

**A Roundtable on
Population and family Planning:
Contemporary Challenges & Opportunities**

12th January 2011

Venue

India Islamic Culture Centre
87 – 88 Lodhi Estate, New Delhi-110003

**National Coalition on Population Stabilization,
Family Planning & Reproductive Rights**

Context

The Government of India is seized with the issue of rising population. A high level meeting, headed by the Minister on Repositioning Family Planning, was held in May. It was followed by a Family Planning week to celebrate the Population Day (July 11). Then in August the Parliament debated the issue for five hours – the seriousness of the issue could be gauged by the fact that there was complete agreement cutting across party lines. The Family Planning website flashed the slogan: **“Control Population!! Have Fun with One!!!”** Just last week, the National Population Commission also held its meeting after a gap of several years – it was presided over by the Prime Minister. There is a growing concern about slow decline in the Total Fertility Rate (TFR) in some States and how to increase the family planning acceptance rate.

The need for a robust family planning programme in India can not be underemphasized, so government’s initiative must be welcomed. However, it is worrisome to connect family planning and high population growth rates. A certain section of the society appear obsessed with the fact that Indian Population is soon going to exceed that of China, and will happen no matter what is done. This issue is talked about and spread as “worry” without checking the ground reality. In fact, this will happen not because Indians desire more children, but because there is a sizeable population of young generation that is in the reproductive age. Even at low rate of reproduction, this large population of young couples will lead to high population growth rate. This is known as “population momentum”. Unfortunately our policy makers don’t appear to understand or recognize this fact.

Another real problem is that the government has failed to provide choice in the family planning methods, which couple want or are more suitable to their needs. The policy makers still seem intent on promoting “sterilization” or permanent methods. They appear totally unmindful of the needs of young couple: They need options to delay the first pregnancy and space out the future births. Why “sterilization” is not a good option for the young people? Studies show high failure rates of sterilization for young couples, beside adding to the possibility of long term adverse consequences. It is unfortunate that despite millions of tubectomy surgeries, including a significant number on young women as young as 21 or even less, government has not carried out studies on the long term consequences.

Recently the Chief Minister of Madhya Pradesh, Mr Shivraj Chouhan, announced that this year the State would pursue a volunteer sterilization target of 7 lakhs, which is more than one and a half times of annual figures in recent years. While the Union Health Minister and the CM are careful to say that there would be no coercion or new legislation, one wonders how the extra numbers would be generated without persuasion and “subtle” coercion through the current system.

Concerns about Sterilization Focused Approach

India has traditionally relies upon female sterilization as the primary family planning tool. No doubt it is a safe method for couples who have completed their families. It also has few contraindications when done with proper care, training, and screening of clients. Unfortunately, however, studies suggest that our screening procedures are inadequate and the quality of care is poor. Moreover, sterilization is not a good option for the young women as shown by literature – it leads to more complications, higher failure rates, and higher possibility of hysterectomy in later life. The main concerns of young couples are delaying the first birth and adequate spacing between children.

Need to Understand Changing Realities

The current realities of the Indian society are: (1) large population of young couples who primarily need safe temporary methods of contraceptives rather than sterilization, (2) More effective intervention at the level of cultural practices such as child marriage and child bearing by the policy makers, (3) Social norms have changed and men are increasingly involved in childcare roles in nuclear families, and (4) Role of men and their participation in family planning needs highlighting.

Need for Vigilance

We are likely in a new era of population control with politically correct language, but with an inadequate understanding of current population dynamics and a limited realistic appreciation of system strengths. With continued emphasis on sterilization, we need to be on look out for unequal burden on the poor and marginalized communities and missing out on the needs of young people.

Need to Mobilized Public Opinion

Before it is too late, we need to mobilize public opinion in favor of strengthening the family planning programme by providing:

1. High quality services on a diverse range of options and move beyond a “sterilization only” focus
2. Strengthen family planning counseling to enable couples and women to make more appropriate choices
3. Ensure supplies and commodity security
4. Include and address contraceptive concerns of young unmarried persons
5. Provide space to involve men as responsible parents and partners

In summary, considering the current situation it is necessary to develop a strategy to ensure that the policy interventions in family planning allow it to become a creative force so that it effectively disseminates information among young people to enjoy their reproductive rights; young women are given the choice of contraceptives appropriate for their age; improves quality of care for contraceptive service delivery; ensures that men are addressed as responsible parents and partners; and above all it ensures that all individuals and couples are provided with the information and services so that they can make responsible contraceptive choices.

SESSION – 1

Continuing Concerns

*Welcome and Context: **Dr. A R Nanda***

*Incentives and Disincentives – **Dr Gita Sen**, IIM Bangalore*

*Quality of Care of Family Planning Services – **Dr Hemant Shah**, Bhansali Trust*

AR Nanda

After welcoming the participants, Mr Nanda set the context of the roundtable. He mentioned that the national Coalition on Population and Development came in existence during April-May 2010 in Pune. Its main aim was to assist the Government of India and state governments,

particularly the demographically vulnerable states in their efforts to control population growth. Based on the experience of last 4-5 decades on issues such as population stabilization, family planning services, and reproductive rights it decided to hold discussions at different places. The present roundtable is a part of it.

Mr. Nanda mentioned that the International Conference on Population & Development held in Cairo in 1994 catalyzed the changes in the way the family planning services needs to be delivered taking into account the changed perspective and demographical realities. The next three years, 1995-97 saw adoption of target free approach to population management by the Government of India.

This paved the way to reposition the family planning initiatives and convert it into a comprehensive reproductive healthcare. It was a significant shift away from the stand alone sterilization targeted approach. Theoretically it was accepted in the national population policy and reproductive child health programme of the government. State governments also followed suit along with deviations in different degrees.

Mr. Nanda reminded that by and large government planners still believe that the target free approach leads to irresponsibility and lack of accountability. While many ground level workers such as ANMs would prefer to work in a target free atmosphere. Yet, the government keeps going back to the target driven actions often calling it "expected level of achievement" or ELA. He was apprehensive that the government's efforts in 150 districts, would meet the same fate when reaching the ground level worker.

Touching upon the issue of incentives and disincentives, Mr. Nanda cited the developments in some states like MP where Nano car and other awards are offered to win the competition of targets, despite claims that no coercion is involved. While giving incentives to poor people can be understood, but distorted forms of incentives only lead to fudging of figures.

Citing his personal experience, Mr. Nanda mentioned that he had seen the system since the targets were first introduced in 1996; it has turned into an ossified target based mentality by now. He was often penalized as district officer for missing the targets. He was frequently asked by the authorities "How would you bring accountability without targets?" The answer is the need based plan by the local unit – village or community. Actually, the need based plan for every village can provide self imposed targets. But in reality, even if some ground level planning is done, targets are always imposed from the top to various levels downwards.

There is a set of quality indicators of healthcare that can be monitored rather than just the numbers, say # of sterilization, contraceptive prevalence rate, etc. It would be better if a village or block is awarded for fulfilling in all indicators rather than just one final number. But this is not followed.

Mr. Nanda mentioned that changing needs in the changing demographics is another important issue for this meeting: Need of the young population, need for spacing methods, basket of choices, etc. and the discussions should aim to come up with plan for future action.

Dr Gita Sen
Incentives and Disincentives

Dr Gita Sen highlighted the target based mindset of authorities by calling it "Stealth Approach" when they don't admit it publicly. Handling this stealth approach is a major challenge. Another big challenge is how to integrate various government programmes such as NRHM, with the population issue. At least our position on these programmes should be clear.

Dr Sen acknowledged the accomplishments of past decades – National Population Policy (NPP)-2000, setting up of Reproductive Child Health (RCH) programme, contributions from the non governmental sector on adolescent issues and their sexuality, the evolution of NRHM and its turning towards maternal mortality. She also counted the “stealth approach” of authorities as a gain for the target free movement. Notwithstanding these gains, there is a need to change the discourse.

Dr Gita Sen tried to dispel the confusion about target and target free approaches. The word “target” actually denotes the phrase “contraceptive method specific targets” that are the basic problems. However, it is a valid for a programme implementer to ask: without targets how will I implement the programme? Therefore, the target must be connected with the context to maintain the focus at the right place.

Another important issue is the redefining of unmet need, Dr Gita Sen pointed out. Defining it only in terms of contraceptive methods is not adequate. No doubt the term unmet need came from the population and family planning side, but it needs to focus on needs not being met. An integrated approach should focus on that.

While the future direction is suggested in Bisaria’s decomposition numbers on factors of population growth – up to 2101 about 70% growth would come from momentum and only about 6% from wanted fertility, and the remaining 24% from unwanted fertility. This has only partially seeped into the general discourse and the official mindset is still occupied with the targets and the “stealth approach” continues.

A major issue for discussion is: if momentum is contributing 70% to the growth, then should 70% of attention be on things like increasing age of marriage, supporting girls’ secondary education supporting jobs for girls, and so on. Similarly the unwanted fertility has several components such as the quality of services, under served population, adolescent sexuality and sexuality outside marriage, etc. Dr Sen emphasized the need to come up with clear implementable strategies starting from arguments based on this decomposition.

On the issue of incentives and disincentives, Dr Sen said they usually lead to distortions and the argument appears to be stuck there – that targets and ELAs create distortions. Some thinking is required on this point. There is another dimension to the arguments about incentives (or disincentives): If all the incentives and disincentives are focused on wanted fertility to lower wanted fertility, which has only 6% contribution to population growth, does it distort efforts on unwanted fertility and unwanted momentum which contribute almost 95% towards growth?

Touching upon the one child policy of China, Dr Sen pointed out that China had laid out foundation of health and education infrastructure when the policy was introduced in 1979. This gives different meaning to the issue of wanted or unwanted fertilities. Further, the policy was never as rigid as it is made out to be. It created a severe sex ratio imbalance due to explicit preference for male child. Circumstances, however, are not that bad in India. However, after 2nd generation the one child policy actually breaks the family culture, which is deeply cherished in our culture. This is a strong and politically correct argument.

Another problem with incentives, say for two child norm, is that it punishes the late born girls ; (3rd 4th in birth order) they are penalized not only by the family but also by the government programme. Most government programmes are similar. But there is a valid counter argument: Are you against all incentives, or for some and against others?

Dr Sen pointed out that it would be wrong to say that we are against targets, per say. The problem is with stand alone targets that are not part of any integrated planning. She

suggested setting up a sub group or a joint committee of government officials and coalition members to work out details of the integrated approach. This will avoid implementation through targets while denying them – the stealth way of doing things.

Finally, Dr Sen expressed hopes for new directions in UNFPA coming from the other countries, such as Indonesia, in next few years and learning from their experiences.

Dr Hemant Shah

Quality of care of family planning services

Dr Hemant Shah started with activities of the Bhansali Trust. He mentioned about the four main activities relevant to the family planning area: safe motherhood project, vaccination, SUVAS, and Integrated child Development services run by the trust covering 1 million population in six blocks of Banaskatha and Patan districts of Gujrat – the most backward area in the state. They track about 22000 pregnant women each year and register about 20000 births every year. The SUVAS project mainly focuses on family planning issues and under ICD services. They run around 1000 Anganwadi, besides a number of hospitals.

Dr Shah's presentation was focused around the quality care practices covering care before, during and after surgery. They have two initiatives: a permanent contraception, Laparoscopic tubectomy and a long term contraceptive, IUC devices. He stressed that the pre- and post-operative cares are the most neglected areas; they take particular care not to overlook anything.

The 2000 strong cadre of trained health workers and their regular dialogue with doctors is what Dr Shah called "the missing link in the government health care." In government healthcare the health worker brings the patient, the doctor operates and the patient goes back. No body knows what happen to the patients there after. But at Bhansali Trust, the trained health workers not only take care of proper selection of the patients, they also bring valuable feedback from the earlier patients. The trust offers them a coercion free atmosphere.

To underscore their wholesome approach to quality care, Dr Shah stressed the point that rather than following the general practice of starting with history taking, they start with health check up and lab examinations. Reason: almost 60% women in that region are anemic. So even if a woman is found unfit for surgery she would at least get treatment for anemia. They always start with hemoglobin test, then the pregnancy test, and finally history taking. Their procedures are based on the experience of 14000 tubectomies done in last ten year.

The next step is recording patient's menstrual history, contraceptive history and the last sexual contact. Menstruation history is important because it brings out some crucial issues. When a woman is affirmative about menstruation it could have lasted just for a day, two days, or sometimes be simply pill induced – MTP pills are easily available even in Kirana shops. The pill induced bleeding can be a real problem jeopardizing the safety of the patient, if operated. So the contraceptive history is important. They also ask for the last sexual contact because the urine test will be positive only after first missed period. Finally a detailed clinical examination is followed.

Dr Shah mentioned that the focus on counseling is generally to explore if the patient really needs the service; it is usually done by the workers. This contrasts the coercive approach of government healthcare.

The success of operations crucially depends upon cleanliness of surgical instruments and devices. In order to actually monitor the time of disinfection, prescribed for 20 minutes, they use timers. Patients are operated in their own clothing and with complete dignity. This draws

people from communities not very receptive to visiting government facilities. They keep the patient for 4 hours after the operation. It is an important part of the patient care. The usual practice of 7 hour camp duration does not allow sufficient time for proper patient care.

Dr Hemant Shah talked about their various improvisations to save time without sacrificing quality; for instance, better disinfectants are introduced that work in lesser time. When organizing camps at outside facilities the workers inspect the place for suitability and hygiene conditions. This underscores the importance of quality of infrastructure. Ironically, he said, there are no laid down guidelines or standards to achieve this.

Another important issue of quality care is the training of the surgeon and his team including the health workers. Dr Shah questioned the basis of 15 surgeries as a measure of proper training of the surgeons and suggested standardization of various procedures to achieve quality care. He highlighted the fact that target pressure combined with inadequate infrastructure and limited number of surgeons forces the government healthcare system to adopt short cuts with sheer neglect of quality of care.

Dr Shah also suggested that giving compensation to patients going to NGO facilities will serve two important purposes: One, it will reduce the burden on government facilities and two, better quality of care for the patients.

Touching upon the Copper T method, making the woman aware of the probable problems before hand is important, else she might have it removed by some other doctor, in case of some complication. Proper selection of candidates for Cu T is also of utmost importance. In fact, proper guidance and counseling is a must for satisfaction of the women.

Finally, Dr Shah stressed the need for a wholesome and integrated approach to patient care rather than just considering the technical aspects of the reproductive service.

An animated discussion followed the lecture of Dr Gita Sen and presentation of Dr Hemant Shah.

Responding to a query regarding quality of training of surgeon, **Dr Shah** emphasized the need to look at the ground realities of government facilities and then decide on the nature and duration of training.

Dr Abhijit Das concurred with Dr Shah and admitted that not enough operational research has been done to solve this issue of surgeons' training.

Then he addressed Dr Gita with the query related to the stealth issue: In order to make quality care, dignified service, and informed choice central to the issue of population control, mindset, providing adequate and appropriate methods, we are trying to use the argument of momentum, which is a sophisticated concept. *The question is how do we build more allies and more momentum? Can we talk about these changes without mobilization and only from sort of programme manager's perspective?* Government is also talking of making it a political view.

Dr Gita Sen: Agreed to the importance of the question, but said that we are stuck in our argument and there is need to refresh it. She further suggested that we can collect evidences from places such as the Bhansali Trust and come up with approaches that should be followed. This will specify the meaning of quality in terms of parameters or indicators. Besides, we can do operational research to look at the programmes and raise the questions about quality.

There is need to offer integrated plans for sterilization and IUDs. If we can do that we will take the momentum back in our hands. Government talks of ISO certification of hospitals. Although

ISO is primarily a management quality tool, but are the quality indicators integrated in the ISO certification strategy?

Dr.Hemant Shah (on a query to their improvisations): With proper training it is possible to go for cheaper alternatives. There is however, a need for operational research to come up with adequate guidelines for surgeon's training.

A comment: Non clinical issues are as important as clinical issues for quality care.

Ms Poonam Muttreja (raised three issues): 1. Government officials don't understand the language of unmet need, wanted or unwanted fertility, momentum, etc. Even no one down the chain understands this language. These concepts need to be spoken in a simple language for better communication.

2. There are people in government healthcare systems who want to provide quality care but have never gone beyond sterilization and lack skills to do even post partum counseling on family planning. The Government appears to be consumed with vertical programmes only.

3. Health Ministry's initiative: ASHAs are now distributors of contraceptives also, more burden. Do they have all necessary skills to satisfactorily do what they are supposed to do?

Dr.Hemant Shah (responding to queries from Ms Vinita)

1. Female perspective should be included in the quality of care

2. For Cu'T' proper procedures are crucial. Popular myths have come from past bad experiences due to lack of quality care.

Dr. Gita Sen (intervened): Rather than calling myths, better to say that if certain things are not followed, certain consequences can follow in minor cases. Informed counseling is the antidote for so called myths or wrong perceptions.

AR Nanda: Calling wrong perceptions only propagates them. Generalizing bad experiences also does the same thing. No compromise with quality of care.

SESSION – 2

Emerging Priorities

Chair: Ms Suneeta Dhar

Changing demographics Changing Needs – Dr Abhijit Das

Increasing the Basket and Informing the choices – Dr Suneeta Mittal, AIIMS

Positioning family planning within comprehensive reproductive health services – Dr Suchitra Dalvie, Common Health

Dr. Abhijit Das

Changing Demographics Changing Needs

In the light of sixty years of family planning in India, Dr Abhijit Das set out to explore whether the current family planning approach is addressing the present demographic needs. Taking note of the recent debate in the parliament, after a gap of 33 years, on family planning issues Dr. Das mentioned that the dominant concern in the minds of the politicians is Malthusian. Speaker after speaker highlighted the fact: 17% of population on 2.5 % of land, which is a

strong argument. They also showed a strong belief that targets and incentives are necessary for population control.

Notwithstanding the talk of targets and incentives, Dr.Das expressed satisfaction that many things that were being discussed for years have become part of the regular conversation of politicians; for example, needs to address girl children, early marriage, need for educating young couples, need for overall development, the issue of illegal immigrants, etc. Over all a new consensus is emerging.

Dr.Das cautioned that the excessive population growth should not be taken as failure of sixty years family planning efforts. It has brought many positive changes too; for example, there is reduction in fertility and mortality rates, life expectancy has gone up, and contraceptive use has increased all across. If we take unwanted need, as a country we are below the so called mythical 2.1 TFR – 14 states have crossed it, many are close to it. But on this benchmark the real issue is with the five states: UP, Bihar, Rajasthan, MP, and Jharkhand. The difference has arisen because individual states are at different points in the demographic transition. Therefore, state specific strategies are needed, though the rhetoric may be more central and universal.

Dr Das underscored the fact that the most important change that has taken place in the age structure and rather than being a population pyramid, we are now a population pyramid on top of a population quadrilateral. Previously the family planning needs may have been for completed family. But now the family planning strategies have to serve the reproductive health issues of younger and younger people.

Talking of population growth, Dr Das mentioned that it is not because people are having more children, but because there is a big proportion of population in the reproductive age. Ironically, while we consider it a demographic dividend, an MP called it a demographic disaster. People have few children but add up to big number numerically – main source of population growth.

This is a momentum driven growth and will take time to slow down. Spreading births over a longer period of time is the ideal way to slow the momentum of growth. But if a permanent method such as tubectomy is used as the main method of choice, people tend to have children quickly and then terminate permanently. So it actually adds to the momentum. The family planning authorities have so far failed to get this simple arithmetic.

People are lamenting the fact that instead of population stabilization at 2045, it will now be at 2070, but Dr.Das see it as a step in the right direction. It is better than achieving stabilization around 2045 by forcing smaller family size, which would really destroys family culture as argued by Dr Gita Sen.

The five problem states are excessively dependent of sterilization method, which being one time remedy works better in poor system. On the other hand, temporary methods require stronger healthcare system. However, these states also need services for the younger people.

Dr.Abhijit Das mentioned that experts advice counseling against sterilization for people below 27, because recent evidence suggest that sterilization at younger age leads to higher complication and failure rates. Incidentally most of our sterilizations are done at younger age, as indicated by latest NFHS-3 data. More ever female sterilization at early age (By 27) also increases the risks of hysterectomy by four times. Heavy dependency on sterilization is depriving younger women other contraceptive choices – something they actually need.

Dr.Das used NFHS-3 data to point out other emerging trends. The figures of education levels and sterilization numbers point to a negative correlation between the level of education and

preference for sterilization – 41% for lowly educated women (up to only 5th standard) compared with 23% for women with higher education (above 10th std). It suggests that with increasing education women want to move away from sterilization.

Similarly, caste wise 80% from the SC/ST/OBC group rely on sterilization compared to average figure of 67%. This again appeared to be an autonomy and coercion issue, which are inversely correlated. However, Muslim women show a trend of increasing preference for non sterilization methods, although the numbers are rather small. Total unmet need seems to be coming down but is still very high.

We are in the TFR 2.1 regime but the population still galloping because the population momentum was not clearly understood by the policy makers. Dr Das mentioned that rapid sterilization leads to what Amartya Sen in 1992 labeled “squeeze”, leading to an adverse child sex ratio. In case of rapid decline in fertility daughters are squeezed. It was experienced in China and we are experiencing it too. He pointed to the fact that TFR of 2.1 does not make NRR equal to one under son preference. Female sterilization is totally inadequate for reducing population momentum because it tends to bunch births earlier, which actually makes momentum faster.

Finally, Dr. Abhijit Das touched the issues related to aging. He argued that when population starts declining at TFR 2.1 it would only continue the southward journey. He cited the example of Japan, which has TFR 1.1 and does not have an open immigration policy. It has led to a situation where there are not enough people in the productive age group to support the pension and healthcare needs of the older people. Comparing this to Indian states, he said while this would not become a reality in states like UP and Bihar, but in Kerala the population of older people beyond 65 is increasing. These are new demographic concerns that need to sink in our thinking, if we want to avoid the mistake made by the Japanese.

Pointing to future steps, Dr Das highlighted the following issues:

- It is now important to consider the needs of the younger population
- We must think of family planning beyond contraception and contraception beyond family planning.
- Limitations of tubectomy need continuous focusing.
- There is need to involve men, but not by giving Nanos or gun. These are wrong examples set by States like UP and MP.
- The thinking of policy makers and service providers needs re-orientation on the issue of quality.

Dr. Suneeta Mittal

Increasing the basket and informing the Choices

Dr Suneeta Mittal focused her presentation around how to increase contraceptive choices and why we need a contraceptive basket in this country. Given the fact that 3/4th pregnancies are unplanned and 1/4th are unwanted and with huge unmet needs, the issue of contraceptive basket becomes all the more important. So far the focus has been on terminal methods and whatever spacing methods are used the continuation rates are very poor.

She highlighted the target focused approach of bureaucrats who in the co-ordination committee meeting of the India post partum program used to completely ignore all talks on contraceptive issues and would pay attention to only sterilization related data.

Next Dr Mittal answered the questions: Where is this basket of choice we are talking about? And what do we have in the basket? It is with the providers and the recipient is supposed to reach them. But since the awareness and motivation to come to the provider is lacking, the basket becomes useless. Therefore, we really need another basket and a different system to make it work. But how can we do that?

Advertising is an option. While it may not motivate but can sure explain the importance, increase awareness and dispel many doubts. It is well known that educated people don't prefer sterilization because they already have awareness and knowledge that uneducated and poor lack. This was the idea when this basket and cafeteria approach was started in National Family Welfare program.

Talking of the ground realities, Dr Mittal said the health workers are still focused on numbers, even if they call it target free – they simply lack priority and perspective. They don't bother or have no time to discuss other related issues. Even for interested couples they can't or don't want to suggest options and their pros and cons. Injecting some humor she said the only place where the basket exists is in the medical colleges and becomes a focus only for examinations.

Continuing the argument, she said most healthcare workers are unaware that there are people with special needs, who really need choices. So there is a talk of introducing medical eligibility criteria in their selection, but this needs to be adopted on a large scale.

After mentioning a long list of possible contraceptive choices, Dr Mittal said that informed choice is possible only if people are informed about pros and cons of each method and if those methods are actually available. Now that more and more women are seeking to postpone their first pregnancy, choices for spacing methods along with the information on their use is all the more urgent. National Family Planning programme must act fast to broaden the choices. Citing demographic research, she said whenever a new method is introduced the contraceptive coverage goes up by 2.4 – 2.5 %. Addition of choices will also increase the quality of family planning services.

Stressing the current increasing demand from younger, Dr Mittal said that selection of choices should consider their needs – temporary and spacing methods. The already best known temporary choice of condom should go beyond HIV and infection prevention. Recalling the National Consensus Consortium on Emergency Contraception in January 2001, she mentioned that Copper T 220 was replaced with 380A, after a gap of 34 years. Now there is need to include injectable contraceptives, flexible IU device, various pills etc among others. She also gladly mentioned the whole hearted support of Mr. A R Nanda who was then the Family Welfare Secretary.

Dr.Mittal stressed that spacing methods need backup availability of emergency contraceptives to erase the perception that they are unreliable and undependable. In fact, both should be promoted side by side. She ended with the final assertion that the family planning system needs repositioning so that the provider reaches the right recipient at the right time.

Dr. Suchitra Dalvie

Positioning family planning within comprehensive reproductive health services

Dr Suchitra Dalvie focused her talk on the need to make the family planning healthcare more complete, wholesome and comprehensive. She particularly stressed the need to reeducate the healthcare professionals who are often focused on one or a few narrow areas and don't comprehend issues from a wider perspective. She defined reproductive health as a state of mental, physical and social wellbeing in all matters relating to the reproductive system at all stages of life.

Dr. Suchitra strongly emphasized the need to see the woman or the couple as a whole in order to understand the various concerns which are part of their lives from early life to the late stages. The family planning initiatives such as fertility regulation, etc are just a small part of it. These initiatives need to be positioned within the context of their entire life.

Dr Suchitra mentioned an interesting idea for an “ideal” contraceptive from a professor in UK – the ideal contraceptive method would be something that you could start using at puberty and have contraception as a default state in life and remove it only 2 or 3 time when you want to have pregnancy. Unfortunately, realities are far away from it – people normally spend 90% of reproductive life trying to prevent pregnancy.

Touching the subject of what would be comprehensive health and how do we fit family planning in it, Dr Suchitra suggested we need to shift from several often disconnected programmes to a holistic comprehensive strategy that places the person at the center and recognizes the spectrum of changing needs across the life cycle.

Dr. Suchitra cited several examples of healthcare professionals and their narrow focus on one or two issues. For example,

- Should the HIV counselor know only about HIV prevention and treatment? Or he/she should also know about contraception, abortion and sexuality?
- Should an abortion provider only be an expert in the technique and provide quality services, but not be aware of gender and rights issues or the consequences of intimate partner violence?
- Can we really provide abortion services without post abortion contraception which is non coercive?
- Those conducting deliveries must know everything about safe labor and post partum hemorrhage. Why should they be expected to know about neo natal health and post partum depression and contraception?
- Those dealing with contraception, do they not need to be aware of sexually transmitted infection and even how to identify possible victims of intimate partner violence?
- Should the adolescent healthcare counselors only be concerned with the health related issues, or should also be skillful in dealing with the issues of sexual abuse, sexuality, as well as life skills and negotiations?
- Equally, those dealing with victims of sexual assault should know about counseling and referral but also need to know about emergency contraception and post exposure profile of HIV which very often is not part of what they are taught about.

This is how we fail to see the woman and her life as a whole, she remarked.

Dr Suchitra also highlighted the over focus on HIV program that gets the maximum visibility and funding, through an interesting cartoon.

Stressing the need to understand the real life situation of a woman, Dr Suchitra commented that any discussion with client about condom use, dual protection, abstinence after abortion, adequate nutrition and rest during pregnancy and lactation, would be rendered ineffectual unless we are able to see the client within the power dynamics of her own interpersonal relationships. To emphasize the need to understand the big picture, she cited an example of a woman who repeatedly comes for abortion. It is clear she can't do any thing about it; all she can do is to have that abortion to get rid of the unwanted pregnancy.

Dr. Suchitra also stressed the point that pregnancy and infections are both sexually transmitted, and we can't deal with one without considering the other. Citing statistics, she said that globally about 10% of reproductive age adults are infected with an STD each year that causes several reproductive health issues. Family planning people need to learn to deal with sexually transmitted infections to make their programme more comprehensive.

Finally, touching upon the changing demographics, Dr Suchitra acknowledged that now young people are more likely to have more than one sexual partner due to changing nature of the society; and it must be taken into account. Likewise there is need to focus on sexuality education of adolescents and to ensure right based and gender sensitive approach in public and private healthcare sector.

Open Discussion:

Dr.Suneeta Mittal: Many multilateral agencies now days focus on select narrow issues, so this presentation puts their work in perspective.

A Comment: NFHS – 3 data also highlight the fact that unmet needs are increasing. There is a need to look at the situation from a fresh perspective. With NRHM funding, money is no more a concern.

A Comment: MP is offering Nano cars and other incentives for sterilization targets. But there are also reports of death during or after sterilization operations, but the issue is hushed up. Another interesting fact is that ANMs and other workers are now even visiting tribal areas, Muslim, and other neglected communities to cover them in this incentive driven initiative.

Dr. Hemant Shah: Quality of care is badly compromised due to target pressures. Another issue is the weight gain after sterilization operations; operational research is needed to establish the real facts. We are also trying to promote Copper T use, but due to over emphasis thus far on tubectomy this will take time.

Dr. Suneeta Mittal: The issue of tubectomy needs further research, particularly when done on younger women. This will also help counter popular myths around the issues that are not very scientific.

Dr. Abhijit Das: Disagreed that there are no scientific evidences and said that Peterson et al have done review of 77,000 cases. There are other papers as well.

The current evidences show that post tubectomy syndrome has been negated but adverse consequences are not. It is adverse consequences that we should be talking about. There has been talk of keeping adverse consequences registry and make a distinction between natural failure due to tissue vitality which takes place 4 or 5 years later compared to what is quality of care related issue, which takes place within a year or two. There is one study from UP (which never saw the light of day) showing 5% failure rate. For half a million operations it becomes 25,000 failures. The point is: since the numbers are so large in the programme that when figures change even by a fraction or few percentage points, numerically the difference is huge.

So we need to have operational figures of acceptable complication rates, given the poor quality of our services. Beyond that there must be accountability of someone.

Dr. Mittal: Some funny cases have been reported where actually there were no tubectomy; just small incision was done on the abdomen to claim numbers. They later reported pregnancy that looked like failed tubectomy that never took place in the first place! All such things are the failure of the programme and the provider.

Dr. Gita Sen (reinforcing the argument of Dr.Das): We need to take results obtained under ideal conditions and set limits of deviations when applied to the real life conditions and try to be within that limit. Any thing beyond that should be taken as bad quality of care.

We also need to move away from arguments like if we don't do certain things we may end up with population explosion, because we are treating family planning as an health issue.

(Question): Are we in the position to say what should be in the basket of choices?

Dr.Hemant Shah: There is a compensation schemes for failure cases. Is there data about how many have been ensured and how many have received compensation?

Dr. Abhijit Das: By default everyone is ensured and we have a data on FPIS.

Some comments from the participants:

(Basket of choices): Public sector actually does not offer choices. Government has been spending heavily on procurement of contraceptives including IUDs every year. When you go down nothing is available. The MIS reports anything out of warehouse as used. If that were the case, contraceptive use should have been much higher.

(Urban poor): As shown by Dr.Abhijit, lower quintile is with terminal method and upper quintile practices spacing methods. In some places the unmet needs of urban poor is high than that of rural poor. Their range of choices and accessibility needs attention.

(Suggestion to improve quality): There is need to report failures alongside the number of sterilizations, and what they do with that. Since failures get attention of everyone, this should improve quality of care.

Ms.Vinita Nayak Mukherji:Referring to Dr.Suchitra's presentation about holistic approach, she explained how the gender dimension and participation of men will change with the introduction of NSV, because men don't come forward for sterilization due to worries about their virility, strength, etc.

Ms.Poonam Muttreja: I would like to raise some politically incorrect and uncomfortable issues: She Mentioned about the conference organized by Mr Amarjeet Singh six months ago on family planning, where he was talking about population explosion/bomb and not stabilization.

Mentioned presentation to the PM Bajpai when he asked what is the real issue, you are talking about health and everything. We could not give any implementable issue to him

(Method mix): injectables are there in the private sector and in other countries. This needs further exploration.There are cases of women who used sterilization as the only family planning method, and that too after giving birth to few children. It clearly indicates utter lack of options. There is a vast pool of data of last so many years; we need to come up with actionable steps based on that.

Dr.Abhijit Das: I just want to share experience of working with men in UP (not on family planning) but on violence and gender. An anticipated side effect is: men are actually taking more active role in parenting and caring conversation with their partners. A quantitative study was done that emboldened us to try something similar in Maharashtra with issues of raising the age of marriage and participation in contraceptive care.

We have been talking too long on supply and methods. It is easier. But we need to put the discussion in lives of people who are recipients. Rather than talking in terms of numbers and economies, we should put it in the true spirit of families and family planning. We have different contraceptive needs at different points in our lives, so we need choices. Why not shift the focus from numbers to developmental approach. We are trying it in some districts in UP and suggested to government but they are silent.

Dr. Suneeta Mittal: Emphasizing the importance of education mentioned a survey done in AIIMS. Going from bottom level employees to high levels, it was found that the average number of children decreased. So education is a good tool for family planning.

A 23 minute documentary film “Haule Haule” was shown.

It was made by Firoz Abbas Khan, the producer of “Gandhi my Father”. It was made at the request of the ministry before the Population Day. It has been widely distributed in North India, for south Indian audience dubbing is awaited. Thousands of copies were asked by the government and the ministry has done a good job of distributing it among people. It has been shown on DD and NDTV, and ground level workers like ANM etc are asking for it and people are enjoying it also.

The group discussed that several issues were raised by the movie such as Issue of early marriage, Use of contraceptives, Issue of son preference and choice, Women’s Health, Spacing of children and male responsibility.

Session – 3

Working Group Discussions on Emerging Priorities & Strategies

<i>Chair: Ms Poonam Muttreja</i>

Ms Poonam Muttreja laid the following issues on the table for discussions:

Need to rethink what and how we communicate. Keeping in mind that majority mindset among officials is still that of population explosion, control, etc, we need to communicate properly so that the new momentum of family planning does not become a population bomb scare or a coercive approach.

We can’t rely on government data. Given the fact that family planning programme will be rolled out in greater intensity, in PM’s Population Commission that met after 5 years, the PM concluded that we can’t rely on government data. So it is important to document activities in various states so that non governmental researchers come up with more accurate understanding of the issues. It is heartening to note that the government appears to be talking in our language like raising age of marriage, etc which were earlier never a part of the family planning programme.

How do we view incentives for family planning? Do we support JSY incentive and oppose others, or oppose all incentives? We need clarity on this issue

Should clients be compensated if they go for family planning in the private sector? Most ground level workers feel that doing this would be positive.

Then Ms Poonam raised the question: Since the Minister is talking about repositioning family planning, maternal and child health and NRHM, how do we ensure that the new initiatives of government will have broader focus on reproductive and sexual health comprehensively?

Dr Gita Sen: The challenge is: How to create a service environment that has 2 aspects – integration of services and quality?

Just putting silos next to each other is no integration. It should be done from the angle of a woman who comes for services. What should she be getting; Conditions that brought her there; What is she looking for; Challenges she faces; etc. So, integration has to happen in terms of the client. Given the way government system operates, the initiative has to come from civil society organizations and NGOs working on the ground and from their experience. They can document good quality practices that can be monitored.

On wanted and Unwanted fertility: Whose job it is to translate this understanding at the ground level?

Reorientation (repositioning) should actually focus on reduction of population momentum and should shift away from targeting the 6% wanted fertility. There are only a few things that we can do to achieve that, but must be done – they are all related to spacing methods, delaying marriage, education of girls, etc. Family planning efforts on these lines would contribute 70%.

Dr.Kiran Ambawani: Ultimately on the ground there are just ANMs, nurses and doctors. They are doing things comprehensively there. They are treating the person as a whole.

Dr. Gita Sen: Two things: An ANM can only look at what an ANM is expected to do. Delaying age at marriage is nowhere in her capacity. So 70% is already gone. Secondly, the ANM can not comprehensively judge reproductive health of the person approaching her. There are range of things far beyond her ability and training. She does different things on different days. Probably Dr Shah can tell what needs to be done when a woman comes for services.

Dr.Hemant Shah: Ground reality is that often the post of ANM is vacant and even if there is an ANM, there is six month's turn over. At our facility we start with laboratory testing of the woman and then discuss the reproductive issues. In case of any general health issues we try taking care of that and than decide if she is fit for surgery. Rest of the follow-up is done by the field workers, which is a long term process.

Dr.Abhijit Das: Let us lay some ground for discussions. Some states have first generation issues. In states like MP collectors are getting into competitive mode something that used to happen in 1980s. Service providers are fighting over Nano cars, etc. The question is how to look at such practices from the angle of vigilance. Besides, there has to be some degree of hard engagement to prevent bad practices. In this case what are the family welfare joint directors doing; they are supposed to be the national representatives sitting at the states to monitor work. We can not allow such gross incentives in 2011.

Dr. Kiran Ambawani: That is why the civil society has to be strong. They have to stand up and say something is going wrong. That is where your contribution is required. Government can't get away with anything if civil society is strong.

Dr.Gita Sen (countered): That's true but the problem is: in the state government meetings the central representatives sit quietly when these kinds of things get decided. And that is not civil society's job alone.

A Gentleman from Bihar: ANMs and ASHAs are given targets that occupy most of their attention and they neglect other things. So there should not be targets of any type.

Dr. Abhijit Das: While talking of targets, I can recommend alternative targets. The film has given some pointers. Where do we need integration? We need it at the family and community level. Then the family planning and issues like early marriages, delaying of pregnancy, etc can be handled at the appropriate levels. Some things can be tracked at the community level, such as

- How many marriages have happened when the girl is less than 18 and education below 10th std. Education can be relaxed in certain areas.
- Similarly, how many children are born within two years of either marriage or two years from the last child birth.
- How many of children below 3 continue to remain without full EPI package.

This gives a clear target and you are looking at thing that you can measure. These have to be set up with concurrent accountability of the state to provide the necessary service and follow up and should be integrated at the level of the Panchayat. The Panchayat can call upon necessary services and may even offer rewards for good practices. We need to reinforce thing we are worried about such as spacing between child, delaying first pregnancy, etc. Such things will never be known by merely counting sterilizations.

Another tendency is to go for national solutions without trying them at smaller scales, say in 50 – 100 districts.

Dr. Kiran Ambawani (agreed): That is a reasonable and doable thing. We make each Gram Panchayat responsible for the village to keep account of relevant numbers such as age of marriage, spacing between children, families with more than 3 children, distribution of pills, etc. These numbers already exist in the registers of ANM, ASHAs and Anganwadi. Displaying these numbers should be made mandatory.

Ms Poonam: In Swaminathan Commission's report on Population there is a socio demographic charter. But such things don't get implemented.

Dr Gita Sen: We have to distinguish between indicators and program targets. What you are talking about are indicators.

Dr. Abhijit Das: I would like to first tie it up with what NRHM already provides. It provides village health planning, which can provide the mechanism to reach these indicators and get your action targets.

Dr Gita Sen (injecting caution): Let us be realistic about how village planning happens. Most health plans are written by ANM with some one else based on last year's data plus 10% or so. This is not really a plan.

Now let us be clear about goals. If the goal is integrated of things with quality then what types of indicators you will need. The critical step thereafter is the program step. Currently the indicators are scattered in different programmes. Can Gram Panchayats get these indicators on their own? Even if, for example, number of girls not married below 18 is obtained, who will be responsible to bring this number down? Probably the best people to ensure this are those who have some interest in this issue, else the silos will continue. Integration is basically a programme challenge.

However, only few things are crucial to integrate, not all; for example, services you provide under family welfare, safe abortion, and maternity. And it must be looked from the woman's perspective who comes for service, and not from the angle of clubbing the programmes together.

Ms. Poonam: We need to lay out a set of things that can be done easily. Experiences such as of Bhansali project will be helpful in that direction.

Dr.Suneeta Mittal: Are we forgetting the role of NGOs? It needs facilitation.

Dr Kiran: Someone from the ground has to build wave for that; demand has to be built. Perhaps government and public both have to work together.

A gentleman from Bihar: He raised the issue of pregnant women not being in the list of ICDS.

Vijay Agrawal: He raised the issue of need to stay for 4 hours after surgery and how that is possible in camps of only 7 hour duration.

Dr.Hemant Shah: Yes, clubbing together pre and post operative care needs 7 hour does not make sense.

Dr. Kiran: The government is trying to do away with camps and wants to encourage regular facilities. Now we are encouraging mini Lap where you don't need gynecologist or laparoscopes and people are being trained for that. We are again encouraging post partum sterilization so that woman can have sterilization immediately after delivery and go home after 24 hours. Another recent initiative is post partum IUCD; the device is put immediately after delivery and is expected to stay for ten years. Of course, it can be removed whenever she wishes.

Ms. Poonam Muttreja : It is a welcome move that you want to go away from camps. Government celebrated Population Day with camps everywhere. The camp mentality is still very strong. But the issue of women needing to stay for 4 hours after surgery has to be addressed.

Ms.Neha Sood: She raised the issue of tracking women after sterilization that will help in improving quality of care.

Dr Abhijit Das: On the issue of post partum sterilization, we were recently in a global meeting around informed choice connected to sterilization. There is global concern around HIV, coercive sterilizations as reported in Roma. One of the FIGO (The International Federation of Gynecology and Obstetrics) recommendations is that you should wait for at least three days to allow the woman enough time to make an informed choice. Informed choice means she must have time to think, study, talk to people and then decide; it is not brow beating.

Dr Kiran Ambawani: The women are counseled in the anti natal period and consent is taken for post partum sterilization.

Dr Abhijit Das: So there must be evidence for that. Mostly the consent form is just a protection for the surgeon. In no way it ensures that informed consent has been taken.

Ms Poonam Muttreja: So you are suggesting counseling and three days.

Dr Abhijit Das: That's just one thing. Another thing coming out of our studies is that the consent form is not with the woman but with the system. No post operative documentation is given to the individual.

One participant: We are working closely with government on family planning issues. There are targets everywhere and family planning has come to mean only sterilization. There is need

to focus on issues of age at marriage, spacing etc. In ISO certification of hospitals very few quality indicators are included. This needs attention. Strengthening counseling is also important, just signatures are taken on the consent form.

Mr. Bishwaranjan Das, Orissa: We often forget quality when we are focused only on quantity. In Mayurbhunj District, we have several cases of failed surgeries but due to lack of documents with the patients they can't do anything about the issue. Also, there is no monitoring of women after sterilizations.

Ms Poonam: We did not discuss the issue of incentives and disincentives.

Dr. Gita Sen: People think that compared to disincentives, incentives are harmless. In the context of two children limit, does the importance of incentive falls away after third child? And whom are you actually punishing by doing this? Now in the light of TFR actually falling across the country the 3rd or 4th child who suffers is likely to be girls.

Ms Poonam Muttreja: I feel that people are not against incentives but they definitely don't like disincentives.

Dr Abhijit Das: The incentive conversation started with JSY. JSY is just a support for institutional delivery – in fact, poor institutional delivery!

Ms Poonam: I think it is a compensation for going to poor quality service.

Dr Abhijit Das: JSY has led to increase in overall impoverishment and indebtedness as shown in the DLHS survey. It has also increased costs and corruption, so it can't be seen as unmixed blessing. The Rs 4500 of Indira Gandhi Matrutva Surksha Yojana has been tied with six months of breast feeding, which is unrealistic for poor women who have to earn, besides who will monitor it. These poor people need support but why conditionality. Why are we treating human beings like Tunisian dogs? That's the basic question.

Neha Sood: Incentives also distort the freedom of choice.

Dr Gita Sen: Incentives also create distortions but not as hard as targets. Distortionary effects of JSY are also seen on the ground.

Dr. Kiran Ambawani & Dr Abhijit Das: Rs 600 for family planning and Rs 1400 for institutional delivery; so make more babies! That is the logic many people appear to be using, but why Nanos to bureaucrats for meeting targets?

Dr. Kiran: I think targets help people work better, the core issue is that there should not be use of force or pressure for that.

Dr. Gita Sen (clarifying the meaning of target): Our basic opposition earlier was against "centrally determined contraceptive method specific Targets". This was too long an expression and became "target" or "target free". Unmet needs are not just family planning; they include a range of things. Targets and indicators should be for whole nexus of things; they are clear outcome indicators of what the recipient would receive over a period of time. In the context of what you want to achieve, the indicators and targets are certainly helpful, else they become distortionary.

SESSION – 4

Future Issues & Plans

Chair: Ms Poonam Muttreja

Respondents: Dr A K Shiva Kumar, Member, National Advisory Council

Dr Kiran Ambawani, DC (FP) MoHFW – Government of India

Summary of Day long deliberations – Dr. Abhijit Das

Summarizing the discussions, Dr Abhijit Das highlighted the main points of various presentations and lectures.

Concerns and emerging concerns. The current field is partly similar to earlier situation but with a big difference: the language has changed. It is difficult to pin down in terms of discrete activities what is coercive or where incentives and disincentives are working. However, the mindset continues to be predominantly in the population control panic Malthusian mode.

Recommendations for future strategy. As Dr. Gita highlighted we should not be saying to the government what it should do differently but instead come out with practical set of recommendations with the government as party, so that it is not only critiques but concrete suggestions as well. We need to continue educating the policy makers and providers because the understanding of momentum issue has not seeped into their mindset; they still continue to focus on very narrow additional wanted fertility which will not contribute more than 6%.

The Chinese one child policy can not be our model because in India there is emotional appeal for the family and the China example would tear down the family structure of the society.

Quality of care. Experiences from Bhansali trust which organizes camp situation tuber ligations keeping quality at the center are valuable. Based on such experiences, Dr Hemant Shah laid out areas where quality issues can be addressed. Dr Shah strongly emphasized the importance of pre and post operative care; quality can not be limited to the operative part only. Another aspect is the issue of screening and rejection of cases.

Inappropriateness of tubectomy. Tubectomy is not suitable to meet the contraceptive needs of the large population of young people; it is good only for a limited section. Temporary options are required for the needs of a large proportion of people, particularly the younger generation.

Basket of choices. The basket is only notional. In reality there is no basket, despite the fact that there is a wide range of contraceptive choices are available, including injectables.

Holistic and comprehensive reproductive healthcare. Dr Suchitra underscored the importance of looking at reproductive care from the angle of the woman and her whole life cycle. So the issue is: Can we create an integrated programme that is so holistic?

RESPONSES FROM THE PANEL

Dr. Kiran Ambawani:

Dr Kiran stressed that demand and vigilance from the community must be strengthened through awareness activities.

On basket of choices, the government is actually repositioning the initiatives and the Copper T programme is finding acceptance. The training for post partum IUCD is very good. We are also trying to improve counseling skills.

Regarding the issue of targets, we need to see it the wider context. But people at the ground should come forward and report distortions and compromises of government initiatives.

Dr. A K Shiva Kumar

Dr. Shiva Kumar raised some relevant questions: To whom are we talking to? Why we have not been able to influence policies? And what and where is our leverage?

On future issues and plans, Dr Shiva Kumar said that we have to consider our own mindset also. Why do we act as if nothing is happening? We need to have a balanced perspective of the ground realities. Nano example is bad but it should not be generalized for the whole country. It is like saying that if Nano were not given, a lot is happening.

Citing data from the Coverage Evaluation Survey 2009 (CES 2009), he highlighted several examples to suggest that something is actually happening. The Survey reports, after interviewing 23,000 women who delivered in last one year, that 73% are institutional delivery; 81% in MP, Orissa has 76% and Rajasthan 70%. This is different from the NFHS -3 data of 2005-06 where these figures are around 40%. Although these figures are too good but point to the fact that something is happening.

On the issue of institutional delivery: only 3% reported it of poor quality service, for 25% it is not necessary; so 75 % do think it is necessary to go to institution for delivery. They may be going just for money, we don't know. 20% said they get better care at home.

Other interesting findings Dr Shiva Kumar reported from the Survey are: 90% in rural areas and 96% in urban areas reached the facility within an hour and on duration of stay at the facility only 25% left in less than 24 hours. Both these findings negate what people generally believe.

Moving on to the issue of incentives, such as JSY, he asked: Is it really a good use of money? How much of reproductive health budget goes to JSY? Quite high: probably over 60%. So what is the opportunity cost? What would be the cost if all women get it, ie, making it a universal scheme? A rigorous analysis is needed on this issue.

On the issue of accountability, Dr. Shiva Kumar said that the data we are collecting tells us nothing about what is happening. Incentives should only go the health workers and not to those whose job it is to do. We need different set of indicators, which can be rated for performance on a simple form and based on that the entire institution or center be rewarded.

Touching upon the issue of governance, he asked: Where do you go if you don't get the service? It has to be linked with accountability and need better integration at all levels. We also need to look at the role of Anganwadi workers and ASHAs.

Finally, Dr Kumar suggested: we need to see if we can interact with the Population Commission. We also need new arguments, new data and reposition what we are saying. If we can come up with new set of indicators of progress as well as quality, that would a great contribution.

Concluding Remarks – Dr Abhijit Das

This roundtable is the beginning of a new cycle of discussions on an old topic. We realize there are many new dimensions. The success of this new cycle would depend on getting new faces, new allies, and new perspectives, so that we come out of the limitations of our usual thinking and arguments.