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# Historical Perspectives on Family Planning Policies and Practices: A Review of Global Trends

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**ABSTRACT**

*Family planning is a multifaceted public health intervention and a sociocultural phenomenon. This study aims to explore the historical underpinnings of family planning policies and practices, tracing their evolution from early traditions to the complex global initiatives of the modern era, historical context, key trends, and diverse approaches employed across different regions and time periods, and to shed light on the multifaceted nature of the family planning as both a social and public health interventions. This research paper provides an analysis of the historical context and key trends that have shaped national family planning initiatives over time. The analysis reveals that family planning policy and practice have evolved over time from the early era to the present era. It also highlights the need for strengthening the healthcare infrastructure to deliver family planning services effectively. Despite progress in contraceptive usage and declines in unmet needs in several states, regional variations persist, underscoring the importance of targeted interventions to address specific challenges in different parts of India. Additionally, it is crucial to prioritize overcoming current obstacles and inequalities in order to attain widespread access to FP services and advance equity in reproductive health.*

**Keywords**: Family planning, Public health, Policies and practices, Contraceptive, Health care infrastructure

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## I. INTRODUCTION

Family planning, the conscious effort to regulate fertility and reproduction, has been a cornerstone of public health and social policy for centuries. This research delves into the historical underpinnings of family planning policies and practices, tracing their evolution from early traditions to the complex global initiatives of the modern era, historical context, key trends, and diverse approaches employed across

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different regions and time periods, The significance of understanding the historical perspectives on family planning lies in its profound impact on population dynamics, public health outcomes, and individual autonomy. Throughout history, societies have grappled with questions of fertility control, reproductive rights, and the ethical implications of intervening in human reproduction. Moreover, exploring the historical trajectory of family planning allows us to contextualize contemporary challenges and debates in the field. From the coercive population policies of the early 20th century to the modern emphasis on reproductive rights and gender equality, the evolution of family planning (FP) reflects shifting societal norms, technological advancements, and ideological currents. By examining the historical roots of family planning initiatives, we can better understand the motivations, ideologies, and challenges faced by policymakers and advocates in different eras.

In the 1960s, national family planning programs emerged across many developing countries worldwide, albeit with varying degrees of effectiveness and coverage. Successful programs typically exhibit key characteristics, including high-quality family planning services and contraceptive options, supported by both governmental and private sector involvement. Clear national policies play a crucial role in structuring these programs, which are further strengthened by on-going monitoring and evaluation, training initiatives, supervision, and logistical support to ensure broad accessibility, effective programs employ extensive outreach strategies targeting both the general population and underserved communities. These strategies may include mass media campaigns, social marketing initiatives, or community-based distribution efforts. Moreover, successful programs prioritize rights-based quality assurance measures to ensure that family planning services are voluntary and based on informed decision-making. Regular monitoring is essential for identifying both successes and areas requiring improvement within national family planning programs. Since 1972, the Family Planning Effort Index has served as a standardized tool for periodically assessing the strength of such programs on a global scale. This index evaluates various components, including policy context, service provision, monitoring and evaluation mechanisms, and access to contraceptive methods, providing valuable insights into the overall effectiveness and sustainability of national family planning efforts.

Ethical access to reproductive health care is elegantly championed by the vision outlined in the Programme of Action forged at the International Conference on Population and Development in Cairo, embraced by 179 nations, and reaffirmed within the framework of the 2030 Agenda for Sustainable Development.

In essence, these international accords and frameworks not only articulate but also exalt the imperative of ensuring ubiquitous access to family planning services and enlightenment as an indispensable facet of broader endeavours to advance of reproductive health and rights on a global scale.

## II. OBJECTIVES

- To explore the historical evolution of family planning practices from ancient civilizations to the modern era, examining the societal, cultural, and technological factors that have shaped contraceptive methods and attitudes towards reproductive health over time.

- To analyse the impact of key historical events, movements, and policy reforms on the accessibility, utilization, and effectiveness of FP services globally, with a focus on the intersectionality of gender, socioeconomic status, and political factors.

- To assess contemporary trends and challenges in family planning, including disparities in access to contraception, cultural barriers, and the implications of population dynamics on global health, gender equality, and sustainable development agendas.

## III. DATA AND METHODS

This exploration is a descriptive study. The required secondary data was gathered from a variety of websites, articles, books, newspapers and other depositories like Shodhganga. The implications and findings were reached after this data was examined and assessed

## IV. ANALYSIS

### *Milestones in Public Health, spanning from 1900 to 1999: Advancements in Family Planning: Early History*

In the 20th century, family planning in the US has been marked by the capacity to achieve desired intervals between births and the desired number of children. As couples opted for fewer children, fertility rates declined, coinciding with reductions in child mortality, urbanization, and delayed marriage (Bongaarts, 1978). Smaller family sizes and longer intervals between births have contributed to improved health outcomes for children, infants and women, while also enhancing the societal and economic roles of women (Maine & McNamara, 1985). Despite their failure rates large in number, traditional methods to control of fertility also played a role in reducing family size (Westoff C. F., 1973).

In 1900, maternal mortality rates ranged from six to nine deaths per 1000 women due to childbirth complications. During this time, one out of every five children failed to reach the age of five. Providing information and advice on contraception and contraceptive methods were banned by federal and state laws (Connell, 1975), and there was a limited understanding of ovulation timing, the length of the fertile window, and other reproductive matters.

In 1912, the modern birth control movement began with Margaret Sanger, a public health nurse, who, concerned about the adverse health effects of frequent childbirth, miscarriages, and abortions, took steps to spread information about and provide access to contraception (Wardell, 1980). In 1916, Margaret Sanger defied laws that limited the sharing of birth control information by founding the initial family planning clinic in Brooklyn, New York. Despite facing closure of her clinic by law enforcement, subsequent legal battles set a precedent, enabling physicians to provide contraceptive guidance for health-related reasons. Sanger persisted in her advocacy throughout the 1920s and 1930s, establishing additional clinics and challenging legal obstacles. As a result, physicians gained the authority to advise patients on contraception and prescribe relevant methods (Gordon, 1975). By the 1930s, some state health departments, including North Carolina's, and public hospitals had initiated the provision of family planning services.

In this period of 20th century, family planning primarily addressed the necessity for married couples to regulate child spacing and reduce family size. Among a national probability sample of 1049 ever-married white women born from 1901 to 1910 and interviewed in 1978, 71% reported practicing contraception. Common methods included condoms (54%), contraceptive douches (47%), withdrawal (45%), rhythm method (24%), and cervical diaphragms (17%). Other reported methods comprised infrequent sexual intercourse (8%), intermittent abstinence (6%), and contraceptive sterilization (4%). The use of abstinence for pregnancy prevention was hindered by uncertainty regarding a woman's ovulation timing. In 1928, the medical establishment determined the timing of ovulation, although the safe interval for intercourse was initially misunderstood to encompass half the menstrual period (Rosenau, 1935).

In 1965, the birth control pill had emerged as the most preferred contraceptive method, followed by condoms and contraceptive sterilization (Forrest, 1994). Additionally, in the same year, the Supreme Court's decision in Griswold vs. Connecticut overturned state laws that prohibited married couples from using contraceptives.

In 1970, federal funding for family planning services was established through the Family Planning Services and Population Research Act, creating Title X of the Public Health Service Act (Dryfoos, 1988). In 1972, funding for family planning through Medicaid was also given authorization. The services provided under Title X expanded rapidly during the 1970s and 1980s, with a subsequent shift in public funding for family planning toward the Medicaid program after 1980 (Dryfoos, 1988).

During the 1970s and 1980s, contraceptive sterilization became increasingly common and is now the most widely used method in the country (Forrest, 1994). Although there was an initial increase in the use of IUDs in the early 1980s, concerns about intrauterine infections led to a decline in their usage (Forrest, 1994). Throughout the 1980s and 1990s, condom usage among adolescents rose, likely driven by growing concerns about HIV infection and other sexually transmitted diseases (STDs) (Sonenstein, 1998). Since 1991, the increased adoption of long-acting hormonal contraception, such as Depo-Provera and Norplant has also contributed to the decline in adolescent pregnancy rates (Sonenstein, 1998). Oral contraceptives provide non-contraceptive health benefits, including lower rates of pelvic inflammatory disease, ovarian and endometrial cancers, recurrent ovarian cysts, benign breast cysts and fibroadenomas, and relief from menstrual cramps (Sonenstein, 1998).

In the United States, healthcare providers predominantly administer intrauterine devices (IUDs), hormonal contraception, and surgical sterilization procedures. By 1994, there were 3,119 organizations—including health departments, hospitals, and planned parenthood branches operating 7,122 publicly funded family planning clinics, catering to approximately 6.6 million women. These clinics play a crucial role in preventing an estimated 1.3 million unintended pregnancies yearly, thereby averting 165,000 miscarriages, 632,000 abortions, and 534,000 unwanted births. Around 22.5% of women obtained reversible contraception from public clinics in 1988, with adolescents (43%), individuals from low-income households (39%), and

unmarried women (34%) being the primary beneficiaries of these services (Frost, 1996).

***Contraception Worldwide***

Contraceptive use stands as the key factor behind decreasing fertility rates in developing nations, explaining 92 percentage of the fertility variance among fifty countries. During the 1960s and 1980s, overall fertility declined by about one-third, dropping from an average of six to four children per woman. This decline was notable in various regions, with a 24% reduction in Asia continent and Latin America (Westoff C. M., 1989), approximately fifty percentage in Thailand, and roughly Thirty-five percentage in Colombia, Jamaica, and Mexico. As fertility rates decreased in developing countries (Westoff C. M., 1989), infant mortality rates also saw a decline, dropping from around 150 deaths per 1000 live births in the 1950s to roughly 80 per 1000 in the early 1990s. Among married women of reproductive age in developing countries, 53% actively plan the size of their families, with 90% of them utilizing modern birth control methods like female sterilization, oral contraceptives, and IUDs (Robey, 1992).

***Key developments in Family Planning in the United States from 1900 to 1997***

**Table-1: Evolution of Family Planning in the United States (1900-1997)**

| | |
|---|---|
| 1900 | The initial standardized death certificate was established |
| 1914 | Margaret Sanger was detained for disseminating information about birth control |
| 1915 | Establishment of the first federal birth registration area. |
| 1916 | Opening of the inaugural birth control clinic in Brooklyn, New York, promptly shut down by the New York Vice Squad after ten days |
| 1925 | Initiation of the first diaphragm manufacturing in the US |
| 1928 | Determinant of ovulation time |
| 1937 | Endorsement of birth control by the American Medical Association |
| 1937 | Inclusion of birth control in a public health program by the first state, North Carolina |
| 1942 | The establishment of the Planned Parenthood Federation of America occurred |
| 1955 | Conducting of the first national fertility survey |
| 1960 | The birth control pill receiving the FDA's stamp of approval |
| 1960 | The intrauterine device garnering FDA approval |
| 1965 | The Supreme Court's decision in Griswold V. Connecticut invalidated state laws that prohibited married couples from using contraceptives |
| 1970 | Creation of Title X of the Public Health Service Act through the FP Services and Population Research Act |
| 1972 | Authorization of Medicaid funding for FP services |
| 1973 | Legalization of abortion by the Supreme Court (Roe vs. Wade) |
| 1973 | Conducting of the first National Survey of Family Growth |
| 1990 | Approval of Norplant® by the FDA |
| 1992 | Approval of Depo-Provera® by the FDA |
| 1993 | FDA approves of female condom |
| 1997 | FDA-approved use of oral contraceptives in an emergency |

*Sources: Hatcher, 2007*

***Effectiveness of Frequently Utilized Contraception Methods and the Proportion of Couples Employing Each Method – United States, 1995***

**Table-2: Contraception Method Usage and Effectiveness in United States**

| Contraceptive method | Perfect use | Typical use | Couples using the method (in %) |
|---|---|---|---|
| (Norplant®/2®) | 0.05% | 0.05% | 1.3% |
| Sterilisation of men | 0.10% | 0.15% | 10.1% |
| Pill | 0.1% | 5.0% | 24.9% |
| Injectable (Depo-Provera®) | 0.3% | 0.3% | 2.7% |
| Female sterilization | 0.5% | 0.5% | 25.6% |
| Intrauterine device | 0.6%† | 0.8%† | 0.7% |
| Male Condom | 3.0% | 14.0% | 18.9% |
| Removal | 4.0% | 19.0% | 2.9% |
| Diaphragm | 6.0% | 20.0% | 1.7% |
| Chemical substances (Spermicides) | 6.0% | 26.0% | 1.3% |
| Periodic abstinence | 9.0%§ | 25.0% | 2.2% |

*Sources: Hatcher, 2007*

***World Fertility and Family Planning 2020***

In commemoration of the 25th anniversary of the International Conference on Population and Development (ICPD) in 1994, governments reiterated the significance of the Programme of Action and its on-going implementation in achieving the Sustainable Development Goals (SDGs). The focus on ensuring universal access to a comprehensive range of safe and reliable family planning methods, empowering couples and individuals to make informed decisions about the timing and spacing of births, remains as vital today as it was in 1994.

The increasing adoption of contraceptive methods in recent years has not only led to health-related benefits such as reductions in unintended pregnancies, high-risk pregnancies, maternal and infant mortality, but also contributed to improvements in education and economic outcomes, particularly for girls and women. Beyond individual impacts, there are population-level benefits as well. From a macroeconomic perspective, declining fertility rates stimulate economic growth by reducing youth dependency and increasing female participation in the workforce.

However, continued rapid population growth poses challenges for achieving the 2030 Agenda for Sustainable Development, especially in sub-Saharan Africa, where countries must ensure provision of healthcare, education, and employment opportunities for growing youth populations. Given that long-term global population trends are largely driven by fertility patterns, understanding the relationship between contraceptive use and fertility, particularly in high-fertility contexts, is crucial for triggering or accelerating the demographic transition and leveraging demographic dividends.

The "World Fertility and Family Planning 2020: Highlights" report presents fresh evidence on trends in contraceptive usage and fertility, offering insights into the interplay between contraceptive use and fertility at global, regional, and national levels among women of reproductive age. This publication draws heavily from data provided by the 2019 revision of the World Population Prospects and Estimates and Projections of Family Planning Indicators 2019 (United Nations Department of Economic and Social Affairs, Population Division, 2020).

1. Globally, women are having fewer babies, but fertility rates remain high in some parts of the world: Globally, there has been a reduction in the number of children women are having, although certain regions still maintain high fertility rates. From 1990 to 2019, the global fertility rate decreased from 3.2 live births per woman to 2.5. Notably, sub-Saharan Africa, known for its high fertility rates, saw a decline from 6.3 births per woman in 1990 to 4.6 in 2019. Similar trends were observed in other regions: Northern Africa and Western Asia decreased from 4.4 to 2.9, Central and Southern Asia from 4.3 to 2.4, Eastern and South-Eastern Asia from 2.5 to 1.8, Latin America and the Caribbean from 3.3 to 2.0, and Oceania excluding Australia and New Zealand from 4.5 to 3.4. Fertility rates in Australia, New Zealand, Europe, and Northern America were already below 2.0 live births per woman in 1990 and remained so in 2019, with an average of 1.8 births per woman in Australia and New Zealand and 1.7 in Europe and Northern America. (United Nations Department of Economic and Social Affairs, Population Division, 2020).

2. The decline of fertility in sub-Saharan Africa has been relatively slow and occurring later compared to other regions: The decline in fertility rates across sub-Saharan Africa has been comparatively slow, occurring later than in other regions. In 1950, the total fertility rate exceeded 6.0 live births per woman in Eastern and South-Eastern Asia (6.1), Northern Africa and Western Asia (6.6), Oceania (6.2), and sub-Saharan Africa (6.5). Over a span of 24 years, from 1950 to 1974, Eastern and South-Eastern Asia saw a decrease in the total fertility rate from 6.0 to 4.0 live births per woman. Conversely, Northern Africa and Western Asia experienced the same reduction over 19 years, from 1974 to 1993, and Oceania over 35 years, from 1968 to 2003. Projections suggest that sub-Saharan Africa may require approximately 34 years, from 1995 to 2029, for fertility rates to decline from 6.0 to 4.0 live births per woman (United Nations Department of Economic and Social Affairs, Population Division, 2020).

3. Although fertility in 2019 was higher in sub-Saharan Africa compared to other regions, a number of countries in this region have seen large declines in total fertility in recent years: During the period from 2010 to 2019, seven out of the top ten countries that experienced the most significant declines in total fertility rates were located in sub-Saharan Africa. These countries include Chad, Ethiopia, Kenya, Malawi, Sierra Leone, Somalia, and Uganda.

4. Globally, fertility rates are on a downward trajectory: Projections from the United Nations indicate a decline to 2.2 live births per woman by 2050 and further down to 1.9 by 2100. In sub-Saharan Africa, fertility is expected to drop to 3.1 births per woman by 2050 and 2.1 by 2100.

5. The prevalence of contraception among women of reproductive age has seen a notable rise since 1990. In 2019, 49% of women aged 15-49 were utilizing contraception, marking an increase from 42% in 1990.

6. Contraceptive usage has witnessed growth across all regions from 1990 to 2019. In sub-Saharan Africa, usage rose from 13% in 1990 to 29% in 2019. Similarly, Oceania saw an increase from 20% to 28%, Western Asia and Northern Africa from 26% to 34%, Central and Southern Asia from 30% to 42%, and Latin America and the Caribbean from 40% to 58%. By 1990, contraceptive prevalence had surpassed 50% in all other regions, including Northern America and Europe (from 57% to 58% by 2019), Eastern Asia and South-Eastern Asia (from 51% to 60%), and Australia and New Zealand (from 56% to 58%).

7. Modern Contraception Dominates: In 2019, globally, 44% of women of reproductive age were using modern contraceptive methods, constituting 91% of all contraceptive users. The remaining 9% relied on traditional methods.

8. Sub-Saharan Africa's Rising Modern Contraception: While modern contraceptive usage was lower in sub-Saharan Africa in 2019 compared to other regions, several countries in the region experienced significant increases. The top 10 countries with the largest growth in modern contraception use between 2010 and 2019 are all located in sub-Saharan Africa.

9. Contraception and Fertility Dynamics: There exists an inverse correlation between contraceptive use and fertility rates. Countries with higher contraceptive prevalence tend to have lower fertility levels. However, in 2019, sub-Saharan African countries, despite increased contraceptive use, still exhibited higher fertility rates compared to other regions.

10. Complexities of Contraception-Fertility Relationship: The relationship between contraceptive use and fertility is multifaceted. Besides contraceptive method choice, various socio-economic factors influence fertility decisions. Other determinants include abortion rates, breastfeeding duration affecting postpartum fertility, secondary sterility prevalence, and the proportion of the population engaged in sexual activity or marriage.

11. Impact of Modern Contraception on Fertility: Further reductions in fertility rates, particularly in sub-Saharan Africa, are anticipated with the continued rise in modern contraception usage. However, achieving these declines will hinge on advancing gender equality and women's empowerment. This necessitates greater male involvement in family planning, promoting female education, eradicating violence and discrimination against women, ending early and forced marriages, and ensuring women's equal access to employment, social protection, and political participation.

12. Fulfilling Commitments to Sexual and Reproductive Health: Achieving universal access to sexual and reproductive health-care services, information, and education by 2030 demands heightened support for family planning. Effective government policies and programs are crucial for meeting this commitment. Through initiatives like the ICPD Programme of Action and the 2030 Agenda for

Sustainable Development, governments pledged to enable individuals and couples to fulfil their reproductive goals. Honouring these commitments entails fully meeting the demand for family planning by investing in and providing accessible reproductive and health-care services for all.

***Family planning in India***

The latest available survey data, NFHS-3 (2005-06) and DLHS-3 (2007-08), are currently utilized to depict the present state of family planning in India. Across the nation, there is widespread acceptance of the small family norm, with the desired fertility rate standing at 1.9 for India as a whole, according to NFHS-3. Moreover, there is nearly universal awareness of contraception, with 98% among women and 98.6% among men reported in NFHS-3. Both NFHS and DLHS surveys indicate a general uptrend in contraceptive usage. In NFHS-3, contraceptive use among married women aged 15-49 years was 56.3%, marking an increase of 8.1 percentage points from NFHS-2. While DLHS-3 also showed an increase from 52.5% to 54.0%, the rise was relatively modest compared to NFHS findings. The key factors influencing fertility, such as age at marriage and age at first childbirth, are displaying positive trends at the national level, reflecting societal preferences.

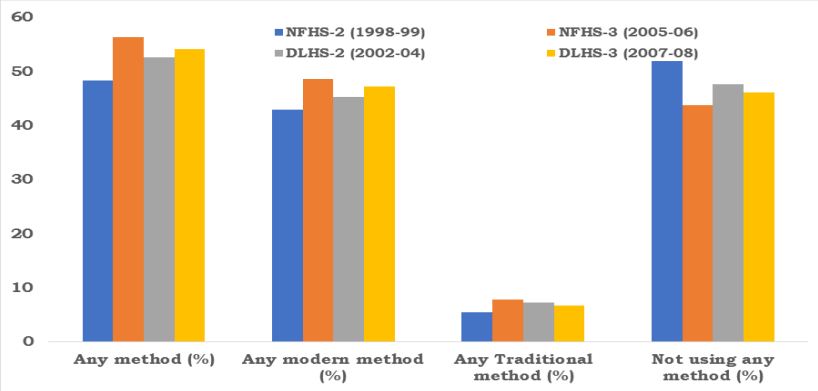
An AHS survey conducted in 9 states, including 8 EAG states and Assam, reveals specific regional variations:

1. Contraceptive use has remained largely stable in most AHS states, except Bihar, which has experienced a decline in the use of modern contraceptives. Rajasthan and Chhattisgarh, however, have witnessed significant increases in modern contraceptive usage.

2. The unmet need for contraception has decreased across all states except for Madhya Pradesh, where it has remained unchanged.

3. Overall, while there are improvements in contraceptive usage and declines in unmet needs in several states, regional variations persist, underscoring the importance of targeted interventions to address specific challenges in different parts of India (Government of India, 2015).

**Figure-1: Trends in Contraceptive Method Use in India**




*Source: Compiled by authors from NFHS & DLHS survey rounds, 1998-2008*

***District Wise Contraceptive Prevalence***

Table-3 shows the districts with the highest contraceptive prevalence.

**Table-3: State Wise TFR, Modern Contraceptive Prevalence & Unmet Need for High Focus States**

| States | Total Fertility Rate (in %) | | | Modern Contraceptive Prevalence (in %) | | | Unmet Need (in %) | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2010 | 2011 | 2012 | 2010 | 2011 | 2012 | 2010 | 2011 | 2012 |
| Uttarakhand | 2.3 | 2.1 | 2.1 | 55.4 | 54.1 | 54.3 | 23.2 | 18.1 | 15.3 |
| Odisha | 2.3 | 2.3 | 2.2 | 44 | 46.8 | 46.3 | 23.2 | 19.1 | 18.9 |
| Assam | 2.6 | 2.4 | 2.4 | 35.7 | 37.9 | 38.1 | 24 | 15.9 | 13.1 |
| Chhattisgarh | 2.9 | 2.8 | 2.7 | 49.5 | 55.4 | 57.2 | 26.4 | 24.8 | 24.4 |
| Jharkhand | 3.1 | 2.9 | 2.7 | 38 | 43.9 | 43.7 | 30.5 | 22.6 | 22.3 |
| Rajasthan | 3.2 | 3.1 | 2.9 | 58.8 | 59.4 | 62.4 | 19.6 | 12.6 | 13 |
| Madhya Pradesh | 3.1 | 3.1 | 3 | 57 | 59.3 | 59.4 | 22.4 | 21.6 | 21.6 |
| Uttar Pradesh | 3.6 | 3.4 | 3 | 31.8 | 37.3 | 37.6 | 29.7 | 24.1 | 20.7 |
| Bihar | 3.7 | 3.6 | 3.5 | 33.9 | 38.2 | 36.5 | 39.2 | 33.5 | 31.5 |

*Source: Compiled by authors from NFHS survey rounds, 2010-2012*

***The Salient Features of the Family Planning Programme in India***

*1. On-going Interventions*

- More emphasis on spacing methods like IUCD.
- Availability of Fixed Day Static Services at all facilities.
- Emphasis on minilap tubectomy services because of its logistical simplicity and associated with less failure and complication rates.
- 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 IUD insertion.
- Ensuring quality care in Family Planning services by establishing Quality Assurance Committees at State and district levels
- Accreditation of more private/NGO facilities to increase the provider base for family planning services under PPP.
- Increasing male participation and promoting Non- Scalpel Vasectomy.
- Compensation scheme for sterilization acceptors, under the scheme, Ministry of Health & Family Welfare provides compensation for loss of wages to the beneficiary and also to the service provider (& team) for conducting

sterilizations. The compensation scheme has been enhanced in 11 high focus States from the year 2014.

- 'National Family Planning Indemnity Scheme' under which clients are indemnified in the eventualities of deaths, complications and failures following sterilization. The providers/ accredited institutions are indemnified against litigations in those eventualities.
- Post-Partum Intra-Uterine Contraceptive Devices (PPIUCD) Incentive for service providers and ASHAs
- Ministry of Health & Family Welfare has introduced short term IUCD (5 years effectivity), Cu IUCD 375 under the National Family Planning Programme. Training of State level trainers has already been completed and process is underway to train service providers up to the sub-centre level.
- A new method of IUCD insertion (postpartum IUCD insertion) has been introduced by the Government.
- Promoting post-partum family planning services at district hospitals by providing for placement of dedicated family planning counsellors and training of personnel.

*2. Home Delivery of Contraceptives (HDC)*

- A new scheme was launched to utilize the services of ASHA to deliver contraceptives at the doorstep of beneficiaries. The scheme was launched in 233 pilot districts of 17 States on 11 July 2011 and later expanded to the entire country from 17th December 2012.
- ASHA is charging a nominal amount from beneficiaries for her effort to deliver contraceptives at doorstep i.e. Re. 1 for a pack of 3 condoms, Re. 1 for a cycle of OCPs and Rs. 2 for a pack of one tablet of ECP.

*3. Ensuring Spacing at Birth (ESB)*

- Under a new scheme launched by the Government of India, services of ASHAs to be utilised for counselling newly married couples to ensure spacing of 2 years after marriage and couples with 1 child to have spacing of 3 years after the birth of 1st child. The scheme is operational in 18 States (EAG, North Eastern and Gujarat and Haryana). ASHA would be paid following incentives under the scheme:
  (a) Rs. 500/- to ASHA for delaying first child birth by 2 years after marriage
  (b) Rs. 500/- to ASHA for ensuring spacing of 3 years after the birth of 1st child and Rs. 1000/- in case the couple opts for a permanent limiting method up to 2 children only
- The PTKs are being made available at sub-centers and to the ASHAs.

*4. Pregnancy Testing Kits (PTKs)*

- Nishchay: Home based Pregnancy Test Kits (PTKs) was launched under NRHM in 2008 across the country and was anchored with the Family Planning Division on 24th January, 2012.
- The PTKs facilitate the early detection and decision making for the outcomes of pregnancy.

***Government Policies and Initiatives Related to Family Planning on a Global Scale***

*United Nations Population Fund (UNFPA):* The UNFPA stands as a global advocate for population issues and reproductive health. It collaborates with nations worldwide to design and implement family planning initiatives, emphasizing access to contraception and maternal healthcare.

*International Conference on Population and Development (ICPD):* The ICPD convened in Cairo in 1994, marking a pivotal moment in addressing global population concerns. It underscored the significance of reproductive rights, gender equality, and accessible family planning services in fostering sustainable development.

*Family Planning 2020 (FP2020):* FP 2020, established in 2012, embodies a collaborative effort to extend family planning services to 120 million more women and girls in low- and middle-income countries by 2020. It operates through partnerships with governments, NGOs, and donors to fortify family planning programs globally.

*National Family Planning Programs:* Numerous nations have instituted comprehensive family planning programs, tailored to their unique contexts. These programs encompass subsidized contraceptives, reproductive health education, and community outreach, serving as cornerstones for reproductive health initiatives.

*Contraceptive Procurement and Distribution Programs:* Governments and international entities actively engage in procurement and distribution endeavours to ensure widespread access to contraceptives. Collaborations with pharmaceutical firms, NGOs, and healthcare providers sustain a steady supply chain, making contraceptives affordable and attainable.

***Policy Reforms and Legislation***

Legislative measures play a vital role in safeguarding reproductive health rights and fostering family planning endeavours. Governments enact laws to guarantee access to contraception, regulate reproductive health services, and uphold individuals' autonomy over their reproductive choices.

***Healthcare Infrastructure Development***

Strengthening healthcare infrastructure is imperative for the effective delivery of family planning services. Governments allocate resources to enhance healthcare facilities, train personnel, and integrate family planning into primary healthcare frameworks, ensuring accessibility and quality care.

***Public Awareness Campaigns***

Public awareness campaigns serve as catalysts for promoting family planning and reproductive health literacy. These initiatives disseminate information on

contraceptive options, debunk misconceptions, and empower individuals to make informed decisions regarding their reproductive well-being.

In essence, these initiatives exemplify concerted global endeavours aimed at advancing family planning objectives, enhancing reproductive health outcomes, and empowering individuals to assert control over their reproductive destinies. Despite progress, addressing existing challenges and disparities remains paramount in achieving universal access to family planning services and promoting reproductive health equity.

## V. CONCLUSION

In summary, the study delves into the historical roots and evolution of family planning policies and practices, highlighting the societal, technological, and ideological influences that have shaped the field. Successful national family planning programs employ diverse, high-quality services supported by clear policies, monitoring, and evaluation, and involve outreach strategies to ensure broad accessibility. The historical context demonstrates the progression from early rudimentary methods to the modern era's emphasis on reproductive rights and gender equality. International agreements and frameworks, such as the Programme of Action and the 2030 Agenda for Sustainable Development, acknowledge the importance of universal access to family planning services and the fundamental right for individuals to make informed decisions about their reproductive health. The report also highlights global trends in fertility rates and contraceptive usage, demonstrating a decline in the number of children women are having globally, with increases in contraceptive usage across all regions. Overall, the study emphasizes the critical role of family planning in promoting sexual and reproductive health and rights worldwide.

In tracing the historical trajectory of family planning, one discerns narrative rich in complexities, marked by both commendable progress and persistent challenges. The antiquated practices of ancient civilizations, reliant on rudimentary methods such as herbal contraceptives and abstinence, laid the groundwork for humanity's exploration of reproductive control. However, the effectiveness and reliability of these early methods were limited, underscoring the arduous journey towards modern-day family planning.

The late 19th and early 20th centuries witnessed the emergence of the birth control movement, spearheaded by visionary activists like Margaret Sanger. Their tireless advocacy for women's rights to contraception ignited a transformative shift in societal attitudes towards reproductive health. Concurrently, the shadow of the eugenics movement loomed large, advocating for coercive measures to control human reproduction, thereby exposing a darker facet of family planning history.

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