Bringing a women's perspective to family planning

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The National Family Planning Programme (FPP) was promoted to restrict the increasing population by reducing the high birth rates in India. It was also encouraged for its potential to reduce poverty, hunger and avert maternal and childhood deaths. Several studies have found a positive association between women empowerment and lower fertility, longer birth intervals and lower rates of unintended pregnancy. Family planning (FP) services gave a sense of autonomy to women to decide when to have children and how many. However, the available services were so women-centric that it puts the burden of FP almost entirely on them, whether it was in the use of contraceptive methods, sterilization or abortions. Despite half a century of efforts to reduce population growth, India still faces challenges in delivering a FPP to help couples delay and space out their children that goes beyond female sterilization. Sharing of FP responsibilities by men during these years has been dismal. The burden of FP also seems to have a negative impact on the economic empowerment of women. This article examines the FPP in India through a women's perspective. It uses empirical evidence to show how burden of FP is mainly borne by women. It recommends shifting the focus on men and making FP a shared responsibility between men and women, if gender equality has to be achieved in FPPs.

Keywords: Family planning, maternal and child health, male involvement, women's perspective.

Background

INDIA is one of the first countries to recognize the need for family planning (FP) and formulate a National Family Planning Programme (FPP) in 1952. FP was emphasized for reducing birth rates 'to stabilize the population at a level consistent with the requirement of national economy' as envisaged in the National Population Policy 2000 (ref. 1). FPP has come a long way and currently it has been repositioned to not only achieve population stabilization but also to reduce maternal as well as infant and child mortality. The initiatives taken up as part of the programme have been able to curtail the burgeoning population in India. It was also encouraged for its potential to reduce poverty, hunger and avert maternal and childhood deaths. The transition from a population control-centric approach to an integrated RMNCH+A (reproductive, maternal, newborn and child health and adolescents)[2] programme strategy has provided a platform for addressing the reproductive rights while integrating the current FP services with maternal, child as well as adolescent health, and is beyond just achieving population stabilization.

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The programme strategy has also been influenced by the global commitments (FP 2020)[3] made at the London Summit 2012 where over 60 developing countries pledged for access to FP services for 120 million (12 crore) additional women, a sizeable 40% of which would have to be generated from India. Vision FP 2020 for India aims at providing contraceptive services to an additional 48 million users but aversion of 23.9 million births, 1 million infant deaths and over 42,000 maternal deaths by 2020. The issue is also important with respect to all UN member countries commitment to goal 3 of Sustainable Development Goals (SDGs). Several studies have found a positive association between women empowerment and lower fertility, longer birth intervals and lower rates of unintended pregnancy. FP services give a sense of autonomy to women to decide when to have children and how many. Formulation of a state's population policy[4] integrated with the state's women empowerment policy is a reflection of how much responsibility is put on women for population control[4].

Empowerment of women encourages well-being of the family and community as there is ample evidence on ground to show that they spend their earnings on family welfare, children's health and education. However, different women's empowerment domains may relate differently to child nutritional status[5]. Women disempowerment is

often associated with high rates of undernutrition in South Asia. Economic empowerment of women is also bound to enhance the wealth and well-being of any nation[6]. Participation of women in the economic activities brought a sense of autonomy among them to adopt measures to decide on when and how many children to bear. However, it also puts the burden of FP entirely on women, whether it is in the use of contraceptive methods, sterilization or medical termination of pregnancy (MTP). On the one hand, there has been a progress towards development of a large basket of contraceptive choices available for birth control and to prevent pregnancy, while on the other general health and safety concerns of women have been ignored as is evident from the deaths of several women during various sterilization drives as part of these FPPs[7]. A general neglect of primary health has also been observed with more emphasis on reproductive and child health care[8].

Despite half a century of efforts to reduce population growth, India still faces challenges in delivering a FPP to help couples delay and space out their children that goes beyond female sterilization. Sharing of FP responsibilities by men has been dismal. The programme has not been able to bridge the gap between the two genders related to contraceptive methods as it gives emphasis on women-centric contraceptives, where women are seen as the clients[9]. Although there is a growing demand for both limiting and spacing births, female sterilization is the dominant method in the FPP and the use of spacing methods remains limited[10]. The burden of FP also seems to have a negative impact on the economic empowerment of women and is reflected in the declining workforce participation of women, which is only 25.5% against 53.2% for men according to the 2011 Census despite more of women being better educated compared to previous years. This article examines the FPP in India through a women's perspective. It uses empirical evidence to show how the burden of FP is mainly borne by women. It recommends shifting the focus on men and making FP a shared responsibility between men and women, if gender equality has to be achieved in FPP.

Maternal and child health indicators

India has been able to make significant improvements in the maternal and child health indicators in the last decade, especially life expectancy at birth, maternal mortality ratio (MMR) and infant mortality rate (IMR), due to expansion of the maternal and child health services as part of FPP. This may be related to an increase in institutional deliveries from only 38.7% in 2005–06 to almost 80% in 2015–16. Institutional births in public facilities have also improved from a mere 18% in 2005–06 to 52% in 2015–16 (Table 1).

The improvement in these key indicators has also been as a consequence of women and children getting access to antenatal check-ups, neonatal check-ups, registrations and post natal care. However, while the institutional deliveries have increased, children were also born at home but taken to health facility check-up within 24 h (2.5%) and received health care (24.3%) from a doctor, nurse/midwife/ANM or any other health professional. Despite several governmental efforts to increase access and coverage of delivery services to the poor, it is clear that the latter do not use skilled birth attendant and are more likely to use private providers[11]. This is responsible for an average out-of-pocket expenditure of Rs 3198 per delivery in public health facility in India (National Family Health Survey-4 (NFHS-4), 2015–16). It is important to mention here that the role of a professional skilled birth attendant has been unfortunately neglected in India, while many countries such as Indonesia have nurtured the professional career of midwives. MMR and IMR also fell short of the targets set for 2015 as part of United Nation's Millennium Development Goals (MDGs).

New targets have been set-up to be achieved by 2030 as part of the SDGs. India still faces challenges with 12.8% of currently married women (15–49 years) having unmet needs of FP. This points to a gap between women's reproductive intentions and their contraceptive behaviour. It is important that FPPs reach and serve these women, as it the most likely group interested in contraception but does not use it[12]. In 2015, 26.8% of women aged 20–24 years got married before the age of 18 years and 7.9% of women aged 15–19 become mothers or were pregnant (NHFS-4 (2015–16), Ministry of Health and Family Welfare, GoI)[13]. While indicators of women empowerment such as level of education, maternal health and life expectancy have been showing an improvement for the whole country, indicators of FP lead us to a totally different scenario from the women's perspective.

Family planning indicators reveal the extent of women's burden

India's sustained efforts over the years to achieve population stabilization have yielded positive results. Overall, the country has accepted the small family norm and total fertility rate (TFR) has been declining from 3.6 in 1991 to 2.3 in 2013 and to 2.2 in 2015–16. India, did not achieve replacement level target of 2.1 as envisaged by 2015 (ref. 14). TFR across the states is, however, not uniform. Fertility decline has been slower in the states that also depict gloomy statistics for other socio-development indicators. TFR in the country has been showing a steady decline to the current levels of 2.2 (NFHS-4), and is projected to reach the targeted 2.1 in 2020. While 24 states/UTs have already achieved replacement level of 2.1 TFR by 2013, states like Uttar Pradesh and Bihar with

Table 1. Maternal and child health-related indicators

Indicators	2005–06 (NFHS-3)	2015–16 (NFHS-4)
Infant mortality rate (IMR, per 1000 live births)	57	41
Under-5 mortality rate (U5MR)	74	50
Maternal mortality ratio (MMR, per 100,000 live births)	254	167
Institutional births	38.7	78.9
Institutional births at public facility	18.0	52.1
Births assisted by a doctor/nurse/any other health personnel	46.6	81.6
MMR (per 100,000 live births)	254	167

Source: National Family Health Survey-3 and National Family Health Survey-4.

Table 2. Family planning indicators

Family planning method	1998–99 DLHS 1	2005–06 NFHS 3	2015–16 NFHS 4
Pill	2.4	3.1	4.1
Condom	3.1	5.2	5.6
IUD/PPIUD	1.9	1.7	1.5
Female sterilization	33.5	37.4	36.0
Male sterilization	1.5	1.0	0.3
Any other method*	57.6	51.6	52.6

*Other methods not shown separately. DLHS, District Level Household and Facility Survey-1.

large population base still have TFR of 3.1 and 3.4 respectively. The other states like Jharkhand (TFR 2.7), Rajasthan (TFR 2.8), Madhya Pradesh (TFR 2.9), and Chhattisgarh (TFR 2.6) continue to have higher levels of fertility and contribute to the growth of population.

As a policy, there has been a focus on spacing services (except for the high TFR states where both spacing and limiting are emphasized upon). Share of post-partum FP methods for spacing or sterilization for women has improved with the introduction of more options for Indian women, but the burden has again fallen more on them. Attaining, replacement-level fertility has not resulted in improved maternal health, because of early marriage and closely spaced births. For instance, in Andhra Pradesh, despite low TFR (1.8), 32% of women between 20 and 24 years were married before the age of 18 and 11% of women between 15 and 19 years had already borne children. Also, 53% of women in the age group of 15–49 years are anaemic and 22.9% of women have body mass index below normal in the state (NFHS-4). The data reveal the sorry state of affairs in AP. It is high time to reposition FP beyond women's fertility control, and envisage it as a health and development issue rather than a programme focusing solely on the women's fertility control. FPP has made the contraceptives easily accessible and affordable. The highest share is of female sterilization, followed by condoms, pills and Intra Uterine Contraceptive Devices (IUCDs) (Table 2). FP indicators reveal the extent of burden on women for taking up FP measures. The share of male sterilization is the lowest.

The improvement in these key indicators has also been as a consequence of women and children getting access to antenatal check-ups, neonatal check-ups, registrations and postnatal care.

Though there has been significant expansion of services related to FP, there are several quality issues pertaining to the availability of these services through public health facilities in India[15]. Failure to adopt the latest technology is one of them. The programme has not been able to bridge the gap between the two genders related to contraceptives. It gives emphasis to women-centric contraceptives and thus women are seen as clients. The integration of gender equity in FP services is needed to achieve comprehensive success of FPP[9]. Female sterilization has for decades remained the mainstay of FPP in almost all the states. Unmet need for FP (12.9%) and unmet need for spacing (5.7) still remained high in 2015–16 and accounted for thousands of preventable maternal and infant deaths. The lack of appropriate counselling and awareness on sexual and reproductive matters, and contraceptives is further weighed down by gender inequality and rooted myths and misconceptions. Although vasectomy is a safer, quicker and easier procedure, data show that the onus of FP predominantly rests with women. Forthcoming contraceptive choices for women, including injectables and oral pills under the FPP also put burden on them.

Lack of male involvement

A major focus in the government programme on FP has been on promoting and providing services for permanent methods – in particular, female sterilization. Though India has done away with the practice of setting population control targets, there is some expected measure of achievement at the district level, which largely constitutes female sterilization. Women account for 98.1% of sterilizations conducted at various family welfare centres[16]. Percentage of tubectomies to total sterilization has increased from only 78.6 in 1980–81 to more than 90 in the 1990s. The number of men seeking sterilization has gone down in last five years from 1% of the total sterilizations in 2004–05, to an all-time low of only 0.3% of the total sterilizations done in the country.

Poor number of male workers in FPP may be impeding male participation as misconception about male sterilization

largely remains unaddressed. Thus, the entire onus of population control rests on women in the country. More positions of male health workers are laying vacant. There is larger shortfall of 10,1287 male health workers at the subcentre level compared to a shortfall of 4679 female health workers. In 2016, there were only 53,422 male health workers compared to 192,531 female health workers/ANM. There are more than 73,848 subcentres in India without a male health workers compared to only 8963 subcentres without a female health worker/ANM in the country[17].

Recent data on contraceptive use show the prevalence of female sterilization at 36% among modern contraceptives used, while the total usage of any modern contraceptive was only 47.8%. This is despite the fact that the procedure is less complicated for men. Even as women take most of the burden of sterilization, they are vulnerable to infections and even deaths due to negligence and poor services. Dismal quality of care for women as part of FPP has been witnessed, especially the sterilization camps[18].

Lower usage of contraceptive usage is reflected in increasing number of abortions to attend to unwanted pregnancies. Unsafe abortion is one of the leading causes of maternal deaths across the world. In 2015–16, 721,381 medical termination of pregnancies (MTPs) were performed as against 701,415 in 2014–15. Highest number of abortions (198,820) was reported from Maharashtra[19]. Other states like Assam, Tamil Nadu, West Bengal, Haryana, Madhya Pradesh and Uttar Pradesh also witnessed a large number of women undergoing MTPs. In India, we do not have reliable data on unsafe abortions, but there are studies indicating higher incidence of unsafe abortions in the country[20]. Unmet needs for contraception and abortion, preference for a male child, preference for private providers and the neglected needs of single, widowed or separated women are some of the common reasons for high morbidity and mortality for a majority of women undergoing abortion, as it is often infrequently used as a safe alternative for women faced with unwanted pregnancies[21]. Often attitudes and perceptions of abortion-service providers' have an influence on the quality of services provided to the women during abortion. This also affects women's own perception towards abortion though more data is still needed[22]. Empirical evidence is necessary to know the extent to which the unmet need for contraception results in unwanted pregnancies or becomes unwanted fertility.

A lack of reliable information, wide regional and rural–urban differences and a thin research base make it difficult for policy-makers, administrators and women's health advocates to develop strategic interventions. For example, awareness on women's rights to safe and legal abortions according to the Medical Termination of Pregnancy Act is not given equal importance as is the concept of Pre-Natal Diagnostic Techniques Act, which impedes with women's access to safe medical termination of pregnancies[23].

Family planning and empowerment of women

Women often find themselves standing at the crossroads to make a choice to fullfil their family needs (mainly reproductive functions) or to take up economic opportunities available to them. The relationship between empowerment of women and FP is thus complex. Adoption of FP methods (contraception or sterilization) is the most commonly studied FP outcome[24]. While there are findings to show consistently positive associations between women empowerment and FP outcomes, there are only few studies to see how this positive association is further strengthened for economic empowerment of women. While improvement is evident from the data on some of the women empowerment indicators which have been collected as part of the NFHS-4 (ref. 25), there has been consistent stagnation in the women workforce participation, which is only 25.51% against 53.26% for males (according to census 2011); it was 25.63% and 51.68% according to Census 2001. The same trend is visible from the latest rounds of data from National Sample Survey Organization

Empowerment of women is one of the key determinants for the success of FPP in general. Studies have confirmed a statistical relationship between the women's status indicators and their ability to control fertility (FP indicators). The strongest relationship to adoption of FP is the educational attainment of women, followed by age at marriage, and women's work participation, particularly in non-agricultural activities[26]. Women have unequal access to economic opportunities and there are mutually reinforcing gender barriers that deny them economic opportunities across the country. While barriers related to women's use of contraception and safe abortion are part of FPP, lack of safe spaces and social security measures such as crèche for children and maternity benefits at workplaces hampers equal work participation of women.

FP enables women to make informed decisions about whether and when to have children, reduce unintended pregnancies as well as prevent maternal and newborn deaths. It also increases educational and economic opportunities for women, and leads to healthier families and communities. Studies have shown that women who are empowered to make choices about childbearing are more likely to invest in their children's education or seize economic opportunities and help in poverty alleviation.

Recommendations

- There is need for a discussion on safest methods of contraception for both women and men while implementing FPP. Lack of women's autonomy in

reproductive decision-making, and poor male involvement in sexual and reproductive health matters are fundamental issues that need to be addressed.

- FP 2020 partnerships intend to support the rights of women and girls to decide freely and for themselves whether, when and how many children they want to have, and to help avert thousands of unwanted pregnancies. This would require an increasing access to better quality FP services and meeting the unmet requirement of contraception. Incentives for men-centred contraception as part of the FP services may also be considered.
- The public health system, FPP and communication strategies should be designed to encourage male engagement. Emphasis should be on changing the mindset and gender stereotypes. Engagement of staff against vacant posts, generation of material for gender sensitization of men, and promotion of men role models through media should also be encouraged.
- Interventions are needed for making the physical space of the healthcare centre more conducive to men. This includes making the literature on men's needs available, attending to males at different hours of the day, and training staff to be more welcoming to men. Involving male health workers in FP counselling, which is currently being done by female workers like ASHA and ANMs can be useful.
- More safe facilities for medical termination of pregnancies have emerged as an alternative to terminating early pregnancies and offer a window of opportunity to expand women's access to safe facilities for abortion.
- Integration of FPP with income generation programmes for women has been successful in countries such as Indonesia. The FP platform can be used to promote economic interventions through group activities. Economic empowerment of women can lead to success of FPP.
- FP, should not be considered only as a women's issue, as it puts more pressure on them and promotes gender inequality. Empowerment of women (education and wealth) will be reflected through improvements in institutional deliveries, immunization and children's nutritional status (stunting and underweight).

Disclaimer: Views expressed are personal and not of organization.

1. India has had two National Population Policies which were drafted in the years 1976 and 2000.
2. Launched in 2013, RMNCH+A approach aims to address the major causes of mortality among women and children as well as the delays in accessing and utilizing health care and services.
3. FP 2020 is an outcome of 2012 London summit on Family Planning.

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