Meeting the Unmet Need

A Choice-Based Approach to Family Planning

Introduction

Family planning is an important tool for fulfilling people's reproductive health and fertility needs and has rightly been at the heart of political and programmatic interventions in India as well as globally. However, India's family planning programme, despite its numerous successes, has had to contend with misconceptions, lack of information around contraceptives, and a continuing gap in public perception on the importance and need for family planning. There has also been a recognition of the persisting unmet need for family planning (henceforth, unmet need), which can be a barrier to women's realisation of their optimal reproductive health and fertility needs.

Simply put, unmet need refers to the "condition of wanting to avoid or postpone childbearing but not using any method of contraception" to do so (Casterline and Sinding 2000: 3). Per National Family Health Survey–4 (NFHS–4 2015-2016), unmet need in India is defined as the "proportion of women who:

(1) are not pregnant and not postpartum amenorrhoeic, are considered fecund, and want to postpone their next birth for two or more years or stop childbearing altogether, but are not using a contraceptive method, or
(2) have a mistimed or unwanted current pregnancy, or
(3) are postpartum amenorrhoeic and their last birth in the last two years was mistimed or unwanted"[1].

Unmet need can be further disaggregated into unmet need for limiting births and unmet need for spacing births[2]. Unmet need also varies across parameters, like geography, age, education, religion, caste, and economic status, among others (New et al. 2017). In India, women in rural areas report a higher unmet need than their urban counterparts and there are interstate variations in unmet need.[3] Unmet need also varies across social indices, with contraception use at its lowest (45%) among women from Scheduled Tribes, followed by Other Backward Classes (47%) and those from Scheduled Caste (49%) (NFHS–4).

Women's unmet need is dynamic and can change over a period of time as their fertility desires alter, when women want to change their contraceptive method, or when deciding to return to contraception following childbirth (Jain et al. 2012). During these

[1] National Family Health Survey 2015–16, henceforth NFHS–4. Although, and as the definition above indicates, unmet need can be assessed through a gap between DFR (Desired Fertility Rate and TFR (Total Fertility Rate), or through childbirths that are classified as "unwanted", scholars have emphasised not using "unwanted" births as a unit of measurement, owing to its susceptibility to underestimate "unwanted" births. For example, many women, post-birth, are likely to classify a live birth as wanted even though the pregnancy was unwanted; unwanted births also does not capture unwanted pregnancies that did not result in births (see, Casterline and Sinding 2000 for a more comprehensive account).

[2] In NFHS–4, unmet need for spacing methods was 5.6% and 7.2% for limiting methods.

[3] As per NFHS–4, overall unmet need was highest in Manipur (30.1%), Nagaland (22.3%) and Sikkim (21.7%), and lowest in Andhra Pradesh (4.6%), Punjab (4.6%) and Chandigarh (6.2%).

phases, women's met need may convert into unmet need if the period of contraceptive non-use is prolonged due to factors like inability to access quality care, find contraceptives that match their needs and desires, or if women are unable to get quality counselling to help them with their contraceptive choices. Various global studies have documented such conversion–of met need into unmet need–particularly due to contraceptive discontinuation, which can subsequently lead to unwanted fertility and childbirths (Jain et al. 2014; Casterline et al. 2004).

This paper examines factors that contribute to unmet need in India and proposes a choice-based approach while formulating and implementing family planning policies and programmes. Following in the footsteps of the approach put forth during the International Conference on Population and Development (ICPD), the choice-based approach recognises that women have different choices and individual preferences for their fertility, family planning and contraceptive use, and aims to build policies and programmes that ensure that women have options to choose from, accurate and complete information to facilitate their choice, and the freedom to exercise their choice. This paper ends with specific recommendations that can uphold and engender choice in developing and strengthening programmes and policies in India to reduce the unmet need and addressing social and cultural determinants of meeting unmet need.

Unmet Need and Family Planning – Global Context

Although unmet need for family planning has been deduced in the perceived gap between women's reproductive intentions and their contraceptive use (previously known as the KAP-gap–or gap between knowledge, attitude and practice), the concept itself came to prominence with the International Conference on Population and Development (ICPD) in 1994 (Bradley et al. 2012; Bradley and Casterline 2014; Visaria and Ved 2016). ICPD was a watershed moment that marked a paradigm shift in the focus of family planning programmes from achieving targets to improving and strengthening the provision of reproductive health-related information and services. Critical of target-oriented population policies and family planning programmes, the ICPD Plan of Action (PoA) rejected them on grounds that they often led women into unwanted and coercive sterilisations–measures that violated women's right to informed consent and disregarded their choice and fertility preferences (Garcia-Moreno and Claro 1994). Instead, ICPD urged for a human rights-based approach to address population concerns, emphasising the possibilities of achieving a desired family size through striving for wider gender development, such as, ensuring gender equality, working for women's empowerment, improving their education and economic independence, and making quality reproductive healthcare accessible to all (UNFPA and PATH 2008; Kulkarni 2020; Sen 2010; Hardee et al. 2014).

Subsequently, meeting the unmet need of women has emerged as a critical measure of reproductive health and family planning that could align the two distinct aspects of family planning programmes–achieving population stabilisation and enhancing reproductive health–while upholding individual choice

and striving for social change, particularly through gender development. Over the years, unmet need has been mobilised as "a rationale for increasing investments in family planning programs; to evaluate national family planning programs and measure [their] progress…", and to set global development goals, such as the Sustainable Development Goal (goal 5) to "…achieve gender equality and empower all women and girls" by ensuring universal access to sexual and reproductive health and reproductive rights (United Nations, Sustainable Development Goals). Most recently, the FP2020 initiative aimed at adding additional 120 million contraceptive users globally by 2020 (UNFPA and PATH 2008; Hardee and Jordan 2019; Hardee et al. 2014).

Unmet Need and Family Planning - India

India launched its Family Planning Programme in 1952, with goals to stabilise population growth rate, reduce fertility levels and improve maternal health. Since then, India has traversed a long path to make sexual and reproductive health services, including family planning, available to a large population in its reproductive age group (15-49 years). As a signatory to the ICPD PoA, India committed to an approach that would focus on people rather than numbers, and address the unmet need by increasing access, availability and choice of contraceptives, ensuring quality of care, and working towards last-mile reach and connectivity through expanding the penetration of reproductive healthcare through frontline workers (Rao 2003). Subsequently, India's National Population Policy (2000) reflected the government's commitment to voluntarism, informed choice and consent in availing reproductive healthcare services. It also called for a comprehensive approach to population stabilisation and for addressing the social determinants of health, promoting women's empowerment and education, adopting a target-free approach, encouraging community participation and ensuring convergence of service delivery at the community level. India was also part of the first cohort of countries who committed to the FP2020 initiative in 2012. These commitments were revitalised in 2017 with the country working to increase modern contraceptive prevalence rate from 53.1% to 54.3% and to ensure that 74% of the demand for modern contraceptives would be satisfied (Family Planning 2020–India).

To realise these commitments, the government of India has undertaken various initiatives that strengthen its family planning programme. India has promoted the use of modern contraceptives and steadily expanded its basket of contraceptive choices, with the most recent addition in 2017, of three new spacing methods: Injectable contraceptive DMPA (Antara)–a 3-monthly injection; Centchroman pill (Chhaya)–a non-hormonal once a week pill; and Progesterone-only Pills (POP). The government also launched Mission Parivar Vikas for increasing access to contraceptives and family planning services in 146 high fertility districts in 7 high focus states (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand and Assam) that reported a total fertility rate of 3 and above (Press Information Bureau 2017). In 2019, India upheld and renewed its commitment to the ICPD PoA made in Cairo in 1994 and at

ICPD+25, where, alongside other signatory countries, India too committed to ensuring sexual and reproductive health and rights for all by 2030 and to engage the private sector towards this end (UNFPA 2019).

The efforts made by the government for decades under the umbrella of the family planning programme have significantly contributed to India's progress toward stabilising its population and strengthening the provision and delivery of family planning services. The pace of India's population growth has steadily slowed down and there has been a decline in fertility rate. According to the NFHS–4, the Total Fertility Rate (TFR)– that is, the average number of live births a woman would have in her life as she passes through her child bearing years–decreased from 3.4 in 1992-93 to 2.2 in 2015-16, just a little over replacement level fertility of 2.1, at which India's population would exactly replace itself from one generation to the next. The decadal growth rate also reduced: from 21.5 per cent in 1991-2001 to 17.7 per cent during 2001-2011[4].

Yet, the desired fertility rate (DFR, also known as wanted fertility rate), which is defined as the number of children a woman *wants* to have in her reproductive lifespan, has continued to lag behind TFR and attests to the fact that women want smaller families than they are able to have. DFR in India is currently 1.8 and per NFHS–4, 13% of married women in the reproductive age group (15-49 years) across India have an unmet need for family planning. This unmet need is likely to expand if one takes into account unmarried and sexually active young women (Bradley et al 2014; Sedgh and Hussain 2014).

Scholars also suggest that unmet need is likely to grow in the coming years if the pace of contraceptive uptake does not increase in tandem with people's desired family size and their need for planned and timed births (Sedgh and Hussain 2014). Others have expressed concern over the steady stagnation in unmet need, particularly noticeable in the minimal change in unmet need between NFHS–3 (13.9%) and NFHS–4 (12.9%) and a decline in the modern contraceptive prevalence rate from 48.5% in NFHS–3 to 47.8% in NFHS–4 (Kulkarni 2020).

According to NFHS–4, female sterilisation continues to account for the highest contraceptive uptake at 75%. Family planning is primarily considered a woman's responsibility and there is limited male engagement as is reflected in the fact that condom uptake (11.72%) and male sterilisation (0.63%) are still significantly low. Given these trends, it is not surprising that a large number of women resort to abortions as a proxy for contraception; one study posits abortions in India at 15.6 million in 2015 (Singh et al. 2018).

Given these figures and trends, it is important to understand factors that contribute to unmet need and examine measures that can alleviate these to reduce unmet need.

[4] Despite decline in fertility and population growth rate, the overall size of the India's population will continue to increase for some more time as two thirds of country's population is under 35 years. Even if this cohort of young population produces only one or two children per couple, it will result in an increase in population size before it begins to stabilise, which, as per current projections, will happen around 2050.

Factors Impacting Unmet Need

Various factors contribute to women's unmet need for family planning. These include access to quality of care, level of information about contraceptives, quality of counselling, and sociocultural norms that hinder contraceptive use. More recently, there has been a disruption of essential health services during the COVID–19 pandemic and extended lockdown periods, which is likely to exacerbate unmet need. Most of these factors could be partially addressed by adequate investments in family planning.

Quality of Care

Quality care, including a **mix of contraceptive methods**, needs to not only be available but also affordable and easily and consistently accessible, especially in regions and within communities that report high unmet need. India has expanded its basket of contraceptive choices and included additional methods for spacing, but the rollout and availability of the new contraceptive methods has been slow and uneven, leaving the opportunity to improve the last-mile reach of quality reproductive healthcare services in underserved regions.

Capacity building of frontline workers (FLWs) is also crucial to ensure quality of care. Along with building the infrastructure for quality reproductive healthcare, FLWs in India are instrumental in connecting women, especially from marginalised communities and those in rural and remote areas, with reproductive healthcare services and can, with adequate capacity building and resources, enhance the deeper penetration of quality family planning care.

Provider attitude in reproductive healthcare delivery significantly impacts the quality of care and women's ability to fulfil their unmet need. Healthcare providers and FLWs may reflect societal values and stereotypes attached with religion, gender, class, and caste, that can negatively affect health-related communication and decisions. In India, with the stigma around premarital sexual activity, partisan provider attitude often deters young and unmarried women from even trying to access contraceptives. Provider attitude may also reflect a healthcare provider's personal preference for one form of contraceptive over others, following which they may not share complete information on all available contraceptives with women. Competing legal frameworks can also create fear and doubt among healthcare providers to prevent young and sexually active people from accessing contraceptives. For example, the Protection of Children against Sexual Offenses Act, 2012 (POCSO) decrees that healthcare providers must inform the local authorities of suspected sexual activity among minors, including seeking contraceptives and contraceptive advice. This can dissuade healthcare providers from offering information, counselling and contraceptives to unmarried and sexually active young people.

Global evidence suggests that the quality of care received at initial method adoption is associated with improved continuation with contraceptive use and a reduction in subsequent unwanted fertility (Jain et al.

2014). Improving the quality of care can reduce unmet need among women by creating demand of contraceptives among new users, preventing attrition among current users, and closing the gap when women are without contraception but do not desire to be pregnant, as happens when women are considering switching contraceptives or planning to return to contraceptive use after childbirth (Jain et al. 2014; Muttreja and Singh 2018; Jejeebhoy et al. 2014; Presler-Marshall and Jones 2012).

Information and Effective Counselling

Several research studies have documented a general lack of comprehensive knowledge about contraceptives among clients as well as providers across developing countries. This incomplete or inaccurate information about contraceptives is a major contributor to women's unmet need in India as well (Bongaarts and Bruce 1995; Viswanathan et al. 1998; Mishra et al. 1999; Jejeebhoy et al. 2014).

The perceived negative health effects of contraceptive use, such as side effects, infertility, and disruption in menstruation cycle, are another deterrent to women's use of contraceptives, often leading to early discontinuation and overall non-adherence despite their desire to limit or space fertility (Sedgh and Hussain 2014). Although, as Muttreja and Singh (2018: 3) note, the introduction of any "new contraceptive method has always been marred by controversies surrounding their efficacy, side effects and safety", these concerns can be easily addressed by the provision of effective counselling services and capacity building of FLWs, that can enable clients to choose a method of their choice, address women's lack of knowledge and fears regarding the health effects of contraceptives, and tailor recommendations based on their needs and constraints.

Social Norms

Another major reason for women's unmet need is the anticipated social opposition from husbands, families, communities, and religious leaders, to the use of contraceptives and to women's desire to regulate fertility. Women may be discouraged from regulating their fertility in societies where this is frowned upon or in societies where more births and more children are encouraged (Casterline and Sinding 2000; Jejeebhoy et al 2014; Hardee et al. 2014; Jain et al. 2014). Women may also internalise these norms as it is evident among newly married women and couples who aspire to get pregnant right after marriage to prove their fertility in contravention of their desires for family planning. In India, the prevalence of son-preference is a major hindrance to the use of contraceptives–women who do not have as many male children as they or their families desire, may be deterred from using contraceptives (Kulkarni 2020).

These social pressures are amplified when women feel they do not have their **partners' support or engagement** in family planning. Men may not participate in discussions on family planning, leaving the burden of decision-making and social opposition on women. Women may also fear that their partners would disapprove, refuse, or respond with violence to any conversation on using contraceptives. Women's inability to negotiate contraceptive use with their partners is yet another element of social opposition that can exacerbate their unmet need.

The knowledge gap that contributes to women's unmet need is often rooted in early childhood and adolescence education that reflects prevailing taboos against open discussions on reproductive and sexual health (Jejeebhoy et al 2014; Hardee et al 2014). In India, **a systemic and institutional discussion on comprehensive sexuality education**, that includes information on conception, contraception, and reproductive health among other aspects, is currently inadequate. Research suggests that having access to comprehensive sexuality education delays sexual debut, contributes to safer sex practices, and improves reproductive health outcomes, such as planned and smaller families and increased spacing between children (UNESCO 2009). Furthermore, introducing conversations on sexuality and reproductive health can also enhance partner engagement in fertility and contraceptive decisions, empowering women to articulate and fulfil their choices.

Impact of COVID-19 on Family Planning

The ongoing COVID-19 pandemic is slated to disrupt the already limited access to reproductive healthcare and family planning services. Guttmacher Institute's recent estimates (Riley et al. 2020) anticipate a 10% decline in use of reversible contraceptive methods in low and middle-income countries that would result in an additional 49 million women with an unmet need for modern contraceptives and an additional 15 million unintended pregnancies globally, over the course of a year.

In India too, COVID–19 has hit reproductive healthcare services hard, and is likely to increase unmet need in the coming years. A comparative analysis of NHM's Health Management Information System (HMIS 2020) data from April-June 2020 with April-June 2019 reveals that contraceptive distribution and uptake decreased significantly during the COVID–19 lockdown period. It shows:

- 86% drop in male sterilisation and 73% drop in female sterilisation
- 50% drop in the use of interval, 19% in postpartum, and 28% in post-abortion IUCD
- 43% reduction in the use of injectables
- 21% drop in OCP and condom distribution, each, and
- 59% drop in Centchroman (weekly) pill distribution.

The impact of this interruption is positioned to negatively affect India's reproductive health indicators in the years to come. As per the Foundation for Reproductive Health Services–India report (2020), the inability to access contraceptives is likely to result in an additional 2.38 million unintended pregnancies, 679,864 live births, 1.45 million abortions (including 834,042 unsafe abortions) and 1,743 maternal deaths.

Recommendations

Taking cognisance of the factors that contribute to unmet need in India, certain recommendations are offered below that are critical to reduce unmet need.

1. **Strengthen Quality of Care and Strengthen Family Planning Counselling**: To fulfil their unmet need, women need access to affordable and quality reproductive healthcare and family planning services, including a basket of contraceptive choices, last-mile connectivity with healthcare services, and interactions with healthcare providers and FLWs that are empathetic and prejudice-free to facilitate informed decision-making around choice of contraceptives and their use.

   Counselling services for reproductive health and family planning must be strengthened to ease women's introduction to contraceptives and facilitate their use by sharing complete information on all available options, how to use them correctly, anticipated health effects and how to manage them. Healthcare providers and FLWs must be trained to assess women's needs and constraints, fertility preferences and experiences, and to suggest contraceptives that are best suited to individual requirements. Regular follow-ups with contraceptive users, including inquiring about their health, their experience with current contraception, and information on any new contraceptives, must be conducted and monitored to ensure that quality counselling and information is provided (for more details, see Population Foundation of India's white paper on family planning Counselling 2020).

   Healthcare providers and FLWs must also be routinely sensitised to eliminate partisan provider attitude that can prevent young people and unmarried women from accessing contraceptives.

2. **Expand the Basket of Contraceptive Choices**: Global evidence suggests that expanding the basket of contraceptive choices by adding new and more contraceptive methods, particularly LARCs, has a positive impact on reducing unmet need. Data from around the world over the course of the last 27 years show that for every additional contraceptive method that is made available, there has been an increase in overall modern contraceptive use (mCPR). The addition of one method available to at least half the population correlates with a 4–8 percentage point increase in total use of modern methods (Ross and Stover 2013). In India too, mCPR increased by 1.8 percentage points (from 52.6 in 2016 to 54.4 in 2019) when two new methods (Injectable MPA and Centchroman) were introduced in 2016 in 146 Mission Parivar Vikas districts, and then gradually made available in all the 718 districts in the public sector. These trends support our recommendation that by expanding the basket of contraceptive choices, mCPR improves, contributing in turn, to a reduction in unmet need. With India's young population and their fertility patterns in mind, it is recommended that methods for spacing rather than limiting be advocated.

Although, in 2017, the Indian government introduced three new contraceptives to the already existing five methods, the rollout and availability of these new methods needs to be streamlined to ensure a pan-India availability of and easy accessibility to the said basket to effectively reduce unmet need in a sustained fashion. It is recommended that the basket of contraceptive choices include **all contraceptive methods that are globally available** and that meet the global health and safety standards. Furthermore, it is recommended that **family planning services provision and delivery is strengthened** in rural areas, in states with high unmet need, and within marginalised communities.

3. **Social and Behavioural Change Communication (SBCC) for Enhancing Community Involvement and Partner Engagement**: The government must continue to work closely with civil society organisations to develop and promote SBCC interventions that challenge social determinants of unmet need, emphasise women's right to make decisions on their fertility and family planning, dispel myths and misconceptions around contraceptive use, and foster partner engagement and community involvement towards reducing unmet need. PFI, for example, developed an edutainment series, *Main Kuch Bhi Kar Sakti Hoon*–I, a Woman, Can Achieve Anything, telecast on national television to inform audience on the importance of reproductive and sexual health and assert women's agency and choice in family planning, with measurable success in enabling long-term positive changes in people's knowledge, attitudes and practices toward sexual and reproductive health, family planning, and contraception use (Population Foundation of India 2017; see also, Seemin and Sadiq 2015). Similar interventions must be designed, supported and implemented as part of family planning programmes to reduce unmet need and create a supportive and enabling social environment for women to realise their fertility desires.

Noting the discrepancies in contraceptive uptake that is currently skewed towards terminal methods, like female sterilisation, it is also recommended that **targeted demand generation campaigns** be undertaken to promote LARCs and create awareness about them to increase their uptake. Collaborating with relevant civil society organisations to create awareness on and generate demand for LARCs and develop strategies to ensure a widespread rollout and availability of contraceptive method mix across India, particularly in currently underserved regions and communities, is suggested.

4. **Sexual and Reproductive Health and Rights for Young People**: To bridge the knowledge gap on sexual and reproductive health and contraceptives, it is strongly recommended that age-appropriate comprehensive sexuality education be made an integral part of the school curricula in India. An encouraging step in this direction is the launching of the school health programme (SHP) under Ayushman Bharat, that aims to foster meaningful discussions on adolescent health and well-being, including their reproductive and sexual health. The recently approved National Education Policy, 2020, also highlights the importance of integrating essential

subjects, skills, and capacities, such as health and nutrition, collaboration and negotiation skills, ethical reasoning and decision making, gender sensitivity, and bodily awareness, in school curricula. This offers an opportunity for the government to collaborate with civil society organisations, like Population Foundation of India, who have been actively working in the arena of developing and disseminating adolescent reproductive and sexual health educational and training programmes through face-to-face interactions and digital platforms (for example, see Population Foundation of India's new digital initiative on adolescent health and well-being, Educately).

5. **Prioritise Family Planning and Reproductive Health Services in Emergency Situations:** The COVID-19 pandemic witnessed the diversion of resources globally towards an emergency response to the outbreak, even at the expense of other essential health services, which is bound to have long term consequences on the health and well-being of women and young people. Going forward, policymakers must put systems in place to ensure due prioritisation of essential health services even in the wake of a public health emergency.

6. **Increase Investment in Family Planning**: The factors mentioned above can be addressed to a great extent by adequate investment in family planning. Based on the National Health Mission (NHM) Record of Proceedings (RoP) assessment, although the budget for family planning activities has steadily increased–from 7 billion in 2014-15 to Rs. 11.56 billion in 2017-18–, it still constitutes a small fraction (4%) of the total National Health Mission budget. Furthermore, the expenditure on family planning has steadily declined from 79% of the allocated budget in 2014-15 to 63% in 2016-17 and to 59% in 2017-18 (NHM Financial Management Reports; Budgetary Allocation for Family Planning 2018). Till date, a majority of the government's expenditure on family planning has gone towards female sterilisation, with only 1.45% spent on spacing methods, and a similarly small fraction spent on trainings, skill and capacity building of healthcare providers and frontline workers (FLWs) (for more details, see Muttreja and Singh 2018).

The overall budgetary allocation for family planning programmes must be increased so as to enhance the quality of care, expand the basket of contraceptive choices and its availability, and to generate demand for LARCs. However, the need of the hour is not only to increase the budget allocation for family planning but to ensure adequate utilisation of the funds to enhance the reach, availability and affordability of quality care. Some suggested avenues of expenditure are towards:

- Investing in building health centres, equipping them with appropriate and adequate equipment and manpower,
- increasing and appropriately compensating FLWs who are responsible for deeper penetration and last-mile connectivity between women and reproductive healthcare,
- expanding and ensuring consistent distribution, easy availability and affordability of the basket of contraceptive choices, by taking

reproductive healthcare services to people,
- strengthening counselling for reproductive health and family planning,
- training and capacity building of healthcare providers and FLWs to eliminate partisan provider attitude.

Conclusion

This paper has examined family planning and reproductive health in India through the register of unmet need. Unmet need, defined as the gap between women's fertility desire and their contraceptive practices, has persisted despite significant advances made in the delivery of reproductive healthcare and improvement in associated indices of fertility, such as the TFR. The persistence of unmet need is indicative that women are still unable to fulfil their fertility desires. This concern is further exacerbated by the stagnation of unmet need in recent years as well as predictions in its growth in the coming years and the disruption caused by COVID-19 in the delivery and access to sexual and reproductive healthcare services. Situated in this context, and to continue building on the progress already made vis-à-vis the provision of sexual and reproductive and health services in India, it is urgent that a revitalised approach to reducing the unmet need is conceptualised.

The paper posits a choice-based approach to family planning, and drawing from local experience and global evidence, proposes certain recommendations that can give women options to choose from, equip them with knowledge to make an informed choice, and secure their freedom to exercise their choice. This paper is an invitation to renew conversations among various stakeholders– government agencies, relevant civil society organisations and activists, the media, healthcare providers and FLWs, women, their partners and the larger communities– so that India can collectively work towards reducing the unmet need for family planning, in ways that are cognisant of women's lived experiences, and by developing policies and programmes that are people-informed and need-centric.

This conversation is even more urgent now in the context of the ongoing COVID-19 pandemic that has already adversely impacted reproductive health services and is slated to negatively affect reproductive health outcomes as well (Development Solutions and Population Foundation of India 2020; Marie Stopes International 2020; Sharma et al. 2020). In this scenario, there is a pressing need to re-draw attention and investment to reproductive health so that women's needs are not neglected and that the gains made by India in the arena of family planning are not lost.

Population Foundation of India also urges the media to use its platforms and its voice to engage in conversations on the importance of family planning and reproductive health so that reproductive health is not perceived simply as a "women's issue" but as one that requires partner engagement and community involvement, and that can contribute to improved health, economic and social outcomes for individuals, households, and communities, increasing their well-being, resilience and adaptability. Within this framework, a choice-based approach to family planning can go a long way in reducing unmet need.

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