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Family Planning

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Abstract
Family planning is defined as an educational, medical or social activity by which an individual decides about the number of children and the distance between each child's birth, and the manner of procreation. Family planning can include deciding how many children a person will have, as well as deciding not to have children, and the age at which they will have them. This is influenced by various external factors, such as marital status, business career, financial status, difficulties which may arise, etc. For sexually active individuals, family planning may include the use of contraception and other methods of controlling their procreation. Other aspects of family planning include sex education, prevention and control of STDs, pre-conception counseling and infertility control. Much attention is paid to maternal health during family planning. Maternal health refers to the care of a woman's health during pregnancy, childbirth and postpartum. Although motherhood is a positive experience that is fulfilling, too many women meets with suffering, poor health and even death.

Keywords: reproductive health, family planning, birth control, abortion

Introduction

Reproductive health is a fraught subject [1]. In most cultures, matters to do with the sexual and reproductive life of individuals, especially female individuals, evoke both tensions as well as (even if less often) respect. Not only is woman defined as non-man primarily because of her reproductive role, this bounded definition is sustained by the valorization of reproduction (in addition to the valorization of reproduction for the continuation of the species of course). This means that even as it (especially the sexuality that must precede reproductive success) is feared and controlled, the potentially reproductive body is also to be protected and nurtured. Such protection, in turn, means that many cultures have elaborate norms about acknowledging the reproductive potential and expression of women (as seen, for example, in the rituals to mark the onset of menses, or those mother-centric ones surrounding the birth of a child) as well as elaborate ways of dealing with possible reproductive problems. The proliferation of local remedies to ensure fertility is but one example of this valorization of reproductive success.

All this means that problems with the reproductive system are often a legitimate form of complaint by women, in a way in which other kinds of health problems do not merit. Problems with mental and emotional health get particularly short shrift, and perhaps it is not surprising that one way to draw attention to these is for women to frame them in the language of reproductive health.

Due to social inequality, discrimination and direct violence against women in many parts of the world, mere medical care is not enough to advance maternal–fetalcare and reproductive health [2]. In order to improve the overall situation, health care professionals have to identify the symptomatic social causes of the physical problems, such as women's low position within their society. Particularly in patriarchal societies the questions of individual rights and gender equality become central, because in these societies the protection of women's health is not a high priority.

The main problem is that a patriarchal social system in general gives women very low social status. The principal duty of a woman in such a society has historically been to bear her husband's children (particularly sons) and to serve as the foundation of the family. The cost to women's health of discharging this duty is often unrecognized, and women's andchildren's ill health is still often explained through fate, destiny and divine will, rather than through the neglect of reproductive health services and social injustice.

Planning

Family planning and STD have an impact on maternal health outcomes [3]. Sexual violence influences contraception, the risk of STD and maternal health outcomes. Moreover, the often difficult and arduous trek by a client to access care for one purpose, such as family planning, provides the opportunity to raise and address other reproductive health concerns. Given the difficulty and infrequency of contact between the health system and the poor, especially poor women, the most efficient possible use should be made of this encounter. This implies designing client interview protocols to surface related concerns, responding to multiple concerns during a single visit rather than requiring return visits, and rapid referral to additional services where necessary. Good quality care implies the integration of essential services, with the definition of essential services depending on the outcome of the reproductive risk analysis.

Family planning, maternal health care and HIV/STD

management are included in the minimum package of health services defined by the World Bank. They are generally considered to be highly cost-effective public health interventions in terms of the disease burden alleviated relative to costs. In most low and middle income countries these three interventions will form the core of a reproductive healthpackage. Preventing and treating sexual violence should be included in the set of core reproductive health services. Sexual violence and the threat of sexual violence contribute to other reproductive health problems, including unwanted fertility, poor maternal health outcomes and the spread of STD. Additionalinterventions may be included as a consequence of the reproductive risk analysis, which identifies the most salient reproductive health problems in a given population.

The accumulated body of knowledge about effective reproductive health care must also be incorporated into the choice of interventions. We know, for example, that family planningprograms must offer the widest feasible array of methods to be effective. Maternal health programs must give priority to emergency obstetrical care if maternal deaths are to be reduced. HIV/STD case detection and management must be part of an STD control program. Support groups for women are needed to reduce sexual violence. Every health manager should develop a taxonomy of essential reproductive health services that reflects the local context and the global body of knowledge.

Birth Control

It has been a little less than 100 years since the words birth control first appeared in print, but birth control, as a social practice, is as old as human history [4]. Since the beginning of civilization, women were expected to produce children from marriage to menopause, in a constant battle to birth more children than died in utero, in infancy, or of childhood disease. Yet women in every era and culture, acting alone or with their husbands or lovers, sought ways to delay childbearing or reduce the odds of pregnancy. They did so in spite of cultural and religious prohibitions or societal pressures to increase the size of the tribe. Couples attempted family limitation for reasons that included their own health and sanity and the well-being of their existing children, economic benefits of a smaller family, to reduce the population in times of disease or famine, and because of particular circumstances of time and place.

Besides contraception, two other deliberate methods of family limitation, abortion and infanticide, have also been practiced throughout history, sometimes rarely and at other times with far greater frequency than contraception. However, neither act, occurring after fertilization and birth respectively, is considered a form of birth control in the context of this narrative. While infanticide is usually viewed as a most extreme form of population control and is universally condemned in the modern era, perceptions about abortion have changed repeatedly over time. Abortion has been conflated with contraception in the past, and strong debate continues as to whether it should be considered an acceptable and legal form of reproductive control. It is worth noting that the birth control movement of the early 20th century, which evolved into a reproductive rights movement that vowed to make and keep abortion legal, set out initially to end the practice of abortion, which was then illegal.

Human pregnancy starts with embryo implantation into the uterine wall at approximately day 6 or 7 postfertilization and is a very delicate mechanism that requires embryo–endometrium dialog [5]. The time period during which implantation can occur (the implantation window) generally ranges from day 6 to day 10 post-ovulation (days 20–24 in a 28-day cycle). By day 10, the blastocyst has become totally encased within the endometrium and embryo development has started.

Reproductive health encompasses a range of health concerns including the ability to go safely through pregnancy and childbirth and have best chance of having a healthy infant and the right of access to appropriate health care services as well as access to safe and affordable abortion facilities [6]. Abortion is an area where getting information in large sample surveys is difficult and in turn they are underreported. Whereas the data related to childbirth is comparatively easier to gather and is very useful as most of the maternal deaths are associated with births. The data would be analyzed by socio-economic characteristics of the women who have given birth in the reference period to capture the differentials. Among the socio-economic characteristics, place of residence gives an idea about the accessibility of the services as also modern values, standard of living index captures the overall living standards of the household and wealth index portrays the economic condition. Education of woman is for awareness, perception and modernity whereas caste variable gives an idea about the accessibility and overall vulnerability.

It is often claimed that both men and women have an equal obligation to provide birth control, and that it is unfair to force women to shoulder the brunt of this responsibility [7]. After all, women voluntarily run the risk of pregnancy by having sex and (setting aside socially imposed requirements and risk of disease) they are the ones who will be affected, not men. On the principle that those knowingly at risk from their own activities are also responsible for risk prevention, some case can be made for the claim that the exigencies of biology ensure that birth control is solely, or at least largely, the responsibility of women. That this conclusion is wrong apparently stems from the intuition that duties and responsibilities should be distributed between the sexes as evenly as possible. Biological differences should be minimized so that moral parity can be maximized. Thus, men should have an equal obligation to provide birth control.

Abortion

Few sociomedical problems have received more attention than induced abortion in the 1970s. For the majority of the world's people, induced abortion used to be a personal drama, lived silently and secretly by thousands of women every year [8]. Abortion has suddenly become a popular issue, receiving coverage in the mass media, debated openly, attracting the interest of professionals and researchers, and even contributing to the rise and fall of governments. This change is not accidental. The attention directed to the abortion issue may be related to three important movements that are sweeping over a good part of the world. These are the birth control movement, the civil rights movement and the women's movement. All of them, although not new, have gained momentum and popularity over recent years. The problem of abortion is a central issue in all three of these movements. Increasing use of birth control has shown the importance of abortion as a method of fertility control in affecting the world's demographic situation. The struggle for civil rights

gives abortion a new political perspective: the right to abortion under safe conditions for all women, without discrimination against the poor and disadvantaged, is accepted more and more widely as a basic necessity for health. The women's movement, emphasizing the appropriation by women of the control of their reproductive function, has espoused the right to abortion as one of its major causes.

The battle to liberalize abortion laws has met with resistance on all fronts. Governments with pronatalist population policies have refused and still refuse even to accept abortion performed for life-threatening conditions. Religious groups have objected to abortion on moral grounds. Professional groups, often ignoring the mortality and morbidity of illegal abortions, have insisted on unrealistic and ill-defined projects for preventing abortion, citing the dangers of induced abortion to health.

Arguments concerning mental health have been used both by those against and by those in favour of the practice of induced abortion: 'Abortion is a psychologically traumatic experience and should therefore not be allowed', claim the anti-abortion partisans, whilst 'abortion is often necessary to safeguard the mental health of women' answer the pro-abortionists. This last point of view has resulted in the introduction of legislation in many countries, to provide abortion for reasons of mental health. The burden of interpreting such laws has generally fallen on psychiatrists, who have been obliged to act as arbiters in deciding who may obtain a legal abortion. The mental health argument in connection with abortion has been developed further by researchers and professionals who have demonstrated how abortion may be necessary not only to prevent the aggravation of existing mental illness, but also to protect primary mental health.

Unwanted Pregnancy

The human practice of abortion is as old as understanding of the cause and symptoms of pregnancy, as historical herbal medicine shows, but access to lawful services remains strongly contested, both for and against [9]. International experience is that countries with the most restrictive laws have relatively high rates of abortion-related maternal mortality and morbidity, showing that laws affect the safety, rather than the incidence, of the practice, while countries with effective birth control access and education have low rates of unwanted pregnancy. Rates of unlawful and therefore clandestine abortion are calculable only by estimates based on maternal deaths and hospital admissions, since safely conducted procedures go unrecognized and are not publicized, and definitional uncertainty remains in law between abortion and menstrual regulation or extraction procedures.

Unwanted pregnancy is commonly a source of anxiety, particularly where counselling is not reliably confidential and termination options may be unlawful. Decisions both to terminate and continue pregnancies, unplanned and planned, can be sources of regret, but opponents of abortion have claimed that a 'post-abortion stress syndrome' exists and is pathological, requiring strong emphasis in counselling. This condition is not part of routine professional counselling beyond advising clients that they will live with the consequence of their choices. In contrast, the authoritative Diagnostic and Statistical Manual of Mental Disorders, now DSM-5, includes postpartum depression and psychosis, with diagnostic symptoms of a major depressive disorder with postpartum onset. This has a history of legal recognition, for instance, by reducing the crime committed when women, within 12 months of delivery, kill their newborn children, from murder to infanticide, with lesser punishment.

Genetic Testing

Human genetic testing has taken place for about fi fty years, using many different methods [10]. Today (and increasingly in the future) it involves looking at DNA sequences in regions of chromosomes that are known to be important and trying to figure out whether a person's sequence is normal or dangerous. For example, the famous breast and ovarian cancer gene, BRCA1 (by convention, gene names should be italicized), is made up of about 80,000 bases near the end of the long arm of chromosome 17. It can be sequenced to see if a woman has a normal version (the vast majority of people), a version known to be dangerous (less than 1 percent of people), or a version that is not normal but may or may not be dangerous (another roughly 5 percent).

Genetic testing can be used in many different contexts. Adults or children can be tested to diagnose, or predict, diseases or traits. Fetuses can be tested before birth, through three different technologies, starting between the tenth and the eighteenth weeks of pregnancy. And embryos created through IVF can be tested before they are transferred for possible implantation and pregnancy, usually about five days after fertilization. The later process, PGD (short, recall, for preimplantation genetic diagnosis), involves taking a few cells from the embryo and then testing those cells. The results of those tests are then used to decide whether to transfer an embryo. In the past twenty-six plus years of PGD's use, it could only be used to test any particular embryo for one or a handful of genes. PGD has been used to look for DNA associated with a genetic disease found in the family, for DNA that would allow an embryo to become a baby that could be a cord blood donor to a family member, or for the embryo's future sex.

Gender Inequities

The economic empowerment of women and girls has become increasingly recognized as an important strategy to reduce gender inequities, including those related to health, between males and females across the globe [11]. Gender inequities, largely attributable to societal norms promoting male dominance, involve the disproportionate allocation of resources, opportunities, and power in decision making that favors men over women. Gender inequities are experienced across all spheres of a woman's life, within their families, intimate partnerships, community, and work- life. The effects of gender inequities persist throughout all phases of women's lives and play a role in determining years of education, opportunities for career and employment, age at marriage, and number and timing of children. Consequently, gender inequities compromise the rights, safety, well-being, and health of women and girls.

Social and economic constraints created by gender inequities lead to poor sexual and reproductive health outcomes in different but often intersecting ways. Both social and economic constraints can reduce sexual decision-making power in relationships with male partners, limit control over use of family planning methods, and increase vulnerability to other sexual risk behaviors, including unprotected sex and sex trade involvement. Considering the intersecting influence of social and economic constraints on

health outcomes is especially important for informing the development of effective programming. For example, the success of economic interventions may be limited in many contexts without also considering women's control over financial decisions in their households, particularly in decisions regarding how financial resources will be used. Economic interventions may also need to consider women's safety and threats of violence as a result of women gaining financial independence from male partners. Furthermore, economic interventions that focus on improving employment or promoting women as entrepreneurs may not be as effective without efforts to support women's freedom of movement in their communities, access to bank accounts, or ability to rent space/property on their own. Overall, economic empowerment approaches may need to also consider social constraints in women's lives. Below, we discuss social and economic constraints that are most relevant to sexual and reproductive health among women and girls.

Law

The field of reproductive health includes examples of almost every type of public health law [12]. Reproductive health has multiple dimensions, ranging from the biomedical to the social. At the biomedical level, it addresses a variety of exposures to physical, chemical, and biologic agents that may affect an entire human biologic system, with possible health outcomes that affect not only a woman but also her partner/spouse and her child. At the individual level, it addresses psychosocial, behavioral, and clinical issues that are often perceived as defining a human being and affect health and quality of life well beyond the spheres of sexuality and reproduction. Communication with a sex partner or a spouse is a key component of these behaviors, which often highlight interdependence within a couple rather than individual free will. At a broader societal level, sexuality and reproduction raise core moral questions that are the subject of intense debate in a free society. Public health laws and regulations are promulgated and enacted and exert their effects within such a complex web of relations.

An understanding of reproductive health law requires recognition that both law and medicine have shaped this area. Most societies view activities such as sexual behavior, childbearing, and birth control as having moral, legal, and cultural implications beyond their health effects, leading to laws intended to control these behaviors. For example, abortion and birth control were subject to state criminal laws that limited access to these services until the mid-1960s, when courts began to find that such laws implicate federal constitutional rights. Thus, several reproductive health law issues implicate constitutionally protected rights, in particular the right to privacy.

The influence of law on reproductive health concerns varies with the outcome of interest and often is affected by the woman's resources. To provide the best reproductive health research and programs, public health practitioners need to be aware of the spectrum of legal influences.

In addition to the provision of education, young people also need good quality, accessible services from health and social care professionals about sexual health, STIs, contraception and relationships [13]. They have a right to confidential advice: anxiety about confidentiality can be a major deterrent to not seeking advice. One of the first reasons that young people contact health services independently is when they need emergency contraception or a pregnancy test. Young people may return repeatedly for emergency contraception or pregnancy tests and these visits can be used as opportunities for sexual health and/or relationships advice. This advice may not be acted on by the young person immediately but may form the basis of a positive advisory relationship for the future. Essential elements for sexual health services for young people include the core provision of reproductive health advice within accessible and young person-friendly settings where non-judgemental staff of both genders are available to offer advice and treatment to self-referred young people.

Conclusion

Maintaining good reproductive health is the primary goal of countries around the world. Lack of care about designing and implementing family planning has negative consequences. A large number of women worldwide die every year from complications during pregnancy, and an even greater number suffer from complications that make it difficult for them to plan for family. Family planning is one of the basic human needs. Family planning informations is an important part of a health service that promotes reproductive health. But many couples do not have access to modern family planning methods. Family planning can reduce maternal mortality by significantly reducing the number of unwanted pregnancies and abortions performed in an unsafe manner. Family planning has a major impact on the health, economic and social side of life.

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