Monitoring the Progress of Sustainable Development Goals in Punjab

Situation Analysis for Selected Targets from SDG3 and SDG5

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List of abbreviations

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

Preface

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

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

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

SAHAJ Team,

September 2018

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SAHAJ Team

Executive Summary

India is one of the 193 signatories that accepted SDGs which were moved in 2015 as detailed agenda over MDGs. Sustainable Development Goals (SDGs) comprise of 17 goals and 169 targets revolving around economic, social and environmental dimensions of development. In India, *NITI Aayog* is assigned the role to coordinate the SDGs whereas, MoSPI is involved in enlisting indicators for all the targets. Simultaneously, several civil society organizations and coalitions (such as, WNTA) are working for monitoring India's progress towards achieving SDGs. SAHAJ has undertaken work related to 'Data Driven Dialogues for Gender Equality and SDGs', wherein we are trying to strengthen the state and national level efforts towards achieving the selected targets from two SDGs that evolve around women and girls.

In a diverse country like India, the processes required to achieve the targets will vary with different contexts and communities. 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. SAHAJ is trying to contribute towards realizing this vision for the selected targets by acknowledging the presence of different social and economic groups that are on different levels in terms of development indicators.

This report is based on state and national level data from secondary sources including Census of India 2011 and NFHS-4, 2015-16. Considering the differences in sampling methods and different sample sizes, this report does not compare the data but presents data from varied sources with gender and health equality perspective. First section of this report deals with socio demographic profile of Punjab and health and nutrition profile of the population of the state. A section on maternal health includes indicators related to ANC, delivery care and PNC services received by women in Punjab and indicators for women's access to information about SRH and the SRH services. Section on gender equality provides report on violence against women, indicators related to child marriage and women empowerment. This is followed by key recommendations for achieving targets under SDG3 and SDG5 in Punjab.

Punjab is one of the economically developed states of India with high productivity of food grains. The economy of the state is heavily dependent on agriculture. The social indicators for the state are not in accordance with its economic development. The health related indicators of the state are also not comparable with other developed states.

The state of Punjab is characterized by strong patriarchal norms and thus strong son preference and gender discrimination (Paul and Saha, 2015). Sex ratio in the state is among the worst in the country. Overall sex ratio is 895 and child sex ratio is 846 (Census of India, 2011). Sex ratio at birth in urban areas is as low as 792 (NFHS-4, 2015-16). Although, skewed sex ratios is thought to be an 'urbanized' phenomenon across India, rural areas of Punjab have recorded even lower child sex ratio (0-6 years) compared to the urban areas of the state (Census of India, 2011). There is no gender disparity in school attendance in both the age groups (11-14 years and 15-17 years). School attendance among both boys and girls drop considerably in the age group 15-17 years (83 percent for male and 81 percent for female) as compared to the age group 11-14 years (95 percent for both male and female). The difference in school attendance for urban and rural areas for the age group 15-17 years for both boys and girls is pronounced and in favor of urban areas (NFHS-4, 2015-16). Less than 2/3rd i.e. 64 percent families have access to piped drinking water into their dwelling, yard or plot (NFHS-4, 2015-16). Half of rural families use solid fuel for cooking (NFHS-4, 2015-16). There is a lot of variation in access to latrines in the state although latest government records project full access (100 percent) to IHHL (*Swachh Bharat Mission* Dashboard) and the state is certified as 100 percent open defecation free. In 2017, 1.13 lac SC households were provided individual household latrines.

Morbidity rates are higher in Punjab as compared to India (NSSO 71st Round, 2014). There is a 15 percent shortfall in number of Subcentres and 26 percent shortfall in number of PHCs in the state (Rural Health Statistics, 2015). The state has no roadmap to fill the gaps with respect to shortage of manpower and infrastructure as a follow up of the facility survey conducted every year (CAG report, 2017).

More than half the women aged 15-49 years are anemic, percentage of anemic women has increased considerably in last 10 years (NFHS-4, 2015-16). Most (58 percent) anemic girls are in the age group of 15-19 years in Punjab (NFHS-4, 2015-16). The double burden of malnutrition seems to be affecting particularly the state of Punjab with an increasing number of overweight/obese women and women with low BMI and

anemia being present in the same population. Urban women were more affected as compared to their rural counterparts. While the consumption of cereals, legumes and pulses in people's diets has remained stable, there has been increase in consumption of sugar, oils, fats and animal products. There is a need for systematic efforts that are geared towards health promotion and health literacy (Kaur, 2016; SPH-PGIMER Chandigarh, 2017).

MMR for the state is 122 which is lower than the national average (SRS, 2014-16). Most ANC indicators are better than the national averages – women receiving 3 ANC checkups, institutional deliveries, PNC visits (HMIS-NHSRC, 2015-16). Percentage of women receiving full ANC (30.7 percent) has improved compared to NFHS-3 (11.8 percent) but is still very low (NFHS-4, 2015-16). C-section rates for the state are very high (NFHS-4, 2015-16; HMIS-NHSRC, 2015). Access to information about SRH services and SRHR needs improvement. 6.2 percent women still perceive an unmet need for contraception (NFHS-4, 2015-16).

Punjab has the highest rates of cancer in the country (Department of Health and Family Welfare, 2013). A household study among breast cancer patients found that 84 percent of households experienced catastrophic health expenditure and 51 percent of households faced distress financing. Urban households were 52.8 percent less likely to face distress financing as compared to rural households (Jain & Mukherjee, 2016).

The number of women in Punjab currently dependent on any substance is 95000, on tobacco is 70,000, on opioids is 8526 and on sedatives, inhalants and stimulants is 6395. One fifth of the women reported experience of any kind of violence during their lifetime (NFHS-4, 2015-16). 27 percent of women experiencing violence sought help. Of those who have sought help, only 7 percent have reported the violence to the police (NFHS-4, 2015-16). Only 18.5 percent women who worked in the last 12 months were paid in cash for their work which is even lower than the national average of 24.6 percent (NFHS-4, 2015-16). The percentage of women owning a house alone or jointly is low for the state (32.1 percent) (NFHS-4, 2015-16). Mean age at marriage for girls in the state is 22.4 years. For those girls who have been married before the legal age of 18 years, the mean age at marriage is 16.9 years (Census of India, 2011). Young women with no schooling are about ten times as likely to have begun childbearing as young women with 12 or more years of schooling (NFHS-4, 2015-16).

To achieve the SDG agenda on time by accelerating progress towards achieving the SDGs in Punjab, needs to consider the following:

- Co-ordinated "Health in all policy" approach.
- Improvement in the infrastructure and staff availability in the health facilities across the state
- Periodic mandatory trainings of health staff at all levels with component on respectful maternity care
- Regulation of private medical sector given the high C-section rate and constantly reducing sex ratio
- Comprehensive approach to addressing women's and girls' reproductive and sexual health
- Strengthening 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 and at the school level with inclusion of life skills trainings
- Increased community participation at all levels from VHNSC to block to district to state.
- Increased monetary investment to improve quality at public healthcare facilities
- Strict implementation of laws such as PWDVA, Child marriage act, MTP act, PCPNDT for improving the status of girls and women
- Sensitization of health service providers and persons from law enforcing agencies towards the survivors of violence through thorough recurrent trainings
- Identification and special provisions for marginalised and 'invisible' groups such as migrants, dalits, LGBT populations and cancer affected women

Introduction

Background- MDGs to SDGs

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

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

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

India is one of the 193 signatories that accepted the Sustainable Development Goals (SDGs) agenda in the year 2015. SDGs are monitored at three levels of 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 with states for reporting the progress on SDGs. At the same time, Ministry of Statistics and Program 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 diverse geographically, economically, culturally and socially. The processes required to achieve targets in different contexts, need to be varied. With the SDGs in place and the Government of India's commitment to align its policies with the SDG targets, this is the right time for CSOs to effectively communicate their concerns to ensure that recommendations are incorporated in the official plans.

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

About SAHAJ

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

About the project

This project is supported by Equal Measures (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. At the outset, a desk review was carried out keeping in mind two essentials i.e., the necessity for reviewing the systems that are in place and the current status of indicators. 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. The data on current situation of states for selected indicators that can depict social, demographic and economic conditions, general health of the population, SRH, SRHR and gender related indicators were analyzed. State level progress towards achieving selected targets as per SDG Plans has also been captured.

- **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 Punjab 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 stratifying indicator 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 analyses generated through census or surveys' data helped in exploring 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 social construct, gives us a context. Thus, while sex disaggregation leads our understanding to whether or not there is a difference, a gender analysis leads to 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 identify the differences in health status or access to services among male and female, because of their social advantage or disadvantage position. Health Equity lens guided us to look at the health status, gaps in outcomes and differences in health needs that exist among different social groups.

Gender and Health Equity analysis has helped in analyzing data from different sources to understand

the factors behind differences among women and men and also intra group differences (based on caste, class etc.). In addition we are also attempting a gender-analysis of accepted SRHR indicators (wherever possible) and working with them further to better capture the gender and equity dimensions of the issue under scrutiny.

Features of the report

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

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

We hope that this report will be a technical and structural input for dialogue around gender equality keeping the SDG framework in mind within the network of CSOs and with the government officials.

Methodology

Data Source and Analyses

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 Punjab. The secondary sources of data include- Census of India 2011, National Family Health Survey-4 (NFHS-4, 2015-16), District Level Health Survey- 4 (DLHS-4, 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 Punjab, 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 DLHS, 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 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

First section of this report is about Punjab State profile and includes information about demographic indicators, household characteristics, health infrastructure, health status of the population and nutrition related indicators among women in Punjab along with the details of current state level efforts related to achievement of targets from SDG3 and SDG 5. Household characteristics such as access to drinking water sources, availability of latrines and type of cooking fuel used are also presented considering the health consequences of these particularly for women. Health infrastructure in the state, health status of the population and nutrition related indicators especially for women are incorporated in this report to have a clear picture of health situation in the state.

Section on women's health includes indicators related to ANC, delivery care and PNC services received by women in Punjab and indicators for women's access to information about SRH and access to select SRH services. Further attempts at monitoring the maternal health services in the state have been documented in this section. Issues such as cancer among women, teenage pregnancies and substance abuse are also covered as part of this section, inequities in access to health care is (an important issues in Punjab) and discussion around social and gender inequities forms the last part of this section.

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 discussion on demands for the integration of LGBTQI group. It contains information on women's work participation, property rights and participation in household decisions that tells us about the status of women's empowerment in the society. 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 - Punjab

Punjab has historically been one of the most economically developed states in the country owing to the high productivity of food grains (which is much higher than all-India average). Punjab contributes to nearly one-third of central pool of food grains for decades. The economy of the state is heavily dependent on agriculture but during last 10 to15 years, the growth rate of economy has reduced to lower than the targeted rate (Punjab Vision 2030).

The per capita income for the state is higher than the national average. Punjab is at the top amongst the eight high income states in the country (Punjab Vision 2030). The Gross State Domestic Product (GSDP) for 2017-18 is 5 lakh crores. Punjab's development model is considered to be the most equitable model among the states. With its focus on equity, Punjab has achieved one of the lowest percentage of families under poverty line (BPL). But, there are paradoxes in the development of the state. The poverty is more pronounced in socially disadvantaged groups such as Scheduled Castes (Punjab Vision 2030). The social indicators for the state are not in accordance with its economic development. Sex ratio in the state is among the worst in the country. The health related indicators of the state are also not comparable with other developed states such as Kerala and Tamil Nadu.

Being a bordering state, there are issues which are peculiar to Punjab, viz. higher levels of HIV/AIDS and Intravenous Drug Users (IDUs). In recent years, Punjab has been known for high prevalence of cancer. NRI marriages, child and forced marriages have led to exploitation of women. Trafficking under the garb of marriage is also an issue in the state. Maximum impact of these conditions is on women and children.

According to the Health Index[2] developed by *NITI Aayog,* Punjab stands second after Kerala in terms of overall performance and ranks 6th in terms of annual incremental performance between 2014-15 and 2015-16 with a moderate improvement compared to other states. Punjab has set up a SDG support unit under the Planning and Development Department, Government of Punjab. This unit provides technical support at the state level and provides evidence, analysis and perspectives to inform public policy in the context of SDGs. No further information about this unit is available in the public domain. Punjab is one of the states that came up with an in depth vision document for achieving the SDGs. Punjab vision document 2030 is published by the Department of Planning of the Government of Punjab. SDG 3 and SDG 5 related part of the document talks about several issues concerned with current work. It states that public health expenditure on health in the state is low 0.89 percent of GSDP). The vision 2030 document for the state also talks about assumptions or programs for change. However, there is no state health policy. Assumptions pertaining to the selected targets are given in the table below.

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

Table 1: Assumptions for selected targets from SDG 3

Target	Assumption/Programs for change
Target 3.1: Reduce the global maternal mortality ratio to less than 70 per 100,000 live births	Increase quality of maternity care (ANC, INC and PNC)
	Increase quality of maternity care (ANC, INC and PNC) - Improve percentage of births attended by skilled health personnel from present 97 (2015) to 100%; - Antenatal care coverage to all from present to 64.6%, to all (and increase to at least four visits) post-natal care coverage for all from present 55.7% (2015). Promote PMSMS for listed checkups under scheme. **Reduce Anemia** - Coverage of iron-folic acid supplements for all pregnant women - Improve women consumption of 10 defined food groups through nutrition surveillance of women in 15-49 age groups (ANM to coordinate mapping and tracking of all women in ICDS locality.) Follow state guidelines for anemia correction. - Thyroid checking of all pregnant women to be maintained. - Launch state campaign on nutrition. - Improve health facilities.
Target 3.7: Ensure universal access to sexual and reproductive healthcare services including family planning, information and education, and the integration of reproductive health into national strategies and programmes.	- Integrate Family Planning Services - Building quality services at PHC and at FRU level. - Promoting non-scalpel vasectomy through training, monitoring and evaluation. - Widen the choice for reproductive health services.

A comprehensive SDG 5 related section of the vision document discusses about Punjab specific gender aspects such as-

a. Lowest sex ratios in the country
b. Level of female literacy, school enrollment for girls and higher school dropout proportions for girls
c. Poor work participation rate
d. Presence of higher gender gaps in access to well-being and economic parameters among the Scheduled castes
e. Need for huge increase in budget spent on gender based rights etc.

The document suggests approach that considers-

a. Gender not women
b. Change in institutions and individuals
c. Integrating schemes into reforms

The document also presents a log frame for SDG-5 targets with Punjab specific gender indicators with accompanying time specific milestones and assumptions for change. In conclusion, the document talks about institutionalizing and mainstreaming gender.

Before going into the details of women's health and gender related indicators, we will have a look at the background indicators for the state.

Socio-Demographic indicators

With a population of 27.7 million (Census of India, 2011) and area of 50,363 Sq. Km., Punjab is one of the densely populated states (population density of 551 persons/ sq. ft.) of India. Urbanization is on the rise in the state with urban population increasing by 37.5 per cent from 2001 to 2011 (Census of India, 2011). Currently, 62.5 percent of the population resides in rural areas which is lower than the national average (68.8 per cent). The household size in the state is 4.8 (DLHS-4, 2012-13).

Sex Ratio

The state of Punjab is characterized by strong patriarchal norms and thus strong son preference and gender discrimination (Paul and Saha, 2015). The overall sex ratio of the state, sex ratio at birth as well as child sex ratio situation for the state is in accordance. Punjab ranks 28th among the states and union territories for sex ratio of the total population. The sex ratio for the state is 895 (Census of India, 2011). Sex ratio at birth is also very low compared to the national average. Although, skewed sex ratios is thought to be an 'urbanized' phenomenon across India, rural areas of Punjab have recorded even lower child sex ratio (0-6 years) compared to the urban areas of the state (Census of India, 2011). Following table gives an account of sex ratio for the state and compares it with the India averages.

Table 2: Sex ratio, Punjab and India

	Indicator	Total	Rural	Urban	Source
Punjab	Sex ratio (Total population)	895	907	875	Census of India, 2011
	Child (0-6 years) sex ratio	846	844	852	
	Sex ratio at birth	860	909	792	NFHS 4, 2015-16
		891			HMIS- NHSRC, 2015-16
India	Sex ratio at birth	919	927	899	NFHS 4, 2015-16
		922			HMIS- NHSRC, 2015-16

Literacy

The overall literacy rate for the state is 75.8 percent whereas literacy rate among women (70.7 percent) is lower compared to male literacy rate (80.4 percent) (Census of India 2011). The gap between literacy rates of men and women has reduced from 11.9 percent (2001) to 9.7 percent (2011). There is a 13.5 percent gap in the literacy rates of women residing in rural and urban areas and it is in favor of urban areas.

According to U-DISE (2013-14), ratio of girls' to boys' enrolment for the state for all the levels is lower as compared to the national average.

Table 3: Ratio of Girls' to Boys' enrollment, Punjab and India, 2013-14

	Primary	Upper Primary	Elementary	Secondary	Higher Secondary
Punjab	0.82	0.79	0.81	0.78	0.81
India	0.93	0.95	0.94	0.90	0.89

Source :U-DISE (2013-14)

Nearly one third (32 percent) of Punjab's population belongs to SC category. At the primary level, the percentage of enrolment of girls belonging to SC category is 39 percent of the total enrolments. For the higher secondary level, the enrolment is 32 percent. Percentage of enrolment of children with special needs at the primary level is 2.86 percent. It further reduces to 0.96 percent at the secondary level and to 0.59 percent for higher secondary level.

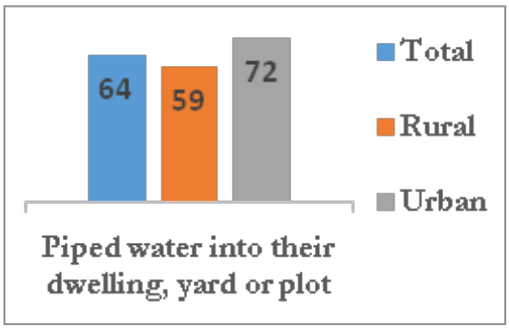
School attendance among adolescents

There is no gender disparity in school attendance in both the age groups (11-14 years and 15-17 years). School attendance among both boys and girls drop considerably in the age group 15-17 years (83 percent for male and 81 percent for female) as compared to the age group 11-14 years (95 percent for both male and female). The difference in school attendance for urban and rural areas for the age group 15-17 years for both boys and girls is pronounced and in favor of urban areas (NFHS-4, 2015-16).

Household characteristics

Household characteristics such as access to drinking water sources, availability of latrines and type of cooking fuel used are important indicators that have health consequences particularly for women. Women and girls are mainly involved in fetching water for drinking as well as other household chores. Type of fuel for cooking is also an important indicator impacting women's health. Women are not only exclusively responsible for cooking but also for gathering fuel for cooking. The use of solid fuel[3] for cooking has been seen to be associated with several adverse health and birth outcomes among women (Mohapatra, Das & Samantaray, 2018). Availability of latrines is important for women as they face both safety and health risks because of its lack (Anand, 2014). Some of the selected indicators for Punjab are given below.

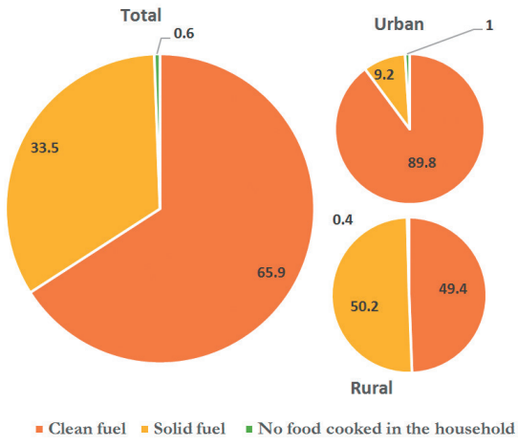
Figure 1: Percent households receiving piped water into their dwelling yard or plot



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

More rural households (41 percent) compared to urban households (28 percent) reported no access to piped water into their dwelling, yard or plot. More than 99 percent households in both rural and urban areas of the state reported access to improved drinking water source[4] (NFHS-4, 2015-16).

Figure 2: Type of fuel used for cooking



Solid fuel includes coal/lignite, charcoal, wood, straw/shrubs/grass, agricultural crop waste, and dung cakes. As mentioned above, women are not only exclusively responsible for cooking but also for gathering fuel for cooking. The use of solid fuel for cooking has been seen to be associated with several adverse health and birth outcomes among women.

Under the *Ujjawala Yojana,* LPG connections were given to 1.18,457 SC persons out of total 2,45,008 (48 percent) during 2016-17, which is commendable (Minutes of the Punjab State Review by National Commission of Scheduled Castes with Chief Secretary and other senior Officers of Government of Punjab (GoP) on 08.03.2018).

Census of India (2011) data show that 21 percent households in Punjab reported no latrines. NFHS-4 (2015-16) data show that 7 percent households in the state (11 percent in rural areas and 2 percent in urban areas) reported no sanitation facility. However, According to the latest *Swachh Bharat Mission* data (IHHL Dashboard, Government of India) for Punjab, show that 100 percent households in the state now have access to Individual Household Latrine (IHHL). 1.13 lac individual household latrines (IHHL) were constructed for SC households during 2016-17.

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

Health and nutrition

Health infrastructure at the village level

The percentage of villages having ASHAs was 94.7 and the percentage of villages having VHNSCs was 58.2 percent (DLHS-4, 2012-13). The CAG report (2017) however has updated information on status of ASHAs and since 2016, 98 percent of the required number of ASHAs (17,360) have been functional since then.

Health infrastructure at the facility level

Rural health statistics report (2015) shows that Punjab has 2951 Subcentres, 427 PHCs and 150 CHCs in the state catering to the rural population. The state lags in availability of health facilities at the primary level. There is a 15 percent shortfall in number of subcentres in the state and 26 percent shortfall is observed in number of PHCs. From among the 2951 Subcentres, 1241 (42 percent) did not have a male health worker. Only 98 (3.3 percent) subcentres did not have both the ANM and the male health worker (Rural Health Statistics, 2014-15).

One fifth (20 percent) of the subcentres were more than 3 kms away from the village and nearly 25 percent PHCs were at a distance of more than 10 kms from the village, both of which affect access for women. Only 53 percent PHCs function 24*7, 37 percent PHCs have a female medical officer which is good from the perspective of provision of services to women. Only 18 percent PHCs have residential quarters for the medical officer. 60.5 percent PHCs have referral services for pregnancies/delivery services available for 24*7 (DLHS-4, 2012-13). While 76 percent CHCs were designated as FRUs and 56 percent were FRUs with C-section facilities only 34 percent had gynecologist/obstetricians (DLHS-4, 2012-13).

Performance of Punjab is better when compared to the national norms for select rural health infrastructure is available in table 4 below.

Table 4: Rural health infrastructure for Punjab against national norms (Punjab draft annual plan, 2012-13)

Rural Health Infrastructure	National Norm	Punjab
Population served per doctor	3500	1210
Population covered by Subcentre	3000-5000	5870
Number of Subcentres for each PHC	6	7
Number of PHCs for each CHC	4	3.4

Box 1: Findings from the CAG report (2017)

The CAG Audit Report (2017) highlights-

- Shortage of subcentres (15 percent) and Primary Health Centres (26 percent) during 2011-16.
- 17 percent to 92 percent of the studied Community Health Centres and Primary Health Centres not equipped with essential infrastructural facilities like ultrasound, blood storage, safe abortion and prescribed drugs.
- Overall 62 percent shortage of medical and paramedical staff (against sanctioned posts)
- 100 percent shortage in some cadres with reference to the Indian Public Health Standards
- No roadmap to fill the gaps with respect to shortage of manpower and infrastructure as a follow up of the facility survey conducted every year.

Health status of the population

The morbidity rate in Punjab is higher than the national average and some other states. It had 16 percent rural and 17 percent urban population with an ailment during a 15 day reference period while at the national level it was 9 percent in rural and 12 percent in urban population (NSSO, 71st Round, 2014). These numbers are high as compared to other high income states such as Maharashtra, Haryana, Gujarat and Karnataka. 4 percent of the population was hospitalized (excluding childbirth) during a reference period of 365 days. The rate of hospitalization was nearly the same for both rural and urban areas and are little low compared to the national average (4.4 for rural and 4.9 for urban population).

Health management information system (HMIS) data are gathered by National Health System Resource Centre (NHSRC) every year. These data are gathered for all the public health facilities and registered private health facilities. Health facility related services data for Punjab are shown in the table below. OPD and IPD per 1000 population is much lower than the national figures, and major surgeries per lakh population is higher.

Table 5: OPD, IPD and Major surgeries per 1000 population, Punjab and India (HMIS, NHSRC, 2015-16)

Indicator	Punjab	India
OPD per 1000 population	639.3	1033.0
IPD per 1000 population	29.8	48.5
Major surgeries per lakh population	410.9	363.0

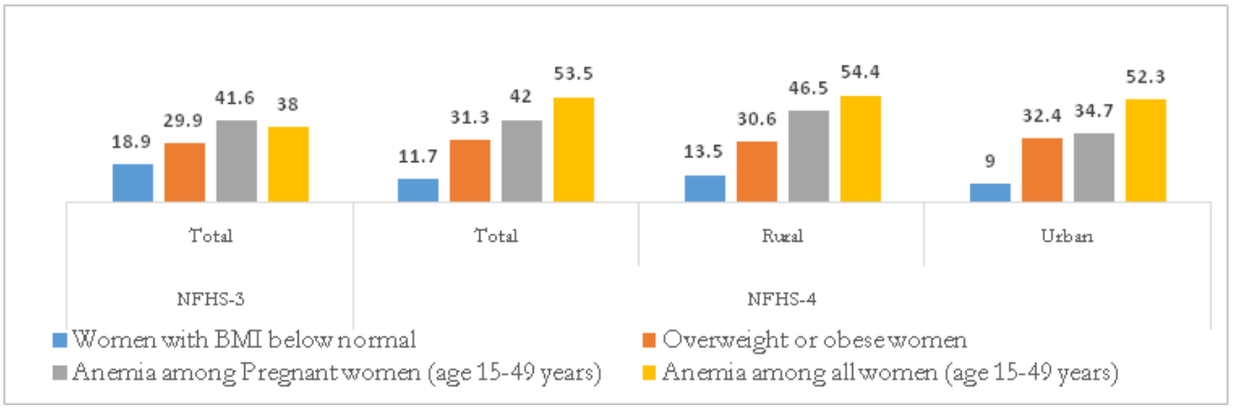
Nutrition indicators among women

India is experiencing a demographic transition with double burden where both undernourished and obese population are on the rise. Punjab also has coexistence of undernourished population and overweight/obese population. There is a steady decrease in percentage of women with BMI below the normal range from NFHS-3 (18.9 percent) to NFHS-4 (11.7 percent) but the percentage of overweight/obese women has slightly increased during this time (from 29.9 percent to 31.3 percent).

According to NFHS-4, more than half the women in the state (both rural and urban areas) are anemic and the comparison between NFHS-3 (2005-06) and NFHS-4 (2015-16) shows that the percentage of anemic women has increased by more than 15 percent.

According to DLHS-4 (2012-13) report, 58 percent pregnant women (15-49 years) were anemic out of which 4.9 percent had severe anemia.

Figure 3: Nutrition related indicators among women



Box 2: Health and nutrition in Punjab

Schemes concerning nutrition of adolescent girls

58 percent of girls in the age group of 15-19 years in Punjab are anemic (NFHS-4, 2015-16). Data from DLHS 2 showed that western districts of the state showed a high prevalence of anaemia among adolescent girls. More than half the adolescent girls in Mansa and Muktsar were severely anaemic, while more than two-fifths of adolescent girls in Bathinda, Ferozepur, Moga and Patiala were severely anemic.

Central as well as state government are implementing schemes for improving nutritional status of adolescent girls. *Kishori Shakti Yojana* is one such scheme with two components- Training and Nutrition. This scheme is targeted towards girls in the age group of 11-18 years, who are living in BPL families. This is currently being implemented in 100 blocks of Punjab state. The scheme has following objectives:

- To improve the nutritional and health status of these girls,
- To provide the required literacy and numeracy skills through the Non- Formal stream of education,
- To stimulate a desire for more social exposure and knowledge and to help them improve their decision making capabilities,
- To train and equip them to improve/upgrade home–based and vocational skills,
- To promote awareness of health, hygiene, nutrition and family welfare etc.,
- To provide supplementary nutrition as per the pattern under Supplementary Nutrition Program.

Rajiv Gandhi Scheme for Empowerment of Adolescent Girls or SABLA is another such scheme with its focus on both nutrition and non-nutrition components. This scheme is launched by merging *Kishori Shakti Yojana* with Nutrition Programme for Adolescent Girls (NPAG) and is currently being implemented on a pilot basis in 6 districts of Punjab. The objective of the scheme is to provide nutrition to the girls in the age group of 11-18 years and to uplift their social and economic status. The expenditure of the scheme is borne by the central and state government together.

Other nutrition related studies

A study (Bhatia, 2013) which analysed data from DLHS, NFHS, NNMB and NSSO found that 41.6 percent of pregnant women in Punjab were moderately anaemic, with Muktsar, Mansa and Hoshiarpur districts being the districts recording highest rates of anaemia. Only 36 percent of infants in Punjab are exclusively breastfed for the first six months of their life. Rates of breastfeeding were found to be lower in urban areas. Contrary to popular belief, children of mothers who have received formal education were much less likely to be exclusively breastfed. Data also revealed that women stop breastfeeding girl children before boy children. Only half of the children in Punjab receive supplementary food after six months (NFHS 3, 2005-06).

The double burden of malnutrition seems to be affecting particularly the state of Punjab. The proportion of obese women was highest in Punjab, as was the increase in the proportion. The proportion of obese women rose by 8 percent during a span of six years (1998-99 to 2005-06). Urban women were more affected as compared to their rural counterparts. As per NFHS 4 data, 31.3 percent of women are reported to be obese. While the consumption of cereals, legumes and pulses in people's diets has remained stable, consumption of sugar, oils, fats and animal products has seen an increase.

A study (Nautiyal, et al., 2007) in an industrial and non-industrial town in Punjab found higher prevalence of symptoms of angina and cardiovascular diseases among the population of the industrial town. Among them, women were found to have a higher prevalence of symptoms. Greater number of women, as compared to men, were found to be diagnosed with hypertension. The number of women who had coronary heart diseases was found to be significantly higher than men.

A study (Tripathy, et al., 2017) among individuals (predominantly women) in Punjab found prevalence of diabetes to be 8.3 per cent and that of prediabetes to be 6.3 percent. Prevalence was higher in urban areas as compared to rural areas. Prevalence of hypertension among study participants was found to be 36 per cent. The study did not find significant variance in prevalence between gender groups. Only 16 per cent of women with diabetes were on treatment for the same. Hypertension, obesity, age group, marital status and family history of diabetes were risk factors significantly associated with DM.

Being a leading cause of NCDs, tackling obesity needs to be taken as a priority by policy makers. Experts in the state have brought to attention of policy makers the need for systematic efforts geared towards health promotion and health literacy. Current health education and health promotion efforts are placed under different programs. The need however is to bring health promotion and education under one integrated program with a dedicated budget. The capacity of mass media and interpersonal communication on health issues remains underutilized. These need to harnessed independent of targeted health and social welfare programs. Co-ordinated policy efforts are needed along the lines of 'Health in all Policy' approach to achieve SDG 3 (Kaur, 2016; SPH-PGIMER Chandigarh, 2017).

Highlights

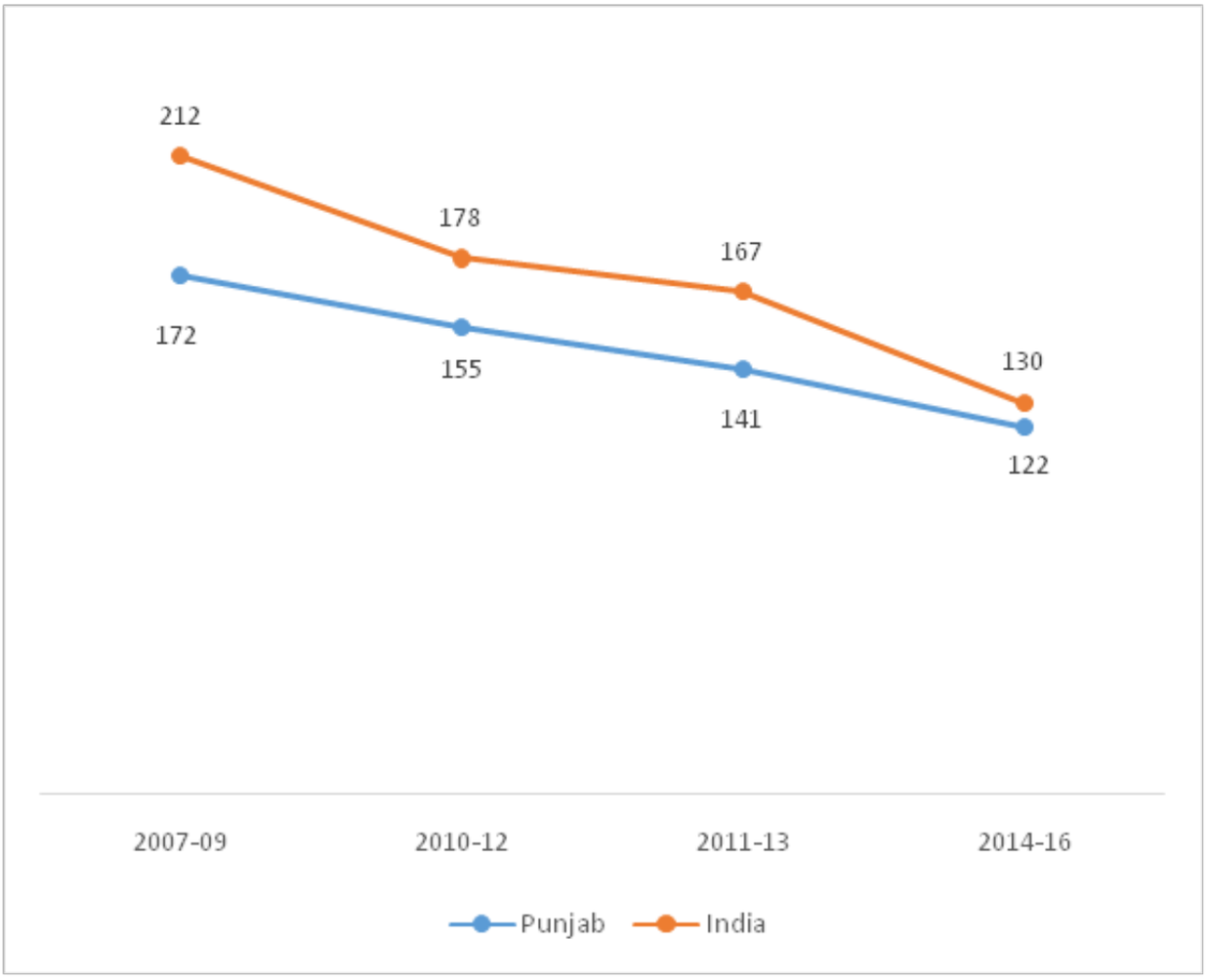
- The population density of the state is 551 persons/ sq. ft. It is one of the most populous states of India (Census of India, 2011).
- Female literacy rate is 70.7 percent (Census of India, 2011).
- Sex ratio for the state is 895 (Census of India, 2011). Sex ratio at birth in urban areas is as low as 792(NFHS-4, 2015-16).
- Less than two third households (64 percent) reported access to piped drinking water into their dwelling, yard or plot (NFHS-4, 2015-16).
- More than half (50.2 percent) households from rural areas reported use of solid fuel for cooking (NFHS-4, 2015-16).
- There is a lot of variation in access to latrines in the state although latest government records show full access (100 percent) to IHHL (*Swachh Bharat Mission* Dashboard). In 2017 only, 1.13 lac SC individual household latrines (IHHL) were constructed.
- There is comparatively quite high morbidity rate wherein, 16 percent of rural and 17 percent of urban population in Punjab reported an ailment during a 15 day reference period (NSSO 71st Round, 2014).
- There is a 15 percent shortfall in number of subcentres in the state and 26 percent shortfall in number of PHCs (Rural Health Statistics, 2015).
- OPD and IPD figures per 1000 population in the state are much lower than the national average (HMIS- NHSRC, 2015-16).
- More than half the women aged 15-49 years are anemic, percentage of anemic women has increased considerably in last 10 years (NFHS-4, 2015-16).
- The double burden of malnutrition seems to be affecting particularly the state of Punjab with the overweight/obese women and women with low BMI and anemia being present in the same population.

Section 2:
Status of SDG 3 implementation to improve maternal health

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

MMR for Punjab in recent years has been marginally low compared to the national average. As we are progressing, the gap between Punjab and India seems to be diminishing. This means that the MMR is reducing at a slower pace in the state compared to India as a country. Currently, the MMR for the state is 122 (SRS, 2014-16).

Figure 4: Trend in MMR, Punjab and India (SRS)



Maternal Death Review to find out the reasons for the maternal death & to take effective measures to reduce the maternal mortality ratio is quite regular in Punjab (under NRHM) since August 2010. After the implementation started, the state witnessed a manifold increase in reporting of maternal deaths (from 23 maternal deaths reported during January to July 2010 to 511 reported during April 2011 to March 2012) (http://www.pbnrhm.org/docs/mdr_status.pdf).

Maternal mortality is caused by many biological and social factors acting together but, it is directly related to factors around pregnancy and obstetric phase. Thus, access to antenatal care (ANC), delivery services and immediate postnatal care (PNC) become important indicators for MMR. Some of the ANC, delivery and PNC related indicators are tabulated below-

Table 6: Select ANC, delivery and PNC related indicators

Indicator	NFHS-3	NFHS-4			
	Total (%)	Total (%)	Rural (%)	Urban (%)	India Total (%)
Full ANC	11.8	30.7	27.9	34.8	21
Four ANCs during pregnancy	60.2	68.5	67.8	69.4	51.2
Institutional delivery	51.3	90.5	91.5	89	78.9
PNC during 48 hrs. of delivery	53.1	87.2	87.7	86.6	62.4
Births attended by skilled health personnel	68.2	94.1	95	92.7	81.4
C-section	16.5	24.6	23.7	25.8	17.2
C-section (Public Health Facilities)	34.3	17.6	18.6	15.9	11.9
C-section (Private Health Facilities)	31.5	39.7	38.9	40.4	40.9

Data on access to ANC, delivery and PNC related services (NFHS-4, 2015-16) for women belonging to social groups based on residence, level of education and religion in Punjab are given in the table below.

Table 7: Percentage of women for select maternal health indicators according to the background characteristics

Background characteristics		Percentage receiving ANC from a skilled provider	Percentage institutional deliveries	Percentage receiving PNC
Residence	Urban	95.1	89	89.8
	Rural	94.3	91.5	91.8
Level of education	No schooling	90.3	77.7	84.9
	<5 years of schooling	89.9	82.8	79.2
	5-9 years of schooling	93.5	88.0	89.7
	10-11 years of schooling	95.8	93.5	92.5
	12 or more years of schooling	96.7	97.3	93.9
Religion	Hindu	95.0	88.6	88.7
	Muslim	87.1	76.5	85.3
	Sikh	94.9	92.5	90.2

Though there are no much differences for women belonging to rural and urban areas, women from Muslim religion are observed to have lower access to all the maternal health services compared to women belonging to Hindu and Sikh religion. The percentage of institutional deliveries and percentage of women receiving PNC services are directly proportional to the level of education among women.

In terms of ANC registrations and checkup the state has performed better than the national average. (NHSRC, 2015-16 and HMIS reports). However, it may be good to triangulate all this information with community based monitoring by civil society organizations that will reflect where the gaps are and what needs to be improved (See Box 3 below).

Table 8: ANC, delivery and PNC indicators (NHSRC, 2015-16)

Indicator	Percent	
	Punjab	India
ANC registration against estimated pregnancies	98	94
ANC registration in first trimester against reported ANC registration	73	62
Women with 3 ANC Checkups against reported ANC registration	88	79
Home deliveries* against estimated deliveries	6.7	9
Institutional Deliveries* against estimated deliveries	79.6	66
C-Section Deliveries	32.3	16.7
PNC Visits within 48 hours of delivery against total deliveries	87	71

**- The total does not add to 100 because 13.7 percent of estimated deliveries are unreported.*

Box 3: Community monitoring of RCH programs

In 2017, community monitoring of reproductive and child health programmes, was conducted by Guru Angad Dev Sewa Society and 3 more NGOs in Ludhian district, Punjab

During this process, following points emerged:-

- There are not enough facilities for pregnant females at designated Government institutions for delivery.
- The payments under JSY are delayed for various reasons.
- The quality of three antenatal checkups done during pregnancy is not up to the mark.
- The identification of warning signs during the course of pregnancy is not done in time by ASHA or ANM.
- Maternal morbidity and Mortality cases are under reported specially from slum areas of Ludhiana city where there is lack of ASHA workers and ANMs.
- The Maternal death audit is done but is not taken to its conclusion

Box 4: Entitlements under schemes

As per NFHS-4, the percentage of mothers who receive financial assistance under the *Janani Suraksha Yojana* in Punjab (19.1 percent) is much lower when compared with national figures (36.4 percent). A study in Punjab (Kaur, Kaur, Kaur, & Devgun, 2015) among women eligible to receive entitlements under the JSY found that 23.8 percent of them had never heard about the scheme and less than half the women had heard about JSY from health workers. 53 percent of the women were aware of the free ambulance service facility provided by the government and only 14.1 percent of the women were accompanied by ASHA workers to the hospital at the time of their delivery. 83.2 percent of the women reported spending more than Rs. 500 on their delivery and only 4.3 percent of women did not spend any money on their delivery. As per NFHS 4, the average out of pocket expenditure for delivery in public health facilities in Punjab is Rs. 1,890. 48.2 percent women reported having received the money they were entitled to under JSY. There is an urgent need to strengthen IEC activities in the state to provide accurate and complete information about the JSY.

Focus group discussions with women and community workers in Fatehgarh district in Punjab revealed that women did not have knowledge on where and how entitlement under schemes could be accessed. They said that they did not have complete information on the entitlements available under government schemes and how they could apply for these. They felt dependent on the sarpanch of the village for information and access. Women expressed a need for a more systematic dissemination of knowledge on schemes. Women also reported that schemes were being misused by privileged classes in villages while the actual rights holders were not able to access their entitlements. Women wanted information pertaining to young girls, education, pensions, economic support, food, animals and livestock, rehabilitation for drug addiction and loans.

All of this points to a stronger focus on Community Action for Health, and strengthening VHNSCs and ASHAs' role.

Box 5: Quality of Care in Maternity Care- disrespect and abuse

More and more women in Punjab are delivering in institutions. While the percentage of institutional births in the state has risen from 51.3 percent in NFHS 3 to 90.5 percent in NFHS 4, and births assisted by a doctor/nurse/lady health visitor/auxiliary nurse midwife/other health personnel, either at home or hospital, have increased over the last decade, from 68.2 percent in 2005 to 94.1 percent in 2015, there is much that needs to be done to improve quality of maternity care services. Research has shown that increasing coverage of skilled institutional care has seen more avoidable maternal mortality and morbidity in those institutions (World Health Organisation, 2016). There are links between childbirth experiences of women and their pregnancy outcomes. Global evidence also suggests that disrespect, abuse, perceived poor quality of care and fear of discrimination during childbirth are key barriers to women seeking facility based care (Bohren, 2014; Kujawski, 2015). Negative experiences contribute to women opting for home based birth, often in the absence of a skilled birth attendant (Sethi, 2017).

A study in Punjab by the White Ribbon Alliance India and PGIMER Chandigarh, found evidence of disrespect and abuse that women face during childbirth in government hospitals in Punjab. The study found that women face neglect, abandonment, verbal abuse, blame, judgmental comments, lack of informed consent, lack of information on the care being provided, rough physical handling, demands for informal payments, discrimination and lack of privacy and confidentiality.

A woman says she has two living kids and is now pregnant with twins. The gynaecologist : "Don't you have any other work except reproducing??" Then adopting a harsher tone she says, "There are many better things to do in life!" She then asks the woman why she is having more kids since she already has a son. The woman says her son is mentally challenged. The gynaecologist said, "So what do you need him to have brains for? He'll grow up to be a vegetable seller only so what use does he have for brains?!"

- Medical professional at secondary care facility

The woman says she was uncomfortable lying down and asks if she can sit up. The nurse agrees but then losing patience, she pushes the woman's knee with the palm of her hand. She addresses her harshly telling her to lie down.

The woman is lying flat on her back, legs spread open, moaning. The nurse is shouting at her saying, "Do you want me to stitch you up or not?! I've been tolerating you for the sake of your child so stop misbehaving! If someone makes a cut on you using a knife you'll obviously feel it so stop crying!"

Upon return, the first nurse begins examining the woman, who is moaning in pain. The nurse sternly reprimands her for 'shouting unnecessarily'. She says, "If you don't stop I'll send you for a Caesarean section. This is not my problem or anyone else's. It's your child so it's your problem. If you want me to deliver your child then stop shouting unnecessarily or later you'll say I was rude to you."

- Childbirth observation at secondary care facility

"When I used to go for check-ups to the [secondary care] hospital, there was one male doctor who never spoke to me or my family members properly. He used to shout at us. I think he behaved like this with us because we are from Nepal. He was nice to the local women who came there. I never saw him shouting at any of them."

- Postnatal migrant woman

"I had gone with [my niece] for her delivery. When we reached the hospital the nurse told me to give her Rs. 1500 saying they have to operate on her to get the baby out. I said I don't have that much money but she kept insisting that we pay her. The nurse got very angry at me. She told us they will not deliver the baby here and told us to get out of the hospital. It turned into quite a fight between me and the nurse. While the fight was happening, the girl went into labour and the child was born.

Afterwards, they told me to give them Rs. 500 and said only then will they give us our child. I did not have that much money on me so I went home to see how much I could gather. I came back with Rs. 400 and bargained with them to accept Rs. 400 and give us our child. I think that if I had not given them any money they would not have given us our baby."

- Mother of postnatal woman at secondary care facility

"Both the empaneled anesthetists live over an hour away and they often say that they will come but don't show up. Even if they come they are always in a hurry. They just put the injection and leave. They know that they'll get the payment really late so they don't bother much. They don't even stay till the Caesarean is finished to make sure that the patient is alright."

-Medical Professional at secondary care facility

Box 6: Respectful maternity care (RMC) (Issues discussed during the consultation)

Respectful Maternity Care (RMC) encompasses seven rights every woman has in maternity care- right to be free from harm and ill treatment; right to information, informed consent, choices and companionship; right to privacy and confidentiality; right to be treated with dignity and respect; right to equality, equitable care and freedom from discrimination; right to healthcare and to the highest attainable level of health; right to liberty, autonomy, self-determination and freedom from coercion.

Research at all three levels of service delivery- primary, secondary and tertiary in Punjab has shown incidents of disrespect and abuse. There is a culture of normalization of disrespect and abuse in health facilities. Research combined with advocacy at different levels- community, government and political- led to RMC becoming an important component of LaQshya program being implemented by the MoHFW in different states of India.

Jan Sunwais in Punjab provide witness for lack of specialists in facilities which is an impediment to achieving RMC. Even with adequate staff in a facility to handle the patient load, instances of disrespect and abuse have been observed at facility level and the vice versa is also true. Respectful medical professionals are also seen in low resource settings. Thus, sensitisation of medical professionals to social and economic conditions of people accessing services at government hospitals is need.

Box 7: Field level issues in accessing maternal health services

- It is always the marginalised and vulnerable sections of a population that faces the maximum impact of an ineffective health system. Civil society organisations can work on changing perceptions of community members to reduce the delays in accessing facilities.
- Registration of women's pregnancies happen so late that pre-existing conditions are not identified and addressed in time. Especially because women do not come regularly for ANC check-ups. Better tracking and follow up of high risk pregnancies is needed. Stronger community involvement is needed to motivate women and track high risk pregnancies, families and community leaders for this. Civil society can play a big role in this.
- Gender component in government interventions is missing. The focus of gender has been limited to maternity care.
- There is a shortage of ASHA workers in settlement colonies where women are staying alone. Thus they are left out of the fold of primary care.
- High risk women must be informed about the facilities that are accessible to manage their complications at the time of childbirth and motivate them to go straight to these facilities to avoid deaths caused by multiple referrals and delays in referrals.
- Consumption of IFA tablets needs to be ensured. One of the causes of high rates of anemia is that IFA tablets are not properly distributed. Supply of IFA tablets is erratic. Supply of sub-standard medicines, such as wet tablets, reduces people's faith in government supplied medicines. There is a need to ensure proper quality assurance at the purchase levels of medicines along with reestablishing faith of people in government medicines.
- Every woman is recommended to get at least three ultrasounds. The cost of each ultrasound is Rs. 800 leading to high out of pocket expenditure.
- Demand for informal payments is another contributor to high out of pocket expenditure.
- Expensive medical education increases corruption in maternity care. Doctors caught for corruption must be held accountable. Policy of hiring and firing can be counterproductive and so we need to find ways to reduce corruption beyond punishment.
- Complaints and grievances of people are not addressed effectively.

Box 8: Pregnant women's health

A study (Gill, Devgun, & Mahajan, 2015) in the slums of Amritsar among women of reproductive age found that pregnant women were 1.68 times more likely to have health problems than those who are not pregnant. The study found that 59.1 percent of pregnant women and 48.5 percent non-pregnant women are anaemic. 13.9 percent of pregnant women reported P/V discharge and 16.6 percent of non-pregnant women reported P/V discharge.

Other common health problems faced by pregnant women were excessive fatigue, nausea, vomitting, pain abdomen, backache, headache, pregnancy induced hypertension, urinary problems, swelling of the body and vaginal bleeding. Common health problems faced by non-pregnant women were anaemia, excessive fatigue, backache, lice infestation, abdomen pain, urinary problems and menstrual problems.

Only 25.2 percent women were found to seek treatment for their health problems and only 19.3 percent women sought treatment from qualified health practitioners.

Box 9: Inequities among social groups

NFHS-4 report informed about following inequities regarding the health indicators among social groups based on caste categories:

- Infant Mortality Rate is almost twice as high for SC children compared with others.
- Coverage of children with basic vaccinations were higher for children not belonging to SC or OBC categories.
- SC women (3.9 percent) were found to be three times more likely to experience violence during pregnancy, as compared to Others (1.3 percent) group.
- Percentage of SC and OBC women who had four or more antenatal care visits was lower compared to women belonging to other social groups. Only 27 percent women belonging to SC and OBC categories and 36 percent women among others received full antenatal care.
- About 88 percent of births among SC took place in health institutions with a majority of these (63.3 percent) occurring in public health facilities whereas for others, 96 percent births were institutional with 55 percent happening in private health facilities.

A study (Sidhu, Kumari, & Uppal, 2005) among adolescent girls belonging to SC category in Punjab found that 70.5 percent of girls suffered from various grades of anaemia. Prevalence of anaemia was found to increase with age and peak at 78.6 percent in the age group of 15+ years girls. Mild anemia was found to be most frequent among those aged 11+ years. The largest percentage of girls were found to have moderate anemia, with majority of these girls being 14 years plus.

A Punjab State Review by the National Commission of Scheduled Castes with Chief Secretary and other senior officers of Government of Punjab was held in March 2018. Following were the key observations made:

- Percentage of expenditure on Scheduled caste specific scheme was only 1.37 per cent in 2015-16 and had reduced to 0.05 percent in 2017-18.
- Despite allocation of money, no expenditure was made on livelihood schemes, schemes for houses to houseless population and loan waiver scheme.
- The dropout rate among SC students was found to have increased between 2015-16 and 2016-17. Dropout rates were found to be high after primary and middle school.
- Only one person belonging to SC population was sanctioned an educational loan in 2017-18 and only 12 students belonging to SC population were sanctioned in 2016-17.

- The Scheduled Castes and Tribes (Prevention of Atrocities) Act, 1989 was not being properly implemented. State Level Vigilance and Monitoring Committee and the District Level Vigilance and Monitoring Committee do not meet as per the PoA Rules. There is a huge difference between the amount to be paid as compensation to victims and the amount that is actually paid.
- The Prohibition of Employment as Manual Scavengers and their Rehabilitation Act 2013 is also not being properly implemented in Punjab

A study (Sharma & Sharma, 2017) reported that 43.3 percent of women belonging to the SC got married before attaining the age of 20 years while only 8.3 percent of women not belonging to the SC group got married before the age of 20 years. Compared with 33.3 per cent of non-SC women, only 20 percent of SC women had an annual family income upto Rs. 2 lakhs. 41.67 percent of SC women had an annual family income of Rs. 50,000. 93.3 percent of SC women's families were landless compared to 90 percent of non-SC women whose families own land. Female work participation was found to be low among both SC and non-SC women. A higher proportion of SC women worked as labourers (regular and casual), while more non-SC women were in service. Only 10 percent of SC women had finished their graduation compared to 20 percent of non-SC women. SC woman were also found to be disadvantaged in terms of immunisation, iron & folic acid supplements and contraception use. Unsurprisingly, more percentage of SC women had more than three children as compared to non-SC women. The study also found that a greater percentage of women belonging to SC group experienced loss of pregnancy. Miscarriages due to maltreatment by husband as found to be a commonly reported phenomenon among SC women.

Sexual and Reproductive Health (SRH) and other health issues

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 maternal mortality part of the section. Some of the other components are discussed here.

Table 9: SRH service indicators (NFHS-4, 2015-16)

Indicator		NFHS-3	NFHS-4		
		Total	Total	Rural	Urban
		(%)	(%)	(%)	(%)
Access to information	Women having comprehensive knowledge of HIV/AIDS	23	49.3	47.1	52.7
	Women age 15-24 years using hygienic methods of protection during menstrual period	NA	84.4	80.7	91.2
	Health workers ever talked to female contraceptive non users about family planning	7.8	29.4	30.6	27.3
	Current contraceptive users ever told about side effects of current methods	39.4	79.2	77.3	82.2
Access to contraception services	Use of contraceptive method (currently married, 15–49 years) (%)	63.3	75.8	75.4	76.4
	Use of modern contraceptive method (currently married, 15–49 years) (%)	56.1	66.3	67.1	65.3
	Unmet Need- spacing (currently married, 15–49 years) (%)	2.7	2.4	2.6	1.9
	Unmet Need- Total (currently married, 15–49 years) (%)	9	6.2	6.8	5.4

Although the knowledge of contraceptive methods is almost universal (NFHS-4, 2015-16), above table shows that the knowledge is not reflected in the use of contraceptive methods in the state. Nearly a quarter of currently married women in the reproductive age group do not report use of any contraceptive method.

According to NFHS-4 (2015-16), only 42.4 percent men think that family planning is women's business and a man should not have to worry about it. But when it comes to undergo sterilization procedure, this is not to be followed. In 2016, 96 percent of total sterilizations carried out were tubectomies/female and 18.6 percent female sterilizations were Post-Partum (PP) sterilizations. Out of 46559 female sterilizations, 1 woman died and 31 women faced complications. In 38 cases, women conceived even after going through the sterilization procedure (HMIS- NHSRC, 2015-16).

According to HMIS data, abortion rate against the estimated pregnancies was 8.1 percent. According to DLHS- 4, the pregnancies ending in spontaneous abortions were 3.2 percent whereas the proportion of induced abortion was 1.1 percent. According to NFHS-4, 13 percent of total abortions were performed at home, 72.7 percent abortions were conducted in private health sector. A total of 26.2 percent women had complications arising from abortions.

Box 10: Community Action For Health

The Community Action For Health Project by the Society for Advancement of Rural People And Natural Resources (ARPAN) in two districts of Punjab revealed the following problems:

- Delays in online payments of JSY and delays in payment to women who do not have bank accounts.
- Delays in ultrasounds during pregnancy
- ASHAs do not have knowledge about epilepsy, Acute Respiratory Infections.
- ASHA does not have stock of sanitary napkins and requisite medicines (like Iron and Folic Acid tablets, de-worming tablets and ORS).
- ASHA workers find it difficult to do their work because of distance between villages.
- VHSNCs are not organised.
- Poor participation of people in VHSNC due to lack of awareness about VHSNC.
- Sub-centres are not adequately staffed.
- PHCs have crumbling infrastructure, inadequate facilities and shortages of staff.
- Lack of availability of ambulances to take women home after institutional delivery.
- Lack of availability of drinking water facility in people's homes.
- Anganwadis lack electricity, toys, bathrooms, weighing machines, gas and utensils to cook.
- Many women are opting for home births and births in private facilities.

Box 11: Cancer in women

Department of Health and Family Welfare of Punjab (Department of Health and Family Welfare, 2013), has reported the highest rates of cancer in the country. The Malwa region of Punjab has the highest cancer prevalence in the state, with Muktsar, Mansa, Faridkot and Bathinda recording highest cancer rates. Presence of toxic metals such as cadmium, lead and uranium have been linked to cancer (Ilychova & Zaridze, 2012; Cheung, 2013). Ground water contaminated due to excessive use of pesticides and fertilisers has also been linked with cancer causation (Mittal, Kaur, & Vishwakarma, 2013). Many banned and restricted pesticides are continued to be in use in Malwa region of Punjab (Mittal, Kaur, & Vishwakarma, 2014).

A study (Blaurock-Busch, et al., 2014) reported more than standard concentration of Aluminium, Barium, Manganese, Strontium and Uranium among women in Punjab. In women who had breast cancer, the concentration of uranium (checked using the hair sample) was found to be six times higher than others. This indicates long-term chronic exposure to uranium among the population of the Malwa region of Punjab. Exposure to Manganese, lead and Uranium were found to be contributors to development of breast cancer in Punjab.

Breast cancer in Punjab significantly affected economic and social lives. Quality of life deteriorated among 74.2 percent patients as they stopped working after their diagnosis, 92.9 percent patients stopped pursuing their hobbies, 95.2 percent of patients stopped exercising and 61.4 percent of patients decreased socializing. Thus, greater counselling regarding cancer, pain management, rehabilitation, stress and anxieties is much needed (Khullar, Singh, Lal, & Kaur, 2018).

A household study (Jain & Mukherjee, 2016) among breast cancer patients reported that 84 percent of households experienced catastrophic health expenditure and 51 percent of households faced distress financing. Urban households were 52.8 percent less likely to face distress financing as compared to rural households. Common ways of financing the expenditure were borrowing money and selling financial assets. 91 percent of households incurred out of pocket expenditure on treatment and only 9 percent of households were financed by insurance (that too only part financing). Cost of drugs and cost of hospitalisation were found to be the leading contributors to costs incurred by households for treatment. The average per day cost of hospitalisation in public hospitals was Rs. 8,834.98 and in private hospitals was Rs. 16,300.68. 90 percent of the study participants were eligible for financial aid under the *Mukhyamantri Cancer Rahat Kosh* but only 14.9 percent of those eligible were informed about the sanctioned amount. The study participants also reported that the cost of treatment increased after they got the amount sanctioned and thus felt that the aid received by them did not help them.

Prevention and treatment of substance abuse and promoting mental well-being

Mental and behavioural disorders contribute significantly to morbidity, disability and mortality, and also have huge social and economic impact. The current mental morbidity in Punjab is higher than the national morbidity, with higher prevalence of alcohol and substance use being the major factor for this (Chavan, Das, Garg, Puri, & Banavaram, 2018). There is a need to strengthen and scale up existing services. The National Mental Health Survey of India (2015-16) showed the co-existence of common mental disorders, severe mental disorders and substance abuse. Rural areas were found to have a higher prevalence of substance use in Punjab. Districts of Mansa and Muktsar were found to have the highest rates of current use and dependence on substances (Avasthi, et al., 2018). The National Mental Health Survey of India, 2015-16 found Punjab to have a prevalence of 7.9 percent of alcohol use disorder and 11.3 percent of substance abuse disorder. Punjab was found to have the highest reported percentage of subjects with illegal substance use disorders. Although majority of users were found to be men. However, the estimates of women currently dependent on any substance is 95000; number of women dependent on tobacco is 70000, number of women currently dependent on opioids is 8526, and number of women currently dependent on sedatives, inhalants and stimulants is 6395. Women were found to have lifetime and current use of 0.8 and 0.6 percent respectively on alcohol (Avasthi, et al., 2018).

Narrowing of gender roles, role of media, globalisation and work-stress related issues were quoted as reasons for increased substance use among women. Independent news reports have highlighted the hidden nature of Punjab's drug problem among women. Women report getting addicted to drugs to escape incest, domestic violence, physical and sexual abuse, low self-esteem and to cope with an addicted husband (Dabas, 2016) (Bedi, 2017). News reports highlight that women find it harder to access government de-addiction centres due to fear of sexual abuse, harassment and lack of privacy at the de-addiction centres (The New Indian Express, 2016). Also reported are instances of female addicts being deserted by families (Dabas, 2016).

In the National Mental Health Survey of India, 2015-16, a female predominance was observed for mood disorders, depressive disorders, anxiety disorders and neurotic and stress related disorders. The study also found that current and lifetime mental health morbidity was greater among females than men. The Survey found huge treatment gaps in Punjab for common mental disorders (79.7 percent), severe mental disorders (57.1 percent) and depressive disorders (82.1 percent). Focus group discussions in the National Mental Health Survey of India (2015-16) Punjab found opioids, cannabis, sedatives (especially benzodiazepine) and inhalants to be the most commonly used substances in Punjab. As one study participant stated, *"elderly females would also abuse Non-Steroidal Anti-inflammatary Drugs (NSAIDs) and alcohol (like beer) abuse in young females is on the rise"*.

The National Mental Health Survey of India, 2015-16 found discrimination and public and self-stigma against persons with mental health problems and substance use disorders. Fear of legal consequences, study participants were found to hide mental health disorders and substance use disorders.

Highlights

- MMR for the state is 122 which is lower than the national average (SRS, 2014-16).
- Most ANC indicators are better than the national averages – 3 ANC checkups, institutional deliveries, PNC visits (HMIS-NHSRC, 2015-16)
- Percentage of women receiving full ANC (30.7 percent) has improved compared to NFHS-3 (11.8 percent) but is still very low (NFHS-4, 2015-16).
- C-section rates for the state are very high (NFHS-4, 2015-16; HMIS-NHSRC, 2015).
- Access to information about SRH services and SRHR needs improvement.
- 6.2 percent women still perceive an unmet need for contraception (NFHS-4, 2015-16).
- 84 percent of households with breast cancer patient experienced catastrophic health expenditure and 51 percent of households faced distress financing with breast cancer patient. (Jain & Mukherjee, 2016).
- As per a report by the Department of Health and Family Welfare of Punjab (Department of Health and Family Welfare, 2013), the state has the highest rates of cancer in the country.

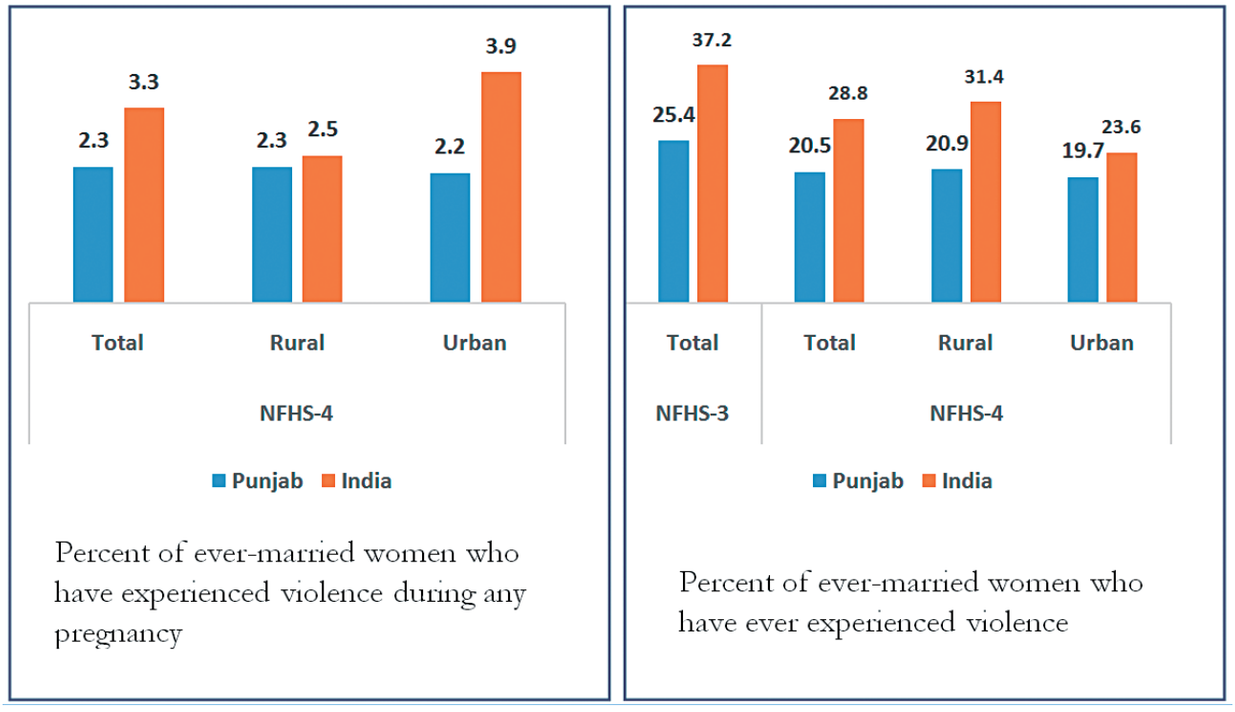
Section 3: Status of SDG 5 implementation on Gender Equality in Punjab

Eliminating Violence against Women (VAW) in public and private spheres (Target 5.2)

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.

As presented in Figure 5 the percentage of ever married women whoever experienced violence decreased from NFHS-3 to NFHS-4. In NFHS-4, 20 per cent of women responded that they had experienced any form of violence from their husbands in the preceding 12 months.

Figure 5: Percent of ever married women who have ever experienced violence



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

Table 10: Various forms of violence committed against women by their husbands (NFHS-4, 2015-16)

Indicator	In past 12 months			Ever
	Often (%)	Sometimes (%)	Often or sometimes (%)	Total (%)
Any form of physical violence	3.0	12.9	15.9	19.9
Any form of sexual violence	1.3	3.0	4.3	5.3
Any form of emotional violence	2.0	4.8	6.8	7.9
Either physical or sexual violence	3.6	13.1	16.7	20.4
Both physical and sexual violence	0.6	2.9	3.5	4.7

Only 27 percent of women who had ever experienced physical or sexual violence by anyone have sought help out of these, 63 percent women have neither sought help nor told anyone about the violence. Women often sought help from their own families. Only 7 percent of women had sought help from police (NFHS-4, 2015-16).

There are only two cases registered under Protection of Women from Domestic Violence Act (PWDVA) in Punjab in the year 2015-16 (NCRB, 2016). Punjab ranks 22nd among the states in India on total cognizable crimes (IPC+SLL) against women.

Table 11: Crime rate for different crimes against women, Punjab and India (NCRB, 2016)

Indicator	Crime rate (crimes per one lakh population)	
	Punjab	India
Rate of total cognizable crimes against women (IPC+SLL)	38.0	55.2
Cruelty by Husband or his relatives (Sec. 498 A)	11.7	18
Kidnapping & Abduction of Women	9.0	10.5
Rape	6.2	6.3
Assault on women with intent to outrage her modesty	7.6	13.8
Rate of IPC crimes	37.3	53.0

In all rape cases except three, victims knew the offenders. Nearly 50 percent of the total rape victims in the state were underage (below 18 years of age).

Box 12: Sexual Harassment

A community based study (Talboys, Kaur, VanDerslice, Gren, & Alder, 2017) in one district in Punjab found that 48.3 percent of study participants reported having been "eve-teased" in the past 1 year. Approximately 50 percent of participants reported that they were eve teased by a man who was known "quite well" to them or was closer in age or older to them. Nearly two-thirds of them were from the upper caste. Over one third of the study participants reported feelings of "fear, worry or tension" and linked eve teasing with depression or suicide. 36 percent of study participants reported feeling "shame" at being eve teased. This is linked with the cultural belief of blaming the victim. Restrictions on mobility of young girls and women was reported as a grave consequence of eve teasing. Only 3 percent of the study participants reported the incident to authorities but 72.7 percent reported the incident to a family member or friend.

Empowerment related indicators

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

Table 12: Select indicators regarding women's empowerment

Indicators		NFHS-4			NFHS-3
		Total	Rural	Urban	Total
		(%)	(%)	(%)	(%)
Currently married women who usually participate in household decisions	P	90.2	90.5	89.6	87.9
	I	84.0	83.0	85.8	76.5
Women who worked in the last 12 months who were paid in cash	P	18.5	19.1	17.5	20.2
	I	24.6	25.4	23.2	28.6
Women owning a house and/or land (alone or jointly with others)	P	32.1	30.9	33.9	NA
	I	38.4	40.1	35.2	NA

Workforce participation rate for women in the state (13.9 percent) is nearly half as compared to the national average (25.5 percent). Women constitute only 12 percent of main workers and 6 percent of marginal workers in the state (Census of India, 2011).

Highlights

- One fifth of the women reported experience of any kind of violence during their lifetime (NFHS-4, 2015-16).
- Only 27 percent of women experiencing violence have sought help. Of those who have sought help, only 7 percent have reported the violence to the police (NFHS-4, 2015-16).
- Only 18.5 percent women who worked in the last 12 months were paid in cash for their work which is even lower than the national average of 24.6 percent (NFHS-4, 2015-16).
- The percentage of women owning a house alone or jointly is low for the state (32.1 percent) (NFHS-4, 2015-16).

Child marriage in Punjab

Mean age at marriage for girls in the state is 22.4 years. For those girls who have been married before the legal age of 18 years, the mean age at marriage is 16.9 years (Census of India, 2011). The table gives details of early marriage among girls in Punjab.

Table 13: Child marriage related indicators

Indicator	Total	Rural	Urban	Source
Female below the age of 18 years and are married	0.5	0.5	0.4	Census of India, 2011
Women (20-24 years) married before the age of 18 years (%)	7.6	8.1	6.9	NFHS 4, 2015-16

Early marriage and child bearing among young girls is very well connected with some of the social aspects. For example, young women with no schooling are about ten times as likely to have begun child bearing as young women with 12 or more years of schooling (NFHS-4, 2015-16). An account of childbearing across some more social groups has been presented in Table-14. There are no differences in rural and urban areas of the state in terms of percent of women in the age group of 15-19 years who have begun child bearing. But, caste group wise categories show differences.

Table 14: Percent women in the age group 15-19 years who have begun childbearing

		Percentage of women Age 15-19 years who-		Percentage of women Age 15-19 years who have begun childbearing
		Have had a live birth	Are pregnant with first child	
Residence	Urban	1.3	1.1	2.5
	Rural	2	0.6	2.6
Caste category	SC	2.3	0.6	2.9
	OBC	1.5	1.5	3
	Others	1.2	0.7	1.9

Box 13: Teenage pregnancies

2.6 percent of girls in the age group of 15-19 years have already begun child bearing with no difference across rural and urban areas. Educational level is an important determinant of teenage pregnancy. Lower the education earlier the child bearing, 20.6 percent of girls with no schooling and 2 percent of girls with educational levels of 12 years and above had begun child bearing in the age group of 15-19 years and 13 percent of girls in this age group already had two children (NFHS-4, 2015-16).

Annual Report on Registration of births & Deaths (2011) shows that women in the age group of 15-19 years have shown birth order up to 4 births. 42.5 percent of those have birth order of two and above where as 10.3 percent have birth orders of 3 and 4.

Age specific fertility rate[5] (age group 15-19 years) is 10.4 (per 1000 women) with 12 in rural areas and 7.4 in urban areas. Age specific marital fertility rate[6] (age group 15-19 years) for the state is 257.6 (SRS Statistical Report, 2011).

5 Age specific fertility rate= Number of live births to women in specified age group.
6 Age specific marital fertility rate= Number of births per year per thousand mid-year married women within the age group

Box 14: Missing aspect of gender- LGBT inclusion in SDG 3 and SDG 5

Commonly, gender is mistaken for sex and thus, generally divided the population in binary groups- Men and Women. But, our understanding of gender goes beyond this and even though invisible in conversations and discussions on inequities, LGBT become important groups to deliberate upon when talking about 'leaving no one behind'. In Punjab, during the consultation on SDG 3 and SDG 5 (20th August 2018), a session was dedicated to presentation and discussions around 'LGBT inclusion in SDG 3 and SDG 5: What Government can do'. Following points emerged from the session-

No data specific to Punjab is available but there are good practices from other states which can be replicated here. Data on Lesbian and bisexual women is even sparser.

Research estimates that 10 percent of the population is LGBT. NACO estimates that the total LGBT population in India is 45 lakhs. Punjab SACS estimates a population of 6,000 MSMs in Punjab. Except for NACO, no national policy talks explicitly of LGBT population in health programs. An approach paper by the National Planning Commission and 12th five year plan have stated that health policy must focus on LGBT populations. The NALSA judgement also stated that the government should provide health services to Trans populations.

In reality, only Kerala has a TG policy and Assam is considering the same. The policy contains access to capabilities, economic opportunities, services, right to dignity and no violence and a right to expression.

There is lack of understanding of LGBT population's health needs. Civil society and government can undertake research focusing on these. Policy decisions for LGBT community must also include their participation.

In Punjab, following things can be done:

- Eliminate discrimination in health facilities by sensitising health officials about their ethical mandate to provide non-judgemental care.
- Inclusion of LGBT health information in medical and nursing curricula.
- Have explicit LGBT friendly registration and admission policies.
- Implement non-discrimination policies in health facilities. These must recognize micro-aggressions that LGBT populations face in hospitals.
- There must be platforms for LGBT people to highlight the issues they face.
- Formulation of a TG policy and TG welfare board in the state.

Discussion and Key recommendations

Punjab has always been considered a developed state. However, the health, development and nutrition indicators of the state do not reflect achievements indicated by economic development indicators. Punjab faces peculiar health issues. For example, the state has highest rates of cancers in the country. Obesity is on the rise, the load of non-communicable disease (particularly lifestyle diseases such as diabetes and cardiovascular diseases) is also huge. When it comes to girls and women, the state is lagging behind on many important indicators related to sex ratio, nutritional status of women, access to crucial SRH services etc.

Although, Punjab is one of the first few states to have started working on the SDG agenda, nothing much could be found on the progress towards the targets. The vision document 2030 is an example of comprehensive thinking about the SDGs. There is a SDG unit established under the planning and development department of the state. Apart from these two steps, no much information is available in public domain. The civil society organizations working in the state will have to concentrate their advocacy efforts towards getting to know more about the steps taken by the state and then can push for the demands of 'no one left behind' and 'eliminating gender discrimination'. For achieving this, bureaucrats must be involved in future civil society processes wherever possible. The state governments are accountable to *NITI Aayog* for taking action to achieve SDGs. This can be used as leverage for advocacy. To achieve the SDG agenda on time by accelerating progress towards achieving the SDGs in Punjab, following steps need to be taken:

- Co-ordinated "Health in all policy" approach
- First steps towards provisioning of health services, leaving no one behind, could be to improve the infrastructure and staff availability in the health facilities across the state. There is a need for demand generation for more infrastructure and human resources in the public sector, rather than outsourcing services to the private sector. Working hours of medical professionals, especially in medical colleges need to be regulated.
- Periodic mandatory trainings of the health staff at all levels will be critical in improving the service provision. The training should include a mandatory component on respectful maternity care. Sensitisation of medical professionals to social and economic conditions of people accessing services at government hospitals is also needed.
- There is a need to focus on human rights of patients and thus create accountability of service providers.
- 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, for marginalised communities.
- 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.
- Increasing community participation at every level from VHNSC to block to district to state. The processes towards achieving SDG targets could be more participatory. Regular dialogues with civil society organisations to see who is being 'left behind' and joint planning for improvements.
- Community participation can be achieved through monitoring process at the local level which can also include PRI members. *Panchayats* need to play a role in the health system monitoring mechanism. Community

monitoring under NHM must be initiated and strengthened. Social audits could be another way of monitoring. *Gram Sabha* must be operationalised as envisioned in constitutional provisions especially for identification of beneficiaries under various schemes. *Gram Sabhas* must be engaged in proper monitoring of schemes and services. Efforts must be made to empower women and marginalised populations in rural Punjab to involve them and *Gram Sabhas* in preventive and clinical health to strengthen services and improve indicators.

- A pressure group of interested individuals can be created. Pressure groups must consist of people at grassroots and those affected by the issues being raised. The group can have regular meetings especially before the state assembly sessions in which key issues can be listed out followed by advocacy with MLAs from all parties.
- Increase monetary investment to improve quality at public healthcare facilities- especially reproductive and sexual health services.
- 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 start an initiative to raise awareness about these acts and the seriousness of offence if they are not followed.
- Sensitization of health service providers and persons from law enforcing agencies towards the survivors of violence through thorough 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. There is also a need for more discussions around IDU from a mental health perspective. For example, special centres with counselling services etc.
- Marginalised and 'invisible' groups such as migrants, dalits, LGBT populations and cancer affected women must be identified and promoted to articulate their needs. Special provisions should be made for these groups so that they are not 'left behind' in the development process.

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Your feedback is welcome. E-mail address for feedback is **sahajequalmeasures2030@gmail.com**

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

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