National Consultation of Civil Society Organizations

on

Family Planning in India

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India International Centre (IIC)

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A Concept Note

Access to contraceptive choices and ability to act upon those choices are two most important aspects of a larger 'reproductive rights' framework. Ensuring access to appropriate, safe and quality contraceptive choices for all its citizen is one of the most important responsibilities of the State. In India, contraception is popularly referred as Family Planning and it is a part of 'Health' systems. In fact, India was the first country to include family planning within health programmes in its first developmental plan in 1951.

"Family planning saves lives" does call attention to the fact that an estimated 212 maternal deaths occur per one lakh live births in India due to complications related to pregnancy and childbirth, of which lack of access to quality family planning services including contraceptives is a major contributing factor. A little less than half (45%) of maternal deaths are among young women between 15-24 years of age.[1]To this end, family planning can prevent a quarter to a third of all maternal deaths saving 140,000 to 150,000 lives a year, worldwide.[2],[3] 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 immediate impact on maternal mortality.[4]

By channeling resources to family planning, nations can save lives, stabilize population growth, slow the spread of AIDS, reduce poverty and improve women's position in society.Those countries in the developing world that have invested in health and education and have provided women access to family planning and reproductive health programs have experienced faster economic growth than those that have not.

When couples can choose the number, timing and spacing of their children, they are better able to adequately feed and educate their children, potentially ending the cycle of poverty. Communities thrive, and in turn, countries fare better.

Family planning is perhaps the only intervention which cuts through 6 MDGs.

With fewer children families can lead healthy productive lives which can lead to the alleviation of poverty (MDG 1). Children are more likely to attend school and attain higher education (MDG 2). Less number of pregnancies can lead women to take up jobs and be empowered with improved status within their family as well as outside (MDG 3) and reduce the risk of maternal mortality either due to complications of pregnancy or an abortion (MDG 5). Well-spaced births can reduce malnutrition and infant mortality (MDG 4). One contraceptive method the condom prevents both HIV transmission and unwanted pregnancy (MDG 6).

Unmet need for family planning

There are an estimated 12.5 per cent women in India who want to delay or avoid a pregnancy but are not using or have access to an effective method of family planning. This has far reaching consequences on the health and economy of India. The disparities are wide – urban-rural, interstate and intra state

There are key states where unmet need for family planning remains high. Also, the adolescent fertility rates in these states contribute largely to high TFR. Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh, Jharkhand and Orissa itself constitute 50 per cent of the total population of India. In these states where Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) are also very high there an urgent need to focus on spacing methods.

The type of contraception used, time of initiation of contraception, continuation rates of temporary methods are some of the factors that influence the relationship between Couple Protection Rates

and Crude Birth Rates. Kerala and Tamil Nadu have reached replacement level of fertility well before CPR of 60% was reached. However, in spite of CPR above 60% Punjab is yet to reach replacement level of fertility.

In addition, there is huge unmet need for immediate post-partum contraception among women who deliver at public sector facilities under the Janani Suraksha Yojana in high focus states. These women are brought to the facility by the ASHA worker as a part of her compensation regulated work and after delivery are discharged within 4-6 hours due to heavy work load and lack of space. The whole focus of JSY has been only on safe institutional delivery driven by compensation package for the delivering woman and ASHA worker. However, these women do not receive any FP information during ANC or PNC period.

Overall, the most prevalent and commonly used method remains sterilization in India. Historically, the whole health system has been geared towards providing this contraceptive method above all others. Therefore, it has now percolated down in the community and grass-roots health provider as the best choice. This practice has its roots in previous regime of 'Targeted approach'. The combined effects of previous drives and current practice of incentives for accepting sterilization has resulted in a kind of method hierarchy where sterilization is seen as the most important method.

This overdependence has resulted in overall low use of spacing methods and thus has negatively impacted in women's ability to control their fertility and violation of right to choice.

State level Issues

In India, inter-state variations are remarkable for various maternal and child health Indicators. Statistics of few states are much higher than the national average while others are equal or lower than the national average.

FP In Northern States

Seven states – Uttar Pradesh; Bihar, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh, Assam have high unmet need of family planning. The key issues from these states are:

- Sex preference for a male child – one leading cause of larger families
- All families with more than 3 children expressed desire for contraceptive services and avoidance of next pregnancy
- Service delivery problems – the public sector health services are very weak
- Present policy focus – currently due to a strong focus on institutional deliveries (Janani Suraksha Yojana) family planning services are no longer a priority
- There is a lack of adequate service delivery points and stocks in rural areas

These states also face lack of trained service providers for provider dependent FP services namely – sterilization, non-scalpel vasectomy, IUD insertion and Injectables. Therefore, there is a very high unmet need among far-flung districts, particularly in rural areas for family planning services.

FP status in Southern States

There is very high unmet need for spacing in even better performing southern states like Tamil Nadu and Karnataka. These states have enforced policies and programmes which are very heavily tilted for sterilizations. Very young girls of age 18-22 are being provided with sterilization services as soon as they complete the family size. There are almost no spacing services provided through public sector health care. In most cases sterilization is the first method of FP used by the women.

Slowing the population momentum

It is in this context there is a need to critically examine the various models used in different states, look at the overall picture, and the background of policy support, the understanding of political leadership vis-à-vis population growth and the need for future actions.

It is essential that the overall family planning program should be made cost effective and qualitative. There is a need to – increase access of required services to the masses, age of marriage be delayed to 19 years, male participation, awareness among women, to popularize "spacing methods", like access to condoms; oral pills and to improve the quality and effectiveness of Intrauterine Device (IUD) .

Setting the context for the FP Summit

The forthcoming family planning summit (earlier called the "Gold Moment") to be held in July in London is the next big frontier in new policy paradigm as well as funding support. The hope is that 2012 will be a "Gold Moment" to ensure that the need for contraception for women in developing countries can be met. The event will aim to generate unprecedented political commitment and resources from developing countries, donors, the private sector, civil society and other partners to meet the family planning needs of women in the world's poorest countries by 2020.

Family Planning within the context of health is one of the flagship programmes of the Government of India. However, the programme is yet to realize its full potential. In India, the programme has achieved a significant success with steadily declining fertility rates in last three decades; along with the reduction in overall unmet need for family planning. However, there are areas of concerns and gaps. Also, the situation in north Indian states like Bihar, UP, MP, Rajasthan and Odisha remains critical with high unmet need for family planning as well as high maternal and neonatal mortality.

It is noteworthy that there has been tremendous development in medical technologies in last two decades. However, the family planning programme has not benefitted from this development. Newer methods have not found a space in the basket of choice. Limited choice of short term methods, lack of availability of existing methods and ease of access are some issues which need to be resolved both at the policy making level as well as at the implementation level.

Lack of adequate facilities and staff within the public health sector has resulted in low demand for contraceptive services and also low supply of whatever demand is generated. Therefore, one of most important intervention in high need areas would be to fortify the service delivery of contraceptive services through trained and skilled service providers in a phased manner at the grass roots level.

Some issues of concern which need to be discussed in the context of making family planning/contraceptive services widely available within reproductive rights approach could be :

1. *Providing family planning information and options to couples at all ages and stages of their reproductive life*
2. *Meeting contraceptive needs of the youth*
3. *Providing quality family planning services in resource constrained settings*
4. *Re-examing the role of incentives, targets and campaign approach for accelerated population stabilization*

5. *Improving access and quality of services – role of the private sector (including non-Government sector)*
6. *Gender equality, human rights and family planning*

CSO Consultation on Family Planning in India

The Civil Society has been very vibrant in India. It has been an active partner and the on-going programmes like the NRHM have carved out spaces for the role of civil society action right from the grass-roots (in form of the Rogi Kalyan Samitis) to the policy level. In fact, it has been civil society voice that has often resulted in programmatic change or innovation. The issues have ranged from sterilization insurance scheme to involvement of grassroots CSO in public hearings.

There is another dimension to the family planning debate in India. In context of strategies dealing with population stabilization in India, it is often understood that family planning and population stabilization are contradictory issues. On the face of it, it appears that policies that focus on population stabilization through family planning have limited space for Reproductive rights framework.

Also, the high unmet need coupled with limited public sector facilities and skilled personnel translates in heavy pressure for service delivery and can lead to lowered standards of quality of services.

Some of these issues have been raisedas a serious matter of concern by Civil Society organizations across India. Therefore, voices of the CSOs would bring an unheard and critical dimension to the whole debate during the global family planning summit.

FPA India is committed to the success of the CSO Consultation in India, which will take forward the emerging recommendations to the Summit. It strives to ensure broad support and commitment across all stakeholder groups. For the Gold Moment to achieve the desired catalytic and transformative results, a series of meetings beginning with state level and culminating at the national level with civil society organisations have been called for. The states of Bihar, Chhatisgarh, Uttar Pradesh, Madhya Pradesh, Odisha, Jharkhand, Rajasthan, Tamil Nadu, Karnataka, Gujarat, West Bengal, Maharashtra and Jammu and Kashmir will be involved.

Expected Partnerships

The national Consultation would draw from the expertise of leading advocacy and service delivery CSOs working in the field of family planning. The CSOs would guide the process and also lead in some of the state level consultations. Initial partnership discussions have started with Indian organizations[1] like Centre for Health and Social Justice; Population Foundation of India, CINI, Chetna, Janani, PSS and others. Partnerships are also sought from coalitions and networks like ARC, Youth Alliance and White Ribbon Alliance.

The Family Planning Summit: The Gold Moment can offer a real breakthrough for meeting unmet need. This is an opportunity to work with all concerned CSOs to bring it to fruition.

[1] Formal approval from the CSOs mentioned is awaited.

The CSO consultation is expected to bring out key issues which will impact the FP programme in the country.

[1]Special Bulletin on Maternal Mortality in India 2007-09. Sample Registration System, Office of Registrar General, India, June 2011.

[2]Singh S, Darroch JE, Vlassof M, Nadeau J. Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care. New York: Alan Guttmacher Institute; 2003. Available at: www.guttmacher.org/pubs/addingitup.pdf.

[3]Collumbien M, Gerressu M, Cleland J. Non-use and use of ineffective methods of contraception.In: Ezzati M, Lopez AD, Rodgers A, Murray CJL, eds. Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors. Geneva: WHO; 2004:1255–1320.

[4]Prata N, Sreenivas A, Vahidnia F, Potts M. Saving maternal lives in resource-poor settings:facing reality. Health Policy.2008;doi:10.1016/j.healthpol.2008.05.007.