

Review Article

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Priority strategies for India's family planning programme

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Strategies to accelerate progress of India's family planning programme are discussed and the importance of improving the quality and reach of services to address unmet contraceptive need by providing method choice is emphasized. Although there is a growing demand for both limiting and spacing births, female sterilisation, is the dominant method in the national programme and use of spacing methods remains very limited. Fertility decline has been slower in the empowered action group (EAG) States which contribute about 40 per cent of population growth to the country and also depict gloomy statistics for other socio-development indicators. It is, therefore, important to intensify efforts to reduce both fertility and mortality in these States. A rationale has been provided for implementing integrated programmes using a gender lens because the lack of women's autonomy in reproductive decision-making, compounded by poor male involvement in sexual and reproductive health matters, is a fundamental issue yet to be addressed. The need for collaboration between scientists developing contraceptive technologies and those implementing family planning services is underscored. If contraceptive technologies are developed with an understanding of the contexts in which they will be delivered and an appreciation of end-users' needs and perspectives, they are more likely to be accepted by service providers and used by clients.

Key words Contraceptive choice - contraceptive technologies - quality of services - users' needs

Introduction

The family planning programme in India has had a long and somewhat turbulent history. It has, over the years, adopted a number of different strategic approaches including a coercive target approach, a policy articulating a reproductive health and rights paradigm, contraceptive-specific incentives, and a family planning camp approach, among others¹⁻¹⁰. Fifty years later, the impact of the programme remains uneven, and India has yet to achieve replacement level fertility. Efforts are currently underway to reconceptualise and reposition the programme so that it can be more responsive to the country's needs which differ among

regions and States. There is an urgent need to re-vitalise and energise programmatic efforts in the empowered action group (EAG) states where progress has been slow. Priority programme strategies for accelerating fertility decline and improving reproductive health outcomes are discussed in this review.

Operationalising the concept of informed contraceptive choice

The first, and perhaps, the most important strategy that must be underscored is the need to translate within the national programme, the fundamental concept of informed contraceptive choice which, despite

much rhetoric, has remained a mirage for the people of India. It is imperative that the principle of “the rights of couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so”¹¹, is operationalised within the national programme. The need to do so is greater now than ever before because couples in India want to both limit family size and space their births. There is, therefore, an urgent need to provide a choice of contraceptive methods to enable couples to achieve their reproductive goals. However, female sterilisation, a terminal method, has for decades, remained the mainstay of the national programme. In 2005-2006, female sterilisation accounted for 66 per cent of contraceptive use. The majority of the women (77%) who underwent sterilisation had not used any method before they were sterilised and more than half were sterilised before they reached 26 years of age¹². Although reported by a negligible minority, female sterilisation was the most commonly used method even by married adolescents¹³. India is, perhaps, the only country where such a pattern prevails.

India’s public sector programme claims to provide a “cafeteria approach” with a “basket of choices”. The method-mix in this programme includes five official methods — female sterilisation, male sterilisation, intrauterine contraceptive device (IUCD), oral contraceptives, and condoms. But modern spacing methods account for a very small fraction (10%) of contraceptive use. Between 1998-1999¹⁴ and 2005-2006¹², there was a minimal increase (from 6.8 to 10.1%) in the proportion of couples using oral contraceptives, IUCDs, and condoms. These data indicate that the programme has not, so far, succeeded in providing contraceptives to delay the first birth and to space subsequent births^{12,15}. Nor has it been able to reach men. Even though the non-scalpel vasectomy technique has greatly simplified the procedure for male sterilisation and condoms have been seriously promoted for the prevention of HIV and other sexually transmitted infections, men’s engagement in family planning has remained minimal^{12,15}. Thus, contraceptive choice has yet to become a reality for the people of India.

Unmet need and unplanned pregnancy

Contraceptive needs of the people have changed dramatically over the past decades. In 2005-2006, the unmet need for contraception in India was 13 per cent, of which 6 per cent was for spacing methods¹². Several studies show that unmet need for family planning is greatest in the 15-19 year olds, in the less educated and

in the poorest households¹⁶⁻¹⁹. These findings underscore the urgent need to provide information and services to these couples who want to limit their family size and/or space their births but are not using any method of contraception.

In 2005-2006, 10 per cent of all pregnancies were mistimed (wanted later) and 11 per cent were not wanted¹² indicating that about 20 per cent of all pregnancies (about 5.6 million) were unwanted and/or unplanned. A significant proportion of unwanted pregnancies are aborted, more than half under unsafe conditions. Infact, abortion is perceived by many to be an extension of the government’s population stabilisation programme. About 8 per cent of maternal deaths are attributed to unsafe abortion in India²⁰. Emergency contraception, a low cost, simple and effective technology, can provide a back-up method for women to use within the first few days of unprotected intercourse to prevent unwanted pregnancy. But despite considerable evidence-based advocacy with the government to promote this method, emergency contraception pills are essentially provided by the private sector mainly in urban areas. It is time for the public sector to institute a programme for providing emergency contraception. Its strategy should be to reach poor, rural women, who do not have access to the private sector. It has been estimated that if all unwanted births were eliminated and the unmet need for contraceptives was adequately met, India’s total fertility rate would drop to replacement level¹².

Early marriage and childbearing

Early marriage continues to be the norm in India. Data from the National Family Health Survey-3 (NFHS-3)¹² show that in 2005-2006, more than two-fifths of all women aged 20-24 years were married before the legal minimum age of 18 years and almost one-half of married adolescents were mothers. Less than 10 per cent of these young couples had used any contraception. A sizeable proportion of births to adolescents were unplanned, underscoring that there is a substantial unmet need for contraception in this population sub-group. Married adolescents (15-19 years) constituted the largest group with unmet contraceptive need, especially for spacing methods. Unmet need among married adolescents was 27 per cent. And, as expected, the vast majority (25%) of unmet need for this group was for spacing methods¹². Fig. 1 shows that between 1988-1989 and 2005-2006, there was no decline in the unmet need for contraception among married adolescents. As adolescents face several barriers (geographic and social) in accessing

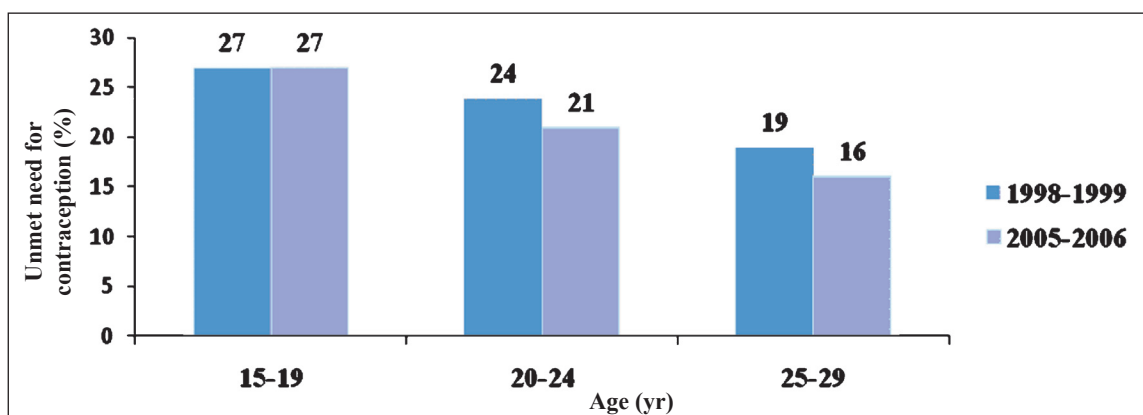


Fig. 1. Unmet need for contraception among women in 1998-1999 and 2005-2006.

Source: Refs 12, 14.

family planning and other reproductive health services, it is important to design and implement programmes strategies to overcome the special barriers that they encounter¹³.

In India, childbearing is concentrated in the 20-29 year age group. Thus, in 2005-2006, women in this age group contributed over 60 per cent of total fertility; 24 per cent of these women had an unmet need for contraception of which 10 per cent was for spacing methods. These data indicate that there is an urgent need for providing these couples, with a choice of methods¹².

In 2005-2006, the median interval between births for women was 31 months; 11 per cent of the births took place within 18 months and 28 per cent within 24 months. More than 60 per cent of births occurred within three years of the previous birth¹². These data underscore the need for enhancing access to reversible contraceptive methods to improve birth spacing. There is ample evidence to show that adequate birth spacing has positive effects on the health of both the mother and the infant²¹⁻²⁶. It is well documented that providing a choice of methods has multiple benefits. Method choice accelerates fertility decline and also reduces maternal, neonatal and infant mortality.

Improving quality of services to provide contraceptive choice

Data from NFHS-3¹² show that although the numbers are small, spacing methods are provided mainly by the private sector. Strategies to engage the private sector through social marketing and social franchising initiatives should be encouraged. But the public system, which is the major provider of

family planning services, especially for the poor, must be strengthened so that a choice of methods can be provided by delivering quality services²⁷⁻³¹. The need to strengthen infrastructure, human resources management, accountability and governance of the public health system has been repeatedly emphasized³² as these are major impediments to the effective delivery of health and family planning services³³. Efforts to do so, however, have been uneven in the country.

It is time to focus serious attention on strengthening the health system's capacity to reach the unreached and to improve service quality. Improving the quality and reach of family planning services will not only address the issue of unmet contraceptive need and thereby accelerate fertility reduction, it will also have an impact on mortality. It is well documented that the life-time risk of maternal mortality declines with reduction in fertility because of the decrease in the number of pregnancies³⁴. Fertility reduction can directly lower the maternal mortality ratio (MMR) by changing the age structure of the population³⁵. Thus, reduction in fertility could bring about a decline in maternal mortality through these two mechanisms thereby, accelerating India's efforts to achieve millennium development goal (MDG 5).

Focusing on India's poorly performing States

Demographic transition is underway and fertility is declining in all the States of the country. A number of States have reached replacement level fertility. However, the pace of fertility decline has been slower in the larger, more populous EAG States (Fig. 2). These States also depict gloomy statistics for other socio-development indicators¹². In these States the levels of education are lower, especially among girls,

the status of women is lower, maternal and infant mortality rates are higher and poverty levels are higher. Couples also want larger families in these States. For example in 2005-2006, in Bihar and Uttar Pradesh, the contraceptive prevalence rates were 34.1 and 43.6 per cent, respectively (Fig. 3) and the total fertility rates were 4.0 and 3.8, respectively (Fig. 2)¹².

Preference for having a son is an important reason for having a larger number of unwanted births. India's declining sex ratio provides stark evidence to show that the girl child is unwanted³⁶⁻³⁹. Declining sex ratio is ironically an outcome of the fact that although many couples desire smaller families, they want to have one or two sons. The desired family size in Bihar is 3.5 and the most commonly desired family composition is one daughter and two or three sons⁴⁰. In order to achieve this family composition, couples must have four or five children. There is, therefore, a clear need to focus efforts in Bihar and other EAG States to reduce fertility. These States have both wanted and unwanted fertility. To address the issue of wanted fertility, it is important to work with couples, families and communities to generate a demand for family planning services⁴¹. Thus far, efforts to generate demand have been limited. There is a need to work creatively with civil society organisations and community-based institutions such as *panchayats* and self help groups to mobilise communities and generate a demand for contraception and other reproductive health services⁴².

The EAG States depict high level of both fertility and mortality. In these States, women and children

suffer higher rates of mortality and morbidity as well as malnutrition¹². There is, therefore, a need to implement an integrated approach for providing health and family planning services. Recent years have witnessed renewed efforts to revitalise and energise the National Rural Health Mission (NRHM) especially in the less developed States. The NRHM is committed to providing integrated services to address people's multiple health needs.

Convergence of services to address multiple needs of clients

Men, women and adolescents have multiple reproductive health needs including, but not limited, to the need for contraception. It is important to ensure a convergence of services at the clients' level to effectively address their multiple needs. Vertical programmes, funded by various donors and implemented by different departments of government, have been found to be wasteful and inefficient⁴³⁻⁴⁵. Yet, the important principle of providing integrated services to address clients' needs has not been operationalised.

There has been a recent resurgence of interest among donors and the government to design and implement integrated programmes to address the multiple needs of individuals, families and communities. For example, efforts being led by the Bill and Melinda Gates Foundation in the State of Bihar aim at implementing integrated interventions, included under the rubric of 'family health', for reducing fertility as well as maternal, neonatal, infant and child mortality

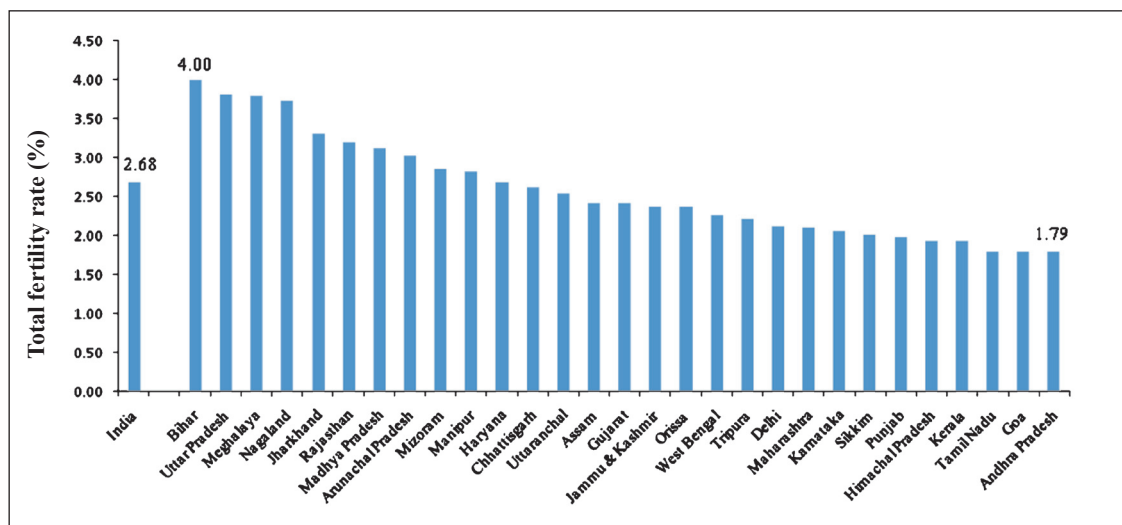


Fig. 2. Total fertility rate by State, 2005-2006.

Source: Ref 12.

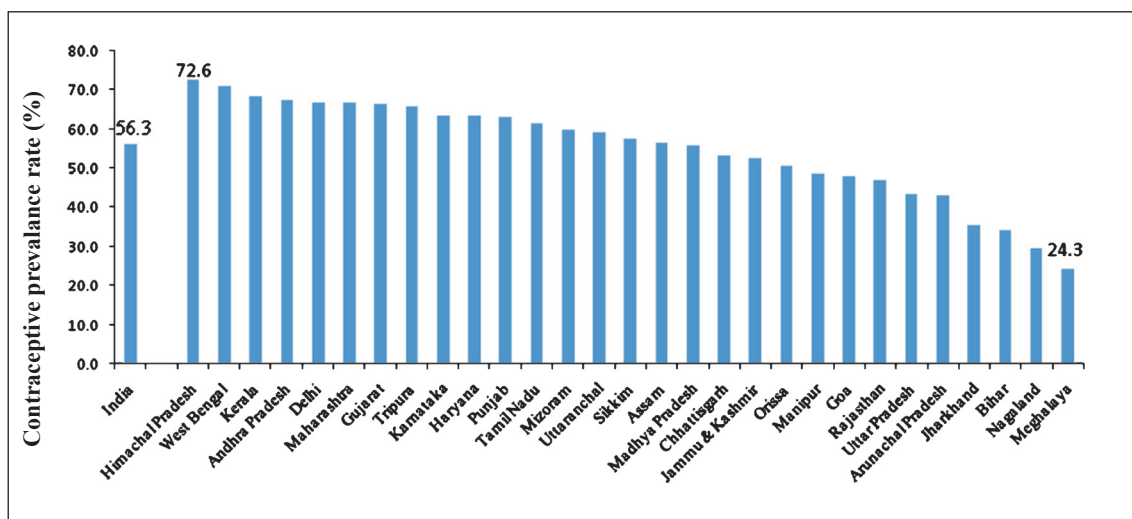


Fig. 3. Contraceptive prevalence rate by State, 2005-2006

Source: Ref 12.

and for improving reproductive health and nutrition. In addition to integrating health services, laudable efforts are also underway to integrate services for water and sanitation and agriculture with health interventions⁴⁶. In implementing these programmes efforts are being made to strengthen both provision of services and generation of demand for services. With diminishing donor support, it is expected that in the next few years, services for HIV and AIDS prevention, treatment, care and support will be integrated within the Reproductive and Child Health (RCH) programme under the umbrella of the National Rural Health Mission (NRHM). As these integrated programmes are planned and implemented, it will be important to undertake programmatic research to facilitate the process of systematically upscaling these best practices.

An integrated approach must, necessarily, be designed using a gender lens because the lack of women's autonomy in reproductive decision-making compounded by the lack of men's involvement and responsibility in sexual and reproductive health matters, lies at the heart of the problem⁴⁷⁻⁴⁹. It is obvious that men's involvement in family planning remains negligible in India. In 2005-2006, a mere 9.1 per cent of married couples used male methods or couple dependent contraceptive methods. Vasectomy was used by 1.1 per cent and condoms by 5.5 per cent men in 2005-2006¹². Therefore, the need to design strategies to increase male participation is obvious⁴⁸⁻⁵⁵. But success in engaging men to take responsibility for family planning has proved to be elusive so far.

There is ample evidence to show that gender disparities not only have an impact on fertility outcomes but also adversely affect mortality and morbidity as well as mental and social wellbeing. The pernicious problem of domestic violence and its adverse consequences on the physical and mental health of women and children is well documented⁵⁶⁻⁷². It is, therefore, important to design and implement strategies for reducing gender disparities that prevail across caste and class, among the rich and the poor, in rural and urban populations, as well as among the educated and uneducated sections of India's patriarchal society. Both short-term and long-term, well coordinated, multisectoral approaches will be needed to address this tenacious problem.

Ensuring collaboration between scientists who develop contraceptive technologies and those who plan and implement family planning services

Several organisations including the Indian Council of Medical Research (ICMR), the Population Council, private industry, and others are making large investments to develop contraceptive technologies. It takes significant resources and a long lead-time of about 10-15 years before a new technology is ready for introduction within family planning programmes. Scientists who develop technologies and professionals who implement programmes are, however, separate constituencies who, for the most part, work in their own worlds. Until recently, there has been little or no interaction between these two groups of professionals. There has been an implicit assumption and a widely-

held belief that technologies are ‘magic bullets’ that can provide a ‘quick fix’. However, experience shows that technologies alone cannot address complex health and development problems. It is now being increasingly understood and acknowledged that technologies are not a panacea. In order to be effective, they must be tailored to local needs^{73,74}.

Historical perspective

Contraceptive technologies have had a somewhat beleaguered history globally. After having contributed to women’s liberation in the 1960s, these technologies became a very contentious issue and a subject of fierce criticism during the 1980s and 1990s⁷⁵. Even today this critique continues in many settings. A current example to cite is the inability to include injectable contraceptives in the national programme in India primarily because of unrelenting opposition by feminists. Injectable contraceptives are available in the private sector but not in the public sector in India.

Women’s health advocates in India remain suspicious of all hormonal contraceptives and especially of methods that are provider-dependent. They are concerned about their potential risks and the likelihood of their misuse and even abuse in programmes that do not have trained staff to effectively deliver these methods. In their view, quality of care and informed choice are essential prerequisites for including these technologies within the national programme⁷³.

The irony is that on the one hand, women want contraceptive choice and on the other, they oppose the introduction of technologies. Women want quality care, and service providers to treat them with respect. They want full information and supportive counselling. They want follow-up care for complications and side-effects⁷⁵. Women want to be able to switch methods when problems arise. These demands are perfectly legitimate but can only be met if the quality of services is improved.

Women’s health advocates call for an approach in which women’s health and reproductive needs shape the health and family planning services that they receive and their confidence and ability to make reproductive decisions is enhanced. This approach recognises that there are unequal power relations between men and women, between providers and users of services and between the state and its people. Women’s health advocates have critiqued the process of contraceptive development because it ignores these power differentials. They have opposed the

introduction of new methods into the public sector programme because of the inadequacies of its delivery system. They argue that the process of contraceptive development must incorporate a more comprehensive analysis of the contextual factors that can affect their safety and effectiveness^{73,76,77}. They advocate for a participatory approach in which women and men are involved in setting the parameters for developing appropriate technologies.

A number of new contraceptive technologies are currently being developed in India and elsewhere. Several innovations to make contraceptives more effective, more acceptable, easy to use, user-controlled, *etc* are being tried. Efforts are underway to simplify methods of delivery⁷⁸ through the development of subdermal implants⁷⁹⁻⁸¹ as well as gels^{82,83} and patches that can be applied to the skin⁸⁴. In addition, intra-vaginal rings⁸⁵⁻⁸⁸ that can be inserted by the woman herself, long-acting methods that minimize clinic visits, postpartum contraception^{89,90}, male contraceptives⁹¹, and immuno-contraception^{92,93} are being developed and tested.

As promising new contraceptive technologies are developed, a dialogue should concurrently be promoted between scientists who are developing technologies in the laboratory and those who will eventually implement them within programmes in different settings. All these stakeholders must understand the needs and perspectives of the end-users of these technologies^{94,95}. This ‘bench-to-bedside’ paradigm should be operationalised to promote such collaboration. If contraceptive technologies are designed with an understanding of the contexts in which they will be delivered and an appreciation of the needs and perspectives of the end users, there is a higher likelihood that they will be accepted by service providers and used by clients.

Conclusion

Despite a long history, spanning some five decades, India’s family planning programme has not yet achieved replacement level fertility. Efforts are, therefore, currently underway to reconceptualise the programme to design and implement priority strategies for achieving programmatic goals. Couples in India have a significant unmet need for both limiting family size and spacing births. Yet, the national programme has not, so far, been successful in providing them with a choice of contraceptive methods. To translate the fundamental concept of informed contraceptive choice, it is imperative that the quality of services is improved. Context-specific, targeted strategies are needed to

provide method choice to enable clients to achieve their reproductive goals. There is an urgent need to address the problem of high unmet contraceptive need among young couples especially among married adolescents.

The pace of decline in both fertility and mortality has been slower in the empowered action group (EAG) States. It is, therefore, important to focus efforts and resources in these States. Integrated programmes, that can more effectively and efficiently address multiple reproductive health needs of the people should be implemented. Such integrated programmes must necessarily be designed using a gender lens as in India's patriarchal society son preference remains strong. Son preference results in larger families as couples try to achieve their desired family composition.

Several promising contraceptive technologies are currently in the pipeline. But for these technologies to be effectively delivered by service providers and accepted by clients, it is important that scientists developing technologies collaborate with professionals engaged with planning and implementing programmes and for all stakeholders to understand the needs and perspectives of the end-users of these technologies. Long years of experience in developing contraceptive technologies and undertaking field-based operations research on family planning programmes has provided valuable lessons. If these key principles are operationalised, it would be possible to develop appropriate contraceptive technologies that can be effectively delivered by the national programme and used by its clients.

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