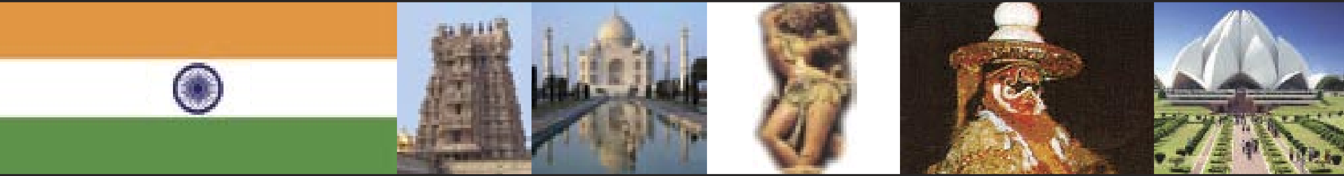


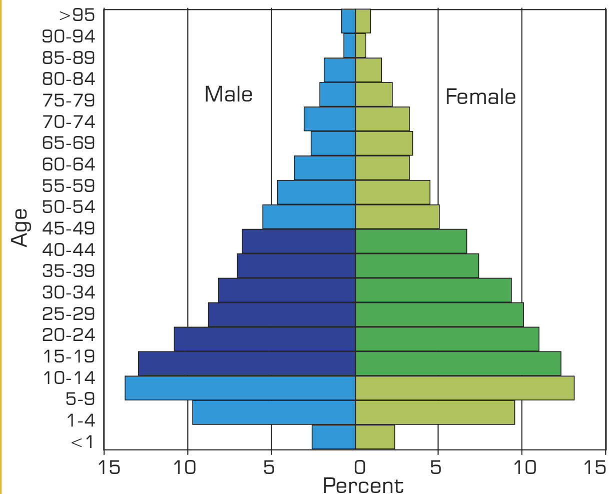
India and Family Planning: An Overview

Background

Since the 1970s, India's economic growth rate has risen, poverty has declined, and social indicators have improved. Nevertheless, over a quarter (28.6%) of India's population currently lives below the national poverty line, and 80% of the entire population lives on less than $2 per day. Twenty-eight percent of the population lives in urban areas. India's social indicators remain weak by most measures of human development, and **living standards are still among the poorest in the world**.

Currently, India's annual population growth rate is 1.74%. India is the second most populous country in the world, contributing about 20% of births worldwide. As shown in Figure 1, out of India's more than one billion people, **one-third are under 15 years of age and 50% are of reproductive age**.

Figure 1: **Population Pyramid India, 1998-99**



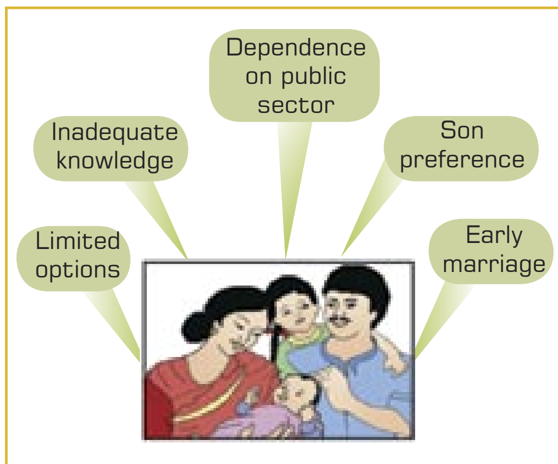
Source: DHS, India: 1998/1999

In 1952, **the Indian Government was one of the first in the world to formulate a national family planning programme**, which was later expanded to encompass maternal and child health, family welfare, and nutrition. India is committed to promoting a small family norm and supporting population control and development programmes. Since the 8th Five Year Plan (1992-97), the government identified "human development" as its main focus, with health and population stabilization listed as two of six priority objectives.

Recent examples of **political will and support for family planning** include the following:

- 1992: The 72nd and 73rd Constitutional amendments and the Panchayati Raj and Nagar Palika Acts further decentralized the family planning programme to the Panchayati Raj Institutions.
- 1994: Legislation was passed in Parliament to regulate and prevent the misuse of modern prenatal diagnostic techniques, largely for sex-selective abortion.
- 1997: The Reproductive and Child Health (RCH) programme was launched, which espouses the principles of client satisfaction in delivering comprehensive and integrated high quality health services.
- 2000: The National Population Policy advocated a holistic, multisectoral approach towards population stabilization, with no targets for specific contraceptive methods except for achieving a national average total fertility rate (TFR) of 2.1 by the year 2010. This resulted in a shift in implementation from centrally fixed targets to target-free dispensation through a decentralized, participatory approach. The target-free approach was recast as the community needs assessment approach.

While India's population already exceeds 1 billion people, total population could exceed two billion in the 21st century.

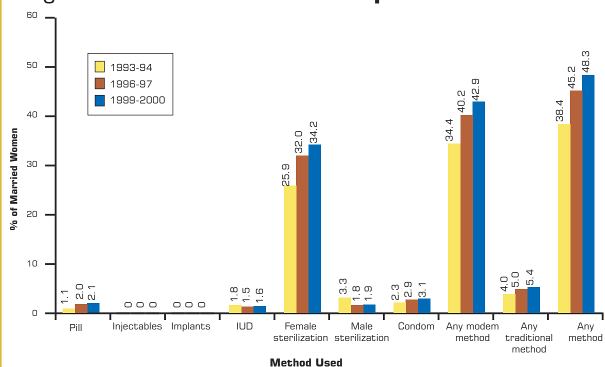


Situation Analysis

The **small family norm is widely accepted** (the mean ideal family size currently reported by young people is 2.5 children) and general awareness of contraception is universal (99% awareness of a contraceptive method). **India's TFR declined** from six children per woman in the 1960s to just under three children, 2.85, at present. **Contraceptive use is generally rising**, as illustrated in Figure 2. Nevertheless, much work remains for India's family planning programme.

There is a societal preference in India for **early marriage soon followed by child-bearing**. Marriage is almost universal with little social acceptance of never-married women. Although the average age at marriage for women is 19 years, this conceals regional variations with some states having an average of only 16 years of age. Approximately half of all women have given birth by the time they reach 20 years. However, evidence has emerged indicating that young couples, despite community norms that favour a first child soon after marriage, would prefer delaying the first birth until they have spent more time together.

Figure 2: **Trends in Contraceptive Method Use**



Source: DHS, India: 1992/1993; 1998/1999; India Reproductive Health Profile, 2003

In 2000 the contraceptive prevalence rate (CPR) among married women was 48.3%. Contraceptive use in India is characterized by:

- the predominance of non-reversible methods, particularly female sterilization;
- limited use of male-/couple-dependent methods;
- high discontinuation rates; and
- negligible use of contraceptives among both married and unmarried adolescents.

Three out of four users rely on sterilization in India, overwhelmingly female sterilization. Sterilization accounts for roughly 85% of all modern contraceptive methods used. Although reported by a negligible minority, sterilization is the most common method used even among married adolescents. The central government has banned the use of quinacrine for female sterilization.

Less than 7% of currently married women use the officially sponsored spacing methods (pills, IUD and condoms). The reported use of traditional contraceptive methods and male/couple dependent methods is low. Figure 3 provides a breakdown of the contraceptive methods used by married women in India.

Over the past decade, two new methods of contraception were introduced in India.

1. The *CopperT-380A*, which enables protection for a period of 10 years; and
2. *Emergency oral contraception*, available by prescription, which is expected to decrease the number of unwanted births and unsafe abortions.

The **public sector provides five contraceptive methods** – female sterilization, male

sterilization, the IUD, oral contraceptive pills and condoms. Methods that are perceived as less effective (including pessaries, spermicides, and diaphragms), or are controversial (such as injectables and implants) are dropped from the public programme, simply not introduced, or given low priority by health workers.

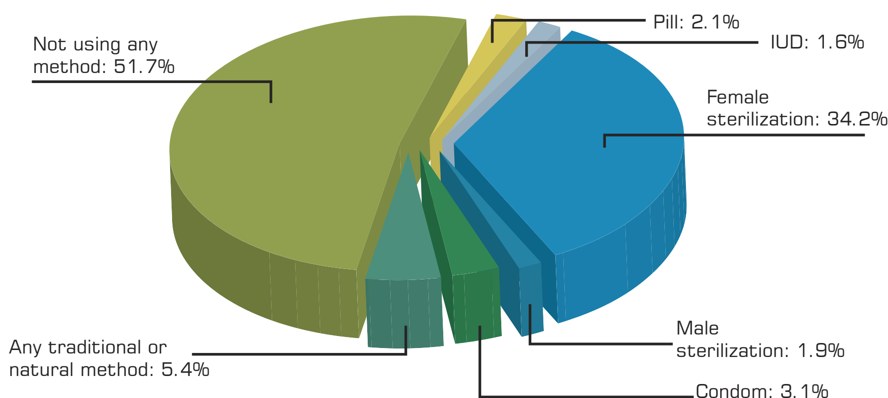
Most women and men do not have access to a wide choice of contraceptives, particularly those who are dependent on the public sector (76% of current users of modern methods). Inadequate knowledge of contraceptive methods, and incomplete or erroneous information about where to obtain methods and how to use them are the main reasons cited for not accepting family planning. Contraceptive use is lowest in the states of Meghalaya (20%), Bihar (25%), and Uttar Pradesh (28%).

The Medical Termination of Pregnancy Bill liberalized abortion in 1971. However, inadequate service provision results in a **large number of unsafe abortions**. In 2002, medical abortion was approved by the Drug Controller of India and local manufacture of the required mifepristone and misoprostol is under way. Although not yet incorporated into the national programme, it is available over-the-counter. Sex determination techniques are regulated to combat abortion of female fetuses. Nevertheless, **sex selective abortion** and female infanticide still result in unbalanced sex ratios in some areas. It is

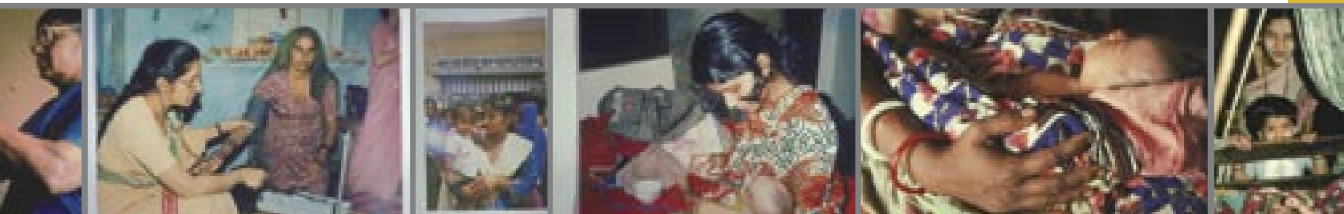
Key Indicators:

Indicator	Value
Total Population, 2003 (in millions)	1,068.6
Population Growth Rate, 2003	1.74%
Population Density, 2003 (people per square km)	324
Urban Population, 2003	28%
Population <15 years of age, 2003	33%
Total Fertility Rate (TFR), 2000-2005	2.85
Contraceptive Prevalence Rate (CPR), 2000	48.3%
- Pills	2.1
- Injectables	0
- Implants	0
- IUD	1.6
- Female Sterilization	34.2
- Male Sterilization	1.9
- Condom	3.1
- Traditional or Natural Methods	5.4
Unmet Need, 2003	15.8%
- For spacing births	8.3
- For limiting births	7.5
Average age at first marriage, 2003	19
Average age at first birth, 2003	20
Crude Birth Rate (CBR) (per 1,000 population), 2000-2001	25.8
Maternal Mortality Ratio (MMR), 2003	540
Infant Mortality Rate (IMR), 2000-2005	66
HIV adult prevalence, 2001	0.8%

Figure 4: **Contraceptive Method Use by Married Women in India, 2000**



Source: India Reproductive Health Survey, 2003



estimated that in 2001 there were more than 3 million missing girl children in India.

It is estimated that if all unwanted births were prevented, India's TFR would drop to replacement level fertility.

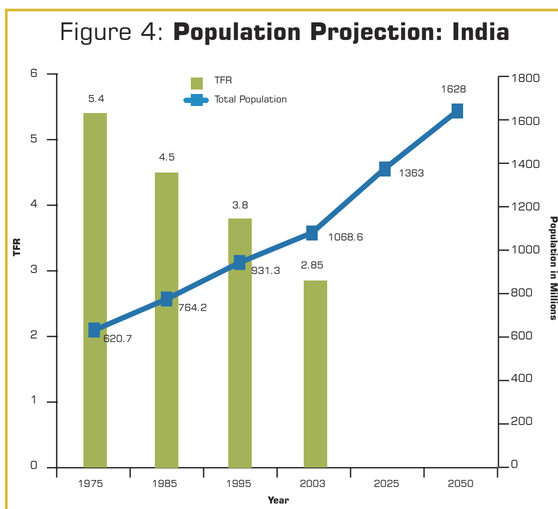
There is still a substantial unmet need for contraception. Despite improved availability and access to contraceptive services, a substantial proportion of pregnancies (21% of all pregnancies that result in live births) are mistimed or unplanned. While the family planning needs of the majority (86%) of women who wish to stop childbearing are being satisfied, the needs of women who wish to delay or space childbearing remain largely unsatisfied (only 30% of these women have their needs met). For this reason, young women are more likely to report an unmet need for contraception. The desire to limit family size and to space the next birth are the main reasons given by the majority of those who seek an abortion, highlighting the large unmet need for contraception among women in India.

Current Family Planning Efforts

The National Population Policy, provides a framework for achieving the twin objectives of **population stabilization and promoting reproductive health within the wider context of sustainable development**. The Tenth Five Year Plan (2002-2007) outlines efforts in three broad areas:

1. Meeting the unmet need for contraception;
2. Reducing infant and maternal mortality; and
3. Enabling families to achieve their reproductive goals.

Figure 4: **Population Projection: India**



Source: PRB, 2003

With regard to addressing the unmet need for contraception, the **government is focusing particularly in areas where fertility declines have been lagging**. Issues such as adolescent reproductive health, unintended pregnancy and access to safe abortion are addressed. Counselling, access to and provision of good quality services and follow-up care are emphasized.

Health and family planning workers are required to regularly visit households in their assigned areas in order to provide information related to health and family planning, counsel and motivate women to adopt appropriate health and family planning practices, and deliver other selected services. **Uncertain of the consequences of the new target approach** however, many states set local goals based on the previous year's centrally assigned targets. Women's involvement in decentralized decision-making has yet to be fully operationalized at the grassroots level. In many states, the involvement of the community and other stakeholders, including Panchayati Raj Institutions, in needs assessments is reported to be minimal.

Contraceptives are supplied through the government's network of health care facilities and with the assistance of NGOs. There is also a good social marketing programme of condoms and oral contraceptives.

Challenges and Opportunities

1. **Socio-economic constraints**. High levels of illiteracy, poor access to information, poverty, and gender-based disparities serve as significant barriers to family planning. These include social stereotyping, lack of male involvement in family planning, and continuing open discrimination against the girl child, adolescent girls and women.

2. **Programmatic constraints**. Major constraints include limited resources, lack of an integrated multi-sectoral approach, insufficient IEC support, and a weak health management information system.

3. **Limited awareness of reversible methods**. Awareness of reversible methods is relatively limited among women and men alike. Information given to clients by providers regarding contraceptive methods is typically

inadequate, most providers have a bias towards sterilization and only a small proportion of clients are informed of reversible methods.

4. **Staff shortages and limitations**. Staff shortages continue to plague the services at all levels. Where workers are available, they are generally poorly trained and have little knowledge of the methods they are promoting. Only 13% of women report receiving a home visit from a health and family planning worker during the last year, and only 11% of those visited report receiving family planning services. Women without any children are least likely to receive a home visit.

The plan focuses on improving the health infrastructure and quality of care, promoting inter-sectoral coordination, and expanding the coverage and quality of health care for vulnerable and under-served populations, including adolescents.

5. **Limited access to quality health services**. Access to quality health services is limited in both urban and rural areas. A substantial population residing in slum areas has no access to family planning services owing to poor health infrastructure. Furthermore, only 37% of rural women live in a village with a primary health centre or sub-centre. Important sub-groups, such as adolescents are neglected or under-served. Contraceptive choice, and the quality of and access to care are limited within the programme.

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