Repositioning Family Planning: A review of evidence on effective interventions

Executive Summary

BACKGROUND

For decades, family planning has been viewed chiefly as a means of controlling the world's population size. However, with declining global population growth rates the imperative to position family planning as more than a means of population control has become increasingly evident. 'Repositioning family planning' was a multilateral initiative launched almost a decade ago to increase political commitment and funding for strengthening family planning services in sub-Saharan Africa [1]. The 2012 Summit on Family Planning in London put the 'repositioning' approach firmly on the global map by winning the support of national governments, civil society and donors from other regions of the world.

In the 'Repositioning of Family Planning' approach, the focus is on reaching all women and men in developing countries with quality family planning information and services in order to meet their need for fertility control. Voluntary adoption of family planning would be a means to reduce maternal and child deaths [2]. Although not explicitly stated, the emphasis on health and well-being and on voluntary family planning is in keeping with the notion of birth control as a reproductive right.

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In India, the National Population Policy, 2000 (NPP 2000) affirmed the government's commitment to voluntary and informed choice and consent of citizens as users of family planning and reproductive health program. One of the objectives of NPP 2000 was to delay age at marriage to at least 18 years and to address unmet need for spacing and limiting births [3]. Ten years later in May 2010, the Ministry of Health and Family Welfare held a national consultation on repositioning family planning. This consultation announced the government's decision to reposition family planning as a means to improve maternal and child health. It is in this context that the Population Foundation of India's (PFI) Strategic Plan (2011-2016), attempts to reposition family planning within a women's empowerment and human rights framework within India's development and Maternal and child health (MCH) policies and programs. This systematic review is a part of PFI's 'repositioning family planning' initiative.

Why reposition family planning in India?

There are several reasons why 'Repositioning family planning' is especially important in the Indian context.

To begin with, nine Indian states have already achieved replacement level fertility. However, low fertility has not resulted in improved maternal health, because of early marriage and childbearing, and closely spaced births. For example in Andhra Pradesh, which had a below replacement level of fertility of 1.79 children per woman in 2005-06, 55% of young women age 20-24 years were married before they were 18 years old, 18% of women age 15-19 had already begun childbearing and 60% of women bore a subsequent child within 36 months of a previous birth [4]. In states with replacement or below-replacement-level fertility, repositioning family planning as a health and development issue could contribute to designing programs that addressed women's other reproductive health needs alongside fertility control.

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Secondly, population momentum is an important contributor to India's population growth. Even with declining average annual growth rates, India continues to add approximately 18 million people annually to its population, because the proportion of people in the reproductive age group is almost 50%. One way in which population momentum can be checked is by delaying age at first birth and by spacing subsequent births by 2-4 years. According to the UNFPA, raising a mother's age at first birth from 18 to 23 could reduce population momentum by over 40 per cent [5]. The Indian version of Family Planning which has become entrenched as a "sterilization only" program needs to shake itself out of its inertia and focus on these newer priorities. The challenge is to not only change tracks but also change the government's way of doing things – i.e. upholding voluntary acceptance and informed choice.

The third reason why repositioning family planning is important is related to the Indian Family Planning Program's long legacy of being driven by a population control logic. Demographic targets as well as targets for family planning acceptance have been the drivers of the program from its inception. With the introduction of the 'Target-Free Approach' in 1997 the program seemed to have lost its fulcrum. There is a need to infuse the program with a new *'raison d'etre'* – that of improving health and well-being and of upholding women's and men's right to fertility control.

The present review: Context, objectives and methodology

The present review is a building block in PFI's initiative to reposition family planning into MCH policies and development programs in Bihar and at the national level. Four focus areas of intervention were indentified in view of the Indian context. These were i) delaying age at first marriage ii) delaying age at first birth iii) promoting spacing between births iv) improving the quality of family planning services

Context

i) Delaying age at marriage

Early marriages are still prevalent among a sizeable population of Indian women. In 2005-06 more than half of rural Indian women (53.4%) and more than one-quarter (29.7%) of urban Indian women age 21-29 were married by 18 years of age [4]. The highest proportion was in Bihar (63.7%) closely followed by Jharkhand (60.2%), Rajasthan (58.4%) and Andhra Pradesh (56.2%) [4]. The proportion of women married before age 18 declined between 1992-93 (54%) and 2005-06 (47%) and corresponded to an increase of only 0.4 years in the mean age at marriage in the same time period, from 16.7 years in NFHS-1 to 17.1 years in NFHS-3 [6].

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ii) Delaying age at first birth

There is an urgent need to reorient family planning programs so that young married women and men are able to achieve their reproductive intentions. Early marriage followed by immediate childbearing is a social norm in India. In 2005-06 for the country as a whole, adolescent birth rate was 90 per 1000, a decline from 116 per 1000 in 1990-92 and 107 per 1000 in 1995-96. Rural areas had close to three times the adolescent birth rate (105 per 1000 women age 15-19) as compared to urban areas (57 per 1000) in 2005-06 [4].

About 1 in 6 women age 15-19, or 16% had begun childbearing in 2005-06. The proportion of women who had begun childbearing was 3% for women age 15 and increased sharply to 36% or more than one in three for women age 19. The proportion is highest in Jharkhand (27.5%), West Bengal (25.3%) and Bihar (25%), all located in Eastern India. In contrast, in Goa, Himachal Pradesh and Jammu and Kashmir less than 5% of women age 15-19 had begun childbearing [4]. Data shows that not all these pregnancies were intended. Unmet need for spacing in 2005-06 among women age 15-19 was 25.1%, and only 32.4% of the demand for

contraception was satisfied among this age group. Only 13% of married women in India age 15-19 were current users of any contraception (2005-06), and only about half of them (6.9%) used a modern method of contraception [4].

iii) Promoting birth spacing

Promoting birth spacing and the use of effective spacing methods of contraception is a major challenge confronting the Indian family planning program. Nationally, the median interval between subsequent births in 2005-06 was 31.1 months [4], lower than the recommended optimal birth interval of 36 months [7]. More than 60% of births occurred within three years of the previous birth and only 28% have an optimal birth interval of 36-59 months. Also, the median birth interval is shorter if the previous child did not survive (25.8 months) as compared to if the child was living (31.8 months). The birth interval falls short of 36 months in all but four states of India – Kerala, Tripura, Goa and Assam. Clearly there is a long way to go towards spacing of births in India [4].

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Non-use of traditional or modern reversible methods of contraception may underlie poorly spaced births in the country. Of the three modern reversible methods available free of cost in India's family planning program, the IUD is the least widely used method (1.7% of married women of reproductive age) while the pill (3.1%) and the condom (5.2%) do only marginally better. In fact, use of IUD has declined between NFHS-1 and NFHS-3 [4].

iv) Improving the quality of care in family planning services

The Indian Family Planning Program, ambitious in scale and coverage, has been successful in achieving steep reductions in fertility across several states. However, many of its early achievements were at the cost of providing quality services to the user.

In his introduction to a compilation of studies on quality of care in India's family planning program, Koenig (1999) noted that the program had been characterized by an "*overriding concern for numbers*" – in terms of acceptors of contraception and specifically, sterilization. The entire program was driven by targets which service providers had to meet under threat of punitive action. This shaped providers' scant attention to quality of care and preoccupation with meeting targets. The studies in the volume stood testimony to poor quality of care in terms of infrastructure and equipment, limited choice of methods, absence of clinical protocols, shocking negligence of infection control practices, and provider-directed decision-making in relation to whether and when a woman should be using contraception [8].

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The Reproductive and Child Health Program that was launched in 1997 promised a paradigm shift towards addressing broader reproductive health needs of the family. Quality of Care was an explicit focus, and targets for contraceptive acceptance were to be replaced by a "Community-Needs Assessment" approach. Clients' needs were to be assessed and program goals at the local level were to be set based on this. Early assessments of the paradigm shift were not encouraging. According to one report, NGOs collaborating with government were not allowed to adopt Community-Needs Assessment approaches and were given targets to achieve [9].

There have been few recent studies on quality of care in family planning services. Data from the National Family Health Survey-3 gives some indications related to specific dimensions of quality of care, viz. informed choice. Less than a third (32.2%) of current users of contraception were informed about side effects or problems of the method they were to adopt, or were using. Even fewer (26%) were informed about what to do if they experienced side effects. In terms of being offered a choice of a range of methods, only 28% of users were informed by a health or family planning worker about other methods that could be used [4]. Yet another paradigm shift may be needed to alter the program ethos to respect and uphold clients' rights in the provision of family planning services.

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Objectives

The review aims to answer the following questions:

I) Are interventions in developing country settings related to (i) delaying age at marriage (ii) delaying age at first pregnancy; (iii) promoting spacing between births and (iv) improving quality of care of FP programs effective?

II) What strategies or combination of strategies have been effective?

Methodology

A systematic search was carried out in major data bases to identify evaluated interventions implemented in developing countries pertaining to the four focus areas, viz., interventions to delay age at marriage; to delay age at first pregnancy; to promote spacing between births; and to improve the quality of family planning services. Identified published as well as unpublished articles in English were further scrutinised for quality as well as strength of evidence, and those that met a set of clear inclusion and exclusion criteria were included.

Publications pertaining to each focus area were examined to identify the major strategies used within each intervention studied. Strategies or combinations of strategies that were found to be effective were listed out. The effectiveness of interventions were gauged based on whether they achieved their intended objectives. In addition, the strength of the evidence was also taken into account, with experimental studies ranking as the strongest, quasi-experimental studies ranking next, followed by 'before-after' studies.

Results

There was a serious dearth of studies that evaluated interventions for all four focus areas. A total of 61 studies were included in the review. Most of the studies were from Africa and South Asia and a few from other developing countries.

Given the small number of studies overall and the limited strength of evidence in many of these, it is difficult to draw firm conclusions regarding effectiveness. Similar interventions would need to be implemented in diverse settings using rigorous study designs before we will be able to do this. Nevertheless, the results we have do point us in the direction of 'promising' strategies/combination of strategies.

Delaying age at marriage

The review included 23 studies that evaluated 16 programs that aimed at delaying age at marriage: seven programs from Africa, two from Bangladesh, one from Nepal and five programs from India. These programs adopted one or more of five strategies:

1) Financial incentives and/or support to keep adolescent girls in school and reduce drop-out rates
2) Life skills education and empowerment programs for adolescent girls and young women
3) Micro-credit disbursement for adolescent girls and young women
4) Life skills education and mobilization programs for young people (both sexes)
5) Community mobilization – Ranging from targeted awareness raising programs among parents and family members of young people to broader social mobilization of community members at large

Interventions that combined multiple strategies - life-skills education for young women or for young people of both sexes, together with intensive engagement of the community – were found to be effective in delaying age at marriage.

Delaying age at marriage for girls was an especially challenging goal to achieve. Community norms on appropriate age of marriage for girls was in some instances well below 18 years, and even with success in changing attitudes towards early marriage, only very early marriages (age 15 and below) could be prevented. In most instances, however, even when the community became aware of the negative health consequences of early marriage, they were unable to change the practice. This was because there was immense pressure from the community on parents of young

women to get them married at the earliest opportunity. There was fear of pregnancy in an unmarried girl, which would bring shame on her family. Also, in South Asian societies in particular, an older girl would find it more difficult to find a groom and may have to pay a higher dowry. Another reason for early marriages was girls' poor access to high schools. When high schools were located far away from the community, parents tended to discontinue their daughters' schooling, and this in turn led to opting for early marriage for girls.

Interventions that combined multiple strategies - life-skills education for young women or for young people of both sexes, together with intensive engagement of the community – were found to be effective in delaying age at marriage. Life skills education was broad-based, included 'empowerment' education alongside information on sexuality and reproduction, and also skill-development. Of equal or more importance was to simultaneously engage gate-keepers such as parents, religious leaders and community elders with specific messages, while the same time carrying out media campaigns raising visibility of the issue within the community. Of these, the PRACHAR project from India which carried out life skills education for boys and girls alongside intensive community engagement has been successfully up-scaled in the state of Bihar.

The 'single' strategy that helped delay age at marriage in two rigorous evaluations was providing financial incentives/support to prevent adolescent girls from dropping out from school. Financial incentives together with intensive community mobilization helped prevent very early marriages (age 15 or below) in Ethiopia, but not marriages between 16-18 years of age.

These findings have important implications in the Indian context. The PRACHAR model has already been up-scaled in one state. The *Kishori Shakti Yojana* education and empowerment program for adolescent girls implemented through the Integrated Child Development Scheme (ICDS) offers a possible entry point for expanding the PRACHAR approach in other priority states. In addition to effecting suitable changes in curriculum and project design in life skills education for girls, parallel life skills programs for adolescent boys and young men would need to be designed, evaluated and integrated. **The key to making these work is to combine** them with broad-based community mobilization as well as targeted efforts to change attitudes of parents and other gate-keepers. This is crucial for changing mindsets and making early discontinuation of schooling and early marriages socially unacceptable.

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As for financial incentives to prevent girls from dropping out, India has several conditional cash transfer schemes operated by the central and various state governments aimed at improving the status of the girl child. Delaying age at marriage till completion of 18 years of age is one of the conditions for cash transfer in more than 10 of these schemes. The *Dhanalakshmi* Scheme and *Balika Samridhi Yojana* of the Government of India, Girl Child Protection Schemes of Tamil Nadu and Andhra Pradesh, *Ladli* Schemes of Delhi and Haryana, *Ladli Lakshmi* scheme of Madhya Pradesh and *Beti Hai Anmol* Scheme of Himachal Pradesh are some examples. It would be important to evaluate the effectiveness of these schemes in preventing girls from dropping out from school and in turn, delaying age at marriage. The evaluations may provide directions for suitably redesigning these conditional cash transfer schemes to better achieve the objective of delaying age at marriage for girls.

Delaying early pregnancy

The systematic search yielded three studies (on two programs) from India, 23 systematic reviews and evidence syntheses from the United States of America and the UK and seven studies from Africa and Asia excluding India. Except for the Indian studies, all were interventions to prevent teenage pregnancies outside marriage.

Effective intervention strategies to prevent teenage pregnancies among unmarried adolescents have been summarized below keeping in mind the changes already occurring in the sexual and reproductive lives of young people in India and also with a view to draw on promising strategies that are relevant to the Indian context.

Systematic reviews of intervention studies from the US and the UK show that sex-education programs by themselves are ineffective in preventing teenage pregnancy. Comprehensive youth development programs which start with interventions from early childhood and address the social determinants of teenage (unmarried) pregnancy – educational opportunities, skill development for livelihood, together with sexuality and relationships education- were found to most effective.

Financial incentives/support to prevent drop-outs and keeping girls in school, found to be effective in delaying age at marriage in two studies from Africa, were also effective in preventing teen pregnancy out-of-wedlock.

Three Indian studies pertaining to two programs, evaluated interventions to delay first birth in married young women, and found these to be effective. In both instances multiple strategies were used. Three main strategies could be discerned: i) Social environment building through interventions with key gatekeepers as well as with the larger community ii) Providing sexual and reproductive health education – jointly to young married couples and also separately for women and men iii) Increasing access to contraceptive and other reproductive health services.

Thus, both demand and supply side factors were simultaneously addressed, and a serious attempt was made to at change social norms through community mobilization.

One of the evaluated interventions is no longer operational, but was the basis on which the second effective intervention was developed. This is the PRACHAR project, being implemented in three districts of Bihar. The scope for up-scaling this intervention and for adapting it to the needs of other Indian states needs to be examined. There is a need for more innovative interventions to address the strong pressures that most young Indian women face to prove their fertility soon after marriage, and the barriers that adolescent and young couples face in contacting the health care system prior to parenthood [10-11].

Working intensively with women and their husbands, alongside building community support plus building health worker capacity in providing suitable services seems to be a promising combination of strategies.

Promoting spacing between births

Nine intervention studies were included in the review. As with interventions to delay early marriage, many of the evaluated interventions to promote spacing between births used two or more of six specific strategies simultaneously. These six strategies included: i) Targeted messages for young married women ii) Targeted messages for young married men iii) Community mobilization – from targeted meetings with gate keepers to broader community awareness building and attitude shaping iv) Engagement with health and allied service providers within the public and private sectors v) Mainstreaming the optimal pregnancy/birth spacing messages within the government health system; and vi) High level advocacy with policy makers to integrate optimal pregnancy/birth spacing as a policy and program goal.

Working intensively with women and their husbands, alongside building community support plus building health worker capacity in providing suitable services seems to be a promising combination of strategies. Four Indian programs - the Healthy Timing and Spacing of Pregnancy (HTSP) project and the the *Pragati project* in Uttar Pradesh, PRACHAR in Bihar and RHEYA in four Indian states adopted this combination of strategies and all of them were found to be effective, three of four being quasi-experimental studies. This is an approach that tackled demand and supply-related factors simultaneously.

Within the above combination of strategies, approaches to working with men need further exploration. Interventions that did not intensively target husbands but worked with men in the community also seem to have achieved good results.

Another combination of strategies worth further experimentation and study is clinic-based intensive counseling of antenatal women and their husbands. This approach appears to be able to achieve effective results with a relatively modest investment of resources.

In the Indian context, mainstreaming the "healthy timing and spacing of pregnancy" within policies and programs would be an important first step. Spacing of births, al-

though mentioned as a priority in policy documents, has not been adequately emphasized within the Indian family planning program. Much work needs to be done in making providers more conscious of prioritizing birth spacing and in enhancing their knowledge on modern as well as traditional methods of spacing pregnancy. The HTSP program in UP and the DISHA program in Bihar/Jharkhand respectively have attempted to mainstream promotion of birth spacing within the government health sector, including provider training and community mobilization. These models have the potential for sustainable and affordable upscale, and need to be explored further.

Making spacing methods acceptable to potential users is yet another challenge to be overcome. Currently, contraceptive use is tilted overwhelmingly towards sterilization. Research is needed to identify barriers to acceptance of spacing methods in different parts of India, and to build context-specific communication and behavior-change strategies based on these. Clinic-based interventions with pregnant women and their husbands offer one major window-of-opportunity to influence attitudes and behavior related to spacing births.

The studies show that targeted interventions with young married women need to be complemented with interventions with their husbands or with groups of young married men. While ASHAs and ANMs could be trained to promote birth spacing with women, it would be important to identify a suitable male cadre to work with young married men.

Improving quality of care in family planning services

This review included 27 intervention studies aimed at improving quality of family planning services. Simultaneous adoption of multiple strategies was a feature also of these interventions. The programs reviewed adopted one or more of 10 strategies to improve access to and quality of family planning services: i & ii) Community based service delivery through female/male health workers respectively; iii& iv) Health facility-based targeted counseling and education for women/men v) Expanding contraceptive choice vi) Provider training for improving quality of care vii) Strengthening service provision through improved organization, equipment and supplies viii) Integrating family planning with post-abortion services ix) Integrating family planning with maternal health and delivery care, and x) Community mobilization

The policy recommendation from this review would be to provide post-partum and post-abortion family planning services that are truly based on informed choice following counseling; offer the full range of contraceptives for the woman/ her partner to choose from, and come together with improvement in overall quality including humane treatment of the client, as described above.

Two combinations of strategies offer most promise in terms of their ability to improve contraceptive use as well in improving client satisfaction with services. The first of these is integration of family planning services with post abortion care and maternal health-delivery care, provided this is not just a mechanical addition of one additional service. The effective interventions examined also involved reorganizing service delivery to suit client convenience, provider training to make service delivery more client-centered and targeted family planning counseling for women, and also their husbands.

Post-partum and post-abortion family planning is well known in India. However, much of the focus has been on post-partum and post-abortion sterilization. Also, imposing sterilization or IUD insertion as a condition for providing safe abortion services has been reported in the 1990s by many studies examining quality of care. The policy recommendation from this review would be to provide post-partum and post-abortion family planning services that are truly based on informed choice following counseling; offer the full range of contraceptives for the woman/ her partner to choose from, and come together with improvement in overall quality including humane treatment of the client, as described above.

The other strategy that appears to offer promise is the use of female and male health workers for community-based education and counseling and distribution of contraceptives. We do not have a male health worker cadre who provides community-based family planning information and services – in fact, we do not have any mechanism to systematically reach men with family planning information. Use of female community-health workers to deliver services is again a strategy well-known in the Indian family

planning program, and the ASHA is now charged with this responsibility. The main difference is that in many instances there are in practice (whatever the official policy may be)'targets' for the community health worker to fulfill. This transforms an intervention that could improve quality of family planning services by providing information and services closer to the woman's home, into one with coercive overtones. We need to reorient the role of the female community health worker and include male community health workers. Their role would be to provide information, facilitate discussion on the pros and cons of different methods and help clients make an informed choice of a method that is acceptable to him/her.

Conclusions

This review has identified a range of 'promising' strategies that would help reposition family planning as a means of upholding the health and rights of women, men and children. The results of the review need to be interpreted keeping in mind the very limited evidence on which it is based. Many interventions have not been documented, and those documented here are yet to be rigorously evaluated. One of the key tasks ahead is to systematically document and evaluate existing interventions.

The review identifies strategies that are worthy of further experimentation and up-scaling from among the pool of interventions that have been implemented thus far. However this should preclude the possibility of innovating what has not yet been tried. There are other potential interventions that are as yet to be tried or even conceived: for example, programs that uphold reproductive and sexual rights; programs that provide a comprehensive range of reproductive health services of which family planning is an integral part. It is as much a priority to design and implement interventions that are out-of-the box, as it is to have rigorous evaluations of what already exists.

Safe abortion services have featured among the strategies examined only as a part of interventions that integrate family planning with post-abortion care. Yet, any attempt to reposition family planning would need to include safe abortion services as an important dimension of upholding women's health and rights. We hope future reviews will examine 'effective' safe abortion services which have the woman's safety and wellbeing as outcome indicators.

Last but not least, all strategies to 'reposition family planning' recommended above are by definition guided by a human rights perspective. If taken out of this context and perspective, and superimposed with a 'population control' imperative, we may achieve fertility reduction, but without a concomitant improvement in population health and wellbeing.

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