bengali Muslims has made the melting pot of diversities even more turbulent. The communal conflicts in Assam have been exemplified in the western districts of Kokrajhar, Bongaigaon, Chirang, Baksa, Udalguri, Darrang and Sonitpur. These districts have a large presence of communities such as Bodo, Adivasi, Rajbongshi, Bengali Muslim and Nepali. Since 2007 these districts have experienced major communal violence 3 times. During the violence between the Bodo and Bengali Muslim communities in 2012 approximately 5 lakh people were displaced, the largest displacement in 70 years of India's independence. Another spat of violence in the year 2014 between the Bodos and the Adivasis, 2 lakh people were displaced. A lot of the people who were displaced due to these conflicts could not return to their villages for months and in some cases years together due to fear of recurring conflict. Like in the case of floods in Assam, in the aftermath of communal conflicts which affect lakhs of people of different communities at the same time, women and children are the most vulnerable. For pregnant women, mothers with infants and young children, the distressing journey during the event of a conflict starts right from the time of fleeing their homes and villages to safety. The affected families have to walk long distances and sometimes through agricultural fields and jungles to reach a safe refuge, which takes a serious physical toll on pregnant women, mothers with infants and children. During conflict, communication is hampered severely which deprives the women of necessary ANC and emergency health services in case of pregnancies. The displaced families have to take refuge in cramped relief camps for months and in case of high risk villages, years; where they are deprived of basic hygiene, sanitation facilities and necessary nutrition. Also, diseases and infections are common among the residents of the relief camps. Such spaces are very unsafe for women and young girls where they are exposed to the risks of sexual abuse, molestation and even trafficking. During communal conflicts in Assam, the affected families' houses and belongings were

burnt and crops could not be cultivated or reaped. Moreover, the households could not engage in productive income generating activities for months together. This led, to adverse long term impact on the income of the households which in turn affected the nutrition levels and access to healthcare of the households. Pregnant women, mothers with infants and children suffer the most due to this loss of basic food security. Communal conflicts do not only impact the families and women in the short term, but also have long term bearing on their physical and psychological health. This leads to negative health outcomes especially for pregnant women and hampers the wellbeing of young children.

Women with disabilities

Amongst other issues of gender equality vis-a-vis women with disabilities, issue of violence against girls and women with disabilities is an area of grave concern, in as much as, most of the instances of sexual abuse, exploitation and violence against them go unreported to begin with and even when it comes into the net of judicial and police systems, post reporting of such incidences, there is little or no effective redressal of the grievances due to other challenges.

To begin with, sexual violence against girls and women with disabilities are usually not reported due to the fact that in almost all such cases, the perpetrators are members of the family or other known people and there is the fear of stigma or because such acts are committed in hostels and shelter homes where victims are completely kept subdued. There is also the challenge of non-reporting of such acts of violence against women with disabilities, because the victims, due to their disability, are unable to identify and / or convey who is the alleged perpetrator and also because these acts come to light only when it is later found that the victim had become pregnant due to such acts.

In Barpeta district of Assam (2016), one girl with developmental disability from the rural area was raped by her neighbour and the parents took a conscious decision not to report the matter to the police and haggled with the neighbours first to marry off the child and then to take financial returns from them. When this didn't work out, they finally reported the matter and case was registered, wherein, special educators from *Shishu Sarothi* were called to interpret the victim's statement in the courtroom. It may be noted that the girl with developmental disability had no speech and the special educators used flash cards to communicate with her to record her statement in the court.

However, it has been observed that there is huge spurt of reporting of instances of rape and sexual assault on women with disabilities in the media over the last few years as well as reporting with police and follow up actions in the judicial systems. This, however, comes with a gamut of challenges, some of which are observed below:

- Cavalier attitude of the police system to register reports of such instances and expedite preparation of charge sheets in the same along with taking other follow up actions.

In July 2018, in Khetri, Kamrup (Metro), Assam, a woman with disability, a mother of two children, was raped by a neighbour. The police were reluctant to register her complaint. Finally, after external intervention with the local police authorities, FIR was registered against the alleged neighbour. While the police sat over the matter thereafter, the said neighbour, a person of some repute in the locality, was absconding and now is out on anticipatory bail.

- Both police stations and court rooms are not equipped with trained human power to facilitate interpretation of statements being given by victims with disabilities, especially who are deaf and / or with developmental disabilities.

> Over the last 2-3 years, representatives from *Shishu Sarothi* have gone to various courts across many districts of Assam including Nalbari, Sonitpur, Barpeta, Kamrup (Metro), Baksa to facilitate recording of statements of such victims on numerous occasions. Such ill-equipped systems in place greatly hamper the right of access to justice of women with disabilities.

- Lack of barrier free built-environment in the police stations as well as courts again hugely hamper the right of access to justice for women with disabilities.
- In case of sexual violence against abandoned, vagrant women with disabilities from the streets, there is also issue of lack of adequate rehabilitation facilities and absence of shelter homes for them.
- The issue of sexual abuse of girls with disability leading to pregnancy and giving birth to a child results in a fragile situation where the need arises of looking at the rehabilitation needs of the young mother as well as the little baby, both of whom would come under the ambit of children in need of care and protection.

There is no emphasis from the state to take up awareness initiatives on sexual and reproductive health rights of girls and women with disabilities. Knowledge can be power and in the absence of information, women with disabilities are not empowered to stand for their sexual and reproductive health rights.

Key recommendations

In order to have accelerated progress towards achieving the SDGs in Assam, following steps need to be taken:

- First steps towards provision of health services, leaving no one behind could be to improve the infrastructure and staff availability in the health facilities across the state. The requirements for different communities and the geographical conditions need to be taken into consideration for this.
- Periodic mandatory trainings of the health staff at all levels will be critical in improving the service provision. The training should include a mandatory component on respectful maternity care.
- Concentrated efforts towards reducing maternal mortality incidence, with a special focus on women from vulnerable groups are needed. For this, provision of appropriate budgetary allocations for better implementation of current schemes is recommended. Stringent monitoring of implementation of schemes and programme is also important. Strict adherence to the GOI MDSR Guidelines and publishing the MDR analysis report every two years would help in implementation improvements.
- There is a need for regulation of private medical sector given the high rates of C-sections in private health facilities and constantly reducing sex ratio in the state.
- Addressing women's and girls' reproductive and sexual health needs in a comprehensive manner - community based programmes on information and counselling will be important in this regard. The sessions could be planned with adolescent groups and at the school level. The sessions could be conducted in local languages/ dialects for better reach.
- Life skills trainings for adolescents, teachers' trainings can be integrated with the schemes for adolescents.
- Increasing community participation at every level from VHNSC to block to district to state. The processes towards achieving SDG targets could be more participatory. Regular dialogues with civil society organisations to see who is being 'left behind' and joint planning for improvements.
- Community participation can be done through monitoring process at the local level which can also include PRI members. Panchayats and traditional governance institutions in Autonomous Council Areas need to play a role in the health system monitoring mechanism. Social audits could be another way of monitoring.
- Adequate cold storage system should be provided for vaccines in the Char areas and hilly areas as these places are inaccessible and take time to reach.
- IEC campaigns for schemes along with awareness programs in the community is important.
- Strict implementation of laws such as PWDVA, Child marriage act, MTP act, PCPNDT for improving the status of girls and women in the state is essential. Government should start an initiative to raise awareness about these acts and the seriousness of offence if they are not followed.
- Sensitization of health service providers and persons from law enforcing agencies towards the survivors of violence through recurrent trainings should be done.
- Counselling services especially mental health counselling (for survivors of violence as well as persons with mental health issues), couples counselling (for issues around sexual and reproductive health, violence) should be in place.
- Grievance redressal cell can go further down from the district to the block level for better accessibility for the people.
- For the people with disabilities, due to the inability to report any incidences of violence/ assault, the chances of their violation are higher thereby adding to their vulnerability and trauma. Awareness around issues related to SRH should be discussed with people with disabilities. It is specifically difficult to do so with people with intellectual disability and deaf and blind. However, some mechanism can be worked out and help from civil society organizations working on such issue can be sought in this regard.
- Some more vulnerable groups whose issues are not addressed in this report include LGBTQIA groups, street girls and women, nomadic groups

such as Banjaras, sex workers, other unorganized sector workers and migrant workers. These groups are not included because of lack of disaggregated data. Special provisions should be made for these groups so that they are not 'left behind' in the development process.

- Understanding that equality breeds inequity and hence the services, the communication and the strategies must be specially developed to empower those who were hitherto left behind.
- Setting up a long term mechanism for monitoring the progress made towards achieving the SDG targets by including the bodies such as SDG cell that are directly involved in the process, institutions like CAG that are involved in periodic audit of the government systems and the civil society groups in the state.

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Annexure

List of participants for SRH consultation in Assam, March 19 to 21, 2018.

Sr. No.	Name of the participants	Organization
1	Jennifer Liang	The ant
2	Martin Rabua	Diya Foundation
3	Niyar Gogoi	Pathikrit
4	Augustus Chermako	Boingaigaon Gana Seva Society (BGSSS)
5	Sheetal Sharma	UN Women
6	Nilanju Dutta	NEN
7	Laxmi Chetri	The ant
8	Usha Lakra	NEN
9	Nur Asma Ahmed	SESTA
10	Ravi Duggal	IBP, India
11	Sonma Burman	UBSSB
12	Bapi Sarkar	
13	Enakshi Dutta	IdEA
14	Utpal Bora	PUPS
15	Sunil Kaul	The ant
16	Priti Chakrabarty	Sanathan Unnayan Sanstha
17	Nandita Deka	HRLN, Assam
18	Soni Daimari	Gramin Bikash
19	Proshik Das	Jeevan Shiksha
20	Ronald Basumatary	IdEA
21	Renu Khanna	SAHAJ
22	Rashmi Padhye	SAHAJ
23	Nilangi Sardeshpande	SAHAJ
24	Meghali Senapati	TISS, Guwahati
25	Kankan Das	Diya Foundation
26	Atul Kalita	Manab Kalyan
27	Joel Rodrigues	NESRC
28	Netaji Basumatary	IGSSS

Data Driven Dialogues for Gender Equality and SDGs

Through this project, SAHAJ and EM2030 are set out to generate a policy dialogue for more encompassing, holistic and realistic state and national level plans for better implementation towards achieving the selected targets for girls and women. This work is going on in six selected states, viz., Assam, Bihar, Gujarat, Kerala, Madhya Pradesh and Punjab and at the national level.

One of the important objectives of the project is to increase political will and dialogue amongst key stakeholders, particularly government, on the importance of data and evidence-based implementation around selected targets from- 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).

Sahaj

towards alternatives in health and development

EQUAL MEASURES 2030