Monitoring the Progress of Sustainable Development Goals in Madhya Pradesh

Situation Analysis for Selected Targets from SDG3 and SDG5

Compiled by
SAHAJ Team

Supported by
Equal Measures 2030

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List of abbreviations

AHS - Annual Health Survey
AIDS - Acquired Immunodeficiency Syndrome
ANC - Antenatal Care
ARROW - The Asian Pacific Resource and Research Centre for Women
ASHA - Accredited Social Health Activist
BMI - Body Mass Index
CAG - Comptroller and Auditor General
CH - CommonHealth
CHC - Community Health Centre
CSO - Civil Society Organization
EAG - Empowered Action Group
EM 2030 - Equal Measures 2030
FGDs - Focus Group Discussions
GoI - Government of India
GRB - Gender Responsive Budgeting
GVI - Gender Vulnerability Index
HHDs - Households
HIV - Human Immunodeficiency Virus
HMIS - Health Monitoring Information System
ICDS - Integrated Child Development Services
ICPD - International Conference on Population and Development
IGMSY - Indira Gandhi Matrutwa Sahayog Yojana
IHHL - Individual Household Latrine
IIPS - International Institute of Population Sciences
IMR - Infant Mortality rate
IPC - Indian Penal Code
JSA - Jan Swasthya Abhiyan
JSY - Janani Suraksha Yojana
MDGs -Millennium Development Goals
MHRC - Maternal Health Rights Campaign
MMR - Maternal Mortality Ratio
MoSPI - Ministry of Statistics and Programme Implementation
MWCD - Ministry of Women and Child Development
MTP - Medical Termination of Pregnancy
NAMHHR - National Alliance for Maternal Health and Human Rights
NCRB - National Crime Records Bureau
NFHS - National Family Health Survey
NGO - Non Governmental Organization
NHSRC - National Health Systems Resource Centre
NHM - National Health Mission

NSS - National Sample Survey
NSSO - National Sample Survey Organization
OBC - Other Backward Classes
PGN - Practical Gender Needs
PHC - Primary Health Centre
PNC - Postnatal Care
PP - Post Partum
PWDVA - Protection of Women against Domestic Violence Act
RTI - Reproductive Tract Infections
RSBY - Rashtriya Swasthya Bima Yojana
SBA - Skilled Birth Attendant
SC - Scheduled Caste
SDGs - Sustainable Development Goals
SGI - Strategic Gender Interests
SLL -Special Local Laws
SPC - State Planning Commission
SRH - Sexual and Reproductive Health
SRHR - Sexual and Reproductive Health Rights
ST - Scheduled Tribe
STI - Sexually Transmitted infections
TFR - Total Fertility Rate
UN - United Nations
VAW - Violence against Women
U-DISE - Unified District Information System for Education
VDRL - Venereal Disease Research Laboratory
VV - Video Volunteers
WHO - World Health Organization
WNTA - Wada Na Todo Abhiyaan

Preface

The Government of India, as well as 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 the country. In this report, SAHAJ has attempted to compile the data from several such sources for the state of Madhya Pradesh with the objective of monitoring the development towards 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 a fair, equitable and inclusive development process. Thus, the analysis in this report builds on gender analysis and social equality.

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

SAHAJ Team,

October 2018

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Executive Summary

In 2015, the international development 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 listing indicators for all the targets. Simultaneously, several civil society organizations and coalitions (such as, WNTA) are working to monitor 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 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 equity perspective.

The first section of this report deals with the socio demographic profile of Madhya Pradesh, as well as the health and nutrition profile of the population of the state with a focus on women. The section on maternal health includes indicators related to ANC, delivery care and PNC services received by women in Madhya Pradesh and indicators for women's access to information about SRH and the SRH services. The section on gender equity contains data on violence against women, women's empowerment related indicators and indicators on harmful practices against women and girls.

Despite an abundance of natural resources, Madhya Pradesh is one of the most poorly developed states in India with a per capita income much lower than the national average. Predominantly an agricultural and pastoral economy, industrial development is concentrated in the more advanced districts of the state. Madhya Pradesh stands at the 25th position in the overall Gender Vulnerability Index (GVI) ranking in a list of 30 states (Plan International, 2017), indicating that it is one of the poorest performing states in the country for gender development indicators. According to the Health Index developed by *NITI Aayog*, Madhya Pradesh ranks 17th among the 21 larger states in terms of overall performance of the state and is among the least improved states between 2014-15 and 2015-16.

Sex ratio (931) is lower than the all India average (940) though the child sex ratio for the state is nearly the same as the national average (Census of India, 2011). The skewed ratio in the state can be attributed both to declining sex ratio at birth due to sex-selective abortions and to continued neglect and poor care-seeking for the girl child (Report of Comptroller and Auditor General of India, 2017).

Female literacy rate (59.2 percent) is much lower than the male literacy rate (78.7 percent). Literacy rate of women residing in urban areas is higher compared to rural areas by 24 percentage points (Census of India, 2011).

Sanitation and access to water are two dimensions that affect women more than men, given their biology and their menstrual health needs compounded by the societal norms of silence and shame around women's bodies. Access to piped water is very low in rural areas of the state. Even in urban areas, half of the households do not have access to piped water. 20 percent of the rural households do not have access to an improved drinking water source (NFHS-4, 2015-16).

The percentage of rural households using solid fuel for cooking (90 percent) is much higher than the urban households (23 percent) (NFHS-4, 2015-16). Clean fuel has a direct impact on women's health, preventing respiratory infections amongst them – around 90 percent of the rural Madhya Pradesh women are at risk of respiratory and eye infections due to biomass fuels.

According to the report of the Comptroller and Accountant general (2015-16), there was shortfall of 22 percent subcentres, 41 percent PHCs and 31 percent CHCs. 53.3 percent subcentres in the state function without a male health worker. 85 percent subcentres have quarters for ANMs and 63.7 percent ANMs stay in their quarters. 42 percent PHCs are functioning without a doctor. There is 80 percent shortfall in overall specialists in CHCs with 85 percent shortfall in surgeons and 83.5 percent shortfall in Obstetricians and gynecologists (Rural Health statistics, 2014-15).

5 percent rural and 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. (NSSO, 71st Round, 2014).

The percentage of women with low BMI has reduced from NFHS-3 to NFHS-4, while the percentage of overweight/obese women has increased. Half of the women in the state are anemic and comparison shows that the percentage of anemic women has decreased slightly in the 10 years between the two surveys.

MMR for the state of Madhya Pradesh has historically been higher than the national average. SRS data for the year 2014-16 reports MMR for the state to be 173, which is higher than the national average of 130.

There is a huge rise in the percentage of C-section deliveries in private health facilities in the state from NFHS-3 (2005-06) to NFHS-4 (2015-16) indicating unnecessary C-sections. Indicators related to ANC, institutional deliveries and PNC show differences across social categories based on residence (Rural- Urban), level of education of women and caste categories. Women from rural areas, women with low levels of education and women belonging to scheduled tribes are the ones who have least access to ANC, delivery and PNC related services (NFHS-4, 2015-16)

MHRC, Madhya Pradesh conducted 'Community Enquiry on Maternal Health' (2016) to understand the status of maternal health services and facilities and the implementation of maternal health schemes at the grassroots level. This enquiry listed shortage of specialized doctors at the PHC and CHC level, shortage of emergency services like blood and operation facilities at CHCs and the attitude and behavior of hospital staff as issues in current system. These issues hinder proper implementation of maternal health schemes that further lead to lack of service provision for maternal health services.

There are many issues of concern when it comes to SRH services in the state. Access to information about SRH services is low for the state and especially for the rural areas where three quarters of the population resides. The percentage of eligible women with unmet need for contraception has not changed at all during the 10 years from NFHS-3 to NFHS-4.

97.5 percent sterilizations reported in 2015-16, were female sterilizations (HMIS-NHSRC, 2015-16). Monitoring of sterilization camps where most of the sterilizations happen, highlighted a shortfall of healthcare providers (including doctors) that led to overload of cases per doctor; lack of basic infrastructure (beds etc.) in the camps and lack of transport facilities while going back from the camps. Once the procedure is done, women were left unattended and were discharged after a particular time even if they were still sedated. Similar issues were highlighted in the videos prepared by community correspondents of Video Volunteers (VV).

Reported percentage of ever married women who have ever experienced spousal violence reduced considerably from NFHS-3 (45.7 percent) to NFHS-4 (33 percent). 33 percent of ever-married women experienced spousal physical or sexual violence from current or most recent husband. Only 11 percent of these women reported to have sought help (mostly from the family), while 81 percent neither sought help nor told anyone about the violence.

Madhya Pradesh ranks 8th among the states in India on rate of total cognizable crimes (IPC+SLL) against women with a crime rate of 71.1. Reporting under Protection of Women from Domestic Violence Act, 2005 is very low for the state with only 90 cases registered during one year (2014-15). Evidence suggests that the outlook of the police could be an important reason for this under reporting.

Crime rate based on reported rapes (rapes reported per one lakh population) in the state was 13.1. In 98 percent of the reported rape cases, the offender was known to the victim. Half of the rape victims were below the age of 18 years (Crime in India, 2016).

Workforce participation rate for women in the state (32.6 percent) is lower than in their male counterparts (53.6 percent) but is higher than the national average (25.5 percent) for women. Women from rural areas of the state

have a much higher workforce participation rate as compared to the women in urban areas (Census of India, 2011). The higher participation of women from rural areas can be attributed to the agriculture based economy as women are involved in many field activities in agriculture. The percentage of women earning in cash has however reduced from NFHS-3 to NFHS-4.

Considering lower levels of attainment for women in terms of socio demographic indicators, access to nutrition and health related services and the levels and intensity of violence and other crimes against women, there is a need for improvement in terms of overall empowerment of women in the state.

Mean age at marriage for females in Madhya Pradesh is 20.7 years. 3.1 percent girls below the age of 18 years are already married. Mean age at marriage for girls who are married before 18 years of age is 16.3 years (Census of India, 2011).

Although some women from each social category (based on place of residence, years of schooling and religion) had begun child bearing at an early age (15-19 years), women from rural areas, women with no schooling and women belonging to scheduled tribes have more chances to do so compared to their respective counterparts (NFHS-4, 2015-16).

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

- Improve the infrastructure and staff availability in the health facilities across the state.
- Concentrated efforts towards provision of quality maternal health services and SRHR services for women
- Periodic mandatory trainings of the health staff at all levels with a mandatory component on respectful maternity care
- Regulation of private medical sector given the high rates of C-section deliveries 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
- Strengthen IEC activities to convey accurate information on maternity benefits schemes such as JSY and JSSK
- Stringent monitoring of implementation of all schemes pertaining to women and girls
- Counselling sessions with adolescent groups, at the school level with inclusion of life skills trainings
- Concrete steps in order to reduce the high dropout rate for girls at the secondary and higher secondary level
- Increasing community participation at every level from VHNSC to block to district to state
- Strict implementation of laws such as PWDVA, Child marriage act, MTP act, PCPNDT
- Single window facility for addressing all the issues related to violence against women
- Attitudinal change towards the survivors of domestic violence, sensitization of health service providers, police and persons from law enforcing agencies
- Counselling services for survivors of violence
- Identifying and integrating marginalized communities

Introduction

Background- MDGs to SDGs

Millennium Development Goals (MDGs), set in the year 2000 by 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 the 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 the 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. 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. The 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 their 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 equity 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 This project is supported by Equal Measures (EM) 2030[1] . 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 be 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 Madhya Pradesh with the objective of monitoring the development of sustainable development goals in the state.

Conceptual Framework

We describe below the conceptual framework that informs our data analysis decisions.

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. 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 and gender roles. 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 or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. "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 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 provide 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 level data from secondary sources such as census and several state level surveys as well as research articles published in national and international journals and some experiences and studies conducted by civil society organizations working in Madhya Pradesh during the two consultations held in Bhopal. The secondary sources of data include- Census of India 2011, National Family Health Survey-4 (NFHS-4, 2015-16), Annual Health Survey (AHS, 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 Madhya Pradesh, Health in India report of 71st round of National Sample Survey (NSS, 2014) conducted by NSSO 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 respondents whereas in datasets such as HMIS service coverage data are presented or in NCRB, the calculations are based on number of cases registered with the police. This report does not compare the data but compiles data from different datasets and analyses them 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 Madhya Pradesh state profile and includes the details of current state level efforts related to achievement of targets from SDG 3 and SDG 5 and the civil society presence in the state, along with information about demographic indicators, household characteristics, health infrastructure, health status of the population and nutrition related indicators among women. 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.

The section on women's health includes indicators related to ANC, delivery care and PNC services received by women in Madhya Pradesh and indicators for women's access to information about SRH and access to select SRH services. The section further discusses a few attempts at monitoring the

maternal health services in the state. Inequities in access to health care is an important issue in the state. Some discussion around social inequities forms the last part of the section.

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 includes some case stories documented by VV on various aspects of violence and gender equality in the state. 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.

Section 1:
State Profile- Madhya Pradesh

Madhya Pradesh has an area of over 3 lakh sq. km. and is the second largest state in India after Rajasthan. Madhya Pradesh is the second richest state in terms of its mineral resources. A large part of the mineral production in India is contributed to by Madhya Pradesh despite its abundance of natural resources, Madhya Pradesh is one of the most poorly developed states in India. In terms of both social and economic development, Madhya Pradesh lags behind most other states in India. It has an agricultural and pastoral economy. The state shows poor industrial development. The per capita income of the state is Rs. 56,182/- which is very low compared to the national average (Rs. 1,03,219) (Press Information Bureau, GoI, MoSPI, 2017).

According to the Gender Vulnerability Index, in terms of Poverty (25th rank), Protection (22nd rank), and Education (26th rank), Madhya Pradesh is one of the poorest performing states in India. For the health aspect although, the state shows satisfactory levels by ranking 14th among the 30 states. It stands at the 25th position in the overall Gender Vulnerability Index (GVI) ranking in the list of 30 states (Plan International, 2017).

According to the Health Index[2] developed by *NITI Aayog*, Madhya Pradesh ranks 17th among the 21 larger states in terms of overall performance of the state and with 1.10 annual incremental change between 2014-15 and 2015-16, it is among least improved states along with two other states- Assam and Odisha.

Efforts towards achieving SDGs in Madhya Pradesh

The state government and UNDP have produced a document named 'Achieving the 2030 agenda at state level'. The state government has also developed 'M.P. @ 75- Vision 2022' which is an effort towards achieving the SDGs. 'Vision 2018' document was prepared by a consultative process with all the departments of the government and other stakeholders with a regular review on defined parameters. Nine task forces were created to lead this process and to design the roadmap for SDG implementation. The State Planning Commission (SPC) has been established as a 'Nodal Point' for SDGs rollout with a functioning SDG cell. Each government department has a Policy planning and SDG monitoring cell and a data management cell is present in the SPC.

The State health policy is available in the public domain. The Department of Public Health and Family Welfare in the state has published Health care investment policy (2012) and Health care investment scheme (2016). Women related schemes currently functional in the state include State *Kishori Shakti Yojana, SABLA,* Beloved *Laxmi Yojana, Usha Kiran scheme* and *Indira Gandhi Matrutwa Sahayog Yojana* (IGMSY)/ Pradhan Mantri Matru Vandana Yojana.

State Planning Commission of Madhya Pradesh came up with a document named 'Women Status in Madhya Pradesh and Planned Interventions- A Gender Review' in 2010 which is an attempt to understand the situation of women and different programmes and provisions made by government of Madhya Pradesh for women in the line of eleventh five year plan (2007-12).

Gender Responsive Budgeting (GRB)

Madhya Pradesh is first state to introduce GRB in 2007-08. The Directorate of Women Empowerment, Madhya Pradesh, the nodal agency for advancement of women in the State, has introduced measures to ensure that gender equality outcomes are met. Schemes such as *Lado Abhiyan, Shaurya Dal, Ladli Lakshmi* and several others have helped in reducing child marriage, reducing domestic violence and raising collective consciousness to address women's issues.

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 Madhya Pradesh

Madhya Pradesh being one of the Empowered Action Group (EAG) states, civil society organizations working from the grassroots levels to the district and state level are in abundance. There are different organizations working in urban and rural pockets of the state on several important issues such as health, gender, livelihood, violence, health rights and related issues. We tried to get some of these organizations working towards achieving social equity on the same platform through our consultations in the state. The list of participants that were involved in the consultative process in the state is given in Annexure I. Following are the details of some of the groups we worked with closely during our project period in Madhya Pradesh.

Maternal Health Rights Campaign (MHRC), Madhya Pradesh

MHRC is a network of civil societies in Madhya Pradesh formed in response to the weak state of maternal health services, unequal distribution of health services, reported high maternal deaths from child birth related complexities and a lack of political will in promoting community centric accountability processes. The campaign aims to strengthen the health care system so that women, especially the socially excluded, have access to quality maternal health services and are free from discrimination. It ensures government's responsibility for provision of free quality maternal health services through community based monitoring and influencing the policy level issues through advocacy.

MHRC has more than 50 civil society organizations as its members across 16 districts of Madhya Pradesh. The campaign strategically works on building capacities of civil society organizations and community level groups on issues related to health and maternal health rights. It ensures representation and participation of marginalized community members in the district, block and village level health committees to enable them to raise problems being faced at the grassroots level.

One of the important activities under the campaign is Maternal Health Watch through Community Based Monitoring to mobilize people from the community for monitoring of health facilities and the quality of care being provided at the village level.

Constructively engaging with health service providers to sensitize them on issues of health rights and social exclusion and advocating for health and maternal health rights are important strategies of MHRC.

MHRC has gained recognition in the state as a network working dedicatedly on the issue of maternal health and health rights. Three rounds of community based monitoring across 14 districts of Madhya Pradesh covering more than 60 villages and 34 PHCs have been conducted. A total of 150 cases of violations/ denials have been documented. The communities at the block, district and state level are actively participating in public health dialogues organized to raise critical issues related to the availability and quality of healthcare services.

The campaign works in collaboration with state as well as national networks such as Jan Swasthya Abhiyan (JSA), National Alliance for Maternal Health and Human Rights (NAMHHR) and CommonHealth.

Video Volunteers

Video Volunteers (VV) is a community media organisation that empowers marginalized people to tell their stories and lead change campaigns, so that their issues don't get swept under the rug and instead become an important feature of the development narrative.

Across 18 districts of Madhya Pradesh, VV's community correspondents produce videos on issues such as gender, maternal and child health, forest rights, education, infrastructure and access to social security schemes. Videos are then screened to the community and government officials to bring about change. One in every four videos produced has solved the problem reported, i.e., 25 percent of all videos lead to change.

Civil Society participation in the process

SAHAJ organized a two day consultation on 'SDGs for SRHR: Advocacy planning for Madhya Pradesh' in Bhopal on April 30 and May 1, 2018 with the following objectives:

- To review the current evidence about the implementation of selected SDG targets in Madhya Pradesh
- To understand the field level situation from the experiences of field level partners with regards to the selected targets
- To apprise government officials regarding the project activities and seek their inputs regarding Government initiatives about SDG 3 and SDG 5

- To prepare advocacy plan for Madhya Pradesh focusing on selected targets

Nearly 50 participants from member organizations of different coalitions such as *Jan Swasthya Abhiyaan* (JSA), Maternal Health Rights Campaign (MHRC), Video Volunteers (VV) and other organizations working in Madhya Pradesh on health, gender, health rights, maternal health and related topics attended this consultation. The studies and experiences shared by the participants during the consultation are part of this report. The issues discussed in this consultation are listed in Annexure II.

SAHAJ conducted another consultation in Bhopal on September 10-11, 2018 on finalization of the first draft of the report. On the first day of the consultation, the civil society organizations in Madhya Pradesh discussed the report. Important points that emerged from these discussions are included in 'key recommendations' at the end of this report. On day two of the consultation, the report was shared with several government officials and policy decision makers. Mr. J. S. Kansotia, Principal Secretary, MWCD and Mr. Suresh Tomar, Joint Coordinator, MWCD were present for the session. The role played by the social activists in contributing significantly towards better delivery of services and facilities was underlined during the session. Mr. Kansotia suggested that NGOs have a key role in ensuring that the needy beneficiaries are not excluded from departmental schemes. This session was well covered by the local print media. Some of the news clippings are attached as Annexure III.

Socio- Demographic indicators

Madhya Pradesh is the 5th most populous state in India with a population of 72,626,809 which is 6 percent of India's total population. The population density of the state is 236 persons per sq. km. More than 75 percent of the population resides in villages. The majority population is Hindu with Muslims making up the largest minority community. The tribes of Madhya Pradesh constitute over 20 percent of the state's population. Out of the total 51 districts in the state, 19 are tribal predominant districts (Census of India, 2011).

Before going into the details of health and gender related indicators, this section briefs about the social aspects of the state such as sex ratio and literacy levels with a focus on women literacy. It then deliberates upon some of the important household characteristics that determine the health status of women and girls. At the end, this section focuses on nutrition related issues in the state.

Sex ratio

Sex ratio for Madhya Pradesh (in both rural and urban areas) is lower than the all India average. Child sex ratio for the state is nearly the same as the national average (Census of India, 2011).

Table 1: Sex ratio, Madhya Pradesh and India

Madhya Pradesh	Total	Rural	Urban	Source
Sex ratio (Total population)	931	936	918	Census of India, 2011
Child (0-6 years) sex ratio	918	923	901	
Sex ratio at birth	927	937	899	NFHS 4, 2015-16
	929			HMIS- NHSRC, 2015-16
India				
Sex ratio (Total population)	940	947	926	Census of India, 2011
Child (0-6 years) sex ratio	919	923	905	
Sex ratio at birth	919	927	899	NFHS 4, 2015-16
	922			HMIS- NHSRC, 2015-16

The skewed ratio in the state can be attributed both to declining sex ratio at birth due to sex-selective abortions and to continued neglect and poor care-seeking for the girl child (Report of Comptroller and Auditor General of India, 2017).

Education

Literacy rate for the state is 69.3 percent. Female literacy rate (59.2 percent) is much lower compared to the male literacy rate (78.7 percent). Literacy rate of women residing in urban areas (76.5 percent) is higher compared to rural areas (52.4 percent) by 24 percentage points (Census of India. 2011).

Only 14 percent of women age 15-49 in the state had completed 12 or more years of schooling, compared with 22 percent of men. Median number of years of schooling completed for women residing in urban areas was 6.2 years whereas for women residing in rural areas, it was 1.9 years (NFHS-4, 2015-16).

Girl's enrolment at the elementary level of schooling for all caste categories is nearly the same as the national average. However, for the secondary and higher secondary level of education, the enrolment is lower than the national average. Though the percentage of girls' enrolment is at par or sometimes even higher as compared to boys for the primary level of education, the ratio of girls' to boys' enrolment for the elementary to higher secondary level shows a gradual decline from 0.94 (primary level) to 0.88 (secondary level) to 0.78 (higher secondary level) (U-DISE, 2013-14). This is also evident from the transition rate between different education levels for boys and girls as shown in the following table-

Table 2: Transition rate between different education levels for boys and girls, Madhya Pradesh (U-DISE, 2013-14)

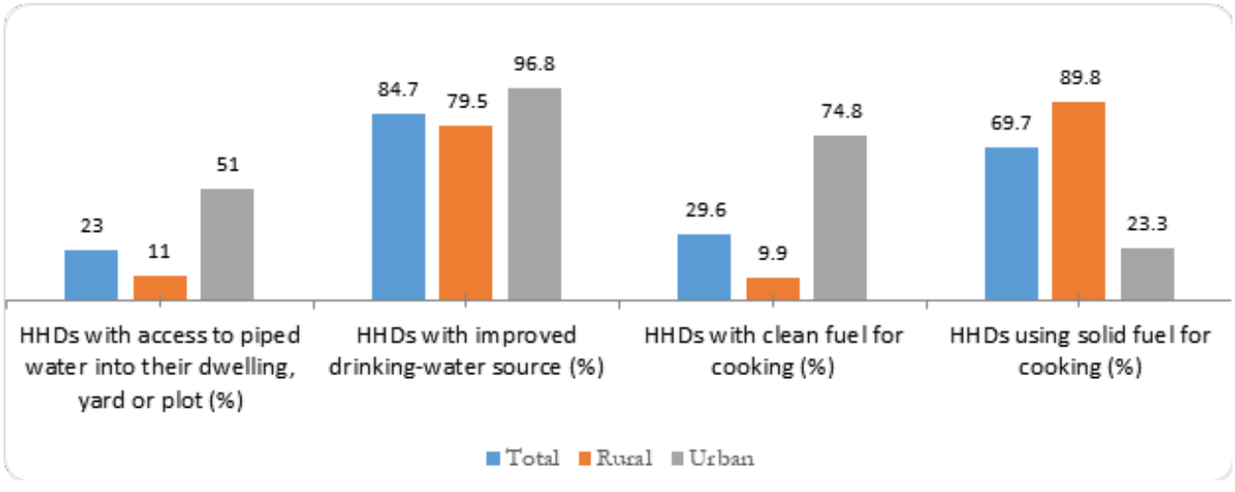
	Boys	Girls
Primary to Upper primary level	87.8	87.1
Elementary to secondary level	86.2	77.6
Secondary to higher secondary level	72.3	67.9

Household characteristics

Household 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. 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 Madhya Pradesh are described in the following figure.

Figure 1: Selected household characteristics, Madhya Pradesh



Access to piped water is very low in rural areas. Even in urban areas, half of the households do not have access to piped water. More than 95 percent households in urban areas have access to improved[3] drinking water source whereas 20 percent of the rural households do not have access to improved drinking water (NFHS-4, 2015-16).

Type of fuel for cooking is an important indicator impacting women's health. Women are not only exclusively responsible for cooking but also for gathering fuel[4] for cooking. The use of solid fuel for cooking has been seen to be associated with several adverse health and birth outcomes among women (Mohapatra, Das and Samantaray, 2018). Nearly 70 percent households reported the use of solid fuel for cooking. The percentage of rural households (90 percent) using solid fuel for cooking is much higher than the urban households (23 percent) (NFHS-4, 2015-16). Clean fuel has a direct impact on women's health preventing respiratory infections amongst them – around 90 percent of the rural Madhya Pradesh women are at risk of respiratory and eye infections due to biomass fuels.

The percentage of households in Madhya Pradesh reporting no latrine is very high (71.2 percent) (Census of India, 2011). Women are at higher risk of reproductive infections because of lack of improved sanitation. According to the *Swachh Bharat Mission* dashboard though, the coverage of Individual Household Latrine (IHHL) in the state is 98.8 percent (Ministry of drinking water and Sanitation, GoI). Madhya Pradesh is one the few states that have not yet reported full coverage of IHHL.

3 Improved water source 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.

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

Health and nutrition

Health infrastructure

Only one percent of villages in the state do not have ASHA workers appointed in the village. There is one ASHA per 935 rural population in the state (An update on ASHA programme, 2013). There are 9192 village level health centres (subcentres) with a shortfall of 26 percent. 806 more subcentre buildings require to be constructed in the state. 53.3 percent subcentres in the state function without a male health worker. 85 percent subcentres have quarters for ANMs and 63.7 percent ANMs stay in their quarters. There are 1171 functioning PHCs in the state which are 41 percent fewer than the required number. 491 (42 percent) PHCs are functioning without a doctor. There are 334 CHCs in the state with a shortfall of 33 percent. There is an 80 percent shortfall in overall specialists in CHCs with 85 percent shortfall in surgeons and 83.5 percent shortfall in Obstetricians and gynecologists (Rural Health Statistics, 2014-15). According to the CAG report (2015-16), there was shortfall of 22 percent subcentres, 41 percent PHCs and 31 percent CHCs.

Box 1: Report of the Comptroller and Auditor General (CAG) of India on General and Social Sectors for Madhya Pradesh (2017)

13 districts out of 43 with predominantly rural population were selected using simple random sampling method. The districts chosen were from three categories- low, medium and high performing, based on their ranking on a Health Index. Within these sampled 13 districts, 27 CHCs, 52 PHCs and 149 subcentres were randomly selected. Data from both primary and secondary data sources was collected and analysed.

One of the objectives of performance audit was to assess the impact of NRHM on improving Reproductive and Child Health in the State by checking the extent of availability of physical infrastructure; extent of availability of health care professionals and quality of health care provided.

The CAG report stated the following points about Madhya Pradesh for the period between 2011-12 and 2015-16-

- State could not attain the goals for IMR, MMR and TFR due to scheme Implementation weaknesses.
- Pregnant women registered for ANC were not tested for HIV and VDRL in 64 and 81 percent cases respectively.
- Out of total home deliveries 74 percent were not attended by SBA trained health professional.
- Shortfall in service for sterilisation and spacing methods was noticed.
- Bottom-up approach was not adopted at district level during planning process.

Health status of the population

5 percent rural and 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. 4 percent of rural and 4.4 percent of urban population were hospitalized (excluding childbirth) during a reference period of 365 days which are a little low compared to the national average (4.4 for rural and 4.9 for urban population) (NSSO, 71st Round, 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. Findings from HMIS data compiled by NHSRC are given in the table below. These data also show lower levels of reporting compared to the national figures.

Table 3: Health facility related services, Madhya Pradesh (HMIS, NHSRC, 2015-16)

Indicator	Madhya Pradesh	India
OPD per 1000 population	633.2	1033.0
IPD per 1000 population	53.5	48.5
Major surgeries per lakh population	213.3	363.0

Health insurance

18 percent households in Madhya Pradesh have any kind of health insurance covering at least one household member. Health insurance coverage is higher for urban areas (23 percent) than rural areas (15 percent). State health insurance scheme (61 percent) and *Rashtriya Swasthya Bima Yojana* (RSBY) (18 percent) are the most commonly availed health insurance schemes in the state. Mere 11 percent women and 13 percent men (age 15-49 years) are covered by any health insurance (NFHS-4, 2015-16).

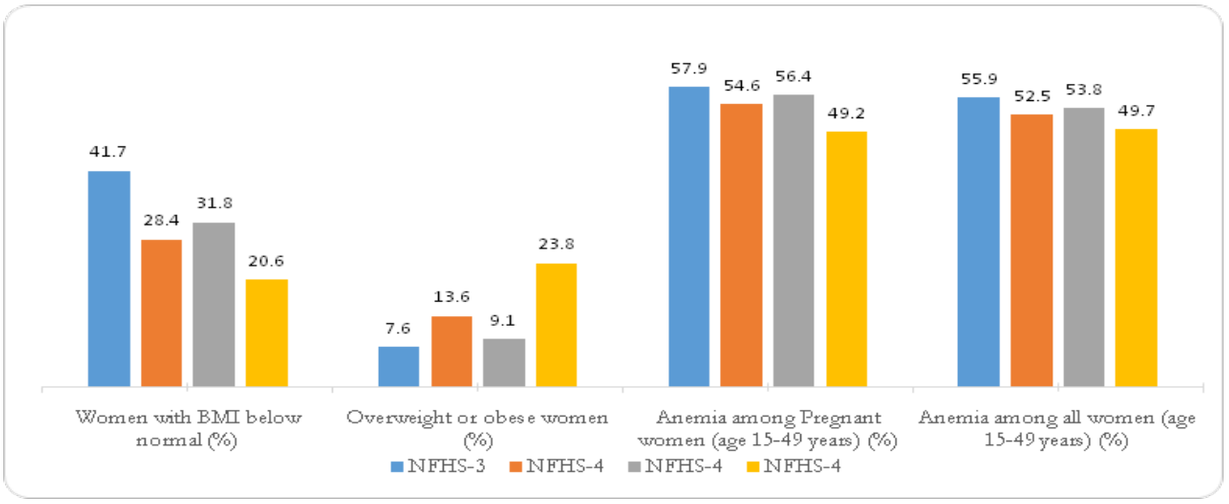
Per thousand distribution of persons by coverage of scheme of health expenditure support for rural areas of Madhya Pradesh shows that only 3 persons per 1000 are covered by government funded health insurance scheme. Rest have no coverage of any scheme or insurance policy. The situation for urban areas is slightly better with 38 persons per 1000 being covered under government funded health insurance scheme, 8 persons per 1000 with employer supported health protection and 6 persons per 1000 were supported by the insurance companies through the households (NSSO, 71st Round, 2014).

Nutrition indicators among women

India is experiencing a demographic transition with the double burden of undernutrition and increasing obesity among the population. In Madhya Pradesh, percentage of women with low BMI (sign of undernourishment) has reduced from NFHS-3 to NFHS-4 but there is still scope for improvement in both rural and urban areas. At the same time, the percentage of overweight/ obese women has increased from 7.6 percent to 13.6 percent. The percentage of overweight/ obese women is much higher in urban areas as compared to rural areas.

Half of the women in the state (both rural and urban areas) are anemic and the comparison (NFHS-3 and NFHS-4) shows that the percentage of anemic women has decreased only slightly during these 10 years.

Figure 2: Nutrition related indicators among women, Madhya Pradesh



Anemia levels among women are high irrespective of the social group to which they belong with small differences within different categories. Among the social groups based on caste categories, women belonging to ST category have very high levels of anemia (64 percent) compared to SC (51.7 percent), OBC (49.9 percent) and Others (47.4 percent). Anemia levels among women (15-49 years) (52.5 percent) are more than double compared to men belonging to same age group (25.5 percent) (NFHS-4, 2015-16).

Budget for Health care and Nutrition in Madhya Pradesh

The budget estimate for Madhya Pradesh is Rs. 186685 crores in 2018-19 and budget outlay for health care and nutrition is Rs. 8385.2 crores and Rs. 1793.63 crores respectively. The percentage share of health care and nutrition is just 4.49 percent and 0.96 percent respectively. The public provisioning for health care has increased marginally from 3.91 percent in 2016-17 to 4.49 percent in 2018-19. The National Health Policy (2017) document has suggested that all the state governments should enhance health care budget to 8 percent of state's total expenditure by 2020. It would be interesting to test whether Madhya Pradesh would be financially capable to enhance its budgetary provisioning to 8 percent by 2020.

Highlights

- Despite an abundance of natural resources, Madhya Pradesh is one of the most poorly developed states in India with per capita income much lower than the national average (Press Information Bureau, GoI, MoSPI, 2017). Economy is predominantly agricultural and pastoral with limited industrial development.
- Sex ratio (931) is lower than the all India average (940) and can be attributed to declining sex ratio at birth due to sex-selective abortions as well as to continued neglect and poor care-seeking for the girl child (Report of Comptroller and Auditor General of India, 2017).
- Female literacy rate (59.2 percent) is much lower than the male literacy rate (78.7 percent). Literacy rate of women residing in urban areas is higher compared to that in rural areas by 24 percentage points (Census of India, 2011).
- Access to piped water is very low especially in rural areas of the state. 20 percent of the rural households still do not have access to improved drinking water source (NFHS-4, 2015-16).
- Around 90 percent of women in rural Madhya Pradesh are at risk of respiratory and eye infections due to use of biomass fuels (NFHS-4, 2015-16).
- According to the report of Comptroller and Accountant general (2015-16), there was shortfall of 22 percent subcentres, 41 percent PHCs and 31 percent CHCs.
- 42 percent PHCs are functioning without a doctor. There is an 80 percent shortfall in overall specialists in CHCs with 85 percent shortfall in surgeons and 83.5 percent shortfall in Obstetricians and gynecologists (Rural Health statistics, 2014-15).
- Percentage of women with low BMI has reduced from NFHS-3 to NFHS-4, while the percentage of overweight/obese women has increased. Half of the women in the state are anemic and the comparison shows that the percentage of anemic women has decreased slightly in 10 years (less than 1% per year).

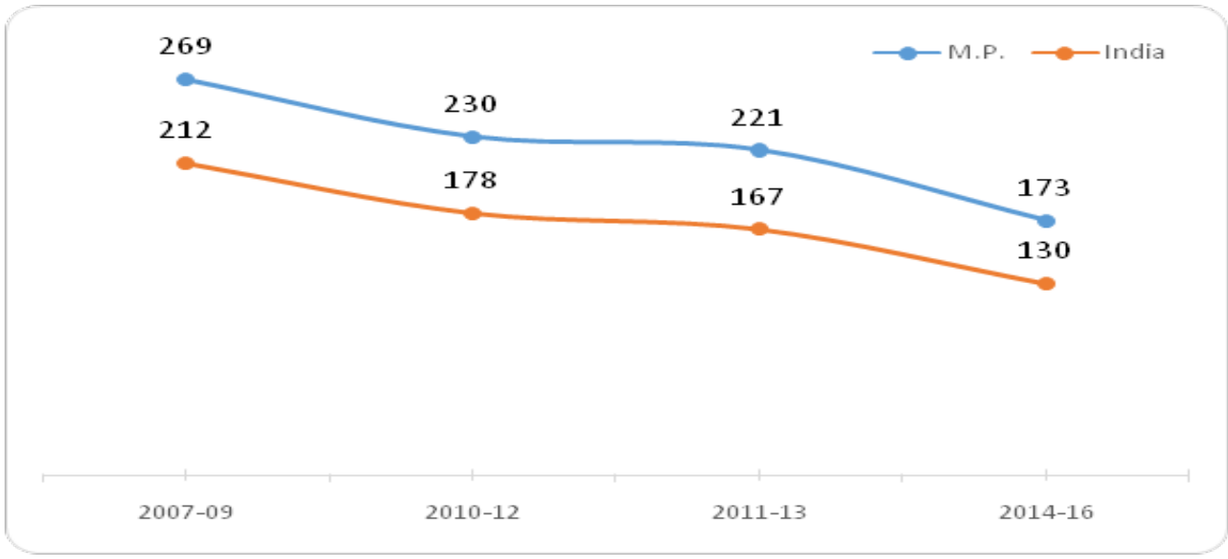
Section 2: Maternal mortality and other SRH issues

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). The first part deals with maternal mortality.

Maternal mortality

MMR for the state of Madhya Pradesh has historically been higher than the national average. The trend in MMR over the last few years in comparison to all India figures is given in the figure below-

Figure 3: Trend in MMR, Madhya Pradesh and India (SRS MMR Bulletins)



SRS data for the year 2014-16 reports the MMR for the state to be 173 which is higher than the national average of 130. Maternal mortality is caused by many biological and social factors acting together but it is directly related to factors around pregnancy and childbirth. Thus, access to antenatal care (ANC), delivery services and immediate postnatal care (PNC) become important indicators for MMR. Table 4 gives an account of some ANC, delivery and PNC related indicators.

The state does not perform well on ANC indicators (Percentage of women who have received full ANC is 11.4 and only 35.7 percent women have received the stipulated minimum 4 ANCs during their pregnancy).

Table 4: Select ANC, delivery and PNC related indicators, Madhya Pradesh (NFHS-4, 2015-16)

Indicator	NFHS-3	NFHS-4			
	Total	Total	Rural	Urban	India Total
	(%)	(%)	(%)	(%)	(%)
Four ANCs during pregnancy	22.3	35.7	29.6	51.6	51.2
PNC within 48 hrs. of delivery	24.9	55	50.3	67.1	62.4
Births attended by skilled health personnel	32.7	78.1	73.8	90.4	81.4
C-section	3.5	8.6	5.1	19.1	17.2
C-section (Public Health Facilities)	6.8	5.8	3.9	11.4	11.9
C-section (Private Health Facilities)	28.8	40.8	38	42.7	40.9

There is a significant improvement from NFHS-3 to NFHS-4 in some of the indicators, viz., percentage of institutional deliveries (26.2 percent to 80.8 percent), births attended by skilled health personnel (32.7 percent to 78.1 percent) etc. Percentage of C-section deliveries in public health facilities has reduced slightly from NFHS-3 to NFHS-4 whereas there is a huge rise in percentage of C-section in private health facilities in the state indicating unnecessary C-sections and thus, unethical medical practice.

Table 5: Percentage of women for select maternal health indicators according to background characteristics

Background characteristics		Percentage receiving full ANC	Percentage institutional deliveries	Percentage receiving PNC
Residence	Urban	19.5	93.8	70.4
	Rural	8.3	76.4	56.3
Level of education	No schooling	5.6	68.1	50.3
	<5 years of schooling	8.9	77.8	59.1
	5-9 years of schooling	10.4	85.6	62.0
	10-11 years of schooling	15.9	92.4	67.8
	12 or more years of schooling	27.7	96.8	75.0
Caste categories	SC	9.5	84.8	60.0
	ST	7.0	60.3	50.6
	OBC	12.5	87.4	63.1
	Others	17.3	90.6	66.5

Indicators related to ANC, institutional deliveries and PNC show differences across social categories based on residence (Rural- Urban), level of education of women and caste categories. Women from rural areas, women with low levels of education and women belonging to scheduled tribes are the ones who have least access to ANC, delivery and PNC related services (NFHS-4, 2015-16).

Box 2: Community Enquiry on Maternal Health (Community based Monitoring Report, MHRC, Madhya Pradesh, 2016)

MHRC has carried out three rounds of community enquiry on maternal health with the objective of understanding the status of maternal health services and facilities and the implementation of maternal health schemes at the grassroots level and tracking the changes between the various phases. The findings from the third round (2016) of community enquiry listed the following issues in the current public health system at the grassroots level that hinder proper implementation of maternal health schemes leading to lack of service provision for maternal health services-

- Shortage of specialized doctors
- Normal delivery not possible at subcentres
- Shortage of emergency services like blood and operation facilities at CHCs
- The attitude and behavior of hospital staff- Demand for money, unnecessary referral of patients, lack of medicines and other infrastructural facilities

Public Health Dialogue with Health System

Based on the findings from the various rounds of community based monitoring, MHRC and partners organized various district and state level public dialogues wherein the community representatives got an opportunity to interact with their health functionaries and highlight the gaps in the functioning of the healthcare system. Memorandums have been submitted to the officials asking for immediate redressal of the problems after each dialogue.

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 63 percent pregnant women in urban areas and 73.6 percent of pregnant women in rural areas received any benefits under this scheme. Health checkups were received by 53 percent pregnant women in urban areas and 63.6 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).

Box 3: Impact of video on not receiving funds under JSY (Based on Video produced by VV)

Three women from Murjhor village, Seoni did not receive Rs. 1400/- under the JSY even after 7-8 months of their delivery. They visited the health facility several times to enquire about the money. They filled the required forms too. These women were frustrated because they were entitled to get the benefit under the scheme and even after several enquiries from their side, they did not get the amount. This issue was captured on video on 4th October 2016 by Rekha Bhangare, a community correspondent of VV. After the video was shared with the officials, all three women received a sum of Rs. 1400/- in their bank accounts in the month of November 2016.

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 (The Asian Pacific Resource and Research Centre for Women (ARROW), 2011).

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

Table 6: Select SRH service related indicators, Madhya Pradesh (NFHS-4, 2015-16)

Indicator		NFHS-4	NFHS-3		
		Total	Rural	Urban	Total
		(%)	(%)	(%)	(%)
Access to information	Women having comprehensive knowledge of HIV/AIDS	18.1	12.1	31.1	20.3
	Women age 15-24 years using hygienic methods of protection during menstrual period	37.6	26.4	65.4	NA
	Health workers ever talked to female contraceptive non users about family planning	20.4	19.3	22.9	15.9
	Current contraceptive users ever told about side effects of current methods	39.3	36.3	48.8	47.1
Access Contraception services	Use of contraceptive method (currently married, 15–49 years)	51.4	51.3	51.6	55.9
	Use of modern contraceptive method (currently married, 15–49 years)	49.6	49.8	49	52.8
	Unmet Need- spacing (currently married, 15–49 years)	5.7	5.6	6	5.4
	Unmet Need- Total (currently married, 15–49 years)	12.1	11.6	13.5	12.1

There are many issues of concern when it comes to SRH services in the state. Access to information about SRH services is low for the state and especially for the rural areas where three quarters of the population lives. The percentage of unmet need for contraception has not changed at all during the 10 years from NFHS-3 to NFHS-4.

Contraceptive prevalence does not vary by place of residence (urban or rural). However, contraceptive use is inversely proportional to level of schooling. 58 percent of currently married women with no schooling reported the use of contraceptive as against only 44 percent of women with 12 or more years of schooling. The religion wise groups show that, women belonging to Muslim religion (45 percent) reported lower use of contraception than Jain (53 percent) or Hindu (52 percent) women.

Open government data platform reported 40,182 MTPs in 2014-15 whereas 51945 abortions (including Spontaneous abortions) were reported in 2015-16 with 4.4 percent abortion rate against estimated pregnancies (HMIS-NHSRC, 2015-16). The state has 14 comprehensive abortion care training centres and 390 medical officers have already been trained in these training centres (Madhya Pradesh health services website).

Box 4: Studies related to medical abortion

MTP seeking behavior among women in Balaghat, Madhya Pradesh (Based on a Dissertation Submitted By Kishu Waghela to IIPH, Gandhinagar, 2018)

Medical Termination of Pregnancy (MTP) act is being implemented in India since 1997 in order to reduce maternal mortality and morbidity because of abortion. Abortion rate for Madhya Pradesh was 4.4 percent against estimated pregnancies (HMIS-NHSRC, 2015-16). According to Annual Health Survey 2012-13, MMR for Balaghat, a tribal district of Madhya Pradesh, is 246 and only 44.5 percent abortions in Balaghat are performed by skilled health personnel. A study was conducted using qualitative methods of data gathering (between April, 2018 and May, 2018) in order to understand the MTP seeking behaviour of the women in Balaghat and assessing the factors influencing these. The tools used included FGDs with ASHAs as key informants, in-depth interviews with women who have undergone MTP within past four years and other stakeholders from health facilities.

Almost all respondents reported induced abortion at home through medicines acquired from illegal providers or pharmacies. Some women suffered from complications following the abortion. Facility based push factors included- minimal availability of MTP services, limited physical and financial access, poor quality of care at public health care facility, lack of awareness and motivation among the medical officers and lack of awareness among the ASHAs. Community based factors were lack of awareness among rural women on legality of MTP, methods of MTP and family planning.

The recommendations of the study were-

- Mandatory training for MTP for Medical Officers at least till CHC level,
- Provision of medical abortion at all levels of public health facilities,
- Sensitization of block medical officers, nurses and ASHAs for improving access and quality of safe abortion practices,
- Strict monitoring and regulation on sales of medicines.

Existence of retail market for medical abortion and knowledge of pharmacists about medical abortion

Medical abortion can contribute to reduced maternal mortality but little is known about the provision or quality of advice for medical abortion through the private retail sector. A study of the retail market for medical abortion was conducted in cities, towns and rural areas of in Madhya Pradesh where 591 pharmacists in 60 local markets were interviewed to gather information on their knowledge about medical abortion (Powell-Jackson T. et al., 2015). 68.5 percent interviewed pharmacists stated that abortion was illegal in India. 359 pharmacists out of these were visited by undercover patients as genuine customers seeking a medical abortion. Medical abortion was offered to these patients by 71.3 percent pharmacists. Only 38.5 percent pharmacists asked clients the timing of the last menstrual period and only 13.8 percent requested to see a doctor's prescription. The study concluded that the retail market for medical abortion is extensive, but the quality of advice given to patients is poor. The study recommended an urgent need to improve the practices of pharmacists.

97.5 percent sterilizations reported in 2015-16, were female sterilizations. 8 percent of these were postpartum (PP) sterilizations. Number of cases of complications following female sterilization were 592 (0.14 percent) out of which 9 women succumbed to death. There were 627 reported failures of female sterilization (HMIS-NHSRC, 2015-16). Most of the sterilizations happen in sterilization camps. A monitoring activity called 'Camp Watch' was conducted by MHRC in 35 sterilization camps in 11 districts of Madhya Pradesh during November 2016 and January 2017 with the objective of monitoring the services in the sterilization camps for their quality. Monitoring was done using two methods- Observation of the camps and exit interviews. A total of 1296 women underwent sterilization in these 35 camps. This monitoring highlighted some of the important issues about quality of care in sterilization camps. These were-

- Shortfall of healthcare providers including doctors that led to overload of cases per doctor.
- Lack of basic infrastructure (beds etc.) in the camps
- Lack of transport facilities while going back from the camps

Once the procedure is done, women were left unattended and were discharged after a particular time even if they were still sedated.

Box 5: Impact of video of health facility on improving sterilization camp facilities (Based on Video produced by VV)

A video prepared by Arti Bai Valmiki, a Community Correspondent of VV in Batiyagarh, Damoh threw light on the dilapidated state of a public health facility that lacked proper infrastructure such as beds for patients. The staircase at the main gate of the facility was broken. It made commuting difficult for patients and their relatives. There were no stretchers for the patients. 2-3 people used to carry the patients in their arms. For the women coming for the sterilization camps, there were no beds available. Women used to lie on ground.

The video captured a doctor taking thumbprints of women who have just undergone the sterilization operation and had not even gained full consciousness and discharging them in that condition by putting cash in their hands. After the issue was discussed with the officials at the district level along with the video, budget was released and it made a lot of difference. Now, there are beds for women coming for sterilization camps. The money is now directly transferred to their accounts. A new ramp has been constructed at the main gate.

Highlights

- MMR for the state of Madhya Pradesh has historically been higher than the national average. SRS data for the year 2014-16 reports MMR for the state to be 173, which is higher than the national average of 130.
- There is a huge rise in percentage of C- section deliveries in private health facilities in the state from NFHS-3 (2005-06) to NFHS-4 (2015-16) indicating unnecessary C- section deliveries.
- Women from rural areas, women with low levels of education and women belonging to scheduled tribes are the ones who have least access to ANC, delivery and PNC related services (NFHS-4, 2015-16)
- Several monitoring efforts have highlighted shortage of staff in government health facilities, shortage of emergency services, lack of basic infrastructure etc.
- Access to information about SRH services is low for the state and especially for the rural areas where three quarters of the population lives.
- The percentage of unmet need for contraception has not changed during the 10 years from NFHS-3 to NFHS-4.
- Induced abortion at home through market purchased drugs is prevalent as a method of abortion, but pharmacists have poor knowledge of both the MTP Act, as well as about the correct procedure for medical abortions.

Section 3: Gender equality

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

Violence against girls and women

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, violence related to property crimes, and violence in workplaces and other institutions. 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 spousal violence (NFHS-4, 2015-16)

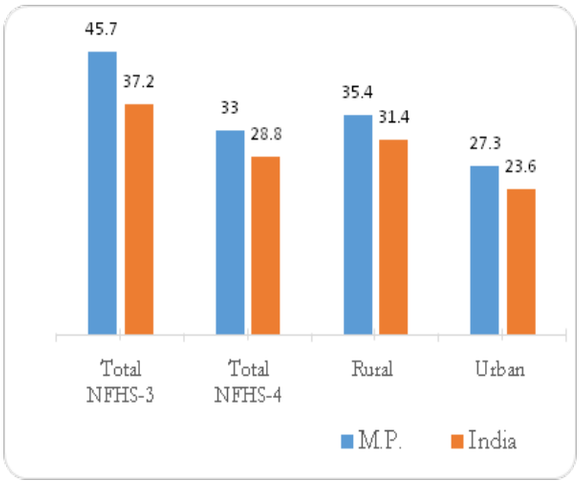
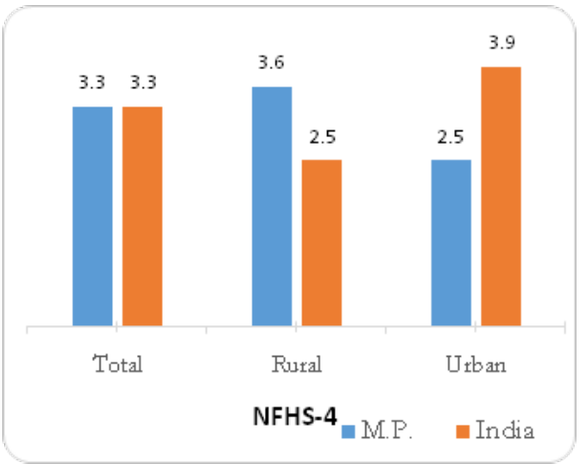


Figure 5: Percent of ever married women who have experienced violence during any pregnancy (NFHS-4, 2015-16)



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

Table 7: Various forms of violence committed against women by their husbands, Madhya Pradesh (NFHS-4, 2015-16)

Indicator	In past 12 months			Ever
	Often	Sometimes	Often or sometimes	Total
	(%)	(%)	(%)	(%)
Any form of physical violence	3.5	22.1	25.6	31.4
Any form of sexual violence	1.1	6	7.1	8.4
Any form of emotional violence	2.2	8.7	10.9	12.4
Either physical or sexual violence	4	23.3	27.3	33
Both physical and sexual violence	0.6	4.7	5.3	6.8

33 percent of ever-married women experienced spousal physical or sexual violence from current or most recent husband. 12 percent ever married women reported emotional violence. Only 11 percent women reported to have sought help (mostly from the family). Only 2 percent of those who sought help went to the police. 81 percent neither sought help nor told anyone about the violence.

Box 6: Case story of a survivor of spousal violence (Based on a video by Community Correspondent Jyoti Kadam and article by Madhura Chakraborty, a journalist in the VV editorial team)

Parvin was married off at the age of 12 by her parents. She refused to go to her in-laws' place. Later she met and got married to Hanif, her husband. After this the parents refused to have anything further to do with her. But her marriage was not a happy one and she faced a lot of domestic violence.

After she gave birth to her first daughter in 1997, the mental and physical assaults from her husband intensified as he wanted a son. Three years later, after illegally determining the sex of the baby to be a girl, Parvin was made to abort. This was repeated after a few months even after her protests. She got pregnant for the third time during that year but miscarried. "I wanted another child. So, the next time I got pregnant, I didn't tell anyone. But in my fifth month, my husband beat me very badly with a hockey stick. I fell down and could not get up. I started bleeding and everyone found out about the pregnancy. It was already the fifth month, so there could be no abortion. I had my second daughter," says Parvin.

Fed up with the continued abuse, she started living separately in 2008 and decided to file for a divorce. In March 2009, her separated husband attacked Parvin brutally in her own house when the girls were out. "(H)e held me by the shoulders and started biting my face. He attacked me and bit me like a wild animal hunting its prey. He bit my nose so hard and didn't let up until it was torn off my face. I cried and shouted for help but no one came to my aid."

Despite this looming threat to her and her daughters' lives, she continues to pursue her divorce case. "We have to put up with a lot, society looks at us with a distorted lens. I am responsible for my daughters and I am bringing them up well," adds Parvin. She works as an anganwadi worker to support her family. She has recently appealed to the High Court in Gwalior for finalising her divorce after it was dismissed in a lower court. Her struggle continues, but Parvin is not about to give up.

Madhya Pradesh ranks 8th among the states in India on rate of total cognizable crimes (IPC+SLL) against women with a crime rate of 71.1. This means that the state has high reporting of crimes against women compared to many other states. Reporting under PWDVA is very low for the state with only 90 cases registered during one year (Crime in India, 2016).

The outlook of the police could be an important reason for this under reporting. When Community Correspondents from VV were monitoring the efficiency of 181 Women's Helpline, they spoke to some police personnel about it. A policeman stationed in Gwalior said that if women come to the police station to complain about their families, it will only make matters worse for them. He was of the opinion that women should refrain from making formal complaints.

Table 8: Crime rate for different crimes against women, Madhya Pradesh (NCRB, 2016)

Indicator	Crime rate (crimes per one lakh population)
Rate of total cognizable crimes against women (IPC+SLL)	71.1
Cruelty by Husband or his relatives (Sec. 498 A)	16.8
Kidnapping & Abduction of Women	13.1
Rape	13.1
Assault on women with intent to outrage her modesty	23.3
Rate of IPC crimes	70.7

Crime rate based on reported rapes (rapes reported per one lakh population) in the state was 13.1. In 98 percent of the reported rape cases, the offender was known to the victim. Half of the rape victims were below the age of 18 years (Crime in India, 2016).

Box 7: Case story of a domestic violence survivor (Based on a video by Community Correspondent Lakhuprasad Prajapati and an article by Alankrita Anand, a member of the VV editorial team)

Gyanwati is currently living in her natal home with her parents and her children. She was subjected to physical violence and verbal abuse for being dark-skinned and eating "too much" in her marital home and thus, had to leave.

When she first went to the local police station to file a complaint against the violence, the police refused to register her complaint. She went to follow-up but no action was taken even then. On the contrary, she was made to stay at the police station all day while her husband was asked to leave in the afternoon; and this made her more suspicious of seeking help from the police. Gyanwati also approached the Family Counseling Centre in her district. It was not of any help either. Gyanwati is not willing to settle for the current situation. She wants to live in her marital home, and wants her children to grow up and go to school in a safe environment. She wants a written guarantee from her husband and in-laws.

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.

Women's empowerment indicators

Workforce participation rate for women in the state (32.6 percent) is lower than their male counterparts (53.6 percent) but is higher than the national average (25.5 percent) for women. Women from rural areas of the state have a much higher workforce participation rate (39.3 percent) as compared to the women in urban areas (15.1 percent) (Census of India, 2011). Women workforce participation is more in the casual labor (39.7 percent) in rural whereas percentage of regular wage or salaried employees (35.6 percent) is higher in urban areas. Women's workforce participation in self-employment is equal to men in both rural and urban areas of the state (NSSO 68th round, 2011-12).

NFHS-4 has some indicators that show women's empowerment. These are tabulated below.

Table 9: Select indicators regarding women's empowerment, Madhya Pradesh

		NFHS-4			NFHS-3
		Total	Rural	Urban	Total
		(%)	(%)	(%)	(%)
Currently married women who usually participate in household decisions	Madhya Pradesh	82.8	80.8	87.7	68.5
	India	84	83	85.8	76.5
Women who worked in the last 12 months who were paid in cash	Madhya Pradesh	29.9	33.5	22.1	32.8
	India	24.6	25.4	23.2	28.6
Women owning a house and/ or land (alone or jointly with others)	Madhya Pradesh	43.5	44.7	41	NA
	India	38.4	40.1	35.2	NA

All the above indicators show that the state averages are at par with the national averages or sometimes even better. The percentage of women earning in cash is reduced from NFHS-3 to NFHS-4. Considering the lower levels of attainment for women in terms of socio demographic indicators, access to nutrition and health related services and the levels and intensity of violence and other crimes against women, there is a need for improvement in terms of overall empowerment of women in the state.

Box 8: Gender Discussion Clubs (Based on an article by Alankrita Anand, a member of the VV editorial team)

Some of the community correspondents of VV run gender discussion clubs in their areas. Ramlal is one such CC who believes that in order to change the gender stereotypes, there is a need for dialogue especially with the boys and men of younger generation along with the engagement of entire families. Ramlal reports, "In my gender discussion club, I have 12-13 boys and men. They discuss gender issues but may not be able to discuss them openly with their families. Gender is learned at home, so unlearning must include the entire household."

Ramlal has been mocked for having conversations on patriarchy and trying to challenge stereotypes. "Things won't change overnight, but conversations are key", he says, hoping to work with the boys towards dismantling patriarchy.

Eliminating harmful practices such as child, early and forced marriage and female genital mutilation (Target 5.3)

Mean age at marriage for females in Madhya Pradesh is 20.7 years. 3.1 percent girls below the age of 18 years are already married. Mean age at effective marriage for girls below 18 years of age is 16.3 years (Census of India, 2011). NFHS-4 has some indicators related to early marriage. These are given in the following table.

Table 10: Select indicators regarding women's empowerment, Madhya Pradesh (NFHS-4, 2015-16)

	Total (%)	Rural (%)	Urban (%)
Women (20-24 years) married before the age of 18 years	32.4	38.6	18.0
Women age 15-19 years who were already mothers or pregnant	7.3	8.6	3.9

The percentage of girls in the age group of 15-19 years who have begun child bearing can indirectly shed light on child marriages. Following table shows that the social category to which a girl belongs determines the age at which she begins child bearing.

Table 11: Select child and early marriage indicators, Madhya Pradesh, 2015-16

Background characteristic		Percentage of women age 15-19 who		Percentage of women age 15-19 who have egunchil-dbearing
		Have had a live birth	Are pregnant with first child	
Residence	Urban	2.6	1.2	3.9
	Rural	5.2	3.4	8.6
Level of education	No schooling	19	7.6	26.5
	<5 years of schooling	9.1	4.7	13.8
	5-9 years of schooling	4.4	2.9	7.3
	10-11 years of schooling	1.2	1.8	3.1
	12 or more years of schooling	1.1	0.9	2
Caste categories	SC	3.9	2.9	6.8
	ST	7.4	3.2	10.6
	OBC	3.9	2.7	6.6
	Other	2.4	2.4	4.8

Although there are some percentage of women from each category who had begun child bearing at an early age, women from rural areas, women with no schooling and women belonging to scheduled tribes have more chances to do so compared to their other counterparts (NFHS-4, 2015-16).

Highlights

- 33 percent of ever-married women experienced spousal physical or sexual violence from current or most recent husband. Only 11 percent women reported to have sought help (mostly from the family).
- Reporting under Protection of Women from Domestic Violence Act, 2005 is very low for the state with only 90 cases registered during one year (2014-15).
- Crime rate based on reported rapes (rapes reported per one lakh population) in the state was 13.1. In 98 percent of the reported rape cases, the offender was known to the victim. Half of the rape victims were below the age of 18 years (Crime in India, 2016).
- Workforce participation rate for women in the state (32.6 percent) is higher than the national average (25.5 percent) for women. Women from rural areas of the state have a much higher workforce participation rate as compared to the women in urban areas (Census of India, 2011). The higher participation of women from rural areas can be attributed to the agriculture based economy as women are involved in many field activities in agriculture.
- Mean age at marriage for females in Madhya Pradesh is 20.7 years. 3.1 percent girls below the age of 18 years are already married. Mean age at marriage for girls who are married before 18 years of age is 16.3 years (Census of India, 2011).

Key recommendations

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

- First steps towards provisioning of health services, leaving no one behind, would be to improve the infrastructure and staff availability in the health facilities across the state.
- Concentrated efforts towards provision of quality maternal health services and SRHR services for women is needed.
- The attitude and behavior of the health facility staff towards patients needs great improvement. Periodic mandatory trainings of the health staff at all levels will be critical in this regard. The training should include a mandatory component on respectful maternity care. Sensitisation of medical professionals to social and economic conditions of people accessing services at government hospitals is also needed.
- 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. Improvement in current counselling services for pregnant women is needed. Counselling on nutrition must be tailored according to local availability.
- Strengthen IEC activities to convey accurate information on maternity benefits schemes such as JSY and JSSK. Information should include the entitlement amounts, application process, authority responsible for grievance redressal and monitoring of receipt of entitlements.
- Stringent monitoring of implementation of all schemes pertaining to women and girls. Stronger implementation of all schemes, especially nutrition and maternal health related schemes.
- Counselling sessions with adolescent groups and at the school level with inclusion of life skills trainings for adolescents. These trainings can be integrated with the schemes for adolescents.
- Concrete steps need to be taken in order to reduce the high dropout rate for girls at the secondary and higher secondary level.
- 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 led committees at village level for social aspects apart from health and nutrition. For example, education and PDS.
- All the health facilities are supposed to have information displays about MTP and safe abortion centres. The participants coming from different districts of the state reported to have not seen such displays in many of the facilities they visit on a regular basis. These should be made mandatory.
- The PCPNDT committees at different levels should be functional with proper representation from the civil society organizations sector.
- Strict implementation of laws such as PWDVA, Child marriage act, MTP act, PCPNDT for improving the status of girls and women in the estate is essential. Government should strengthen the initiative to raise awareness about these acts and the seriousness of offence if they are not followed.
- There should be a single window facility available for addressing all the issues related to violence against women. Proper implementation of Sexual Harassment at Workplace Act is needed. The unorganized sector should be taken into the purview of this act.
- There should be an attitudinal change towards the survivors of domestic violence. Sensitization of health service providers, police and persons from law enforcing agencies towards them 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.

- The marginalized communities in the state need to be identified and in order to 'leave no one behind' efforts should be concentrated towards integrating these communities or groups by extra/ special need based provisions for these groups. Regular dialogues with the representatives of marginalized communities or civil society organisations working with these communities to see who is being 'left behind' and joint planning for improvement would be helpful in achieving this.
- There are grave issues around service provision for the marginalized communities. Some of the marginalized communities identified during the consultations include, people (especially women) residing in urban slums, tribal groups residing in forests, homeless people in urban areas etc.

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Annexure I

Participants list Madhya Pradesh Consultations

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Rekha Bhagre	VV
Sangita Thakur	VV
Jahanara Ansari	VV
Laxmi kaurav	VV
Pritee batham	New samajik Sewa santhtan
Rekha Gujre	Pradeepan
Anupam Sahu	Kadam Jan Vikash sanstha
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Annexure II

Following issues emerged during the discussions in the consultation:

- Construction and actual use of toilets as against the data from the dashboard by the government
- Issues in universal LPG connections
- Anemia and its linkages with nutrition related schemes (MDMP, ICDS) and PDS in general
- Issues with linking of all entitlements with Adhaar number.
- Challenges of working on sexual health of adolescents
- Need for helpline for children's issues
- Quality of services and Behavior of staff in government health facilities
- Infrastructure availability in government health facilities
- Issues such as under reporting in the current data on violence against women.
- The issue of child marriage
- Witch hunting in some communities with the purpose of sexual abuse or for land/ property rights that originally belongs to a woman

Annexure III

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एक्सप्रेस न्यूज

सहज ने की 'सतत विकास लक्ष्य' पर चर्चा

भोपाल (ईएमएस)।

सतत विकास लक्ष्य 3 व 5 पर राज्य स्तरीय सम्मेलन का आयोजन होटल सुरेन्द्र विलास पैलेस में आयोजित किया गया। राज्य स्तरीय सम्मेलन में सहज से नीलांगी जी व रश्मि जी ने उपस्थित महिला स्वास्थ्य व जैण्डर के मुद्दे पर कार्यरत विभिन्न जिलों के स्वैच्छिक संगठनों व मातृत्व स्वास्थ्य हक़दारी अभियान की सदस्य संस्थाओं के प्रतिनिधियों व मीडिया साथियों के साथ प्रस्तुतिकरण करते हुए व्यापक जानकारी दी।

साथ ही अध्ययन व शोध में प्राप्त स्थिति व आंकड़ों के आधार पर तैयार की गई रिपोर्ट के ड्राफ्ट को प्रस्तुत किया। उक्त राज्य स्तरीय सम्मेलन में मध्यप्रदेश मातृत्व स्वास्थ्य हक़दारी अभियान के डॉ. रामजीशरण राय दतिया, आर एस गौर भिण्ड, नरसिंह राठौर ग्वालियर, शोभा शिवहरे मुरैना, सुशील शर्मा अनूपपुर, आनंद इंदौर, स्मृति भोपाल अरुण त्यागी सीधी सहित अन्य साथी उपस्थित रहे।

उक्त उपस्थित रहे साथियों ने रिपोर्ट के ड्राफ्ट में आवश्यकतानुसार विन्दुओं को सम्मिलित कराते हुए रिपोर्ट को अंतिम रूप प्रदान किया गया।

Consultation meet on progress of sustainable development goals in MP concludes

Consultation meeting on progress of sustainable development goals in MP underway.

■ Staff Reporter

A TWO-DAY consultation meet was organized in state capital for monitoring the progress of sustainable development goals (SDG) in Madhya Pradesh . During the meet J.N.Kansotia, Principal Secretary, Minister of Women and Child Development said that the needy beneficiaries should not be excluded from departmental schemes. Speaking on the occasion Dr Shalini Kapoor, Consultant, Tata Trust said that social activists Should Play an Active Role in Evaluation of Mortality Rates .

As part of the Consultation Nilangi and Rashmi from SAHAJ made a presentation to representatives of NGOs working on women's health and gender issues, member organizations of the Maternal Health Rights Campaign and Media colleagues present at the occasion. Representatives at the Consultation also presented their feedback on the draft report and data of the research conducted by SAHAJ which was presented. The Consultation was moderated by Dr Ramjisharan Rai from Maternal Health Rights Campaign, Madhya Pradesh. The vote of thanks was presented by Nidhi Shukla. This meet was organized by SAHAJ non government organization . This consultation is organised by a group of civil society organizations as part of the project, Data Driven Advocacy for Gender Equality and SDGs. Through this project SAHAJ - in partnership with Equal Measure 2030 is working on developing more encompassing, holistic and realistic state and national level plans to meet SDG targets and better implementation towards the selected targets in an effort to 'Leave No one Behind'. M.P. is one of the states selected for this project. SDG Goal 3 ensures healthy lives and promote well being for all at all ages. SDG Goal 5 achieve gender equality and empower all women and girls. Talking in the meet Suresh Tomar, Joint Director, Women and Child Development said that there is need to work closely with network of civil societies . The census of 2021 will be crucial to decide to understand the statistics and strengthen the health care system. One of the best examples is seen in Bhind district where child sex ratio has enhanced. The district, once at the bottom of sex ration not only in the country but also in Asia, is now writing a new script. Highest number of girls were born in Bhind district this year among the districts where Beti Bachao-Beti Padao campaign was implemented in the country. According to Census-2011, Bhind was the district which had the lowest sex ratio in Madhya Pradesh. There were only 896 daughters on one thousand boys in Bhind. But now the figure has now reached 929 in the year 2017. This is a good sign but more effective approach is required to bring in change at ground level. Further he added that the role of maternal health rights campaigns in State is very crucial .The campaign also aims to ensure governments responsibility for provision of free quality maternal health services through community based monitoring . As part of this project, a state level report 'Monitoring the Progress of Sustainable Development Goals in M.P.: Situation Analysis for Selected Targets from SDG3 and SDG5' was also released This report is prepared based on review of data from secondary data sources, field level experiences and small studies shared during previous consultation, and M.P. state level efforts towards achieving SDGs. The report analyzes data pertaining to current situation of the state for selected indicators depicting social, demographic and economic conditions of the states, general health of the population, SRH, SRHR and gender related indicators.

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एक्सप्रेस न्यूज

■ -सतत विकास लक्ष्य 3 व 5 पर राज्य स्तरीय सम्मेलन में बोले कंसोटिया

पात्र हितग्राहियों को मिले सरकारी योजना का लाभ

■ सुरेश तोमर बोले, महिला सुरक्षा हेतु विभिन्न योजनाओं में सहभागी बनें

■ डॉ. शालिनी ने कहा, मातृमृत्यु की समीक्षा में सामाजिक कार्यकर्ता अपनी भूमिका

■ भोपाल (ईएमएस)।

सतत विकास लक्ष्य की प्रतिपूर्ति तभी हो पाएगी, जबकि हर पात्र हितग्राही को सरकारी योजना का सही तरीके से लाभ मिल सके। योजना से कोई भी पात्र वंचित न रहे इसके लिए स्वैच्छिक संगठनों की अहम भूमिका है। यह बातें मप्र महिला एवं बाल विकास विभाग के प्रमुख सचिव जेएन कंसोटिया ने कहीं। वे सतत विकास लक्ष्य (एसडीजी) 3 व 5 पर वर्तमान स्थिति पर आधारित राज्य स्तरीय सम्मेलन को संबोधित कर रहे थे। यह सम्मेलन गुजरात की संस्था 'सहज' द्वारा भोपाल में सोमवार व मंगलवार को आयोजित किया गया। इसमें विभागीय अधिकारी, स्वैच्छिक संगठनों व मीडिया के प्रतिनिधि शामिल हुए। टाटा ट्रस्ट की सलाहकार डॉ. शालिनी कपूर ने मातृमृत्यु की समीक्षा में सामाजिक कार्यकर्ता अपनी भूमिका का निर्वहन करें ताकि सेवाएं व सुविधाओ को बेहतर बनाया जा सके। वहीं महिला बाल विकास विभाग के संयुक्त संचालक सुरेश तोमर ने राज्य में महिला सुरक्षा हेतु विभिन्न योजनाओं में सहभागी बनकर हिंसामुक्त समाज बनाने में योगदान देने की अपील की। सम्मेलन में सहज से नीलांगी व रश्मि ने उपस्थित महिला स्वास्थ्य व जैण्डर के मुद्दे पर कार्यरत विभिन्न जिलों के स्वैच्छिक संगठनों व मातृत्व स्वास्थ्य हक़दारी अभियान की सदस्य संस्थाओं के प्रतिनिधियों व मीडिया साथियों के साथ प्रस्तुतिकरण करते हुए व्यापक जानकारी दी। साथ ही अध्ययन व शोध में प्राप्त स्थिति व आंकड़ों के आधार पर तैयार की गई रिपोर्ट के ड्राफ्ट को प्रस्तुत किया उक्त ड्राफ्ट पर अपनी-अपनी प्रतिक्रिया भी दी गयी। मध्यप्रदेश मातृत्व स्वास्थ्य हक़दारी अभियान के डॉ. रामजीशरण राय ने इसका संचालन किया। कार्यक्रम में निधि शुक्ला आर. एस. गौर भिण्ड, नरसिंह राठौर, श्रीप्रकाश निमराजे, अनुपम साहू ग्वालियर, शोभा शिवहरे मुरैना, सारथी से प्रवीण भटनागर, सुशील शर्मा अनूपपुर, आनंद, अंजली इंदौर, स्मृति, निधि शुक्ला भोपाल, अशोक मन्द्रे छिंदवाड़ा, अरुण त्यागी सीधी, शेषमणि शुक्ला सहित अन्य साथी उपस्थित रहे। उक्त उपस्थित रहे साथियों ने रिपोर्ट के ड्राफ्ट में आवश्यकतानुसार बिन्दुओं को सम्मिलित कराते हुए रिपोर्ट को अंतिम रूप प्रदान किया गया।

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