Family planning programme in India

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Adapted from a presentation by Dr Sundari Ravindran for students of AMCHSS

A pioneer in Family Planning

- As we all know, India had a family planning programme in place as early as 1952. This programme provided contraceptive services free of costs through public health facilities.

From contraceptive services to 'population control' policy

- In the early years (1952-1966), the programme provided contraceptive services to those who requested it
- In the early 1960s, the pill and IUD became available.
- Since 1966, following an economic crisis, India's family planning programme started to focus on fertility goals to be achieved.

Target "obsessed" programme

- Based on the level of fertility that was desired to be achieved, targets were set for number of acceptors of each method of family planning.
- These targets were given by centre to states and from states to districts and down to PHCs.
- All health providers were required to work for achieving these targets
- Those who did not meet their targets were punished, sometimes even with salary cuts

Target “obsessed” programme

- Postpartum sterilisation and IUD insertion were the norm for hospital deliveries.
- In order to reach the maximum number of clients in a limited time and with limited health personnel, “camps” became the main route for performing sterilisations and inserting IUDs

Women cast as perpetrators of the population problem

- What this policy did, was to transform the problem of high fertility – of which women and children were the victims – into the problem of "women having too many children" – of which women were the perpetrators.

No choice for individuals or couples

- The programme did not allow couples or individuals to choose if they wanted children, when and how many. It went against internationally guaranteed human rights.
- Only married women were catered to, thus denying the rights of single women and men to fertility control.

ICPD MOVED TO REPRODUCTIVE HEALTH

- Meeting client needs became an important perspective
- Acknowledged needs beyond FP
- Therefore talked of addressing reproductive health concerns, not just FP
- RH/FP should not be a "women's only" problem. Men should not only share the burden of contraception, but should also be encouraged to be responsible and supportive partners

ICPD was :

about Women's Equality

about RH instead of FP

about Informed Choice

against coercion

What happened in India?

- Target Free Approach as part of RCH I which started in 1995.
- Couples were to be able to choose from various contraceptive methods including condoms, oral pills, IUDs, male and female sterilization
- Safe services for medical termination of pregnancies
- Other New Services
  - Treatment of RTI/STI is given.
  - Promotion activities for adolescents health.

What happened in India?

- Nothing else except suspension of explicit targets changed very much in service delivery.
- In states where health services were well organised and where literacy levels increased, fertility rates started declining rapidly.
- In other states also, fertility has been declining, but not at the pace that government wants
- This has led to a return to targets for the sake of efficiency

Recent developments

- 2012 – London Summit on Family Planning supported by Billa and Melinda Gates Foundation
- Renewed commitment to family planning
- India has made a commitment of protecting 48 million couples by 2020 with family planning
- Return to targets?

RMNCH+A strategy document

- A new strategic direction has been developed for the family planning programme, wherein it has been repositioned to not only achieve population stabilisation but also to reduce maternal mortality as also infant and child mortality. A target-free approach based on unmet needs for contraception; equal emphasis on spacing and limiting methods; and promoting ‘children by choice’ in the context of reproductive health are the key approaches to be adopted for the promotion of family planning and improving reproductive health.
- These services will be delivered at home, through community outreach and at all levels of health facilities and include adolescents and adults in the reproductive age group.

Current Family Planning Programme

Strategies under Family Planning Programme in India	
Policy Level	**Service Level**
Target-free approach	More emphasis on spacing methods
Voluntary adoption of family planning methods	Assuring quality of services
Based on felt need of the community	Expanding contraceptive choices
Children by choice and not chance	

Issues in India's Family Planning Programme

- Continuing fear of "population explosion"
- Continuing emphasis on targets
- Continuing reliance on camp based sterilization services
- Incentives for sterilization
- Two –child norm
- Lack of information among women, men, girls, boys

Gender and Family Planning (?)

- About 1/3 of all pregnancies are believed to be unwanted or mistimed
- TFR would fall by nearly one child per woman if women had their desired family size
- Of 58% practicing contraception, less than 1/3 use a male method or male cooperation
- Gender norms
- Women have no decision making or control; on the other hand, most methods only for women
- Men's sexual pleasure and prowess of prime importance – rejection of male methods
- Availability of contraceptives to those not married, or in reproductive age group

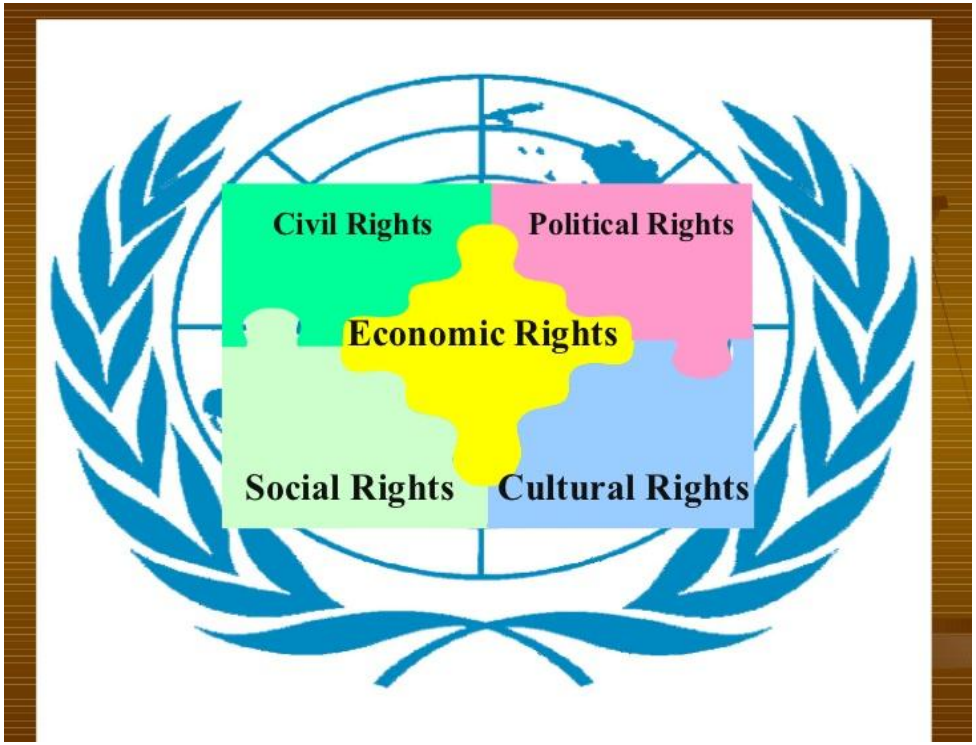
Rights Based Health Services

What are human rights?

- Rights that someone has simply because he/she is a human being.
- Core principles:
  - Human dignity
  - Equality
  - Non discrimination
  - Universality
  - Inter dependence
  - Indivisibility
  - Inalienability

Universal Declaration of Human Rights

- Adopted by the UN General Assembly on December 10, 1948.
- Specifies minimal conditions for a dignified life.



- Article 1 Right to Equality
- Article 2 Freedom from Discrimination
- Article 3 Right to Life, Liberty, Personal Security
- Article 4 Freedom from Slavery
- Article 5 Freedom from Torture and Degrading Treatment
- Article 6 Right to Recognition as a Person before the Law
- Article 7 Right to Equality before the Law
- Article 8 Right to Remedy by Competent Tribunal
- Article 9 Freedom from Arbitrary Arrest and Exile
- Article 10 Right to Fair Public Hearing
- Article 11 Right to be Considered Innocent until Proven Guilty
- Article 12 Freedom from Interference with Privacy, Family, Home and Correspondence
- Article 13 Right to Free Movement in and out of the Country
- Article 14 Right to Asylum in other Countries from Persecution
- Article 15 Right to a Nationality and the Freedom to Change It

- Article 16 Right to Marriage and Family
- Article 17 Right to Own Property
- Article 18 Freedom of Belief and Religion
- Article 19 Freedom of Opinion and Information
- Article 20 Right of Peaceful Assembly and Association
- Article 21 Right to Participate in Government and in Free Elections
- Article 22 Right to Social Security
- Article 23 Right to Desirable Work and to Join Trade Unions
- Article 24 Right to Rest and Leisure
- Article 25 Right to Adequate Living Standard
- Article 26 Right to Education
- Article 27 Right to Participate in the Cultural Life of Community
- Article 28 Right to a Social Order that Articulates this Document
- Article 29 Community Duties Essential to Free and Full Development
- Article 30 Freedom from State or Personal Interference in the above Rights

Common myths about human rights

- Human rights = civil rights
- Economic and social rights are privileges.
- Human rights apply only in poor countries, foreign countries
- Human rights are concerned only with violations
- Only lawyers can understand human rights

What are Rights Based services?

- A human-rights-based approach is based on the fact that all citizens have a right to a range of public services like health care services, and to education
- Providing such services is an obligation (farz) that the government is required to fulfil.
- All persons are considered as **rights-holders**, while the government and its agents are **duty-bearers.**

Right to highest attainable standard of health

Essential points contained in General Comment 14, ICESCR

The four AAAQ criteria

Availability

- Services, facilities, goods, programme, in sufficient quantities
- Trained personnel (and with necessary skills)
- Essential drugs
- Determinants of health e.g. water, sanitation etc.

Accessibility

- Non-discrimination
- Physical accessibility including for vulnerable groups (old, disabled, dalits, PVTGs, those living in their fields etc…)
- Economic accessibility
- Information (along with confidentiality)

Acceptability

- Culturally appropriate (Life –cycle, gender, minorities)
- Medical ethics

Quality

- Scientifically, medically appropriate
- Skilled personnel
- Rational, unexpired, quality drugs
- Aseptic procedures
- Safe blood

Reproductive Rights and Sexual Rights

Paragraph 7.3 of: United Nations Population Fund. Programme of Action of the International Conference on Population and Development, Cairo, 5–13 September 1994. New York, United Nations, 1996 (UN Doc. A/CONF.171/13)

and repeated in

Paragraph 95 of: United Nations. Platform for Action of the Fourth World Conference on Women, Beijing, 4–15 September 1995. New York, United Nations, 1996 (UN Doc. A/CONF.177/20).

- Based on human rights that are already recognised in national laws, international human rights documents and other consensus documents.

- Basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.

Important concepts

- Right to autonomy: make decisions concerning reproduction (and other matters) free of discrimination, coercion and violence.

- Right to bodily integrity – no one can do anything to my body against my wishes. Linked to the concept of consent.

Government's responsibilities

- The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government - and community-supported policies and programmes in the area of reproductive health, including family planning.

- Full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.

Reproductive health eludes many of the world's people because of

- inadequate levels of knowledge about human sexuality and
- inappropriate or poor quality reproductive health information and services;
- the prevalence of high-risk sexual behaviour;
- discriminatory social practices;
- negative attitudes towards women and girls;
- limited power many women and girls have over their sexual and reproductive lives.

Life cycle perspective

- Adolescents are particularly vulnerable because of their lack of information and access to relevant services in most countries.
- Older women and men have distinct reproductive and sexual health issues which are often inadequately addressed.

Sexual rights

- Based on human rights that are already recognised in national laws, international human rights documents and other consensus documents.

- Include the right to
  - the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
  - seek, receive and impart information related to sexuality;
  - receive sexuality education;
  - respect for bodily integrity;
  - choose their partner;
  - decide to be sexually active or not;
  - consensual sexual relations;
  - consensual marriage;
  - pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.

Source: ***Defining sexual health: report of a technical consultation on sexual health, 28–31 January 2002, Geneva. WHO 2006.***

Key human rights principles and standards

- Non-discrimination in the provision of SRH information and services
- Availability of SRH information and services
- Accessibility of SRH information and services
- Acceptability of SRH information and services
- Quality in the provision of information and services
- Informed decision-making based on Autonomy and Bodily Integrity
- Privacy and confidentiality in provision of services
- Participation in decision-making related to the SRH programme and policy, and
- Accountability