Review Article

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Need for integration of gender equity in family planning services

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The family planning programme of India has shown many significant changes since its inception five decades back. The programme has made the contraceptives easily accessible and affordable to the people. Devices with very low failure rate are provided free of cost to those who need it. Despite these significant improvements in service delivery related to family planning the programme cannot be said to achieve success at all levels. There are many issues with the family planning services available through the public health facilities in India. Failure to adopt the latest technology is one of these. But the most serious drawback of the programme is that it has never been able to bridge the gap between the two genders related to contraceptives. The programme gave emphasis to women-centric contraceptive and thus women were seen as their clients. The choice to adopt a contraceptive though is 'cafeteria approach' in family planning lexicon; it is the choice of the husband that is ultimately practiced. There is not enough dialogue between husband and wife and husband and health worker to discuss the use of one contraceptive over another. The male gender needs to be taken in confidence while promoting the family planning practice. The integration of gender equity is to be done carefully so as not to make dominant gender more powerful. Only when there is equity between genders while using family planning services the programme will achieve success.

Key words Contraceptives - equity - family planning - gender - sex - sex-ratio

Introduction

Despite the world population crossing seven billion and having almost equal number of women as men, the status of women in society has not improved much over the years particularly in low- and medium- income countries[1]. The much talked about gender equity is still to show good effects. The decision makers in many societies are still the men. The decisions are usually forced upon the females of the home and they are not given any choice. This is true for family planning practices followed in homes. Although delivery and accessibility of family planning services in India have improved greatly since its inception in 1952; gender inequality, rooted in cultural norms, continues to cause poor family planning practices nation-wide. This paper describes the current scenario of gender imbalance in family planning practices in India and stresses upon the need of integrating gender equity in future family planning policies of the nation.

Understanding gender and gender roles

Gender is not same as sex. Gender refers to the economic, social, political, and cultural attributes, opportunities, and constraints associated with being a woman or girl, man or boy; sex refers simply to the biological and physical differences between men and women. Gender is currently recognized as a term that reflects the complex social relations between men and women. Accepting biologically determined differences as being more unchangeable, the focus is on socially constructed roles that have developed historically within and across cultures. Gender roles and gender norms are culturally specific and thus vary tremendously around the world. However, men and women differ substantially from each other in power, status and freedom, men having more power than women in almost all societies. Women's gender roles give them some power but are more limited and mainly influenced by her culture, age, income and education. Gender roles can be divided into three types, reproductive roles mainly played by women because of their capacity to give birth and assuming that child rearing is women's job. Productive roles played by men though informal economic activities considered not productive, yet contributing to society are being conducted by women. Community roles can again be divided in to cultural activities where women are supposed to take part actively and leadership and political roles, where men plays significant roels.

Gender inequality through health indicators

A skewed distribution of health indicators is the characteristics of the nation since independence. It is seen in adverse sex ratio. The female to male ratio is decreasing every decade as shown in the census conducted every 10 years[2]. Female foeticide is rampant and has been documented from all parts of India[3]. Less number of women seeks health care compared to men. A girl child needs to have more episodes of diarrhoea or more severe respiratory infection to see a health professional[4]. High stress levels among women lead to increased vulnerability to behavioural problems. The health centres are not equipped enough to be women friendly ranging from less women in health work force to lack of privacy at OPDs and wards.

Evolution of family planning programme in India

Family planning refers to the use of various methods of contraception to regulate the number, timing, and spacing of child births. It allows couples, particularly women, to plan their lives without being overly subject to sexual and social imperatives[5]. Attempts to control human reproduction are not entirely a modern phenomenon. Throughout history, human beings have engaged in various activities to control birth of children like prolonging breast-feeding to delay the next conception. Family planning programmes as organized efforts to give contraception services to men and women were one of the major health and social interventions started in second half the 20th century[6]. These programmes exist in almost all countries of the world where around 99 per cent of the global population lives[7]. The rationales of any family planning programme are demographic, health and human rights. These were mainly done to space births and maintain equilibrium between resources and population size. But in many societies, population regulation practices did not bring equivalent or beneficial results to everyone.

In 1952, the Indian Government was one of the first in the world to formulate a national family planning programme. In the mid-sixties the Union Government introduced the method specific target for each State[8]. The State programmes were directed to meet these targets down to the lowest administrative level resulting in workers over-reporting their work and coercing the couples to use the sterilization, the terminal method of contraception[9]. The MTP (medical termination of pregnancy) act of 1971 enabled women with unwanted pregnancy to seek and obtain safe abortion services. Increasing concern about rapidly growing population led to the Family Planning Programme being included as a priority sector programme during the Fifth Five Year Plan[10]. The massive forceful sterilisation drive of 1976 resulted in eight million persons undergoing sterilisation[11]. The programme despite being renamed as family welfare programme in 1979[12] is detrimental to women's right and welfare. In 1992, the 72nd and 73rd constitutional amendments and the *Panchayati Raj* and *Nagar Palika Acts* decentralized the family welfare programme to the *Panchayati Raj* institutions[13]. In 1994, legislation was passed in Parliament to regulate and prevent the misuse of modern prenatal diagnostic techniques, largely for sex-selective abortion[14]. The era of Reproductive and Child Health (RCH) programme was started in 1997. It encompasses the principles of client satisfaction in delivering comprehensive and integrated high quality contraceptive services. The National Population Policy of 2000 advocated a holistic, multi-sectoral approach towards population stabilization, with no targets for specific contraceptive

methods except for achieving a national average total fertility rate (TFR) of 2.1 by the year 2010[15]. This resulted in a shift in implementation from centrally fixed targets to target-free dispensation through a decentralized, participatory approach. The target-free approach was known as the community needs assessment approach.

Current status of family welfare programme of India

Analysis of the current situation shows that the couple prefers small family, there is high knowledge of contraception, total fertility rate is declining and the use of contraceptive is increasing. Contraceptive use in India is characterized by the predominance of non-reversible methods, particularly female sterilization; limited use of couple/male dependent methods; high discontinuation rates; and negligible use of contraceptives among both married and unmarried adolescents[16]. Currently public health system of the country provides five contraceptive services free to its citizens, sterilization (males and females), combined oral contraceptive pills, intrauterine devices and condoms. Despite all the progress, the main challenge which is faced by the policy makers is the lack of access to wide range of contraceptives to a majority of population which results in large unmet need of family planning and lack of awareness about the correct usage of spacing methods. According to the revised estimates unmet need of family planning in India is 13.9 per cent[17].

Gender in family planning programmes

Male gender norms are widely accepted as factors influencing a range of family planning and reproductive health behaviours[18]. These include informed use of family planning methods, condom use for disease prevention and actions to prevent violence against women[19]. The fertility as a whole is declining but there is no scope for celebration. We are currently facing the lowest growth rate since independence, for 2001-2011, the decadal growth has become 17.64 per cent, a decrease of 3.90 percentage points. But sex ratio in 0-6 yr age group has declined from 927 in 2001 census to 914 per 1,000 males in census 2011[20]. The main reasons for this decline are decreasing fertility where less number of children is born persistence of male child preference, and sex selective abortion leading to female foeticide. Gender difference is starkly seen in family planning programme of India when one compares the usage of different methods of contraception by couples. Though every three out of four couple using contraception are sterilized, majority of users are females. The three National Family Health Surveys (NFHS)[21] show that female sterilization is on rise and male sterilization is on constant fall. Gender inequalities favour men and sexual and reproductive health decisions are usually made by them. In a study of women in the slums and villages in Maharashtra, male dependent methods accounted for less than 10 per cent of total contraceptive prevalence[22]. The family planning programme relies mainly on women as clients. The government is fascinated with high-technology contraceptives; relatively simple methods such as the diaphragm/female condoms have received very little attention. In designing programmes, there is often a lack of information about men's perspectives as they are viewed as irresponsible or not appropriate clientele at reproductive health services. National family welfare programme has been successful in reducing fertility but has failed in reducing gender inequality.

Gender integration into family planning programmes

Integrating gender into the family planning programme will improve the health of the nation and gender equity. The vicious cycle of poverty and overpopulation with un-empowered women at the centre leads to more gender inequality. The change in fertility practices will occur when the women are empowered enough to realize their dreams. This can be done by imparting quality education and by some local efforts. Empowering women is half battle won against the gender equality. Involving men at each step is equally important. The family welfare programmes should educate and enable men to share more equally in family planning and in domestic and child rearing responsibilities. There are notes of caution though. Involving men in family planning education and services could further erode women's control over reproductive health decisions. Without genuine gender equity, involving men will perpetuate existing gender inequalities. In Zimbabwe family planning programme is relatively more successful and men are encouraged to play a greater role in family planning decisions. This had negative effect on gender equity wherein greater proportion of men thought that they had sole control over contraceptive decision making in the family[23]. This is definitely not desirable. Gender integration can begin anywhere in the family planning programme cycle. During the assessment of the situation, data can

be collected and analysed to identify gender-based constraints and opportunities relevant to programme objectives can thus be formulated. The programme objectives can so be designed that strengthen synergy between gender equity and health goals. Identification of key programme strategies to address gender-based constraints and opportunities is important. Indicators can be developed that measure gender-specific outcomes. Finally impact of programme on health and gender equity outcomes can be measured. The design should be adjusted accordingly to enhance successful strategies.

Conclusion

A family planning service that simply give women the technical means to control their fertility would only address their practical needs. In order to meet their strategic needs the service would also need to enable women to choose between a range of contraceptive methods, empower women to be able to take decision regarding the methods of their choice, identify the various strategies needed to promote their own well-being and encourage men to take responsibility. For family planning and reproductive health professionals worldwide, this is another opportunity to build on and highlight programmes that promote gender equity by including men in family planning and placing the responsibility of contraception in the hands of both women and men.

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