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THEME: INTEGRATED AND COMPREHENSIVE SRH SERVICES: A GLOBAL VIEW

Commentary: Sexual and reproductive health services in Tamil Nadu: Progress and way forward

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The state of Tamil Nadu in India, increasingly recognised for sustained political and bureaucratic commitment to poverty reduction and human development (Muraleedharan, Dash, & Gilson, 2011) began providing some elements of sexual and reproductive health (SRH) services well before the 1994 International Conference on Population and Development (ICPD). After 1994, the state gradually added to these services while also working to improve health equity. Tamil Nadu is unique within India in sustaining a public health cadre at the district level and an effective network of primary health centres (PHCs), which have together provided a strong platform for integrated SRH services (Das Gupta, Desikachari, Somanathan, & Padmanaban, 2009; Muraleedharan et al., 2011). Higher female literacy, social reform movements leading to greater female autonomy and rising social aspirations have also been identified as key contributors to the success analysed below (Muraleedharan et al., 2011; Visaria, 2000).

Investments in reproductive health services began with the introduction of family planning in the mid-1970s. Services were gradually expanded to include maternal health, particularly safe delivery services, and, to a lesser extent, induced abortion (Padmanabhan, Sankararaman, & Mavalankar, 2009; WHO, Regional Office for South-East Asia, 2009). The introduction of the national Reproductive and Child Health (RCH) programme in the years following ICPD increased funding and training of personnel for providing these services (WHO, Regional Office for South-East Asia, 2009). The state also responded in innovative ways to the challenges of HIV/AIDS in the early 1990s by partnering with NGOs to increase awareness and provide specific interventions for populations at risk (Ramasundaram et al., 2001). Treatments of sexually transmitted infections (STIs) and reproductive tract infections (RTIs), as well as school-based adolescent health education, were also included and continue to be a central part of the strategy for HIV prevention (Health and Family Welfare Department, 2012).

Major health indicators suggest the effects of these interventions. The total fertility rate (TFR) of the state fell dramatically from 3.8 in 1981 to 2.2 by 1991, reaching 1.7 by 2005 (Health and Family Welfare Department, 2012; State Health Society, 2012). A strong public health infrastructure coupled with demand-side financing (a maternity

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benefit scheme) helped to increase the institutional delivery rate to 90.4% for the period between 2004 and 2006, while the rest of India lagged significantly behind at 40.7% (Padmanabhan et al., 2009; WHO, Regional Office for South-East Asia, 2009). The maternal mortality ratio (MMR) fell from 319 in 1982–1986 to 111 in 2004–2006, declining at a rate faster than the rest of the country (Muraleedharan et al., 2011). The antenatal prevalence of HIV/AIDS declined from 1.13% in 2001 to 0.25% in 2007 (Health and Family Welfare Department, 2012). The state's policy against user fees also probably contributed to the rise in the proportion of public maternity services used by the poorest quintile, from 22% in 1995 to 30% by 2004 (Acharya, Vaidyanathan, Muraleedharan, Dheenadayalan, & Dash, 2011).

The state used additional funds received under the National Rural Health Mission (NRHM) in 2005, to further reduce maternal mortality, by strengthening public health facilities and increasing access to emergency obstetric care. Tamil Nadu's MMR declined considerably to 97 in 2007–2009, making it one of very few Indian states that have realised this target under Millennium Development Goal 5 (MDG-5; State Health Society, 2012). Flexible funding made it possible for PHC managers to take initiative to fill infrastructure gaps and improve service delivery, which in turn increased utilisation, especially for maternity care. Deliveries in the public sector increased from 57.4% to 67.3% of total deliveries in the state between 2005 and 2010, and probably also contributed to reductions in out of pocket payments for healthcare (State Health Society, 2012). Cervical and breast cancer screening programmes were added in 2011 (Health and Family Welfare Department, 2012).

Tamil Nadu offers many lessons in the area of reproductive health care delivery. Innovations such as its drug procurement and delivery system have been adopted by other states (Muraleedharan et al., 2011; WHO, Regional Office for South-East Asia, 2009). The state has also proved that a target-free family planning approach, introduced from 1992, does not inhibit fertility reduction (Visaria, 2000). The role of well-trained women field workers in delivering antenatal care as well as other SRH services has also been recognised (Muraleedharan et al., 2011).

While significant gains have been made in achieving the ICPD commitments, the state is still faced with system-wide challenges, namely the inadequacy of trained providers and shortcomings in the quality of services. Excessive dependence on female sterilisation, which accounts for 89.5% of contraceptive prevalence in the state (International Institute for Population Sciences & Macro International, 2007), needs to be addressed by expanding contraceptive options for individuals and couples, including the young. The public sector must increase the priority given to provision of accessible, safe abortion services. Maternal anaemia has yet to be tackled effectively. Adolescent health services must be put back in focus, particularly the provision of comprehensive sexuality education, with special attention to reaching out of school and unmarried young people. SRH services must be expanded to meet the needs of underserved and vulnerable populations, such as tribals and migrants.

Equipped with a robust public health delivery system, efficient public management and adequate resource allocation, Tamil Nadu seems well poised to address these challenges and achieve the goal of integrated and comprehensive SRH services for its population.

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