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A Review of Family Planning in India

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Abstract - It's imperative that all components of India's family planning program be better coordinated, including planning, programs, monitoring and training. To be effective, family planning programs must place a high priority on high-quality treatment. India's family planning targets have yet to be met, despite the country's best efforts. There is also a need for more male engagement, both as facilitators and beneficiaries, and to address the sexual and reproductive issues of youth. The government must make sure that family planning is given top priority in the national development agenda. In order to attain the Sustainable Development Goals, efforts must be taken to increase access to and raise the quality of family planning services.

Kwywords - family planning, family, health, rationale, contraceptive

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1. INTRODUCTION

The Indian government is the primary source of funding for family planning activities in India. Between 1965 and 2009, the number of married women using contraception more than tripled (from a share of 13 percent to a share of 48 percent), while the country's fertility rate remains at 2.24 children per woman. There are questions concerning long-term population growth in the nation as a result of this. An additional million individuals are born in India every 20 days. An increasing number of people are concerned about family planning in order to limit the world population from exceeding two billion people by the end of this century and beyond.

A total of 15.6 million abortions were performed in India in 2016, with an overall fertility rate of 2.30 births per woman and a total of 47.0 per 1000 women aged 15 to 49 years. Unwanted pregnancies are common among women aged 15 to 49 as a consequence of the high incidence of abortions. India has a high abortion rate of one-third of all pregnancies, with over half of those pregnancies being unintended. Indian population growth has slowed due to reduced birth and death rates.[1]

1.1 Contraceptive usage

Indian women aren't getting adequate information on contraception and the things they put in their bodies. Between 2005 and 2006, just 15.6% of Indian women who use contraception were informed about all of their options and what those techniques really accomplish. Contraceptive methods are becoming more popular in India. When it comes to married women who use modern contraceptive methods, the proportion has risen steadily since 1970, from 13% to 35% by 1997, and finally to 48% by 2009.

Almost many Indian married women are aware of the several methods of birth control at their disposal. According to a 2009 poll, 76 percent of married Indians had trouble accessing a wide range of contraceptive choices. The statistics in the table above shows again again how difficult it is for Indians to have access to contraceptive methods. In 2009, 48.4% of married women were projected to use some kind of contraception. The most popular technique of birth control in India, female sterilization, was utilized by 34 of these women. Condoms were used as a means of contraception by 3% of the population in the United States. At under 20%, the state of Meghalaya has the lowest percentage of contraceptive usage in India. Uttar Pradesh and Bihar's usage rates were similarly below 30%. Keeping this in mind, sterilization is a common practise in India. Indian contraceptive methods are heavily influenced by sterilization, which suggests that contraception is mostly used for birth control rather than to plan a family's future. Sterilization is typically enforced in segregated institutions. A person's consent is not required to do this treatment.[2]

1.2 Family Planning Programme

In India, the Ministry of Health and Family Welfare is in charge of developing and implementing policies related to family planning. Contraception and family planning services in India are represented by an inverted red triangle. Other factors, such as greater healthcare facilities, higher education, and more women in employment, have

also contributed to the decline in fertility rates in several Indian cities. The program's goals are in accordance with those specified in a number of policy documents. There are still areas of India where the fertility rate is much greater than the national average. The Ministry of Health and Family Welfare launched Mission Pariwar Vikas, a national family planning initiative, in 2017. This initiative intends to increase access to contraceptives by offering assured services, ensuring commodity stability, and accelerating access to high-quality family planning services. The fertility rate in India should fall to 2.1 by 2025. Family planning programmes benefit not just parents and children, but also society and the nation as a whole. As fewer people are born, the population will expand less slowly. There will be more resources accessible to people now in the Indian population, which means that life expectancy and health will improve because of lower population growth.

1.3 Fertility rate

In 2016, an average of 2.3 children were born to every Indian woman. As fertility rates have decreased, the average replacement rate has not yet been attained in India. Despite this, India's population continues to grow. The replacement rate is 2.1 on average. A population can expand at this rate, there is data to support it. It's known as the "replacement rate" when a population replaces itself at an exact rate. World Health Organization estimates that in rich nations, the replacement rate for babies is around 2.1, whereas in developing ones it is about 2.5. (due to higher mortality). Fertility rates have declined rapidly in rural areas, but more slowly in densely populated metropolitan areas. Rural populations are more likely to have lower fertility rates than urban populations. To put it simply, if a nation falls below the replacement rate, it is on its way to a population decline that will eventually lead to population stability. However, a number of factors, including but not limited to family planning limitations and the age at which a woman marries or gives birth to her first child, have affected recent trends in Indian fertility.. Despite the major overpopulation issues in India, the country's population and fertility rates are decreasing.[3]

1.4 Modern Initiatives in Reproductive Health

Little progress has been made on family planning and reproductive health. The infant mortality rate in India is the highest in the world, at 34.6 per 1,000 live births in 2016, while the maternal mortality rate was 174 per 100,000 live births in 2015. Infection, preterm, birth asphyxia, pneumonia, and diarrhoea are the top causes of mortality for babies. Maternal mortality rates are disproportionately affected by haemorrhage. Maternal mortality is a major contributor to sepsis. To address some of these issues and others, India started the National Rural Health Mission in 2005. The NRHM's mission is to offer high-quality healthcare to rural residents, with a focus on individuals with limited financial resources or other special needs. There has been a special focus on adolescents in the NRHM since they are more likely to participate in risky sexual behaviors and are less likely to seek medical attention. India's Millennium Development Goals for reproductive health are the ultimate objective of the National Reproductive Health Mission (NRHM).

1.5 History of Family Planning Programmes

Raghunath Dhondo Karve published a Marathi language periodical named Samaj Swasthya from July 1927 until July 1953. Through the use of contraceptives, he stressed the need of population control to society's well-being throughout the book. He argued that using contraceptives will minimize unwanted pregnancies and abortions. The Indian government reacted angrily to a population control plan proposed by Karve. Mahatma Gandhi was the most outspoken opponent of birth control. Self-discipline, in his opinion, was the best method of birth control. Periyar, on the other hand, had views that differed significantly from those of Gandhi. His view was that birth control was a tool women could use to take back control of their own health and well-being. In 1952, India became the first country in the developing world to implement a national family planning programme. The primary objectives of the programme were to lower fertility rates and put a stop to population expansion in order to stimulate economic development.[4] The programme was driven by five key ideas.:

1. "The community must be prepared to feel the need for the services in order that, when provided, these may be accepted
2. Parents alone must decide the number of children they want and their obligations towards them
3. People should be approached through the media they respect and their recognized and trusted leaders and without offending their religious and moral values and susceptibilities
4. Services should be made available to the people as near to their doorsteps as possible
5. Services have greater relevance and effectiveness if made an integral part of medical and public health services and especially of maternal and child health programs"

2. RATIONALE FOR FAMILY PLANNING

Family planning is now recognized as a basic human light. Its ultimate aim is to ensure that every child is a wanted one and that its coming into the world is the result of a responsible decision on the part of its parents. Family planning helps people in many ways. It (I) helps a women to apace her pregnancies In

order to safeguard her health rind that of her children: (h). protects a women from pregnancy until her baby has been weaned andshe wants to have another child; (c). gives parents the opportunity to provide a betterstartin life of each of theirchildren; (d). helps men and women to enjoy their married life without fear of unwanted pregnancy; and (c) provides future-well-being of the family.[5]

There are many reasons that may encourage a couple to decade to limit their family or space the birth of their children. Some of the benefits of family planning are mentioned below:

1. **Health:** Family planning protects the health of the mother and assures healthy children

2. **Economic conditions:** Family planning helps people from becoming poorer, gain a higher standard of living and afford recreation.

3. **Family Welfare:** Family planning helps people improve their children's life, have a happier family life, do a better job of rearing children by devoting more time to each child, avoid overcrowding in their house and enable each child to enjoy more fully.

4. **Marriage Adjustment:** Family planning helps to provide husbands and wives with more leisure and give them more opportunity to enjoy each other's companionship, improve sexual adjustment by ensuring that couples do not Sear unwanted pregnancy and prevent childbearing when the wife is nearing menopausal age.

5. **Individual Welfare:** Family planning permits either the husband or wife to find a Job so that they can enjoy their marital life without monetary pressure and an intelligent and talented wife to fulfill other roles outside the home.

3. CURRENT FAMILY PLANNING EFFORTS

Family planning has ushered in a new era of reduced maternal and neonatal mortality and morbidity. In states with a high prevalence of contraception, infant and maternal mortality rates are much lower. In order to decrease the negative effects of fast population growth, more support for family planning might help women achieve their desired family size and avoid undesired or mistimed deliveries. When contraceptives are used, however, the number of deaths may be minimized.[6]

3.1 Contraceptive services under the National Family Welfare Program

Spacing and permanent procedures are the two most used in India. In the case of a medical emergency, one alternative is the emergency contraceptive pill.

3.2 Spacing Methods

Couples who want to have a family in the future should utilise reversible contraceptive methods. There are a few that fit this description:

A. Injectable Contraceptive MPA under the 'Antara' programme – which has been recently introduced in the current basket of choices.

B. Oral contraceptive pills (OCP)

- Taking these pills at the same time each day, preferably in the morning, is suggested. For those days when you aren't taking hormones, there are additional iron pills in the strip. For the most part, ladies may use this technique after screening by a qualified healthcare professional.
- ASHA now has a plan in place for delivering OCPs to recipients' homes for a low fee. "MALA-N" is offered at no charge at all public healthcare institutions.
- Centchroman "Chhaya"- The once a week non-steroidal oral pill has also been recently introduced in the current basket of choices.

C. Condoms

- Barrier measures are used to prevent unwanted pregnancies as well as the transmission of RTI/STIs, including HIV. The "Nirodh" brand is available for free at government health institutions and at a reasonable cost via ASHAs.

D. Intra-Uterine Contraceptive Devices (IUCD)

- IUCDs containing copper are a great method of long-term birth control.
- Not recommended for use by women with uterine anomalies or those at risk of STI/RTI (women with multiple partners).
- Following IUCD installation, the acceptor should be scheduled for a follow-up visit at 1, 3, and 6 months to ensure the device has not been remove
- There are two kinds:

- Cu IUCD 380A is available (10 yrs)
- The 375 Cu IUCD (5 yrs)

3.3 Permanent Methods

These procedures, which tend to be irreversible, may be used by any member of the partnership.

A. Female Sterilization

Two methods are available:

Minilap -The procedure is carried out by making a small incision in the abdomen. Bring the fallopian tubes close to the incision to cut or limit them. This procedure can only be performed by MBBS physicians.

Laparoscopic -A long, thin tube with a lens is put into the wound during a laparoscopic procedure via a small incision in the abdomen. With this laparoscope in the abdomen, fallopian tubes may be obstructed or damaged. This procedure can only be performed by an MBBS doctor or an expert.

Post Abortion Sterilization - In this instance, it refers to sterilization done within seven days after a thorough abortion surgery.

B. Male Sterilization

- A small incision or puncture in the scrotum reveals the two sperm tubes going to the penis (vas deferens) and the provider may either cut and bind them shut or use heat or electricity to block them (cautery). An MBBS doctor versed in these techniques performs the surgery. For the first three months after sterilization, the couple must use an extra method of contraception to verify that no sperms are identified in the semen.
- Two techniques being used in India:

  1. Conventional
  2. Non- scalpel vasectomy – no incision, only puncture and hence no stiches.

3.4 Emergency Contraceptive Pill

- In the case of an unexpected or unprotected contact leading to an emergency scenario, this is a valuable tool.
- Pill should be taken within 72 hours after intercourse, but it should never be used as a replacement for a regular contraceptive procedure.

3.5 Other Commodities - Pregnancy testing kits

Up to a week after the previous period, a woman's menstruation may still be recognized as pregnant, giving her the opportunity to have an early medical termination of her pregnancy and therefore sparing lives from unsafe abortions.

3.6 Service Delivery Points

- Starting at the Sub-Centre level, IUCDs and OCPs provide a wide range of space alternatives for public health organisations. As these treatments are not skill-based, they may be provided by competent ASHAs in the communities, as can OCPs, condoms, and emergency contraception tablets.
- A Primary Health Center may not be able to conduct permanent operations, which need a higher degree of care. There are MBBS-trained doctors who can perform these services. Patients at community health clinics must be sterilized by gynecologists and surgeons who specialize in laparoscopic procedures (CHCs).
- These programmes help around 20 million eligible spouses. Here, you will find a breakdown of the many services available at each level of the facility

4. SALIENT FEATURES OF THE FAMILY PLANNING PROGRAMME

A. On-going interventions

- The importance of PPIUCD and IUCD as Spacing methods is rising.
- Every facility offers Fixed-Day Static Services.
- As a result of their decreased failure and complication rates, minilap tubectomy procedures are highly recommended.
- There shall be at least one provider of IUCD, Minilap, and NSV at each of the four health institutions (DH, CHC, PHC, and SHC) via a well-thought-out human resource development plan.
- State and District-level quality assurance committees to guarantee that Family Planning services meet the highest quality standards have been established
- The PPP model should accredit more private and non-profit organisations to provide family planning services.
- Encourage men to participate in non-scalpel vasectomies and to expand their participation.
- To make up for any income lost as a consequence of the sterilization operation, MoHFW reimburses both the beneficiary and the service provider (and team) who conduct it. At least 11 states with a significant need for reform

have made changes to their compensation plans since 2014.
- Sterility-related deaths, illnesses, or failures are covered by the "National Family Planning Indemnity Scheme," which protects providers and approved institutions from legal action.
- The PPIUCD incentive programme is open to both service providers and ASHAs.

b. Ensuring Spacing at Birth (ESB):

"To ensure a two-year separation after marriage and a three-year separation after the birth of the first child, ASHAs are utilized in this programme to provide advice to newlyweds and couples with a single child. The technology is presently in use in 18 states (EAG, North Eastern and Gujarat and Haryana). ASHA members are eligible for the following benefits as part of the programme".[7]

- To ASHA for postponing the birth of the first child by two years after marriage, Rs. 500 has been given.
- ASHA would get Rs. 500 for guaranteeing a three-year interval after the birth of the first child.
- Rs. 1000/- if the couple decides to restrict the number of children they have to two.

c. Pregnancy Testing Kits:

- In 2008, Nishchay made its debut under NRHM and has been connected with the Family Planning Division since January 24, 2012, when it was formally inaugurated.
- With the use of PTKs, ASHAs and Sub Centers are able to make better judgments on the outcomes of pregnancies.
- Management of contraceptives in remote areas has been improved.
- Posters, billboards and audio and video displays are used to generate interest in a product.
- Family Planning assessments, monitoring, and comprehensive supervision visits were done at the state and divisional levels in order to improve service.
- Strong political will and action, especially in states with high fertility rates.

5. QUALITY ASSURANCE IN FAMILY PLANNING

The amount of quality assurance given by family planning services is closely connected to the acceptance and usage of contraceptive methods and services. Sterilization techniques and standards must be implemented by the Union of India and the States/UTs in order to maintain uniformity in sterilization practices as per an order from the Supreme Court of India.[8]

- To carry out sterilization surgeries, doctors and health institutions must be enrolled and the conditions for empanelment defined.
- The development of a pre-sterilization checklist for clinicians to follow.
- A uniform consent form for sterilizing procedures should be created.
- The creation of a Quality Assurance Committee to monitor adherence to sterilization standards both before to and after surgery.
- All states should have the same sterilization insurance coverage.

The Supreme Court of India, in a decision dated September 14, 2016, has issued explicit instructions for the government, the states, and the territories of India to follow in order to provide effective family planning services. The major strategic actions and timelines for each of the aforementioned instructions have been communicated to all states and are as follows:[9]

- The list of sterilization providers and Quality Assurance Committee members who have been approved by the Ministry of Health and Family Welfare, Government of India, should be posted on the State/UT website and linked to the MoHFW website.
- In accordance with Government of India rules, all permission papers and post-operative instruction cards must be translated into the local language and explained to patients.
- Qualified Advisory Committee (QAC) members are also responsible for preparing and uploading a yearly report card on the State/UT website that includes statistical and non-statistical information such as meetings held, inquiries undertaken and corrective actions that have been implemented.
- Maintaining a regular service schedule by strengthening Primary Health Care Centers in order to phase down sterilization camps over a three-year timeframe.

6. RECOGNIZING FAMILY PLANNING AS A HUMAN RIGHTS ISSUE

Convenient access to contraception and technology improvements isn't enough to improve women's health. A woman's autonomy, choice, and access to high-quality reproductive health care are critical considerations. Quality family planning is not only a basic human right, it is also essential for the

progress of individuals, communities, and the nation as a whole.[10]

7. CONCLUSION

There are many people that have a stake in the success of India's family planning program, including researchers, politicians, service providers, and consumers. Families that have access to a variety of contraceptive options can play a critical role in regulating population increase through family planning. In order to have a successful family planning program, the government, civil society groups, and commercial providers must have a shared goal. Involved parties should make sure that young people and adolescents in the nation have their sexual and reproductive needs met. There is little doubt that if men are more actively involved in their spouses' lives, they will be more likely to utilize contraception. The clock is ticking. In order to achieve more gender equality and allow everyone to live a decent life, we must first make a deliberate effort to empower women, extend family planning options, and promote greater gender equality.

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