Welcome Kit for Parliamentarians

Family Planning as a Reproductive Health and Sexual Right

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Family Planning as a Reproductive Health and Sexual Right

Family planning programmes are thought to be controversial because people at large perceive them as an invasion of their privacy, deal as they do with highly sensitive issues of birth control and sex. Lack of streamlining of messages on family planning creates unnecessary confusion, which creates an environment of uncertainty, which inturn adversely impacts the choice of using a family planning measure. Family planning programmes are unambiguously placed on the abortion debate, their effectiveness in terms of reducing fertility is often questioned as is the very need of advocating for a family planning programme. In this context, even though family planning\welfare programmes have evolved from a population control measure meant to decrease levels of poverty to focusing on reproductive rights as human rights, many stakeholders in society still need to be convinced of the need to have a state-backed family planning\welfare or reproductive health programme. This policy booklet on family planning seeks to:

1. Explore the shift from population control to family planning
2. Understand the human rights implications of the aforementioned shift
3. Analyze the neglect of reproductive health and sexual rights
4. Make policy recommendations to push reproductive health and sexual rights up the political agenda and to ensure equity in accessing related services.

Family Planning v/s Population Control

Family planning services are defined as "educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved."[1] These services, which form an important part of the family planning programmes of the state are then associated with decisions regarding use of birth control, spacing in between births, number of desired children, preferred use of birth control, reproductive and child health etc. Many a time, family planning is used as a synonym for birth control, however, as the aforementioned definition suggests, most family planning programmes have components of sex education, prevention and management of reproductive tract infections (RTIs) and sexually transmitted infections (STIs), pre-conception counselling and management, dissemination of information about limiting and spacing methods of birth control and ways of addressing infertility.

Family planning/welfare programmes are often pitted against population control, which is the practice of limiting population control by reducing the birth rate of the country. The concerns that drive population control have little to do with the reproductive rights of citizens and are entirely hinged on misplaced notions of links between poverty and increase in population. And therefore, the fact that the earliest state-led experiments in birth control were actually measures of poverty alleviation comes as no surprise.

[1] U.S. Department of Health and Human Services, Administration for Children and Families

It is the difference between the two approaches to questions of birth control and the preference of the former by many public health activists that drives home the fact that freedom and the right to adequate information on these issues are important components of any form of birth control and family planning.

Family Planning: A Policy Issue

India's population numbered 238 million in 1901, doubled in 60 years to 439 million in 1961, doubled again, this time in only 30 years to reach 846 million by 1991[2]. India has 17 % of world's population and has less than 3% of the earth's land area. While the global population has increased 3 times, India has increased its population 5 times during the last century, and crossed one billion on 11th May, 2000. In India because of its large reproductive age group the population will continue to grow even when replacement level of fertility is reached (two children per couple). Population is increasing currently by about 16 million each year in the country.

Reasons for India's high population growth rate:

1. Population momentum[3]
2. Unmet need for contraception
3. Unplanned pregnancies
4. Negligible use of contraceptives among adolescents and young couples
5. Men's attitude towards contraception - they see it as a female problem
6. The predominance of non-reversible methods (particularly female sterilization) and limited use of male-/couple-dependent methods

Why should we be worried about rapid population growth?

In an effort to ensure that the population control ideology continues to operate even after it has been widely discredited many enthusiasts of the former try to conflate population control and family planning\welfare by justifying family planning measures on grounds that were used to justify population control. Sample this as a somewhat standard defence of family planning measures by population control activists:

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2 Major Schemes and Programmes (2000) Ministry of Health and Family Welfare (pp143) Government of India.

3 Population momentum refers to the tendency for population growth to continue beyond the time that replacement-level fertility has been achieved, because of a relatively high concentration of people in the childbearing years. Source: Glossary of Sustainable Development Modules. The Development Education Program. The World Bank Institute (WBI)

Family planning measures have often been justified as a means of controlling population growth because experts are convinced that rapid population growth would mean the following:

- **Increased Pressure on Limited Resources:** Intense pressure on limited land resources has forced people to migrate to already densely-packed urban areas. Low incomes and miserable living conditions define life for a vast number of India's urban-dwellers. The rapid increase in India's city population (presently around 28 per cent)[4] has resulted in the growth of slums or squatter settlements resulting in serious social, economic, and environmental problems. Approximately 20 to 25 per cent of India's urban families live in slums, squatter settlements or refugee colonies due to the non-availability of affordable housing in modern urban settlements. The lack of basic civic amenities like clean drinking water, sanitation and health facilities and the related health risks means that they are duped out of a chance of leading a healthy lifestyle.
- **Increased Competition for Natural Resources:** India's limited natural resources also face the brunt of a rapid increase in population as the competition for the already scarce resources increases.
- **Increased health risks** Increase in family size without proportionate increase in income leads to malnutrition and starvation. Increased number of pregnancies within short time intervals (less than 2 years) results in infant and child mortality. Overcrowding results in increased risk for spread of infectious diseases (like diarrhoea and pneumonia, which are major child killers). Due to increased competition for health care and hospital beds, public facilities have been overburdened and private facilities are fast becoming unaffordable.

These for them provide an easy answer to a question that the state likes to often ask itself in the bid to get the very answers that will give their policies, the necessary push or approval that they seek – why should we be worried about population growth in the country? The formulation of the question in these terms smacks of the lack of thought that the state has given to reproductive and sexual rights. Many public health experts argue that family planning debates should be contextualised in terms of human rights i.e. health rights that every individual has by the virtue of being a human being. Having said which, before we set out to point the core human rights aspects that have been neglected by family planning programmes over the decades it is important to get a sense of the kind of services that have been made available under these programmes.

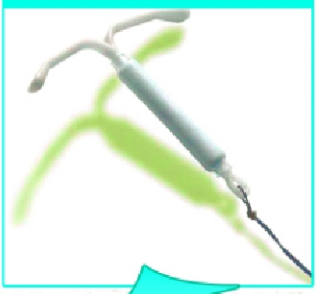
India: Urban Poverty Report 2009 Factsheet. UNDP

FAMILY PLANNING

CONDOMS

CONTRACEPTIVES

IUDs



Among the three spacing methods offered by the government family planning programme (pill, IUD, and condom), the pill is most widely known among women (85 percent) and the condom is most widely known among men (93 percent).

Most pill users (62 percent) and a substantial proportion of condom users (44 percent) use social marketing brands.

Factors Influencing the Access of Family Planning Services

High levels of illiteracy, poor access to information and contraceptives, poverty, lack of open discussions on sexuality among adolescents, and gender-based disparities have proven to be significant barriers to the access of family planning services. These include social stereotyping, lack of male involvement in family planning, and continuing open discrimination against the girl child, adolescent girls and women. Some of these are related to women's lack of decision-making power, particularly pertaining to contraception, and gender-based violence. Women often have to bow to decisions made by extended families in general and mothers-in-law in particular. It is considered highly promiscuous in rural areas, for example, for single adolescent women to seek health care and advice on contraception. Furthermore, female doctors are not available in rural and vulnerable areas; and caste based discrimination impedes equity in accessibility of services.

Even though these barriers are evident, programmes over the years have not taken serious note of them and have instead invested time and thought into improving physical infrastructure, training of personnel and buying of equipment at the cost of providing quality care and ensuring that access to a range of contraceptives is available to the maximum number of people. In understanding of perceptions, beliefs and attitudes that shapes treatment seeking behaviours need to be built into these programmes. There is a lack of emphasis on spacing or temporary methods of contraception for delaying and spacing pregnancies (ignoring the needs for contraception among young couples). Health workers need to be encouraged to go beyond routine reporting and service delivery strategies to address socio-economic and cultural barriers that come in the way of individuals in accessing family planning measures. There is also a pressing need to provide the health workers with a new orientation so that they can encourage women and men to become equal partners in decision making.

Furthermore, the new reproductive health orientation of the state, also, requires major changes in both the content and delivery of information, education, and communication programmes. Messages communicated to the public about family planning and reproductive health must go beyond raising awareness about contraception and the small family norm. Local norms, perceptions and beliefs in the area of reproductive health need to be assessed, with messages tailored to differences in culture, language and community needs (such as prevalence of sexual activity among young people, enforcing legal age for marriage, education about the human body, sexual behaviour and sexually transmitted diseases)

The Neglect of Reproductive Health and Sexual Rights

In order to understand reproductive health and sexual rights, one needs to place them in the wider societal context of marriage, employment, and abortion laws etc. and social and cultural practices. A recent study in Lancet (Raj et al 2009) argued that child marriage is associated with

less controlled fertility, poor fertility outcomes such as unwanted and terminated pregnancies, and repeat childbirths in less than 24 months. These pregnancies have also found to be linked with maternal mortality and infant and child morbidity and mortality. It is interesting to note that though the legal age for marriage in India is **18 years for women** and **21 years for men** (since 1978), there has been a decrease of only 5% in child marriages since the last survey in 1998-99[5]. In fact, more than half of women marry before reaching the legal minimum age at marriage in Bihar (64%), Jharkhand (60%), Rajasthan (58%), Andhra Pradesh (56%), West Bengal (53%), Madhya Pradesh (53%), Uttar Pradesh (52%), and Chhattisgarh (51%)[6]. This has also been one of the reasons why government planners feel sterilisation to be the most logical contraception to promote, as most married couples have already achieved the desired family size by the time they are in their mid-20s, and divorces are often rare.

In India, women's health and reproductive rights need to take into account the *socio-cultural conditions governing the decision making powers of many women*. Conditions such as the age of marriage, the woman's right to earn and own property, access to education, and vulnerability to violence all have to be taken into account so that policies designed to secure reproductive rights share a deep resonance with these and thereby reflect the actual conditions of a woman's life. Having said which, it is also important to note, that Family Planning\Welfare programmes have traditionally not paid adequate attention to employment laws or to women's accessibility to education and these need to be taken careful note of. India's family planning programme has historically been implemented as a political and economical issue (because of its ostensible linkages with poverty) and only recently has it become a health and human rights issue. Since its inception in 1951, the National Family Planning Programme has focused primarily on sterilization, at the cost of individual choice, which took a further beating during the emergency era, where strong political will was used to link incentives to compulsory male sterilisation (vasectomy). This lack of acknowledgement of individual needs and choices within family planning programmes resulted in a gross violation of reproductive rights[7].

After the State's Family Planning Programme evolved into Family Welfare programme in 1977, the Department managed family planning and also maternal and child health services through various primary and community health centres and district and sub-district hospitals. This programme linked incentives with the achievement of a specified number of sterilization targets. As a result of which, health care workers often over-reported the use of reversible contraceptives and sometimes also coerced a number of couples into sterilisation to 'curb' the growing fertility of the country in order to meet the targets that were set for them. The

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5 Salvi V. (2009) Child marriage in India: a tradition with alarming implications. The Lancet. Published Online March 10, 2009 DOI:10.1016/S0140-6736(09) 60452-9

6 Press Briefing Kit on Fertility. NFHS-3 (2005-06)

7 Khadija R. Turay: A Population Policy Transition - Human Rights and Population Politics in India During the 1975-1977 Emergency and Today. Paper presented in Tenth Berlin Roundtables on Transnationality, March 2009

programme, furthermore, was widely noted as being biased against women's needs and rights as service seekers. For example, during many clinical trials for new hormonal contraceptives female volunteers were not allowed to remove their implants.

Many believed that a new era was ushered in when in April 1996, contraceptive targets were removed as a barometer for measuring the success of the health policy and we witnessed a change from 'numbers' to 'needs'. This was then followed by the launch of Government of India's Reproductive and Child Health Programme (RCH) in October 1997, which in many ways, was also thought to be representing a paradigm shift. And when in 2000, the Union Cabinet approved the National Population Policy, the programmatic vision as enshrined in the RCH, was said to be taken forward. Many in the civil society presumed that this meant that a reconceptualisation of the population ideology of the state had brought about a shift in this focus from demographic goals to individual needs of the population at large. At closer scrutiny, however, this presumption didn't hold good. The sexual needs of individuals didn't figure in these policy initiatives in a prominent way.

Within the human rights discourse, there is a growing realization that people's experience of sexuality needs to be incorporated; and people need to be seen as more than just reproductive beings so that they can make safe, responsible choices about their sexual and reproductive health. Traditionally, reproductive health services have concentrated on married women without paying adequate attention to adolescents and young, unmarried men and women at the expense of a focus on sex education, dissemination of information about family planning methods, preventive and curative measures for RTIs\STIs (including HIV and AIDS) and other such adolescents friendly health services, which have been largely neglected. These focuses need to be done away with. Reproductive and sexual rights need to be recognised as important components of the right to health, which makes up an important part of human rights.

The Government of India has participated in several key international conferences and endorsed the development goals and human rights principles contained in the resulting consensus documents, such as Universal Declaration of Human Rights, 1948 International Conference on Human Rights, 1965 Convention on the Elimination of All Forms of Discrimination against Women; 1979 International Conference on Population and Development (ICPD), 1994 World Conference on Women and 1995 United Nations Millennium Declaration[8]. The right to health, including reproductive health care, and the right to decide freely and responsibly the number and spacing of one's children have been well established as deriving from basic human rights and these international commitments have served to reinforce these.

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[8] Lawyers Collective (2004) Sources of Law and Policy In Women Of The World: Laws And Policies Affecting Their Reproductive Lives (pp76) Published by: The Center for Reproductive Rights U.S.A.

What are Reproductive Rights?

Reproductive rights today include some or all of the following rights:

1) The right to control one's reproductive functions
2) The right to access quality reproductive healthcare
3) The right to education about contraception and sexually transmitted infections
4) The right to legal and safe abortion services
5) Freedom from discrimination, violence, coerced sterilization and contraception
7) Protection from gender-based practices such as female genital cutting (FGC) and male genital mutilation (MGM).

The Ministry of Health and Family Welfare (MOHFW) reoriented and renamed its former Family Welfare Programme as the Reproductive and Child Health Programme in 1997 to improve the quality, distribution and accessibility of services and to meet the health-care needs of women and children more effectively. Prevention and management of unwanted pregnancies is one of its key components and its chief focus is on providing client-centered quality services. The decentralized participatory approach seeks to adapt the concepts for reproductive health and rights that emerged from the ICPD. India's National Population Policy (2000) also aims to address the unmet need for contraception with universal access to family planning information, counselling and services, including both spacing and limiting methods. Recently, the MOHFW has drafted a National Health Bill (2009)[9] for protection of rights related to health and obligations of Central and State Government. It enumerates the right to reproductive and sexual health care for all adolescents and adults (male and female) including choice of safe and effective methods of contraception, including emergency contraception.

Evaluation of the Family Planning\Welfare and Related Policies

The performance of the family planning programmes in India has been rather average with a predominant focus on *limiting methods without any thought being given to the equity of services*. During the past five decades total fertility rate (TFR) has declined from 5.2 per woman in 1971 to 2.7 in 2005. These figures, however, don't reflect the inter-state as well as the rural-urban differences that should ideally drive the policies at the state level. Ten states have already reached the replacement level or below replacement levels (TFR of 2.1)[10]. Many urban areas have already reached replacement level but rural areas continue to have a high TFR of 3.0. The overall contraceptive prevalence rate is much higher in urban areas (64%) than in rural areas

[9] Draft National Health Bill 2009. Ministry of Health and Family Welfare (January 2009)

(53%), but sterilization is equally common among urban and rural women. The unmet need for family planning is highest among the 15-19 years age group (at 27 percent), as compared to 13 percent overall combined for all the age groups[11]. Reproductive health services have traditionally focused on married women and reproductive health care for adolescents and young, unmarried men are largely neglected - such as sexuality education, knowledge about family planning methods, education about preventive and curative measures for RTIs/STIs (including HIV), and adolescent friendly health services.

Reproductive and Child Health Programme (RCH)

The RCH programme emphasises measures to reduce variables such as maternal and infant mortality and to promote family planning. However, it does not advocate for empowerment of women and children or for preventives to counter inequality and its host of symptoms for example, female foeticide and infanticide, child marriage, domestic violence, child sexual abuse, the low female literacy rate, unavailability of services and unequal access to services, non-existent maternity leave and welfare benefits for women in the unorganised sector. Furthermore, minimal sexual education creates a lack of awareness amongst children and young people, which increases their risk of sexual ill-health, abuse and/or victimisation. These different policy issues are vital for the creation of sustainable programme activity with an emphasis on prevention and promotion of good health and safe sexual practice.

National Family Health Survey-3 reveals that only about **one-third of modern contraceptive users were told about the side effects** of their chosen method, and just one-quarter were told what to do if those side effects occurred. Fewer than 3 in 10 were informed about alternative methods. Women who know about alternative contraceptive methods and their side effects can make informed choices.

National Rural Health Mission (NRHM)

The NRHM review mission[12] has analyzed that family planning activities have not received the same degree of attention as the maternal health and child health activities. The unmet need for contraception raised issues about performance of basic services by facilities. Spacing methods are promoted only by ANM, but counselling was found to be cursory, an extra pill packet was not being given (to prevent stock-out at the level of the user) and drop-outs were not methodically contacted. There was no monitoring of side effects.

Today there exists a wide range of contraceptive options. However people face considerable misinformation about these options and their side-effects, accessibility, and affordability. Moreover, people also remain inadequately informed about what to do if their

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10 Press Briefing Kit on Fertility. NFHS-3 (2005-06)

11 Family Planning. NFHS-3 Publication (2005) Chapter 5

12 Second Common Review Mission of the National Rural Health Mission, Ministry of Health and Family Welfare, November-December 2008

contraception fails and possibilities for obtaining Emergency Contraception (EC), commonly known as "the morning after pill". Although not suitable for regular usage, EC is highly effective when there is risk of conception in case of condom bursts, missed oral contraception pills, forced sexual intercourse, etc.

Policy Recommendations

In a recent article, Bongaarts et al (2009) shared a series of responses to issues surrounding family planning efforts and revealed that family planning programmes have had a major and unambiguous impact on fertility rates in many countries[13]. They also concluded that few public health interventions are more important and less expensive than family planning in reducing the morbidity and mortality of mothers, infants and young children. Even though this is the case, in the recent past, family planning programmes have not received the kind of attention they deserve from parliamentarians and civil society organisations alike. Family Planning Programmes improve maternal and child health through reduction in fertility (which reduces lifetime risk of maternal mortality) and reduce infant mortality through birth spacing. These benefits have ensured that family planning targets have been included in the Millennium Development Goals, specifically in Target 5.b.to provide universal access to reproductive health by 2015 and to reduce the unmet need for family planning.

It is absolutely necessary to reprioritize family planning efforts in India to satisfy the unmet demand for family planning services and ensure the recognition of right to family planning as a fundamental human right. A set of recommendations are shared below:

1. Strengthen existing strategies and sharpen the focus of existing infrastructure to ensure delivery of quality service in response to the needs for family planning among target populations.
2. Expand the basket of choices for contraceptives by taking into account the variety of new demands (especially for reversible methods for delaying and spacing pregnancies)
3. Increase service delivery points, while ensuring a variety of points to enhance access and acceptability of family planning.
4. Legislate on family planning.
5. Ensure the inclusion of access to contraceptive methods (with emphasis on reversible methods of contraception) under the Chapter II- 'Obligations of Governments In Relation to Health' in the National Health Bill. The section on Right to Reproductive and Sexual Health

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[13] Bongaarts J.,Sindind S.W. A Resposnse to Critics of Family Planning Programmes (2009). International Perspectives on Sexual and Reproductive Health Volume 35, Number 1 Pages 39-44

Care in Chapter III 'Collective & Individual Rights In Relation To Health', should also include right to reversible methods for spacing pregnancies.

6. Ensure the strict enforcement of the Child Marriage Restraint Act, 1976, implying prevention of marriages of girls and boys below the legally permissible ages of 18 and 21, respectively, so as to reduce occurrence of high risk teenage pregnancies. Mandatory registration of all marriages should be practiced.
7. Uphold individuals' right to health by ensuring access to information, required services and counselling.
8. Ensure equity in services across both rural and urban populations and across all socio-economic classes.

You Can Make a Difference!

How to Use the Policy Bbooklet

Elected representatives play a critical role to ensure access to family planning and welfare services as well in upholding the right to health of every individual of the country.

Based on the issues raised in this policy booklet, Parliamentarians can do the following:

Within Parliament

- ✓ Raise questions, seek information on and bring attention to the issue at hand through the utilization of the Question Hour, Special Attention Motions and other such parliamentary procedures
- ✓ Review specific government spending on and initiate discussions on present budgetary allocations (esp. for spacing methods of family planning) and rally with other parliamentarians to ensure that this allocation is systematically hiked up to meet infrastructural needs that are so crucial for the strengthening of public health delivery systems in general and success of specific health projects in particular.
- ✓ Review the current laws in context of family planning and reproductive and child health and formulate/reform laws accordingly. For example, does the current legal system adequately deal with complications and emergencies faced by women for which they may not receive adequate services?
- ✓ Take initiative to join specific parliamentary committees to look in to issues concerning family welfare and reproductive and child health and push for expanding the range in contraceptives available (introducing the new spacing and long acting products which have been technologically validated in Indian conditions and found locally acceptable)

As a Representative of Your Constituency

- ✓ Hold mass information dissemination sessions to inform your voters about their legal entitlements and service guarantees from the public health system.
- ✓ Initiate a campaign among youth for delaying and spacing pregnancies.
- ✓ Initiate a process of dialogue with MLAs of your constituencies. Encourage and motivate them to regularly review the functioning of public health service delivery system and take action to correct shortcomings and undo past failures in service deliveries.
- ✓ Initiate social audits of public schemes that have been put into place.
- ✓ To ensure accountability of public health officers, regularly invite them to public forums where service seekers can ask them questions and demand answers.
- ✓ Ensure that all health facilities are fully staffed with skilled professionals. Put in place complaints redressal mechanisms for employees and patients to ensure that their needs and concerns are adequately addressed.

As a Member of a Political Party

- ✓ Educate fellow party men and women on the issues of family planning and reproductive and child health and high maternal mortality and morbidity rates in India.
- ✓ Raise awareness on the importance of protecting women's health as a part of their obligations towards their constituencies. Ensure that party colleagues support victims in cases of denial of healthcare, and stay clear of interventions in health staff postings and transfers.

Population Services International, India (PSI)

PSI is a non-profit organization, founded in 1970, with health programmes in more than 60 countries in Africa, Asia, Latin America and Eastern Europe. In India, PSI began its operations as a registered society in 1988. Our highly motivated workforce of almost 800 staff enables us to improve consumer access to health products, services and information in 223 states and Union Territories. PSI has successfully implemented multi-year, multi-state projects; our experience and size enable us to quickly initiate and manage programme effectively.

PSI's mission is to empower the people of India to lead healthy lives, by addressing priority public health challenges using social marketing, social franchising and behaviour change communication techniques. Programmes have evolved substantially over the years to include a full menu of targeted marketing activities in reproductive and child health, and the prevention of HIV/AIDS, tuberculosis (TB) and malaria. PSI is also involved in the prevention of lifestyle diseases, through its work in tobacco control.

PSI partners with the NACO and the Ministry of Health and Family Welfare to develop good policy for support of behaviour change programming. At state and district level, PSI India works with Commissioners for Health and the State AIDS Control Societies, community-based organizations and other NGOs are important partners in deepening and increasing reach of social marketing interventions and linkages to key services such as care and support. PSI also works with private providers and local retailers for promotion of birth spacing and good maternal/child health practices.

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