

Family Planning

A Right and a Choice



सत्यमेव जयते

Ministry of Health & Family Welfare
Government of India



United Nations Population Fund – India

“Family planning is the most effective and cost-efficient public health intervention for reducing maternal and child mortality, and improving the health status of women and children in our country. This booklet has been published by Jansankhya Sthirata Kosh to encourage the required focus on family planning by programme managers.”

Dr. Rakesh Kumar

Joint Secretary (RCH), and
Executive Director, JSK

“United Nations Population Fund wants to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. We believe that providing information about and access to contraceptives and services is imperative for the development of any country.”

Frederika Meijer

Representative
UNFPA, India

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A RIGHT AND A CHOICE

“Family Planning: A Right and a Choice” is meant for those whose job involves rolling out family planning related activities, primarily at the district and state levels. The purpose is to help them understand that access to quality family planning products and services is every individual’s **right**. Also, it is only the individual himself/herself who has the **choice** to decide if, when and which family planning products or services to use. This document will help to link programme implementation to the needs of the people, keeping the related social and ethical sensitivities in mind.

India was the first country to launch a national family planning programme in 1952. The objective of this programme was “reducing birth rate to the extent necessary to stabilise the population at a level consistent with requirement of national economy”. The first ever World Population Conference in Bucharest in 1974 emphasised the need to invest in family planning and asked member States to draft population policies that focussed on curbing rapid population growth. Over the following decade, global experience on family planning programmes grew. The next population conference in Mexico City in 1984 saw the world integrating women’s issues with family planning and emphasising linkages between high fertility and lack of education, employment opportunities and health care for women and overall low social status.

Another ten years later, while there was global evidence about the limited demographic impact of existing family planning programmes, there was sufficient data to call attention to the effect of these programmes on women’s health. At the International Conference on Population and Development (ICPD) held at **Cairo in 1994**, there was a “**paradigm shift**” in the thinking on family planning programming, the aim of which shifted **from population control to individual well-being**.

At the ICPD, a Programme of Action (PoA) was developed to guide population and development for the next 20 years. The PoA focused on meeting the needs of individual women and men rather than on achieving demographic targets. It advocated for universal availability of and access to family planning services and empowering women through education on and provision of more choices. Thus the PoA formally recognised the rights of individuals to have **children by choice, not by chance**.

India is a signatory to the ICPD PoA. In keeping with its commitments, India adopted the target-free approach in family planning in 1996. This means that family planning uptake is to be guided by the needs of the population and decided by the clients through informed choice.

In India, family planning is guided by the National Population Policy, 2000. Programmatically, it is an integral component of the Reproductive Maternal Newborn and Child Health plus Adolescent Health (RMNCH+A) Strategy that was launched under the National Rural Health Mission (NRHM) in 2013. This strategy is based on ICPD principles, and follows the continuum of care approach across all life stages, from adolescence, through pregnancy and childbirth, and on to the infant and child. It details the interventions required at each stage to ensure optimal health (especially sexual and reproductive health) of the individual. Family planning, as an intervention, cuts across life stages for all men and women, starting from adolescence and covering the complete reproductive life span.

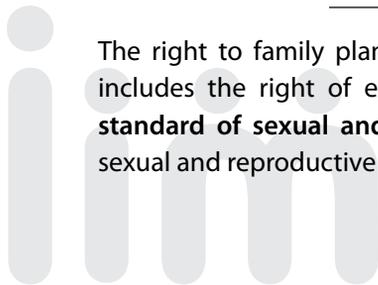
Universal access to family planning by 2015 is one of the Millennium Development Goals (specifically MDG 5). India is a signatory to the Millennium Declaration.

Reproductive health – what does it mean?

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease, in all matters relating to the reproductive system, and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to **reproduce** and the **freedom to decide if, when and how often** to do so. Implicit in this last condition are the rights of men and women to be informed about and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

What does the right to family planning include?

The right to family planning is encompassed in the broader gamut of reproductive rights which includes the right of every individual to not only **plan his/her family**, but also **attain highest standard of sexual and reproductive health**. Inherent is the right to make decisions related to sexual and reproductive health **free of discrimination, coercion and violence**.



No human right, including the right to reproductive health, can be viewed in isolation and the realisation of one human right is often a pre-requisite to and/or requires the realisation of another. Family planning helps people enjoy other rights such as the right to health, right to education and the right to live a life with dignity not just for themselves, but also their future generations. Conversely, the realisation of other rights (such as the right to privacy, the right to non-discrimination) is integral to stake a meaningful claim to reproductive rights by the rights holders.

A rights-based approach is operationally directed towards developing the capacities of rights holders to claim their rights and the capacities of duty bearers to meet their obligations.

Every individual (irrespective of sex, age, marital status, socio-economic level etc.) is entitled to:

- Access to the full range of legally permissible family planning goods and services, including spacing and limiting methods
- Access to family planning information, which is scientifically accurate, objective, free of prejudice and discrimination
- The ability to make an informed choice about family planning, free from discrimination, coercion or violence

On the other side, every State (nation) must ensure:

- Availability of the full range of legally permissible family planning methods
- Accessibility for all those who need family planning, including adolescents and youth, and even unmarried people
- Acceptability of the family planning methods being offered in view of the social, economic and cultural backdrop of the State
- Quality of family planning products and services

Ensuring quality of care in family planning

It is not enough to only ensure availability and geographical and economic access to family planning services. Quality of services (perceived or real) strongly predicts choice of provider as well as the decision to use family planning. At other times, poor quality may lead to loss of return to follow-up or even discontinuation of use of family planning.

Ensuring quality of family planning services includes a number of elements such as

- **Choice:** Clients must be offered all the choices legally available in a non-judgemental manner. Provider discretion and biases (“conscientious objection”) should not be allowed to impact the clients’ decision to either use or not to use family planning or the method of choice.
- **Information:** To enable clients to make a choice that is right for them, complete information regarding method effectiveness and the advantages and disadvantages of each should be shared with them. Once the client has made a decision about the method s/he would like to opt for, information on correct usage, potential side effects, follow-up requirements etc. should be clearly explained. This reduces the chances of discontinuation and/or failure due to incorrect usage.
- **Client-provider relationship:** Respect should be the basis of the client-provider relationship. A listening and guiding attitude on the part of the provider leads to increased acceptance of, and satisfaction with, family planning methods. Both auditory and visual privacy are important, during client-provider interactions as well as during provision of services. This will make the client feel more comfortable discussing her/his individual needs and increase follow-up rates. Information shared by the client during her/his interaction with the provider should be kept confidential.
- **Technical competence of provider:** The provider needs to be trained in the appropriate medical and surgical skills (as required for the cadre) and also in counselling skills. Provision of skilful services prevents potential complications and reduces failure and discontinuation rates.
- **Constellation of services:** The acceptance and uptake of family planning services is best when provided as a component of a constellation of services, such as services for maternal and child health.



Family Planning

NEEDS OF ADOLESCENTS & YOUTH



Adolescent fertility and its undesirable consequences have not received the attention they require. Adolescent pregnancies place the girl at a much higher risk of complications and even death. Even if she delivers safely, there is increased likelihood of the birth of a low birth weight baby, which exposes the child to a higher risk of a host of other problems in childhood and later in life.

Married youth

In India, most adolescent sexual activity and fertility happens within the confines of marriage. According to DLHS-3 (2007-08), 42.9 per cent of the currently married women aged 20-24 years were married before the legal age of 18 years, and 5.6 per cent of all births are by girls in the age group 15-19 years. In fact, 16 per cent of the girls aged 15-19 years who were interviewed for NFHS-3 (2005-06) had already given birth or were pregnant at the time of the survey.

Young girls at this age are physically and psychologically immature and are unable to make an informed decision about when and how many children to have. In fact, their families and existing social norms pressurise them to bear children early on in marriage. The unmet need for family planning among married adolescents is significantly higher than for married older women. This means that adolescent girls want to delay their first and/or subsequent births. However, these young people often lack information on the family planning choices as well as where to seek them. Usually these needs are not recognised by the system.

Unmarried youth

There is limited data in national level surveys about the sexual behaviour of unmarried adolescents.

Young men, involved in “casual/experimental sex” are more in need of contraception not only to avoid fathering an unwanted child but also to protect themselves against sexually transmitted infections.

However, the stigma attached to pre-marital sex prevents unmarried youth from accessing family planning services even when they are aware of the place where the required products and services are available. Pregnancy in the unmarried is not acceptable in Indian society, and usually results in either an unsafe abortion or a risky birth without the presence of a skilled attendant. Both situations pose serious threats to the health and life of the young mother.

“Family planning” programmes need to ensure that the services are available and accessible to all those who need it, irrespective of their marital status.

Sexual and reproductive health education

Age-appropriate education on sexual and reproductive health includes many aspects related to the biology of sex and reproduction and sexual health, including the potential negative impacts of early and unprotected sex. It covers issues like the importance of family planning to enable people to have children by choice and not by chance. Concerns are often raised that provision of sex education to adolescents encourages them to indulge in sex. Both global and local evidence refute this perception.

As many young girls get married early, sexual activity begins in adolescence itself. The right knowledge imparted through comprehensive sexuality education programmes, together with access to related services, will enable these girls (couples) prevent adolescent pregnancy which carries a greater risk of maternal morbidity and mortality.

Even for unmarried girls and boys, provision of authentic, scientifically correct information about sexual and reproductive health addresses their innate curiosity about this aspect of their lives and leaves them with less desire to “experiment”, as they are aware of the potentially dangerous repercussions on their lives. Such education programmes are linked with lessons on safe sex practices, including messages on how to protect oneself from an unplanned pregnancy as well as sexually transmitted infections, including HIV/AIDS. These programmes are even more effective when linked with service provision. Comparison of data from countries with similar average age for initiation of sexual activity shows that countries where children have greater access to comprehensive sexual and reproductive



health education and sexual health services, including family planning, have lower rates of adolescent pregnancy, birth and abortion rates.¹

Adolescents need help to “plan their families” in the broadest sense of the term. They need help from all sectors (education, health and livelihood), their own families and the society at large to:

- **Delay marriage** till at least the legally permissible age, and even beyond
- **Delay the first birth** till at least two years after marriage
- **Space the birth** of subsequent child at least three years apart

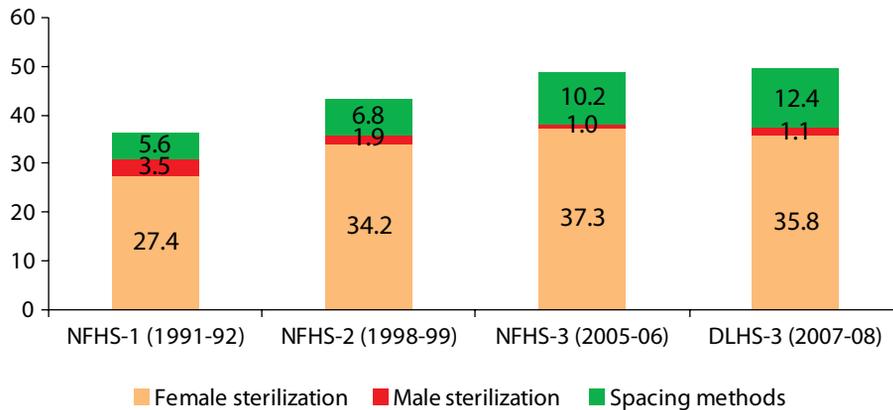
¹State of World Population 2012. By *Choice, Not by Chance*. (Pg 49) UNFPA. New York. 2012 (ISBN 978-1-61800-009-5)

THE CASE FOR Family Planning FACTS & FIGURES



Contraceptive method mix

Chart 1: Use of contraceptive methods in India, 1991-2008



Contraceptive prevalence rate (CPR) refers to the proportion of currently married women in the reproductive age group (15-49 years) who are using a method of contraception. Chart 1 shows the increasing trend in CPR over the years, for all modern methods, including spacing methods, which is encouraging. However, it also shows that reliance on permanent methods continues, and while the overall proportion of sterilisation is increasing, the proportion of male sterilisation has decreased over the years. Such a method mix, with little focus on spacing methods, does not enable the couple (and the country at large) to benefit from the complete range of contraceptive methods offered under the programme (see Myth 6)

Contraceptive prevalence rate, total fertility rate and infant mortality rate in select states of India

Chart 2: Contraceptive prevalence rate and TFR and IMR, India and select states

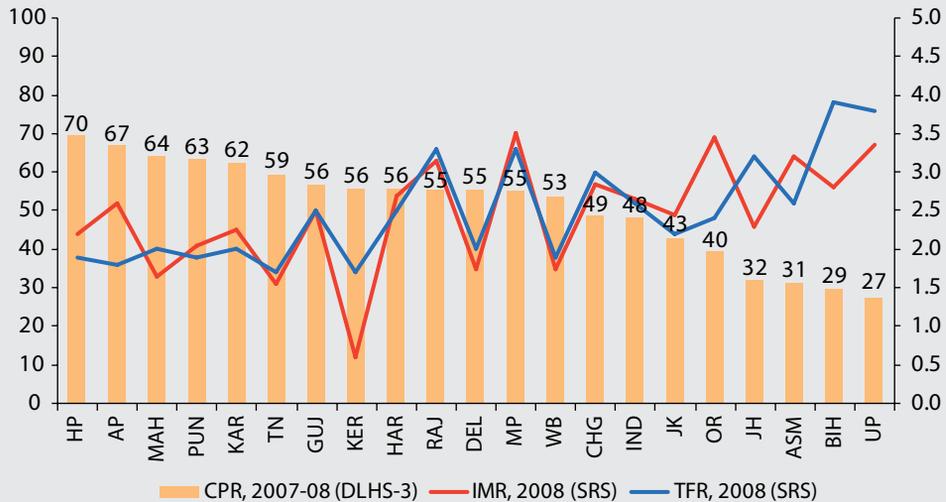


Chart 2 depicts the CPR levels in the period 2007-08 for select states in India, arranged in descending order. By and large, a lower level of CPR is associated with a higher total fertility rate (TFR), indicated by the blue line. TFR indicates the number of children a woman is expected to bear in her lifetime, given the current age-specific childbearing rates. It can also be seen that states with a lower TFR also have lower infant mortality rates, indicated by the red line. The steep decline of IMR in Kerala as well as the “unexpected” peak for IMR in MP indicates that while CPR and TFR are important determinants of infant mortality, there are other factors too that impact mortality.

Unmet need for family planning and maternal mortality ratio in select states of India

Chart 3: Contraceptive prevalence rate, unmet need for family planning and maternal mortality, India and select states

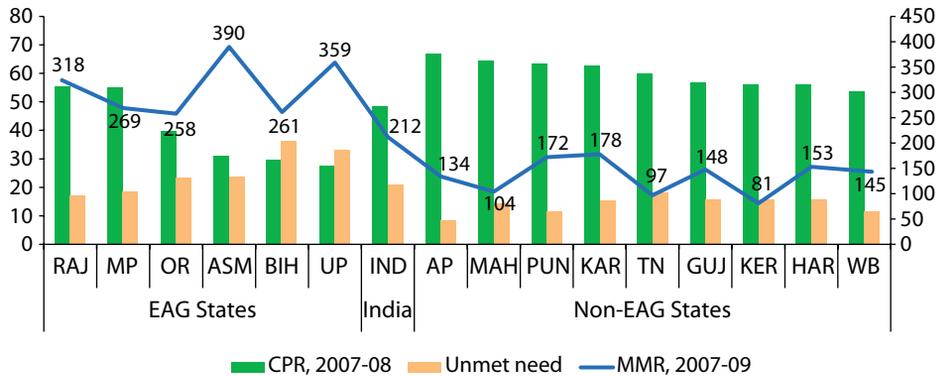
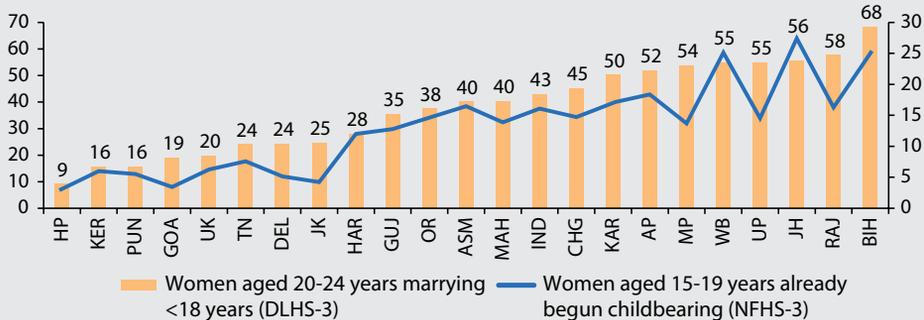


Chart 3 shows significantly higher levels of CPR in the non-Empowered Action Group (EAG) states compared to the EAG ones. A higher CPR is generally associated with a lower level of unmet need. The latter indicator reflects perceived need which is not addressed by the current level of services. As unmet need is dependent on felt “need” (for spacing births or limiting family size) as well as service delivery (or the lack thereof), its level should always be interpreted in light of the corresponding CPR levels. The chart clearly shows that higher CPR levels and lower unmet need rates are associated with lower maternal mortality.

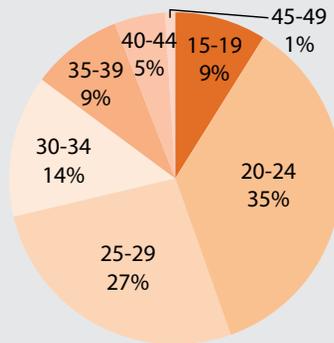
Age at marriage, adolescent fertility and its contribution to maternal mortality

Chart 4A: Percentage of women aged 20-24 marrying before 18 years of age and women age 15-19 already begun childbearing, India and select states



It is clear from Chart 4A that girls' age at marriage is strongly correlated to the age at childbearing. States with a larger proportion of child marriages also have a larger proportion of births occurring to girls in the adolescent group. Adolescent pregnancies pose a significantly higher risk to the life of the mother than pregnancies later in the reproductive age group. Girls in the age group 15-19 years account for 5.6 per cent of all births (NFHS-3, 2007-08) and 9 per cent of all maternal deaths (Chart 4B), clearly indicating riskier childbearing during adolescence compared to later ages. Thus, delaying the first birth to beyond the adolescent age group can help reduce MMR substantially.

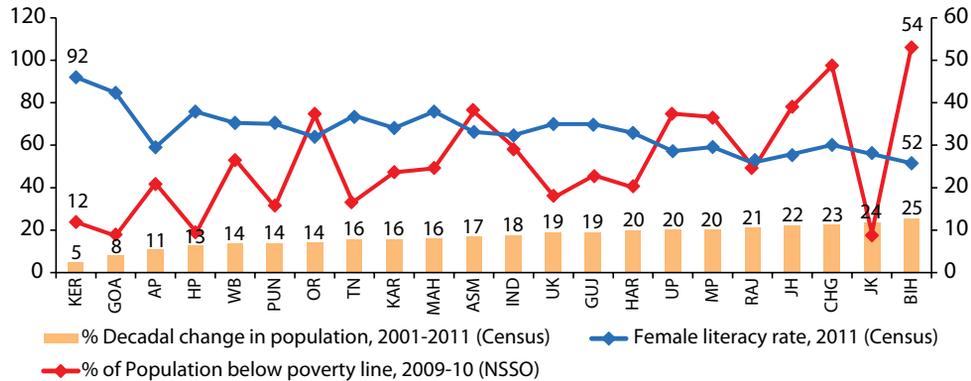
Chart 4B: Proportion of maternal deaths by age category of women, India



Source: SRS 2007-09

Correlating population growth rates to other development indicators

Chart 5: Decadal change in population, female literacy and percentage of population below poverty line, India and select states



While on the one hand family planning ensures reduced growth rates and population stabilisation, it also is about individual well-being. The focus of these programmes is human development. States with successful family planning programmes have managed to reduce the population growth rates significantly. It is no coincidence that the same states also witness a higher level of literacy and per capita income and lower levels of poverty for the people living there (Chart 5). Thus family planning can help improve the quality of life of the people, the community and the nation as whole.



Family Planning

MYTHS & MISCONCEPTIONS



Myth 1

The fact is that population growth rates and fertility rates have been declining in the country over the past three decades. According to the 1991 Census, the annual growth rate of the population for the decade 1981-1991 was 2.16 per cent, which decreased to 1.97 per cent in the 2001 Census and is currently at 1.64 per cent (2011 Census). As a result of this reduction in growth rate, 2001-2011 is the first decade when the absolute addition in population is less than that for the previous decade. With reference to individual women, the total fertility rate or TFR (i.e. the number of children a woman is expected to bear in her lifetime) has decreased from 3.8 in 1990 to 2.4 in 2011 (SRS 2011).

India has a very young population, with 49 per cent of the people in the reproductive age group of 15-45 years (ORGI Population Projections for 2011). Despite reduction in fertility rates, the absolute number of births is still very high because of the large number of young couples ("youth bulge"). Even if all couples produce only two children, it will take about two generations for the impact of slowdown to be felt. This is called "**population momentum**". An easily understood analogy will be a fast moving train. The train will take time to come to a halt even after the application of brakes because of momentum.

India's population is growing at a very fast rate

2.16%

1.97%

1.64%

by choice and not by chance

Myth 2

The most
important
advantage of
family planning
is population
stabilisation

Family planning should be made accessible to every woman and man who needs it so that they can exercise their reproductive health rights, according to which everyone should be able to freely and responsibly decide how many children to have and when (that is, children “By Choice, and not by Chance”).

Family planning helps women and couples limit their family size, and space the births too, if they so desire. By exposing the woman to fewer pregnancies in her lifetime, family planning reduces her lifetime risk of illness and death associated with pregnancy and childbirth. Due to a reduction in unwanted and mistimed pregnancies, fewer women undergo abortions (many of which are unsafe and pose a threat to the woman’s life and health). Research also shows that pregnancies that are too early, too many and too closely spaced adversely impact the health of both the mother and the child. By helping women to reduce such “higher-risk pregnancies”, family planning ensures a healthy mother and child.

a healthy mother and child

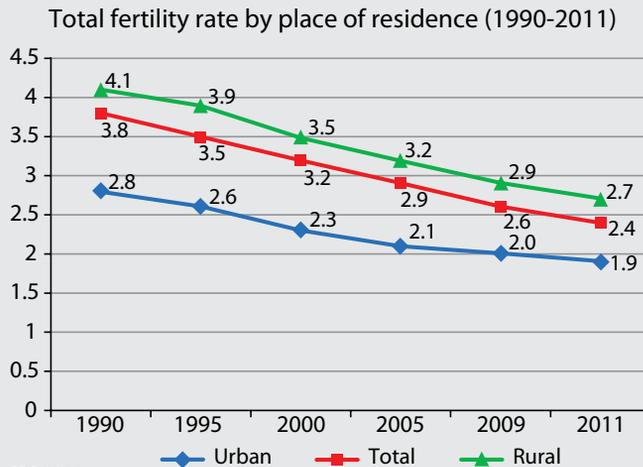


overall reduction in family size

Myth 3

The country has witnessed an overall reduction in family size over the past four decades. Data shows that the decline in fertility levels cuts across socio-economic strata as well as the rural-urban divide. In 1970, the TFR in the rural areas was 5.6, while it was 4.1 in the urban areas. According to the 2011 SRS data, TFR currently stands at 2.7 for rural areas (a decline of 2.9 points from 1970) and 1.9 for urban areas (a decline of 2.2 points).

The rural and uneducated still produce a large number of children, while the urban educated have reduced the family size



Source: SRS 2011

Despite the massive reductions in TFR, rural India continues to have a relatively larger average family size compared to urban India because it started with a higher “baseline”. Improved and equitable access to family planning information and services across rural and urban areas will result in accelerated decline of TFR.

unmet need 12.8%

spacing 6.2%

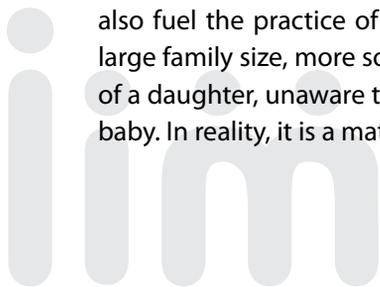
Myth 4

Couples who have many children do not understand the benefits of family planning

DLHS-3 data shows that awareness about at least one modern method of family planning is almost universal in India. These national level representative surveys also highlight high levels of unmet need for family planning. According to NFHS-3 (2005-06), the overall unmet need in India is 12.8 per cent, of which 6.2 per cent is for spacing, and 6.6 per cent is for limiting the family size. Unmet need captures those women who do not wish to have children either in the next two years (unmet need for spacing) or ever (unmet need for limiting), and are not using any method of family planning. It can be easily inferred that women (couples) who are desirous of spacing their children and/or limiting their family size understand the importance of doing so. They are also aware of how this can be done. The most important issue is **lack of access** to family planning information and/or supplies and services. Services may be inaccessible geographically (health facilities are located far away from their homes) or financially (the out-of-pocket expenditures for travelling to the facility, loss of wages or buying the product may be unaffordable). Another reason may be a perceived lack of quality of services that discourages couples from seeking out such services.

Other **socio-economic and cultural reasons**, such as child marriage, high levels of infant mortality, lack of economic security and inability of women to negotiate contraception due to gender discrimination, also fuel the practice of having larger families. Son preference is also an important determinant of large family size, more so in the lower socio-economic strata. Society blames the mother for the birth of a daughter, unaware that biologically it is the sperm from the father that determines the sex of the baby. In reality, it is a matter of chance.

limiting 6.6%



men have
decision making power

Myth 5

Family
planning
is a woman's
issue

Just as the process of procreation requires the involvement of the man and woman, the choice and decision regarding children (how many and when to have them) ideally lies jointly with the couple. Biologically, most of the burden of pregnancy and childbearing falls on the woman. Hence it is assumed that the interest in and benefit from preventing an unwanted pregnancy would be largely hers, and family planning programmes target women as their primary clients. What is often ignored is that owing to the subordination of women in society, most women have negligible powers to negotiate for safe sex. Since men hold the power of decision making with regard to the use of contraception, informing them about the benefits of family planning and involving them in related decisions will result in greater uptake of services.

It must also be recognised that men, as individuals in their own right, also require information and services from the programme. Their need for contraception and dual protection (that is, preventing unwanted pregnancy as well as sexually transmitted infections) is at least equal to, if not sometimes greater than that for women, and should be addressed by family planning programmes.

require information
and services

condoms male sterilisation

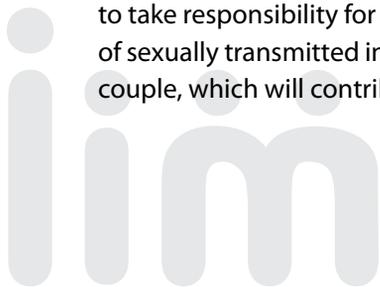
Myth 6

Suitable family planning methods for men are not available

Theoretically, it is “easier” to devise contraceptive methods for women than men, because of the ease of “controlling” the release of the single ovum in a month, compared to the millions of sperms released in every ejaculate. Hence, the hormonal methods are all directed for use by the woman.

However, pregnancy can be effectively avoided by barrier methods as well as sterilisation. Male-centric methods such as condoms and male sterilisation are scientifically sound methods, but do not find many takers due to various negative perceptions (often incorrect) about them. For example, a reduction in sexual pleasure is the reason most commonly quoted for men’s aversion to condom use, while the fear of loss of virility following the surgery is why men avoid vasectomy. It is often not known that these methods offer some very distinct advantages over female-focussed options. The condom is the only family planning method that not only protects the couple from unplanned pregnancy but also from sexually transmitted infections. Vasectomy, especially when done using the newer technique known as “no-scalpel vasectomy” (NSV), is an easier, less invasive, cheaper and safer procedure than female sterilisation. Men who have undergone vasectomy often cite

concern for their partners’ health, or discontinuation of other methods by their partners due to side effects as the reason for undergoing the procedure. Promotion of male methods thus encourages men to take responsibility for childbearing issues, protecting themselves and their partners against the risk of sexually transmitted infections, and can help in forging a deeper bond of love and care between the couple, which will contribute to a more equal position of men and women in society.



ideal birth spacing interval is 3-5 years

Myth 7

Closely spaced
childbirth
helps the
mother and
families bring
up children
more easily

19

Women are encouraged to have their children with minimal age gap so that they can undertake the responsibilities “in one go” and “free” themselves of this “burden” sooner. However, evidence clearly shows that spacing children too closely together has deleterious effects on the health of both the mother and the child and may even endanger their lives.

Research informs us that the ideal birth spacing interval is 3-5 years.² Children born 3-5 years after the previous birth are more likely to survive through all stages of childhood – including neonatal period (less than 28 days), infancy (less than 1 year), till 5 years of age – than children born less than 2 years apart. Such children also face a reduced risk of malnutrition. The probable causes for this are maternal depletion due to inadequate time to recover from a previous pregnancy causing inadequate development of the unborn child, and even premature delivery resulting in a low birth weight baby. A relative reduction of breast milk may cause slower growth of the child. Other bio-social factors such as inadequate attention given by the mother to the children as well as greater chances of sibling rivalry may contribute to the poor health effects seen in children born too close together.

Women who give birth 27-32 months after a previous birth also have a reduced risk of dying, and of facing pregnancy-related complications compared to women who deliver 9-14 months after a previous pregnancy.

²Setty-Venugopal, V. and Upadhyay, U.D. *Birth Spacing: Three to Five Saves Lives*. **Population Reports**, Series L, No. 13. Baltimore, Johns Hopkins Bloomberg School of Public Health, Population Information Program, Summer 2002. (ISSN 0887-0241)

children

if

when

Myth 8

how many

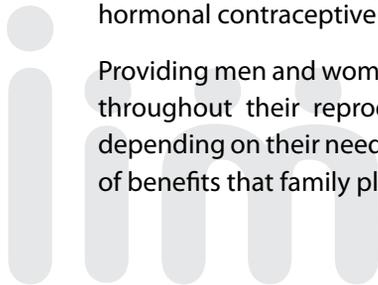
Family
planning
programme
means
provision of
sterilisation
services

The purpose of a family planning programme is to enable men and women to decide if, when and how many children to have. While permanent methods can help avoid another pregnancy after the couple have reached their desired family size, they do not help the couple to decide whether or not they want to have children and when to have them. According to DLHS-3 (2007-08), the unmet need for spacing is 5.2 per cent. This means of all the married women in the reproductive age group, 5.2 per cent do not wish to have another child for the next two years, and yet are not using any family planning method to prevent it.

Family planning programmes focussing on sterilisation only limit the programmatic impact on child and maternal mortality. This is because spacing helps in reduction of maternal and infant mortality as mentioned in Myth 7. Reversible methods can help the couple space their children, and can be used for longer duration to even limit family size. Spacing methods include condoms, combined oral contraceptive pills and two variants of intra-uterine contraceptive devices (Cu-T 375 and CuT-380 Ag), all of which are freely available in the public health sector. Also available are emergency

contraceptive pills, which are useful following an episode of unanticipated and/or unprotected sex. Additional methods available in the private sector include spermicidal gels, creams, sponges, non-hormonal contraceptive pills, mini-pill, hormonal IUCDs and injectable contraceptives.

Providing men and women with a wide variety of family planning methods, both spacing and limiting, throughout their reproductive life span, and enabling them to choose an appropriate method depending on their needs at a particular stage is the only way to take advantage of the complete range of benefits that family planning offers.



side effects

minor

All spacing methods have undergone rigorous scientific evaluation proving their safety even for long-term use (throughout the woman's reproductive life span). Most methods require a screening of the potential client (sometimes by self, and often by the service provider) to ensure that she does not suffer from any rare condition that might preclude the use of these methods.

The known side effects of spacing methods, if any, are minor and relatively rare. Though uncomfortable, these side effects are not harmful to the health of the woman (or man). On the contrary, the adverse impacts of an unplanned, unwanted pregnancy are far more serious than the possible side effects of contraceptives. Clients should be advised about the potential side effects of their method of choice at the time of their acceptance of the method. This will mentally prepare them for any problems that they may encounter. They should also be informed that if the discomfort caused by a particular method is serious enough to warrant discontinuation, there are other options available for them to choose from. It is important for them to know that shifting from one method to another is absolutely natural, acceptable, and actually desirable in such cases, instead of leaving the couple unprotected.

relatively rare

Myth 9

Spacing methods have many side effects that adversely affect the user's health

provide right information

address social norms

Myth 10

Sharing family planning related information with the couple is sufficient to bring about behaviour change

People's behaviours on most issues, including those related to reproductive health and family planning, are deeply rooted in traditional knowledge and said-unsaid norms related to the same. As with any behaviour change effort, providing the people with the right information regarding the advantages and methods of family planning is a necessary, but usually not sufficient, step towards adopting the recommended practice.

In order to develop effective communication and behaviour change programmes, it is important to understand the social context. The practice of early marriage with the corresponding social pressure on the young bride (couple) to prove her (their) childbearing capabilities at the earliest is the main factor that fuels adolescent fertility rates. In areas with high infant and child mortality, having more children is seen as an insurance against the possibility of death of a child. Similarly, in many poor families, having many children is perceived as having additional hands for labour and family income, without factoring in the rising cost of education as the latter is not perceived to be important.

Another deep-rooted social issue is that of son preference. Son preference often results in either pre-natal sex determination followed by termination of pregnancy in case the foetus is female, or in repeated childbirths in the hope of producing at least one male child. Both these options have an adverse impact on society at large.

It is important that family planning messages talk about not just the advantages of having a small family but also address such social norms, including emphasising the equal status of girls and boys, in order to tackle the impending social disaster due to the increasingly adverse sex ratio in the country.

MANAGING Family Planning PROGRAMMES



If you are reading this document as part of your job, then in all likelihood, running the family planning programme is part of your many responsibilities at the district/ state level. Here are a few tips on how you can use the information in this document to ensure that the family planning programme addresses the needs of the population. (For more details refer to Ministry of Health & Family Welfare website and guidelines on family planning)

Planning

- Use the current data on family planning (CPR and unmet need levels, contraceptive method mix) to understand the successes and gaps in the programme.
- Instead of using pre-determined targets based on broad demographic formulae, set local targets based on an assessment of the felt and unmet needs at the community level. Thus, district level plans should be based on a collation of village and block/urban area plans.
- Programme planning should ensure logical integration not just with other components of the National Health Mission, but with other sectors such as education, livelihood and youth programmes.

Implementation

- As family planning is an integral part of primary health care, ensure the availability of suitable facilities at each health care level, beginning with doorstep delivery of family planning products like condoms and pills by the ASHAs.
- Link family planning services to other RMNCH+A services. Counselling and services should be available at ante-natal clinics, post-natal wards, adolescent clinics, RTI/STI clinics and HIV counselling and testing centres.
- Service providers should be trained not just in the technical aspects of method provision but also in counselling skills. Uptake of family planning methods should be based on informed choice.

- Engage the media on family planning and related social issues such as early marriage, early childbearing, son preference, etc. This will generate interest and discussion on this issue among the general public and may help in gradually changing social norms.

Monitoring

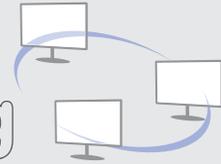
- Compare the progress of the programme against the plan on a regular basis. Use the regular meetings on health and development issues to discuss the family planning programme, its successes and challenges.
- When on field monitoring, try to visit various levels of health facilities. Assess the quality of family planning services being provided by asking the following questions:
 - Are the clients being offered an informed choice?
 - Are the providers trained in the provision of services?
 - Are there adequate stocks of family planning products?

If possible, talk to a few clients to assess their level of satisfaction with services. Check on the quality of services available at the health facilities, with special focus on whether or not service providers are offering the clients appropriate counselling to enable informed choice.

- Engage community based organisations such as the village health and sanitation committees, the *mahila mandals*, and the youth groups for periodic monitoring of the programme at the community level. Such community led action would make family planning a “people’s movement”.



Family Planning



PROGRAMME INFORMATION & WEB LINKS

About Jansankhya Sthirata Kosh (Population Stabilisation Fund)

Jansankhya Sthirata Kosh (JSK), also known as National Population Stabilisation Fund, is an autonomous body under the Ministry of Health and Family Welfare (MoHFW), created on the recommendations of the National Commission of Population. It has been formed to ensure that population stabilisation remains an important area of focus in the national agenda. To enable this, GOI has provided Rs. 100 crore as corpus fund to signify its commitment to the activities of the Kosh. JSK has to use the interest on the corpus and also raise contributions from organisations and individuals that support population stabilisation to advocate for and conduct activities that will assist in moving towards population stabilisation.

JSK's work is managed by a Governing Board, the members of which include both government and non-government representatives. JSK also runs a membership drive to include in its fold experts in population studies and allied sectors, medical associations, industry and trade associations, banks, NGOs and even general citizens; in other words, anybody who is interested in or can help with work on population stabilisation.

JSK works by leveraging the strength of different economic and social sectors to reach out to needy population groups through innovative strategies. Details about JSK and its ongoing schemes and programmes can be accessed from its website. The main areas of JSK's advocacy efforts are addressing social norms on son preference, age at marriage and birth of first child, spacing between children, as well as ensuring state prioritisation of family planning and reproductive health.

RMNCH+A

Under the National Rural Health Mission, a new comprehensive strategy, called the Reproductive Maternal Newborn and Child Health plus Adolescent Health (RMNCH+A), has been launched recently. Family planning is an integral and cross-cutting component of this strategy that covers adolescent, maternal and child health. In order to operationalise this strategy, GOI has launched many schemes to strengthen the family planning component, such as the delivery of contraceptives by ASHAs at the doorstep, for which the ASHAs receive compensation for promoting spacing methods too.

Important web links

Jansankhya Sthirata Kosh: <http://www.jsk.gov.in>

National Rural Health Mission: <http://www.nrhm.gov.in>

Family Planning Schemes under NRHM: <http://www.nrhm.gov.in/nrhm-components/rmnch-a/family-planning/schemes.html>

Reproductive Maternal Neonatal & Child Health plus Adolescent Health Strategy:
<http://childsurvivalsummit.in/1.%20RMNCH+A%20Strategy.pdf>

National Population Policy 2000: <http://india.unfpa.org/drive/NationalPopulation-Policy2000.pdf>

Supreme Court ruling on Writ Petition related to sterilisation services: http://www.2cnpop.net/uploads/1/0/2/1/10215849/sterilisation_case_supreme_court_order.pdf

UNFPA global: <http://www.unfpa.org/public/>

UNFPA India: <http://india.unfpa.org/>

State of World Population 2012 (By Choice, not by Chance): <http://www.unfpa.org/public/home/publications/pid/12511>

World Population Day: <http://www.un.org/en/events/populationday/>

The Universal Declaration of Human Rights: <http://www.un.org/en/documents/udhr/>

Millennium Development Goals: <http://www.un.org/millenniumgoals/>

Family Planning 2020: <http://www.londonfamilyplanningsummit.co.uk>





United Nations Population Fund – India