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Family Planning Issues in Rural Areas of India

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ABSTRACT

Family planning is a key means to achieving many of the Sustainable Development Goals. Around the world, governments and partners have prioritized investments to increase access to and uptake of family planning methods. In rural areas of India, the government and its partners have made significant efforts to increase awareness, supply, and access to modern contraceptives. Despite progress, uptake remains stubbornly low. This calls for systematic research into understanding the 'why'—why people are or aren't using modern methods, what drives their decisions, and who influences them. We use a mixed-methods approach, analyzing three existing quantitative data sets to identify trends and geographic variation, gaps and contextual factors associated with family planning uptake and collecting new qualitative data through in-depth immersion interviews, journey mapping, and decision games to understand systemic and individual-level barriers to family planning use, household decision making patterns and community level barriers. We find that reasons for adoption of family planning are complex– while access and awareness are critical, they are not sufficient for increasing uptake of modern methods. Although awareness is necessary for uptake, we found a steep drop-off (59%) between high awareness of modern contraceptive methods and its intention to use, and an additional but smaller drop-off from intention to actual use (9%). While perceived access, age, education and other demographic variables partially predict modern contraceptive intention to use, the qualitative data shows that other behavioral drivers including household decision making dynamics, shame to obtain modern contraceptives, and high-risk perception around side-effects also contribute to low intention to use modern contraceptives. The data also reveals that strong norms and financial considerations by couples are the driving force behind the decision to use and when to use family planning methods.

KEYWORDS: *family planning, rural areas, India, government, data, contraceptives, sustainable, development*

INTRODUCTION

Rural India continues to be characterized by high and early fertility, due to the commonality of adolescent marriage and non-contraceptive use prior to female sterilization, a procedure typically occurring after age 30 years .In fact, family planning programs often attempt to reach these young wives only after they reach their family size goal, despite indications that newly married young couples would prefer to delay first birth. Among rural wives aged 15–24 years, contraceptive use is reported by only 18% of the population[1,2] and the majority of these women opt for female sterilization rather than spacing contraception, even at this very young age. More than 60% of young women in rural India are married prior to the legal age of 18 years, and adolescent and young adult wives (age 15–24 years) are more likely than older wives not to use contraception and have unplanned and rapid repeat pregnancies. Consequently, 37% of married Indian women 15–49 years have been sterilized, and 77% of sterilized women report never having used any other contraception prior to their sterilization. Improvements in spacing contraception use are a goal in India, but clearly have had limited success. This study examines qualitatively reasons for non-use of spacing contraceptive methods among young rural couples, their health providers, and mothers of young husbands in rural India, to guide spacing

contraception programs. [3,4]Prior research documents both practical and sociocultural barriers impeding use of spacing contraception, but much of this work is more than a decade old. Practical barriers historically included cost, in both time and money. Over the decades, however, there has been considerable expansion and strengthening of the public health care infrastructure and family welfare services across the country, and only a negligible minority of women (<5%) perceive availability, accessibility or cost as major impediments to using contraception. Nonetheless, in practice, access to and availability of quality services are significant issues of concern. Where workers are available, they are generally poorly trained and have little knowledge of the methods they are to provide. Older providers, trained under the historic public health approach emphasizing female sterilization, may also be less supportive of provision of spacing contraception. [5,6]Limited knowledge regarding family planning methods and particularly spacing contraception was also an historic concern. Currently, however, the small family norm is widely accepted (the mean ideal family size reported by young people currently is 2.5 children) and general awareness of contraception is universal (99% of currently married women in the reproductive age group were aware of a contraceptive method). However, awareness of modern spacing contraception is least likely among rural young wives, particularly married adolescents and those early in marriage. Even among those aware of modern spacing contraception, historic research documents myths and misconceptions regarding its side effects and potential health consequences, as well as fears regarding in effectiveness of these methods. Little recent research from India provides insight into whether these concerns remain. Socio-cultural concerns related to prescribed social roles of motherhood as well as expectations regarding childbirth, son preference, and family size are major issues preventing spacing contraception use,[7,8] and continue to disproportionately affect rural women .Women's limited autonomy in these contexts combined with social expectations regarding her becoming a mother and having son results in lack of acquisition of reproductive health services .Social stigma against contraception use, particularly in early marriage, historically reinforced non-use as well Research has also documented that individual beliefs of women, husbands and families, particularly mothers-in-law, in India are often more tradition in the rural context, resulting in more restrictions and religious prohibitions related to sex, contraception, and expressions of reproductive health care needs. [9,10]

Discussion

In rural India, most people live in joint families. In this study, about one-fifth of the respondents cited family pressures as the reason for non-acceptance of family planning. The acceptance of family planning has been reported to increase significantly in an urban slum area where health care services were combined with classes for prospective fathers. A significant proportion of the respondents considered male offspring as old age pensions. An additional 17.32% considered child's wages as an additional source of income. From their point of view, it made sound sense to have many children because the extra income from the child's wages would offset the cost of their food and upbringing. Since income is seasonal for most rural communities, it is possible that they opt for large families in order to diversify their various sources of income. Indian agriculture is labour intensive and child labour is common in the industrial and service sectors. According to the National Sample Survey (38th round), there were 16.6 million child labourers in India in 1986. Introduction of social security schemes may increase acceptance of family planning. It has been said that development is the best contraceptive. But studies in India have shown that even in states that have advanced on the economic front, there has been no improvement in the status of women, if they lacked education. Less educated women have been reported to suffer both during financial crises and during prosperity. However in states where literacy was high, the more educated were found to face less discrimination in food distribution and access to health care, compared to their less educated sisters. In the present study, the decision regarding family size by in-laws was less in families where the respondents were more educated. Thus, female literacy coupled with social security may act as the best contraceptive, at least in rural areas. The fear of possible complications due to sterilisation cited by 18.6% of the respondents can be tackled by a personal approach in motivation and regular follow-up of the acceptors.[11,12]

A majority of women with more than 8 years of schooling reported having opted for more than two children due to pressure from in-laws. The decision making by in-laws was significantly higher in families where the respondents were less educated. It may be necessary to motivate the in-laws (the decision-makers) by using innovative health education

technique to provide the much needed boost to the National Family Welfare Programme. Currently, motivators target the eligible couple instead of the real decision-makers in the joint family system. In conclusion, women may have a say in deciding the size of their families only if education of girls is made compulsory. The introduction of social security schemes, target-ting traditional decision-makers in families and better health services to ensure child survival will go a long way in increasing the acceptance of the small family norm.[13]

The implementation of National Family Welfare Programme has been satisfactory with the performance in IUCD insertions increasing from 52,75,440 to 55,40,743 and sterilisations increasing from 40,30,409 to 40,70,597 from 2014-15 to 2015-16 as per HMIS reports available with the Ministry of the Health and Family Welfare. Family Planning has been a key priority area of the Government and it has been vigorously pursued through the National Rural Health Mission launched in the year 2005 in line with the policy framework for population stabilization as envisaged in the National Population Policy, 2000. The main objectives of National Population Policy, 2000 was to address the unmet needs for contraception and achieving a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development and environmental protection. As a result of the initiatives of the Government, the country's Total Fertility Rate (TFR) has declined from 2.7 in 2006 to 2.2 in 2016 (NFHS- IV). The decadal growth rate has declined from 21.54 % in 1990-2000 to 17.64 % during 2001-11. The Crude Birth Rate has declined from 23.8 in 2005 to 20.8 (SRS 2015) and 24 states/UTs have already achieved the replacement level TFR of 2.1 or less out of 36 states/UTs.

Initiatives under the Family Planning Programe of Rural India[14,15]:

- Mission Parivar Vikas: The Government has launched Mission Parivar Vikas for substantially increasing the access to contraceptives and family planning services in the high fertility districts of seven high focus states with TFR of 3 and above. These 146 districts are from the seven high focus, high TFR states (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand and Assam) that itself constitutes 44% of the country's population.
- New Contraceptive Choices: The current basket of choice has been expanded to include the new contraceptives viz. Injectable contraceptive, Centchroman and Progrsterone Only Pills (POP).
- Redesigned Contraceptive Packaging: The packaging for Condoms, OCPs and ECPs has now been improved and redesigned so as to influence the demand for these commodities
- New Family Planning Media Campaign: A360 degree media campaign has been launched to generate contraceptive demand.
- Enhanced Compensation Scheme for Sterilization- The sterilization compensation scheme has been enhanced in 11 high focus states (8 EAG, Assam, Gujarat, Haryana)
- A new IUCD (Cu 375) with 5 years effectivity has been introduced in the programme as an alternative to the exiting IUCD (Cu 380A with effectivity of 10 years).
- A new method of IUCD insertion i.e. PPIUCD has been introduced.
- Emphasis on Postpartum Family Planning (PPFP) services with PPIUCD and promotion of minilap as the main mode of providing sterilization in the form of post-partum sterilization to capitalize on the huge cases coming in for institutional delivery under JSY.
- Scheme for ensuring drop back services to sterilization clients
- Appointment of dedicated RMNCH+A counsellors at high case load facilities.
- Assured delivery of family planning services - In last four years states have shown their commitment to strengthen fixed day family planning services for both IUCD and sterilization.[16,17]
- Scheme for Home delivery of contraceptives by ASHAs at doorstep of beneficiaries.
- Scheme for ASHAs to ensure spacing in births:

- Under the scheme, services of ASHAs are being utilized for counselling newly married couples to ensure delay of 2 years in birth after marriage and couples with 1 child to have spacing of 3 years after the birth of 1st child.
- The scheme is being implemented in 18 states of the country (8 EAG, 8 North East, Gujarat and Haryana). Additionally the spacing component has been approved in West Bengal, Karnataka,

Andhra Pradesh, Telangana, Punjab, Maharashtra, Daman Diu and Dadra and Nagar Haveli[31,32]

- Celebration of World Population Day & fortnight (July 11 – July 24):

- The World Population Day celebration is a step to boost Family Planning efforts all over the country.
- The event is observed over a month long period, split into an initial fortnight of mobilization/sensitization followed by a fortnight of assured family planning service delivery.
- June 27 to July 10: "Dampati Sampark Pakhwada" or "Mobilisation Fortnight"
- July 11 to July 24 "Jansankhya Sthirtha Pakhwada" or "Population Stabilisation Fortnight"[18,19]

Results

On-going Interventions under Family Planning Programme

- Ensuring quality of care in Family Planning services by establishing Quality Assurance Committees in all state and districts.
- Increasing male participation and promotion of 'Non Scalpel Vasectomy''.
- Operating the 'National Family Planning Indemnity Scheme' (NFPIS) under which clients are insured in the eventualities of deaths, complications and failures following sterilization and the providers/ accredited institutions are indemnified against litigations in those eventualities.
- Compensation scheme for sterilization acceptors - under the scheme MoHFW provides compensation for loss of wages to the beneficiaries on account of undergoing sterilisation.
- Accreditation of more private/ NGO facilities to increase the provider base for family planning services under PPP.[29,30]
- Improving contraceptives supply management up to peripheral facilities
- A rational human resource development plan is in place for provision of IUCD, Minilap and NSV to empower the facilities (DH, CHC, PHC, SHC) with at least one provider each for each of the services and Sub Centres with ANMs trained in IUCD insertion
- Emphasis on Minilap Tubectomy services because of its logistical simplicity with less failure rates.
- Demand generation activities in the form of display of posters, billboards and other audio and video materials in the various facilities[20,21]

Stretagies adopted by Jansankhya Sthirata Kosh/National Population Stabilization Fund for Population Control in rural India:

Prerna Strategy:- JSK has launched this strategy for helping to push up the age of marriage of girls and delay in first child and spacing in second child birth in the interest of health of young mothers and infants. The couple who adopt this strategy awarded suitably. This helps to change the mindsets of the community.

Santushti Strategy:- Under this strategy, Jansankhya Sthirata Kosh, invites private sector gynaecologists and vasectomy surgeons to conduct sterilization operations in Public Private Partnership mode. The private hospitals/nursing home who achieved target of 10 or more are suitably awarded as per strategy.[22]

National Helpline:- JSK is also running a call centers for providing free advice on reproductive health, family planning, maternal health and child health etc. As per the available report from the National Programme on Technology Enhanced Learning (NPTEL), which is an initiative by seven Indian Institutes of Technology (IIT Bombay, Delhi, Guwahati, Kanpur, Kharagpur, Madras and Roorkee) and Indian institute of science (IISC) for creating course contents in engineering and science, the problems resulting from overpopulation is given below:

Summary of NPTEL Report

Challenges of Rapid Population Growth in Rural India among others are:

- Providing employment to growing population:
- Problem of utilisation of manpower
- Over-strained infrastructure
- Pressure on land and other renewable natural resources
- Increased cost of production
- Inequitable distribution of income [23,24]

The States and rural areas have utilised the funds provided for the Family Planning programme and State/UT wise expenditure under the component 'Family Planning' in 2015-16 is given below:

S. No.	States including their rural areas	Expenditure (2015-16)
A. High Focus States and rural areas		
1	Bihar	9795.53
2	Chattisgarh	1952.12
3	Himachal Pradesh	472.51
4	Jammu & Kashmir	257.88
5	Jharkhand	3497.04
6	Madhya Pradesh	11915.66
7	Orissa	3578.35
8	Rajasthan	7946.13
9	Uttar Pradesh	6616.58
10	Uttarakhand	1045.22
	Sub Total	47077.02
B. NE States and rural areas		
11	Arunachal Pradesh	50.70
12	Assam	2283.66
13	Manipur	58.21
14	Meghalaya	152.12
15	Mizoram	78.06
16	Nagaland	106.42
17	Sikkim	16.21
18	Tripura	187.36
	Sub Total	2932.74
C. Non-High Focus States and rural areas		
19	Andhra Pradesh	3289.53
20	Goa	53.63
21	Gujarat	6585.20
22	Haryana	2050.26
23	Karnataka	2338.35
24	Kerala	310.75
25	Maharashtra	3539.06
26	Punjab	911.62
27	Tamil Nadu	2679.45
28	Telangana	1086.31
29	West Bengal	3873.14
	Sub Total	26717.29
D. Small States/UTs and rural areas		
30	Andaman & Nicobar Islands	11.23
31	Chandigarh	19.84
32	Dadra & Nagar Haveli	18.39
33	Daman & Diu	7.16
34	Delhi	197.38
35	Lakshadweep	0.66
36	Puducherry	76.17
	Sub Total	330.83
	Grand Total	77057.88

The Family Planning programme in India is target free and voluntary in nature and it is the prerogative of the clients to choose a family planning method best suited to them as per their reproductive right.[25,26]

Conclusions

Despite India being the first nation in the world to launch family planning program in 1952, it has still not attained the desired level of temporary contraception usage in certain parts of rural India. Rural India is a declared difficult area under the Indian Act and this study focused on married women of rural areas and found temporary contraceptive usage prevalence with its determinants. Only one eighth of the married women of the rural India are currently using temporary contraceptive. [27,28]The mass media is reported to be the main source of information followed by health personnel regarding contraceptive use. SES, education of women, number of living children, type of family, and distance from health center were found to be strong five predictors of the use of spacing contraceptive methods. Dissemination of the scientific information through regular awareness campaigns and educational sessions regarding contraceptive use needs to be tailored to community by the devoted health-care personnel and mass media. Field researches need to enhance to unfold intricacies involved in this context to integrate new information that may emerge into the future programs to help create healthy society.[33]

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