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Family planning in India: The way forward

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Abstract

Given the magnitude of the family planning programme in India, there is a need to strengthen the coordination of all its aspects, focusing on planning, programmes, monitoring, training and procurement. The quality of care in family planning must be a major focus area to ensure the success of family planning programmes. Despite serious efforts and progress, India has yet to achieve its family planning goals. Furthermore, there is a need for greater male participation both as enablers and beneficiaries and also address the sexual and reproductive needs of the youth. It is imperative for the government to ensure the prioritization of family planning in the national development agenda. Family planning is crucial for the achievement of the sustainable development goals, and subsequent efforts need to be made to improve access and strengthen quality of family planning services.

Keywords: Contraceptive choices, quality of care, sustainable development goals, unmet need

Introduction

Over the years, social scientists have argued the relationship between demographic change and economic outcomes, and it is now well established that improving literacy and economic conditions for individuals lowers birth rates, while low fertility in turn plays a positive role in economic growth. Family planning (FP) programmes impact women's health by providing universal access to sexual and reproductive healthcare services and counselling information. FP also has far-reaching benefits which go beyond health, impacting all 17 sustainable development goals (SDGs)[1]; however, the focus is on goals 1, 3, 5, 8 and 10. FP has been recognized as one of the most cost-effective solutions for achieving gender equality and equity (goal 5) by empowering women with knowledge and agency to control their bodies and reproductive choices by accessing contraceptive methods[1]. A women's access to her chosen family planning method strongly aligns with gender equality. Birth spacing can have great implications on health, for instance, reduction in malnutrition (goal 2) and long-term good health (goal 3) for the mother and the child[1]. Access to contraceptives helps in delaying, spacing and limiting pregnancies; lowers healthcare costs and ensures that more girls complete their education, enter and stay in the workforce, eventually creating gender parity at workplace.

Today, the demographic dividend is in India's favour and FP can and should be used to leverage it. Longer lives and smaller families lead to more working-age people supporting fewer dependents. This reduces costs and increases the country's wealth, economic growth (goal 8) and productivity of the people. Ultimately, these result in reduction in poverty (goal 1) and inequalities (goal 10) leading to the achievement of the SDGs through a multiplier effect.

Research shows that adequate attention to family planning in countries with high birth rates can not only reduce poverty and hunger but also avert 32 per cent of maternal and nearly 10 per cent of childhood deaths, respectively[2]. There would be additional significant contributions to women's empowerment, access to education and long-term environmental sustainability[2]. The United States Agency for International Development (USAID) estimates that 'every dollar invested in family planning saves four dollars in other health and development areas, including maternal health, immunization, malaria, education, water and sanitation'[3,4]. Thus, investing in family planning is the most intelligent step that a nation like India can take to improve the overall socio-economic fabric of the society and reap high returns on investments and drive the country's growth.

With over half of its population in the reproductive age group and 68.84 per cent of India's population residing in villages, opportunities are plenty but so are the challenges[5]. It is still an unrealized dream of the healthcare system to be able to reach the last mile, especially women belonging to scheduled castes and tribes (SC and ST) in distant and remote parts of the country. As a result, the mortality among these groups is high. Scheduled tribes in India have the highest total fertility rate (3.12), followed by SC (2.92), other backward class (OBC) (2.75) and other social groups (2.35)[6]. Contraceptive use is the lowest among women from ST (48%) followed by OBC (54%) and SC (55%) while female sterilization is the highest among women from OBC (40%) followed by SC (38%), ST (35%) and other social groups (61.8%)[6]. There is an urgent need for universal and equitable access to quality health services including contraceptive methods.

Favourable policy environment to meet high unmet need for contraception

An estimate done by the Ministry of Health and Family Welfare (MoHFW), Government of India, states that if the current unmet need for family planning is met over the next five years, India could avert 35000 maternal deaths and 12 lakh infant deaths[7]. If safe abortion services could be ensured along with increase in family planning, the nation could save approximately USD 65000 million[7]. Yet, the fourth National Family Health Survey (NFHS-4)[8] states that almost 13 per cent of women have an unmet need for family planning including a six per cent unmet need for spacing methods[9]. The consistency in these numbers since the NFHS-3 in 2005-2006[6] suggests that despite increasing efforts to create awareness on the subject, there is an existing gap between a woman's desired fertility and her ability to access family planning methods and services.

There is a direct correlation between the number of contraceptive options available and the willingness of people to use them. As shown in Fig. 1A, it has been estimated that the addition of one method available to at least half of the population correlates to an increase in use of modern contraceptives by 4-8 percentage points. Fig. 1A shows a projection of the rise of modern contraceptive prevalence rate (mCPR) in India, based on the trends observed by Ross and Stover[10] and using the current mCPR of 47.8 for India (from NFHS 4)[8] as the base value.

Expanding the basket of contraceptive choices led to an increase in overall contraceptive prevalence in Matlab, Bangladesh, where household provision of injectable contraceptives in 1977 led to an increase in contraceptive prevalence from 7 to 20 per cent[11,12]. As of 2015, injectable and pills together accounted for about 73 per cent of the modern contraceptive usage in Bangladesh, which has an mCPR of 55.6 per cent[13]. In addition to Bangladesh, Fig. 1B shows the mCPR of other neighbouring South East Asian countries such as Bhutan, Indonesia, Nepal and Sri Lanka where the availability of seven (or more) contraceptive methods corresponds with a higher mCPR. India, with five available methods of contraception (as of 2015), recorded the lowest mCPR among these countries (Fig. 1B)[8,13,14].

In India, efforts have been made over the years by the government to create a favourable policy environment for family planning, in the form of several important policy and programmatic decisions. At the London Summit on Family Planning held in 2012, the Government of India made a global commitment to provide family planning services to an additional 48 million new users by 2020[14]. According to the FP 2020 country action plan 2016[14], the government aims at focusing on mCPR, keeping in mind the current annual mCPR increase rate of one per cent as compared to the 2.35 per cent annual increase required to reach the FP2020 goals for India[14]. As a signatory of the SDGs in 2015, India has committed itself to achieving good health and well-being (goal 3) as well as gender equality (goal 5) by 2030[15].

In 2015, the announcement of the introduction of three new contraceptive methods - injectable contraceptive, centchroman and progestin only pills by the government of India[16] indicated a much-needed shift from the terminal method of female sterilization, which accounted for two-thirds of contraceptive use in India until 2015-2016, to more modern limiting methods of contraception[9]. Introduction of new contraceptive methods has always been marred by controversies surrounding their efficacy, side effects and safety. Consistent efforts need to be made to educate not just the users but also the service providers in every aspect surrounding a newly introduced method so that their capacities are strengthened. The users will also benefit from the strengthening of service providers; they will have better, more accurate access to information surrounding various contraceptive options, enabling them to make more informed choices. The third and equally important partner is the media. Greater efforts need to be made by both the government and civil society organizations to educate media to promote unbiased reporting and avoid creating panic on introduction of new methods.

Like any medical solution, contraceptive methods can also have side effects but it is imperative to note that the ability to access the available range of contraceptive choices is every woman's reproductive right. Implementation of pilot programmes is of utmost significance and relevance to generate further evidence on the efficacy of various contraceptives in different contexts. This enables a better understanding of the impediments in introduction as well as sustained usage of new contraceptives. To prevent early discontinuation and also dispel-related myths and misconceptions, women will need proper counselling on the usage and side effects of contraceptives.

Empowering community health workers to ensure better quality of care

India has close to 900,000 Accredited Social Health Activists (ASHAs) who are the access point for meeting the health needs and demands of the remotest sections of the population, especially women and children[17]. In addition to the ASHAs, other community health workers such as the auxiliary nurse midwife (ANM), reproductive, maternal, new born, child and adolescent health (RMNCH) counsellors and adolescent health counsellors are crucial in covering for the shortage of specialized healthcare providers in the country. Capacity building of community health workers can be of significance in reaching the last mile. The training of frontline workers has to be technical and beyond; there needs to be greater emphasis on trainings around community mobilization and counselling for contraceptive technologies, addressing myths and misconceptions prevailing in the communities regarding modern methods of contraception.

Quality of care (QoC), consisting of its crucial components such as access to contraceptive choices, quality counselling services, information and follow ups, can ensure that the unmet need of millions of women across the country is met, and there is an accelerated reduction in fertility. Efficient responsiveness to users not only creates demand but also ensures return of the clients, ensuring long-term effectiveness and sustainability of the programme. To ensure that quality services reach the last mile, services need to be geographically convenient. And finally, quality services cannot be provided in the absence of adequate infrastructure and competent and unbiased service providers and frontline workers.

The landmark verdict in the Devika Biswas versus Union of India case in 2016 made a number of recommendations to ensure a diligent functioning of the Quality Assurance Committees at the State and district levels[18]. The judgment took cognizance of “The Robbed of Choice and Dignity” report of the multiorganizational fact-finding mission led by Population Foundation of India (PFI) on the sterilization deaths in Bilaspur, Chhattisgarh in November 2014[19]. It also directed the State and Union government to move away from a fixed target-based approach for family planning. And finally, it made specific

recommendations to the government to improve the quality of services being provided under the family planning programme. This was a significant move to advance women's reproductive rights and choices in the last several decades and ensures a promising way forward for family planning in India.

Recognizing family planning as a human rights issue

Women's health goes beyond providing technical solutions or increasing the availability of contraceptive methods. Of tremendous significance is a woman's agency, choice and access to quality reproductive services. Access to quality family planning is not only a human right; it is extremely important for individual and societal well-being, and for the nation's development as a whole.

Addressing critical indicators such as child marriage and early pregnancy Child marriage violates the basic rights of children and especially the right to enjoy a free and joyful childhood. India is among the countries with the highest number of girls married before the age of 18[20]. Early marriage is typically followed by immediate childbearing. A systematic review of 23 programmes from Africa, Bangladesh, Nepal and India conducted by PFI showed that social pressure to prove fertility, insufficient knowledge on contraceptives and limited decision-making power among women were the main reasons for the high levels of early pregnancy[21]. The country needs policies in place that empower women, rather than those that restrict access to contraception.

According to NFHS-4, eight per cent women between 15 and 19 yr of age were either already mothers or pregnant[8]. NFHS-4 data also reveals that between 2005-2006 and 2015-2016, the percentage of women (between 20 and 24 yr) married before 18 yr of age dropped by 21 per cent, while there was a 12 per cent decrease in the percentage of men married before the age of 21[8]. While these figures depict a positive trend, one cannot ignore the fact that over one out of four (27% of girls) were married before the age of 18.

The government and civil society organizations should continue to work on the issue of child marriage by adopting different strategies including, but not limited to, raising awareness, behaviour change communication (BCC), community participation, conducting empowerment programmes for adolescents and not merely offering cash incentives.

Easy access to safe abortion services for women The World Health Organization has stated that ‘every eight minutes a woman in a developing nation will die of complications arising from an unsafe abortion’[22]. An estimated 15.6 million abortions occur annually in India[23]. Only five per cent of abortions in India occur in public health facilities, which are the primary access point for healthcare for poor and rural women[23]. Unsafe abortions account for 14.5 per cent of all maternal deaths globally[24] and are most common in developing countries in Africa, Latin America and South and Southeast Asia, with restrictive abortion laws, while the unmet need continues to be high. Such abortions are preventable by ensuring access to quality family planning, safe abortion and counselling services as well as by providing comprehensive sex education[25].

The social stigma surrounding abortion compels women to resort to unsafe abortion methods at the hands of unqualified service providers. In the Indian context, a study conducted in Bihar and Jharkhand found that abortion providers in both the public and private sectors favoured offering abortion and counselling services to married rather than unmarried women[26]. The same study pointed out that only 31 per cent of all participating providers agreed that all women regardless of marital status should receive information on contraception on request[26]. This act of restricting abortion services to women based on their marital status highlights the prejudice of providers against unmarried women and leads to high instances of unsafe abortions in the country.

The Medical Termination of Pregnancy Act (MTP), 1971 intends to provide safe and easily accessible abortion services to women with unwanted pregnancies on the approval of a medical practitioner, provided the pregnancy is within 20 wk gestation[27]. In India, unsafe abortion is routinely performed by unregistered medical practitioners without any medical training as well as by women who prefer to self-medicate themselves. Such practices often lead to severe health complications. According to International Centre for

Research on Women, 59 per cent of women in Madhya Pradesh surveyed revealed that they had an abortion because they did not want any more children. In addition, 22 per cent confessed using abortion as a proxy to contraception and as a means of birth spacing[28].

To improve access to safe abortion services, a draft amendment bill to the MTP Act, 2014 has been proposed by the Ministry of Health and Welfare, which allows abortion between 20 and 24 wk if the pregnancy involves risk to the mother and child or has been caused by rape[29]. It would also allow Ayurveda and Unani practitioners to carry out medical abortions. While increasing the time limit is in line with the technological advancements and would give the couple adequate time to decide, it can also lead to an increase in sex-selective abortions in the country.

Finally, there is a paradox when it comes to men's attitude towards abortion which needs to be acknowledged and addressed. Men need to be more involved in every dimension of sexual and reproductive health and family planning, right from being users of contraception to being supportive partners to their significant other as she makes a crucial decision about abortion.

Enhanced male engagement in family planning

In many parts of the world including India, family planning is largely viewed as a women's issue. A disproportionate burden for the use of contraception falls on Indian women. Female sterilization accounts for more than 75 per cent of the overall modern contraceptive use in India (Fig. 1B). In contrast, India's neighbouring countries such as Bangladesh, Bhutan, Indonesia, Nepal and Sri Lanka exhibit a more balanced method mix scenario which subsequently translates into a higher mCPR (Fig. 1B).

As per NFHS-4 data, the two methods of contraception available to men - vasectomy and condoms - cumulatively account for about 12 per cent of the overall mCPR suggesting that women are the driving force behind the family planning vehicle in India[8], and 40.2 per cent men think it is a woman's responsibility to avoid getting pregnant[30]. Most family planning programmes focus on women as primary contraceptive users while men are viewed as supportive partners, despite evidence depicting interest from male users to existing programming[31]. There needs to be greater recognition of the fact that decision-making on contraceptive use is the shared responsibility of men and women and programmes should cater to men as FP users. Family planning initiatives should address beliefs, myths and misconceptions surrounding contraceptive services as well as other barriers that refrain active male participation[32]. The family planning programmes should restructure their communication methods and strategies in a manner that includes men as both enablers and beneficiaries, hence making them responsible partners.

It is also important to reach men and adolescent boys as users not just in family planning programmes but also in government policies and guidelines as well as in research to create more male contraceptive options[31].

Addressing the sexual and reproductive needs of the youth

Youth (15-34 yr) account for 34.8 per cent of the total Indian population, of which an enormous number still do not have access to contraceptives[33].

According to a 2006-2007 subnational youth survey in India, while most youth had heard of contraception and HIV/AIDS, there was lack of detailed information and awareness[34]. While 95 per cent of youth had heard of at least one modern method of contraception, accurate knowledge of even one non-terminal method was considerably low among young women, with only 49 per cent reporting positive knowledge[34]. Likewise, while 91 per cent of young men and 73 per cent of young women reported having heard about HIV/AIDS, only 45 per cent of young men and 28 per cent of young women had comprehensive awareness of HIV[34]. The recently released findings of the UDAYA study in the States of Uttar Pradesh and Bihar by the Population Council revealed low levels of knowledge regarding sexual and reproductive health across all adolescents[35,36]. In both States, among older adolescents (15-19 yr), slightly less than a quarter of unmarried boys and girls and one in two married girls knew that a girl could become pregnant

even when she had sex for the first time[35,36]. Correct knowledge of oral and emergency contraceptives was considerably low across all adolescent groups in both States which indicated an urgent need to improve awareness, strengthen service deliveries and evaluate outreach strategies[35,36].

In its 2016 report, the Lancet Commission acknowledged the 'triple dividend' of investing in adolescents: 'for adolescents now, for their future adult lives, and for their children'[37]. According to an estimate by the Guttmacher Institute, 38 million of the 252 million adolescent girls aged 15 to 19 years in developing countries are sexually active and do not wish to be pregnant over the next two years[38]. These adolescents include a staggering 23 million with an unmet need for modern contraception[38]. It is more important now than ever to make a shift from one-size-fits-all approaches and cater to the needs of married and unmarried adolescents.

Increased investment in family planning

The National Health Policy 2017 talks of increasing public spending to 2.5 per cent of the GDP, which is a welcome sign[39]. However, much higher health allocations are necessary to take forward the nation's family planning agenda in favour of reproductive health and rights. The Government's newly launched Mission *Parivar Vikas* Programme focuses on improving access to contraceptives and family planning services in 145 high fertility districts in seven States[40]. In addition to higher health allocations, the government needs to ensure efficient and complete utilization of funds already allocated to family planning activities.

India spent 85 per cent of its total expenditure on family planning on female sterilization with 95.7 per cent of this money going towards compensation, 1.45 per cent on spacing methods and 13 per cent on family planning-related activities such as procurement of equipment, transportation, Information Education and Communication (IEC) and staff expenses in 2016-17[41]. According to our analysis of the National Health Mission (NHM) Financial Management Report[41], the total budget available for family planning activities under the NHM was ₹12220 million in India during 2016-2017. Of the total money for family planning, 64 per cent was directed for providing terminal or limiting methods, nine per cent towards ASHA incentives for FP activities, 5.3 per cent for training, 5.5 per cent for procurement of equipment, 3.7 per cent for spacing methods and 3.6 per cent towards BCC/IEC activities for family planning (Fig. 2)[41]. The total spending was ₹7415 million indicating that only 60.7 per cent of the total money available for family planning activities was spent during 2016-2017. Of the total expenditure for FP activities, 68 per cent was spent on terminal or limiting methods of which compensation for female sterilization constituted 92.7 per cent; 13.3 per cent was incurred for ASHA incentives, 3.7 per cent was incurred for spacing methods of which incentives to providers for post partum intrauterine contraceptive device (PPIUCD) insertion constituted 73.2 per cent and compensation for intrauterine contraceptive device (IUCD) insertion at health facilities constituted 14.2 per cent, 2.8 per cent on interpersonal communication (IPC)/BCC activities and two per cent was spent for training (Fig. 2).

Investing in behaviour change communication (BCC) The above mentioned numbers suggest that although family planning programmes in India have made significant progress, the budgetary spending and allocation is still skewed towards terminal methods, with inadequate emphasis on training of service providers and investment in BCC/IPC. The issues surrounding family planning and sexual and reproductive health emerge from deep-seated social norms, which cannot be uprooted overnight. It is imperative to strategize effectively to work with communities to influence social norms.

Social and Behaviour Change Communication (SBCC) can address sociocultural norms such as sex selection, early marriage, unwanted pregnancies, domestic violence and gender inequality. PFI's transmedia edutainment intervention, *Main Kuch Bhi Kar Sakti Hoon - I*, (A Woman, Can Achieve Anything, MKBKSH) is one such example[42]. PFI's experience with MKBKSH Season 1 and 2 shows that entertainment education (EE) initiatives have tremendous reach and potential to change the knowledge, perception and behaviour among viewers.

In addition to SBCC, interpersonal/spousal communication has the potential to significantly improve family planning use and continuation. In countries with high fertility rates and unmet need, men have often been considered unsupportive partners as far as family planning is considered[32] suggesting lack of adequate spousal communication. SBCC is a key avenue in the existing communication within the family

planning programme in a country like India where frontline workers reach populations where other media cannot reach. It is the time to not just increase investments in health and family planning but to fully utilize the currently available budget and rearrange the existing allocations in favour of reversible contraceptive methods and SBCC to challenge and change existing sociocultural norms.

Conclusion

The success of India's family planning programme is shouldered by researchers, policymakers, service providers and users, who will need to do their part to ensure equitable access to quality family planning services. The praxis of family planning is simple and the availability of a basket of contraceptive choices can play a crucial role in stabilizing population growth. An effective and successful family planning programme requires a shared vision among key stakeholders, which include the government, civil society organizations and private providers. These stakeholders should ensure that the sexual and reproductive needs of youth and adolescents in the country are fulfilled. In addition, greater male participation as active partners and responsibility bearers can certainly ensure increased use of contraception. The time to act is now. And this should begin with a concerted effort from everyone to empower women, expand family planning choices and strive for greater gender equality so that every individual can lead a dignified life.

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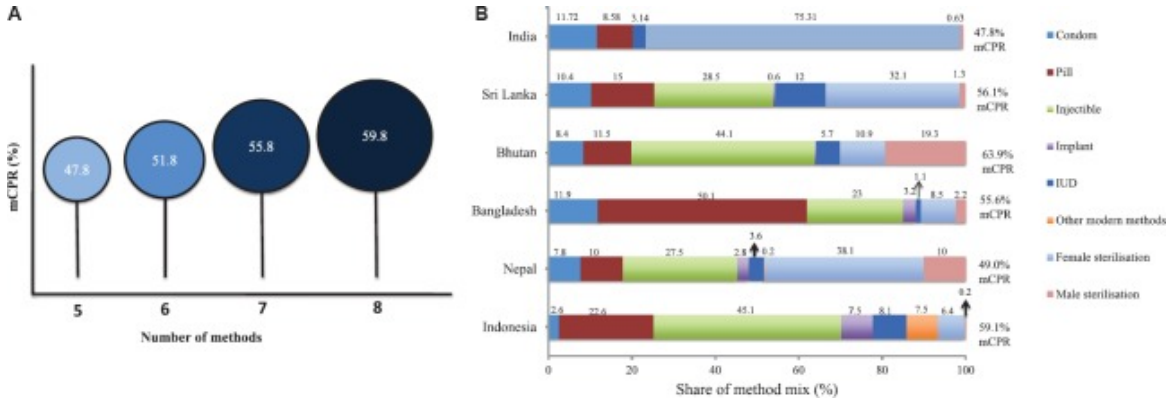
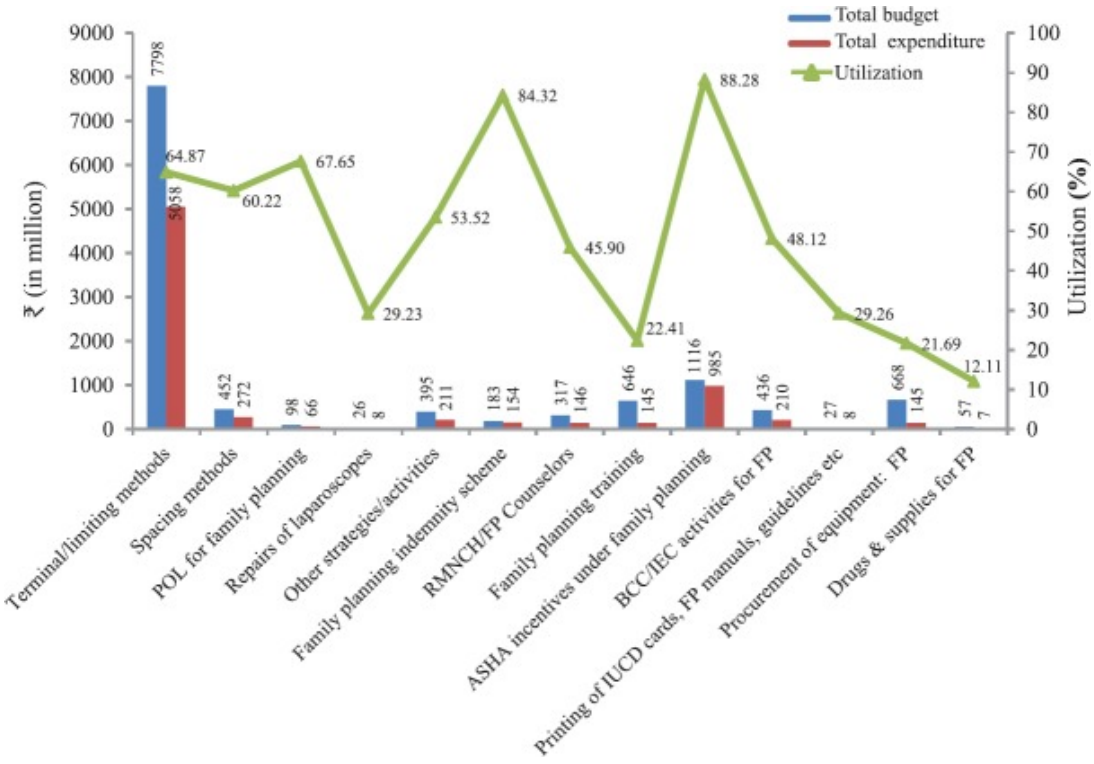
Figures and Tables

Fig. 1



Effect of number of contraceptive methods on modern contraceptive prevalence rate (mCPR). **(A)** The graphic is a projection of the rise in modern contraceptive prevalence rate (mCPR) in India with every additional contraceptive method. This estimation is based on the mCPR of 47.8 from the National Family Health Survey 4 (NFHS-4). *Source*: Refs [8], [10]. **(B)** Evidence on contraceptive method mix in developing countries South/South-East Asia. The mCPR has been represented on a scale of 100 percentage points to depict the distribution of contraceptive method mix for each country. *Source*: Refs [8], [13], [14].

Fig. 2



Allocation, expenditure and utilization of FP budget 2016-2017. POL, petroleum oil and lubricants; RMNCH, reproductive, maternal, newborn, child, health; FP, family planning; bcc, behaviour change communication; IEC, Information, Education and Communication; IUCD, intrauterine contraceptive device. *Source*: Ref. 41.