India and Family Planning: An overview

Background

India has experienced remarkable growth over the past two decades and is ranked third globally in terms of purchasing power parity (after the United States of America and the People’s Republic of China) (National Family Health Survey - 3, 2005–06). It is home to 17% of the world’s population – a population of diverse cultures, languages and religions. India has also made progress on most of the MDGs and has invested resources generated from growth into programmes to deliver services to the poor (Reproductive Health at a Glance, World Bank, June 2010).

The relevance and importance of family planning in India has to be understood in the context of the burgeoning population, and the persistence of relatively poor social indicators in spite of a booming economy. India, the second most populous country in the world, is projected to exceed 2 billion people by the turn of the twenty-first century. According to the Census of India 2011, the population was nearly 1.210 million, of which 31% are below the age of 15 years and 53% of women are in the reproductive age group (15–49 years).

Situation Analysis

India was the first country in the world to launch a family planning programme, in 1952, with the objective of “reducing birth rate to the extent necessary to stabilise the population at a level consistent with requirement of national economy”. Gradually, the focus of the programme moved away from population control to population stabilization, and then was integrated with the maternal and child health programme, as family planning became viewed as an important tool to reduce maternal and child mortality.
Data for India, especially regarding contraceptive use, are a little out of date as no nationally representative surveys have been undertaken following the third round of the National Family Health Survey (NFHS) – India’s DHS – in 2005–2006.

**Table 1. Key indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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<tbody>
<tr>
<td>Total population (in million), 2011</td>
<td>1.21</td>
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<tr>
<td>Annual population growth rate, 2011</td>
<td>1.25%</td>
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<td>Population density (people per square km), 2011</td>
<td>382</td>
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<td>Urban population, 2011</td>
<td>31.1%</td>
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<td>Population below 15 years of age, 2011</td>
<td>30.8%</td>
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<td>Total fertility rate, 2012</td>
<td>2.4</td>
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<tr>
<td>Contraceptive prevalence rate, 2005–2006</td>
<td>56.3%</td>
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<tr>
<td>– Pill</td>
<td>3.1</td>
</tr>
<tr>
<td>– IUD</td>
<td>1.7</td>
</tr>
<tr>
<td>– Female sterilization</td>
<td>37.3</td>
</tr>
<tr>
<td>– Male sterilization</td>
<td>1.0</td>
</tr>
<tr>
<td>– Condom</td>
<td>5.2</td>
</tr>
<tr>
<td>– Injectable</td>
<td>0.1</td>
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<tr>
<td>– Any modern method</td>
<td>48.5</td>
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<tr>
<td>– Any traditional method</td>
<td>7.8</td>
</tr>
<tr>
<td>– Not currently using</td>
<td>43.7</td>
</tr>
<tr>
<td>Unmet need for family planning, 2005–2006</td>
<td>12.8%</td>
</tr>
<tr>
<td>– Unmet need for spacing</td>
<td>6.2</td>
</tr>
<tr>
<td>– Unmet need for limiting</td>
<td>6.6</td>
</tr>
<tr>
<td>Median age at first marriage for girls (in years), 2005–2006</td>
<td>17.2</td>
</tr>
<tr>
<td>Median age at first birth (in years), 2005–2006</td>
<td>20</td>
</tr>
<tr>
<td>Crude birth rate (per 1000 population), 2012</td>
<td>21.6</td>
</tr>
<tr>
<td>Maternal mortality ratio(per 100000 live births), 2010–2012</td>
<td>178</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live births), 2012</td>
<td>42</td>
</tr>
<tr>
<td>HIV adult prevalence rate (age 15–49 years), 2005–2006</td>
<td>0.28%</td>
</tr>
</tbody>
</table>

**Sources:** Census of India 2011; NFHS-3, 2005–2006; Sample Registration System (SRS), 2012; and SRS, 2010–2012.

**Total fertility rate (TFR)**

Due to intense efforts to control population growth in India, the TFR has been steadily declining over the past few decades. The current TFR of 2.4 in 2012 is down from 3.1 children per woman in 2001, but is still above replacement level fertility. In urban areas, the TFR has reached below replacement levels at 1.8, but in rural areas the TFR is 2.6.
Contraceptive prevalence rate (CPR)

According to NFHS-3 in 2005–2006, the CPR among currently married women was 56.3% for any method and 48.5% for modern methods of contraception. CPR for modern methods has been increasing steadily from 36.5% in 1992–1993 (the time of NFHS-1), to 42.8% in 1998–1999, and reaching 48.5% in 2005–2006. CPR varies considerably with socioeconomic parameters. For example, in 2005–2006 use of any modern methods of family planning was significantly less among Muslims (36%) as compared to Hindu women (50%), while it was highest among Sikh women (63%). Similarly, CPR for modern methods was only 35% among women in the lowest wealth quintile, compared to 58% among women in the highest wealth quintile.

An urban–rural divide in the use of contraception was seen to exist in all rounds of NFHS, with 56% of urban women using modern methods of contraception compared to only 45% of rural women in 2005–2006. The use of contraception has increased steadily in both urban and rural areas, but the pace of change has been somewhat faster in rural areas. The geographical diversity of this vast country is also reflected in the CPR, which varies substantially across the states from a low of 19% in Meghalaya to a very high 71% in Himachal Pradesh for modern methods.
Contraceptive method mix

Contraceptive use by type of method indicates a dominance of female-oriented contraceptive methods in India. In 2005–2006, female sterilization was reported to be the most used method (37%). Conversely, male sterilization was least used. Among temporary modern methods, use of condoms was 5%, followed by pills (3%) and IUDs (2%). A significant proportion of current users were using traditional methods (8%), primarily the rhythm method (5%) and withdrawal method (3%) (Figure 4). Condom use was three times higher in urban than rural areas.

Since 1998–1999, the CPR due to female sterilization has increased by 3%; on the other hand, male sterilization has declined by 1%. Use of condoms and pills has increased by 3 and 2 percent points since 1992–1993 (Figure 5). Other modern methods of contraception such as IUDs and vasectomy continue to find very few takers.

Figure 4: Contraceptive method use by married women, 2005–2006


Figure 5: Trends in contraceptive use, 1992–2006

Source: NHFS-3, 2005–06
Unmet need for family planning

In 2005–2006, nearly 13% of currently married women had an unmet need for family planning. The unmet need for limiting (7%) is slightly higher than unmet need for spacing (6%). With the increase in CPR, total unmet need for family planning has declined by 3% since 1998–1999; a higher decline is observed in unmet need for spacing than for limiting methods. The decline in unmet need for family planning is slower than the increase in CPR, revealing that overall demand for family planning has increased; however, the system has not been able to address the increased demand fully.

Unmet need in 2005–2006 varied from 5% in Andhra Pradesh to 35% in Meghalaya. Urban women have a lower unmet need than rural women. It is particularly high for Muslim women and low for Sikh and Jain women, and decreases with an increase in wealth quintiles.

Adolescent fertility

The adolescent fertility rate is relatively high in India. Most teenage pregnancies occur within the confines of marriage, due to the cultural practice of early marriage. The adolescent fertility rate has declined, from 42 births per 1000 girls aged 15–19 years in 2008 to about 32 in 2012 (Figure 6). In India, according to the law, the minimum age of marriage is 18 years for girls and 21 for boys. Despite such a law governing the age of marriage, early and teenage marriages are common. In 2005–2006, 47% of women aged 20–24 were married before the age of 18. The median age at marriage for women (aged 20–49 years) was 17 years and median age at first birth was 19.8 years. More than a fifth (22%) of women in the age group 20–24 years had already given birth before the age of 18. Moreover, 16% of adolescent girls (aged 15–19 years) have begun childbearing1 in India; this percentage ranges from 3% in Himachal Pradesh to more than 25% in Bihar, Jharkhand and West Bengal.

Figure 6: Trends in adolescent fertility rate, 2008–2012


1Were either pregnant at the time of the survey or had already given birth to a child.
In 2005–2006, only 7% of women in the age group 15–19 years were currently using any modern method of family planning as compared to 64% of women aged 35–39 years (Figure 7).

Figure 7: Women using modern methods by age category, 2005–2006


Access to family planning information and services

In India, knowledge of permanent methods of contraception is high among both men and women. More than 90% of men know about condoms compared to three quarters of women. Similarly, about 70% of women and half of men know about intrauterine devices, a female-oriented method. Less than half of men and women know about injectable contraceptives.

Figure 8: Knowledge of modern contraceptive methods, 2005–2006

Source: NFHS-3, India, 2005.
In 2005–2006, nearly 61% of women and 92% of men acknowledged that they had read, seen or heard family planning messages through mass media in the few months preceding the survey. Television was the most common source of family planning messages for both men and women. Nearly half of women saw a family planning message on television; one-third heard a family planning message on the radio; about one-quarter saw a family planning message on a wall painting or hoarding; and, 22% saw a family planning message in a newspaper or magazine. Two-thirds (67%) of currently married women and more than four-fifths (82%) of currently married men who are not currently using contraception know a place where a method of contraception can be obtained. However, less than one-fifth (18%) of women said they were ever informed by a health or family planning worker about any method of family planning.

Current Family Planning Efforts

The current family planning programme in India is run under the National Health Mission. The programme has been repositioned from being a means for population stabilization to being an important intervention for reducing maternal and newborn mortality and improving maternal and child health. The family planning programme focuses on the strategies listed below.

- Increasing use of spacing methods (reversible contraceptives). To enable this, the Government has started a programme for doorstep delivery of contraceptives through community-based health workers, known as accredited social health activists (ASHAs).
- Owing to a phenomenal increase in institutional deliveries, utilizing the increased access to women in the postpartum period to promote postpartum family planning, especially postpartum IUD insertion and postpartum female sterilization.
- Availability of fixed day static services for sterilization at all facilities.
- Emphasis on minilap tubectomy services, due to its logistical simplicity and requirement of only MBBS doctors and not postgraduate gynaecologists/surgeons.
- A rational human resource development plan is in place for provision of IUD, minilap and no-scalpel vasectomy to empower health facilities (district hospitals, community health centres, primary health centres, sub-health centres) with at least one provider each for each of the services and sub-centres with auxiliary nurse midwives trained in IUD insertion.
- Ensuring quality of care in family planning services by establishing quality assurance committees at state and district levels.
- Accreditation of more private/non-governmental facilities to increase the provider base for family planning services under public private partnerships.
- Increasing male participation in family planning and promoting no-scalpel vasectomy.
- Compensation scheme for sterilization acceptors – under the scheme, the Ministry of Health and Family Welfare provides compensation for loss of wages to both the beneficiary and service provider (and team) for conducting sterilizations.
- National Family Planning Insurance Scheme under which clients are insured in the eventuality of death, complications and failures following sterilization. The providers/accredited institutions are indemnified against litigations in such eventualities.
- Focusing on adolescents and young couples. To enable this, the Government has initiated an incentive scheme for ASHAs called “Ensuring spacing of birth”, where in the ASHA is given a monetary incentive if she is able to convince a young couple in her catchment area
to delay their first childbirth to beyond 2 years of marriage, and space the subsequent birth by at least 3 years.

- Improving contraceptives supply management up to peripheral facilities.
- Demand generation activities in the form of poster displays, billboards and other audio and video materials in the various facilities.

**Challenges and Opportunities**

1. **Limited method mix:** India is a signatory to the Family Planning 2020 (FP2020) commitment, and is responsible for increasing contraceptive access to an additional 48 million girls and women by the year 2020. This is 40% of the global target, and will require a significant increase in CPR. Although past surveys have shown a gradual but steady increase in CPR, the rate of increase will need to be accelerated significantly if India hopes to achieve the FP2020 goals. Apart from strengthening the existing programme, India needs to add more products to the contraceptive basket available within the public health sector, as global evidence shows a significant jump in CPR with the addition of any new product.

2. **Focus on adolescents:** India has the largest number of adolescent population in the whole world. While it can prove to be a great demographic dividend, investing in adolescents would necessarily mean taking steps to reduce adolescent pregnancy rates so that these girls and women can actively contribute to the nation’s economic growth. Beyond the provision of contraceptives to adolescent boys and girls, the country also needs to focus on intersectoral linkages to delay age at marriage. Investing in girls’ education is a known strategy to delay marriage. Also, adolescents will need comprehensive sexual education to enable them to make informed choices regarding contraception.

3. **Linkages with the private sector:** Survey data show that while public health facilities account for the provision of a significant proportion of sterilization services, women and couples access reversible methods through the private sector. Thus linkages with the private sector, whether through initiatives such as social marketing and social franchising or through accreditation, will go a long way in increasing access to services.

4. **Focus on quality:** The Government of India’s programme is focusing on quality of services, especially in relation to quality of services for clinical and surgical methods of contraception, by training service providers, and ensuring infection prevention practices etc. Greater focus is needed on important areas of quality, especially ensuring informed choice through good quality counselling, so that the programme adheres to the commitments made under the ICPD programme of action.

**References:**