

FAMILY PLANNING

WHY FAMILY PLANNING (FP)?

It's the right of all individuals to decide, freely and for themselves, whether, when, and how many children to have.

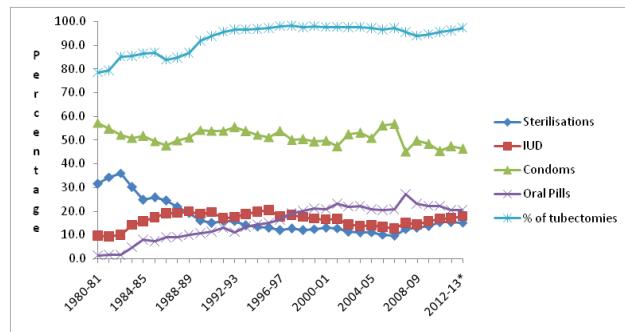
Rights-based FP is a key development and public health success in the last 50 years. It has transformed and saved the lives of millions of women and children, helped reduce population growth, and supported families to break the poverty cycle.

In developing countries, tens of millions of women want to delay or avoid pregnancy but have no access to or are not using effective FP methods.

- At least 222 million women have an unmet need for FP.
- Worldwide, there are 80 million unintended pregnancies and 40 million abortions every year.

Indian statistics

- According to DLHS data, around 48.2% of married women use a modern method of sterilisation; the urban percentage (53.8%) is higher than rural (45.6%).
- Female sterilisation was reported by 35.8% of married women; the urban percentage (36.2%) is closer to rural (35.6%).
- Male sterilisation was very low, with only 1.1% of married women reported using it; the urban percentage (0.9%) is closer to rural (1.2%).
- Intra Uterine Devices were more commonly used by urban women (2.7%) than rural (1.3%). Condom usage was higher among urban women (9.8%) than rural (3.5%).
- About 12.8% of women reported unmet FP needs; the rural percentage is higher (14.1%) than urban (9.7%).



(% of tubectomies is the proportion of tubectomies among all sterilisations)

WHAT ARE THE COMMON FP OPTIONS?

- 1) **Birth control pills:** Medication that women take daily to prevent pregnancy. Also called 'pills' or 'oral contraception'.
- 2) **Birth control injection:** A hormone shot that prevents pregnancy for three months.
- 3) **Morning-after pill or emergency contraception:** Emergency contraception is a safe, effective way to prevent pregnancy after unprotected intercourse. Useful in cases contraceptive failures, burst condoms, forced sex or sexual assault.
- 4) **Condoms:** Two types – male condoms and female condoms.

Both prevent pregnancy and reduce the risk of sexually transmitted diseases.

- Male condoms are worn on the penis during sex. Made of thin latex or plastic moulded into the shape of a penis; also called 'rubbers', 'safes' or 'jimmies'.
- The female condom is a pouch used during intercourse.

- 5) **IUD:** Small 'T' shaped devise, called Copper-T. Inserted in a woman's uterus by a healthcare worker. Different types of IUDs work for periods from three years to ten years.

- 6) **Sterilisation for women:** During this procedure, a healthcare provider cuts a part of the fallopian tube or uses clips, clamps or rings. Sometimes, a small piece of the tube is removed; this procedure is called tubectomy.

- 7) **Sterilisation for men:** Called vasectomy, in this procedure a health care provider closes or blocks the tubes that carry sperm, ensuring that it cannot leave a man's body and cause pregnancy.

- 8) **Other methods:** Include birth control implants and patches, sponges, vaginal patches, abstinence, withdrawal method and the menstrual cycle method.

- 9) **Newer methods:** Include gel injection in vas and new types of hormonal preparations in males and females.

WHAT ARE BENEFITS OF FAMILY PLANNING?

1) For the Mother:

Family Planning can help the mother to:

- DELAY pregnancy immediately after marriage
- SPACE pregnancies so that the next child is born only after she has completely recovered her strength, regained the nutrients of which she has been drained by the growing baby, and built up the blood she has lost during labour.
- HAVE only the number of children she feels capable of looking after properly.
- SAVE her life, particularly if she is under 20 or over 35 and in her fifth labour.
- TAKE part in activities outside the home.

2) For the Children:

Illnesses tend to recur when there are many children in the family.

- Mother weakened by frequent pregnancies tend to give birth to weak and sickly babies who run a high risk of death due to infections such as diarrhea and pneumonia.
- Babies born at less than two-year intervals or to teenage mothers tend to be premature and are at a higher risk of mortality.
- Babies who have to be weaned too early because the mother is again pregnant, may suffer from malnutrition through early weaning, bottle-feeding and infection.
- Babies of mothers over 40 may suffer from congenital defects.

3) For the Father:

With few children, the man will be able:

- To give his children a 'good home and good food' which will make them strong and healthy, and educate them to the best of their potential, so they can get a good start in life.

4) For the Family:

The health and happiness of the individual members of the family is reflected in the welfare of the entire family.

5) For the Country:

Increasing access to family planning information, services and supplies has dramatic health benefits for women and children. Recent evidence indicates that family planning is a cost effective intervention and has an immediate impact on maternal mortality. Family planning is also useful to control unsustainable population growth and the resulting negative impacts on the economy, environment, and national and regional development efforts.

in children through rights-based prevention of unintended pregnancies in women living with HIV. Condoms also prevent new HIV infections in women, men and adolescents; as well as maternal mortality.

- FP is useful to ensure healthy lives and promote wellbeing for all (SDG 3: sub-targets 3.1 by 2030, reduce global maternal mortality ratio to less than 70 per 100,000 live births; 3.2 by 2030, end preventable deaths of newborns and under-five children) and ensure healthy lives and promote wellbeing for all (SDG 5: sub-targets 5.1 end all forms of discrimination against women and girls everywhere; 5.2 eliminate violence against women and girls in public and private spheres, including trafficking, sexual and other types of exploitation).
- FP also helps to end poverty everywhere (SDG 1: sub-targets 1.1 by 2030, eradicate extreme poverty, currently measured as people living on less than \$1.25 a day; 1.2 by 2030, reduce by half the proportion of men, women and children living in poverty according to national definitions; 1.3 implement social protection systems and measures, including floors, and by 2030 achieve substantial coverage of the poor and vulnerable; 1.4 by 2030 ensure that all, particularly the poor and vulnerable, have equal rights to economic resources, and access to basic services, ownership, and control over land and other property, inheritance, natural resources, appropriate new technology, and financial services including microfinance) and help end hunger, achieve food security and improved nutrition, and promote sustainable agriculture (SDG 2: sub-targets 2.1 by 2030, end hunger and ensure access by all, in particular the poor and vulnerable including infants, to safe, nutritious and sufficient food always; 2.2 by 2030, end all forms of malnutrition, including achieving by 2025 internationally agreed targets on stunting and wasting in children under five, and address the nutritional needs of adolescent girls, pregnant and lactating women, and elderly).
- The overall social and economic benefits also ensure availability and sustainable management of water and sanitation for all (SDG 6: sub-targets 6.1 by 2030, achieve universal and equitable access to safe and affordable drinking water for all; 6.2 by 2030, achieve access to adequate and equitable sanitation and hygiene for all, and end open defecation, paying special attention to the needs of women, girls and the vulnerable) and ensure access to affordable, reliable, sustainable and modern energy for all (SDG 7: sub-targets – ensure access to affordable, reliable, sustainable and modern energy for all).
- It promotes inclusive and sustainable economic growth, full and productive employment and decent work for all (SDG 8: sub-targets 8.1 sustain per capita economic growth in accordance with national circumstances, and in particular at least 7% per annum GDP growth in least developed countries), reduce inequality within and among countries (SDG 9: sub-targets 10.1 by 2030, progressively achieve and sustain income growth of the bottom 40% of the population at a higher rate than the national average; 10.2 by 2030, empower and promote social, economic and political inclusion of all irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status), and make cities and human settlements inclusive, safe, resilient and sustainable (SDG 11: sub-target 11.1 by 2030, ensure access to adequate, safe and affordable housing and basic services, and upgrade slums; 11.2 by 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of women, children, the vulnerable, disabled and elderly; 11.3 by 2030, enhance inclusive and sustainable urbanisation and capacities

WHAT IS THE ROLE OF FAMILY PLANNING IN THE POST 2015 AGENDA?

- The United Nations Committee on Economic, Social and Cultural Rights in the General Comment No. 14 on Article 12 of International Covenant on Economic, Social and Cultural Rights (2000) agreed that the Right to Health included the right to control one's health and body including sexual and reproductive freedom.
- The International Conference on Population and Development (ICPD Programme of Action) in 1994 recognised that voluntary, quality FP services that include counselling and access to contraceptives must be available, accessible and affordable as a core element of a comprehensive Sexual and Reproductive Health services package.
- The World Association for Sexual Health (WAS) General Assembly adopted the Sexual Health Declaration in April 2007 in Sydney, Australia. According to the WAS Declaration, sexual rights are an integral component of basic human rights and hence universal and inalienable. Sexual health is integral to the right to the enjoyment of the highest attainable standard of health. Sexual health cannot be obtained or maintained without sexual rights for all. It was also recognised that sexual health requires gender equality, equity and respect. Gender-related inequities and imbalances of power deter constructive and harmonious interaction for attainment of sexual health. It was also acknowledged that reproduction is a critical dimension of sexuality and may contribute to strengthening relationships and personal fulfillment when desired and planned.
- FP2020, an outcome of the 2012 London Summit on FP is a global partnership that supports the rights of women and girls to decide freely and for themselves whether, when, and how many children they want to have. FP2020 works with governments, the civil society, multilateral organisations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020. It has highlighted 10 dimensions of FP: Agency and autonomy; availability; accessibility; acceptability; quality; empowerment; equity and non-discrimination; informed choice; transparency and accountability; and voice and participation.
- FP, a vital component of the Post 2015 Agenda, is one of the three agreed pillars by which to accelerate reduction of maternal and newborn mortality and morbidity - alongside emergency obstetric and newborn care, and skilled birth attendance. Its benefits range from improved maternal and child health to increased education and empowerment for women, to more financially secure families, to stronger national economies. Availability of contraception and dual protection is also the key to reducing potential HIV infection

for participatory, integrated and sustainable human settlement planning and management).

- It ensures sustainable consumption and production patterns (SDG 12: sub-targets 12.1 implement the 10-Year Framework of Programmes on sustainable consumption and production (10Y FP), all countries taking action, with developed countries taking the lead, taking into account their development and capabilities), promote peaceful and inclusive societies for sustainable development, provide access to justice and build effective, accountable and inclusive institutions (SDG 16: sub-targets 16.1 reduce violence and related death rates; 16.2

end abuse, exploitation, trafficking, violence and torture against children; 16.3 promote lawful rule at national and international levels, and ensure equal access to justice) and strengthen implementation and revitalise the global partnership for sustainable development (SDG 17: sub-target 17.1 strengthen domestic resource mobilisation, including through international support to developing countries to improve domestic capacity for tax and revenue collection; 17.19 by 2030, build on existing initiatives to develop measurements of progress on sustainable development that complement GDP, and support statistical capacity building in developing countries).

WHAT IS THE STATE OF FP IN INDIA?

- India is committed to deliver full services to pregnant women and children. It provides post-partum IUD services and places dedicated FP Counsellors in public health facilities with heavy caseloads of deliveries.
- The FP programme in India is repositioned as a critical intervention to reduce maternal and child mortality and not just for population stabilisation. Now the emphasis is on birth-spacing and terminal methods. Strengthening community-based service delivery is a key focus area where Accredited Social Health Activists (ASHAs) are delivering contraceptives to the doorstep of beneficiaries and counselling them about spacing births. Auxiliary Nurse Midwives in sub-centres provide FP counselling and supplies.
- The programme proposes to distribute contraceptives at the community level through 8,60,000 community health workers and 1,50,000 rural health sub-centres and trains 2,00,000 health workers to provide IUDs; and to include FP as a central effort to achieve Universal Health Coverage.
- A 'continuum of care' approach is adopted under NRHM with the articulation of strategic approach to Reproductive Maternal, Newborn, Child and Adolescent health (RMNCH+A) in India. It focusses on adolescence as a critical life stage and links child survival, maternal health and FP efforts. It aims to strengthen the link between community and health services, and various levels in the health system.
- India plans to focus on improving programme interventions in FP through:
 - Revitalising IEC Campaign vigorously
 - Strengthening post-partum FP services at all centres where deliveries takes place
 - Focussing on delay of age at marriage, delay in first childbirth and spacing between births
 - Involving (AYUSH is an acronym that is used to refer to the non-allopathic medical systems in India. It includes the Indian medical system of Ayurveda, Yoga, Unani, Siddha and also Homeopathy.

In the current terminology of the Ministry of Health in India, non-allopathic doctors are now referred to as AYUSH (meaning "life" in Sanskrit) doctors in FP programmes

- Education for adolescents about family life including reproductive and sexual health issues at a younger age; and women empowerment
 - Emphasising on research to develop innovative contraceptives and expand choices
 - Availability of more funds for health sector and FP
- The National Population Stabilisation Fund was constituted under the National Commission on Population in 2000. Later

it was transferred to the Department of Health and Family Welfare in 2002, and reconstituted as Jansankhya Sthirata Kosh (JSK) under the Societies Registration Act (1860) in 2003.

- Prerna

- In order to delay girls' age of marriage and birth-spacing, JSK has launched Prerna, a responsible parenthood strategy in the focus states of Bihar, Uttar Pradesh, Madhya Pradesh, Chhattisgarh, Jharkhand, Odisha and Rajasthan. It recognises and rewards couples that break the stereotypes of early marriage and childbirth, and repeated births. This strategy is changing people's mindset.

- Santushti

A strategy of JSK for Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh and Odisha. JSK invites private sector gynecologists and vasectomy surgeons to conduct surgeries in Public Private Partnership mode. An accredited private nursing home or hospital can sign a tripartite (State Health Society the first party, accredited private health facility the second party and JSK the third party) (MoU) with JSK. Private hospitals/nursing homes get incentives when it conducts 10 or more tubectomy/vasectomy cases per month.

- Private facilities conforming to these criteria can claims Rs 1,500 per case from NHM while an extra Rs 500 per case is paid by JSK.
- JSK also pays wage compensation to people undergoing sterilisation equal to the sum paid in the public facility: Rs 600 for tubectomy and Rs 1,100 for vasectomy.
- Reputed NGOs can participate in the scheme on fulfilling criteria for quality assurance.
- NGOs can also use the Primary Health Centre (PHC) and Community Health Centre (CHC) infrastructure not being utilised optimally.

- National helpline

- JSK initiated a national helpline that aims to provide information on reproductive health, sexual health, contraception, pregnancy, child health and related issues. It's specially for adolescents, the newly married and about-to-be married from Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh, Jharkhand and Chhattisgarh. The helpline has so far answered around 2,12,612 calls, mostly on contraception, pregnancy, sexual health and infertility issues.

- The Family Planning Insurance Scheme (FPIS), introduced in 2005, takes care of failures in sterilisation, medical complications or deaths resulting from sterilisation, and to provide indemnity for doctors/health facilities performing the procedures. Since 2013, states/union territories processed and made claim payments to acceptors of sterilisation in the event of death/failures/complications/indemnity cover.
- A report on the quality of care in providing female sterilisation and IUD services in Bihar found that though physical infrastructure like electricity and water have improved, many facilities had unsanitary environments without even space for providers and clients to meet.
 - No waiting areas. A third of the facilities had no designated examination rooms; most had no counselling rooms.
 - Most facilities lacked very basic minimum equipment, drugs and supplies for sterilisation. No essentials like scissors and narrow forceps. No availability of emergency/post-operative drugs.
 - Shortage of staff, from doctors to perform sterilisations and post-partum IUD insertions, to nurses and assistants to provide post-procedural care. Only a third of facilities had FP counsellors; they often lacked the interpersonal skills and training to give FP information and services to women in a gender sensitive manner.
- There was a tragic incident in Chhattisgarh in November 2014 when 16 women who underwent tubectomy died after the procedure. A report on the situation observed the following:
 - No conclusive evidence on the cause of deaths. Possible reason: Drug contamination. Clinical pictures inconclusive. Blood cultures did not grow anything ruling out sepsis.
 - Quality of care grossly compromised.
 - Lack of a well-rounded FP programme that includes spacing methods, oral pills, condoms and IUDs. Health officials did not discuss temporary methods, choice and rights.

Key Gaps

- Lack of a rights-based approach to Family Planning. Though, FP is a part of the health programme and population programme, there is a lack of rights-based language. Indeed, access to FP is a part of sexual and reproductive rights – which themselves are human rights.
- Quality of care is compromised in most of the PHCs and camps. Though the government has guidelines for FP, they are often not completely followed at the centres. Confidentiality and appropriate counselling about various methods (not just providing information) is also missing in many centres.
- There is a lack of focus on providing a well rounded family planning programme. These include choices like oral pills, condoms, and IUDs.
- Though the FP programme discusses adolescents, there appears to be a lack of integration of various policies and programmes. Some of these programmes - National Health Policy, National Youth Policy, National Mission for Empowerment of Women should be integrated to have a comprehensive FP strategy.
- No new choice of FP strategies in the past two decades.

Key Priorities

- India should use a rights-based approach to Family planning.
- Develop indicators for Quality control. Regular auditing of all centres to maintain the quality standards.
- Increased investment in the health sector, with specific increased allocation for FP. The investment in FP can be used for research and development purposes. Newer options (for males and females) should be a priority for the government.
- Training and updating knowledge of all services providers (doctors, nurses, and counsellors)
- Integration of multiple policies – Health and Family Welfare Programme, Adolescent Education Programme, National Youth Policy, National Mission for Empowerment of Women, Child Protection Policy

WHAT ARE THE RECOMMENDATIONS?

Parliamentarians

- Develop a rights-based FP programme. Policies should fit within international treaties and obligations. Treaties should be included in the preamble of the National FP programmes. Their focus should be population and health.
- Increase budget allocations for health programmes. Current expenditure of 1% of GDP to be increased to 3% of GDP.

Government officials

- Invest more in research of new contraceptive products – especially for males.
- Include FP information (methods, advantages and disadvantages) in education curriculum.
- Ensure availability of resources and clean sterile environments at centres.
- Provide training to personnel involved.
- Develop quality indicators and monitor performance and accountability of centres.
- Promote sustainability in all components of FP services.

Civil Society Organisations

- Monitor and hold governments accountable in their international commitments to SRH – especially FP.
- Advocate to governments to ensure people's increased access for sexual and reproductive health information and services focussed on contraceptives and FP.
- Ensure that funds are allocated for FP from national budgets.
- Identify peer leaders in the community and discuss FP emphasising on choices - especially for men.
- Partner with the government to train healthcare providers in FP centres.
- Collect data (quantitative and case reports) and utilisation to report pros and cons of FP services.
- Partner stakeholders (government, donor agencies, legal personnel, healthcare personnel, community members) to develop training and service programmes in FP.

Media

- Document/publicise cases of good experiences with FP and how they have changed lives.
- Be sensitive while reporting cases of problems due to sterilisation (like the Chhattisgarh incident). Highlight safety (quality control, recommended procedures). Encourage access to family planning.
- Use locals in video clips to sensitise population on different forms of FP.

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FPA India is a national level non-governmental organisation working with the communities for improving their sexual and reproductive lives since 1949. It is an ISO 9001:2008 certified civil society organisation that provides comprehensive sexual and reproductive health information and services to over 30 million people, making sexual and reproductive health (SRH) care easily accessible to those who are in need, viz. socio-economically vulnerable men and women, young people, PLHIV, people who use drugs, MSM (men who have sex with men), transgender, and sex workers. With its Headquarters based in Mumbai, it works through its 44 Branches and Projects in 18 states of India. FPA India is a Member Association of International Planned Parenthood Federation.

This document has been produced with the financial assistance of the European Union.
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