

# Family Planning: Policy Analysis



## Policy Brief

The expansion of family planning services in urban Uttar Pradesh requires a thorough knowledge of the policy, social, and economic factors that affect contraceptive use. This document is one in a series of white papers that analyse recent data with the aim of understanding the impact of these factors on family planning. Increasing contraceptive use prevents unplanned pregnancy, and reduces maternal and newborn deaths.

### Background

India launched the national Family Welfare Programme in 1951, with the objective of “reducing the birth rate to the extent necessary to stabilise the population at a level consistent with the requirement of the national economy.” Since then the programme has expanded both in concept and scope. Budget allocations have increased dramatically, the service delivery system has been expanded, a broader range of contraceptive methods is available, commitment to voluntarism has been strengthened, and family planning is now an integral part of a broader programme of reproductive and child health services. From a strong emphasis on demographic targets in the first

decades of its existence, the programme is now committed to the twin objectives of population stabilisation and reproductive health. Since the beginning of the family planning effort in India, population has grown from 360 million to more than 1.15 billion people in 2011.

Fertility has declined from a total fertility rate of 6.5 in 1971<sup>[1]</sup> to 2.7 in 2007,<sup>[2]</sup> and contraceptive prevalence has increased substantially over the same period from a low level of 10.4 percent in 1971<sup>[1]</sup> to 56.3 percent<sup>[3]</sup> in 2006. However, while states like Kerala, Tamil Nadu, Andhra Pradesh, and the Punjab have achieved replacement-level fertility, others, including Uttar Pradesh, Madhya Pradesh, and Bihar are still far from that goal. Uttar Pradesh

**Table 1. India’s Demographic Achievement (1971–2008)**

Parameters	1971	1981	1991	2001	Most recent
Crude birth rate (CBR)	43.5	38	35	28.2	22.8
Total fertility rate (TFR)	6.5	5.4	4.6	3.5	2.7
Crude death rate (CDR)	21.3	16.0	13.6	9.3	7.4
Infant mortality rate (IMR)	129	110	73	66	53
Life expectancy at birth, male	44.0	50	55.5	60.8	62.6
Life expectancy at birth, female	43.0	49	56	62.3	64.2
Contraceptive prevalence rate	10.4	22.8	44.1	48.2	56.3

Sources: For data from 1971, 1981, 1991, and 2001: A. R. Nanday, 2004. For most recent CBR, CRD, and IMR: Government of India, *Sample Registration System (SRS) Bulletin 44*, no. 1 (October 2009), available online at [http://censusindia.gov.in/Vital\\_Statistics/SRS\\_Bulletins/Bulletins.aspx](http://censusindia.gov.in/Vital_Statistics/SRS_Bulletins/Bulletins.aspx) For most recent TFR: Office of the Registrar General and Census Commissioner, India (RGI), *Vital Event Registration and Decennial Census, 2009*. For life expectancy at birth, male and female: RGI, *Vital Event Registration and Decennial Census, 2008*. For CPR: *Third National Family Health Survey, India: 2005–2006*

has higher total fertility rate (3.8) and a smaller proportion of its eligible population using modern contraception (29.3 percent) than almost any other state in India.<sup>[3]</sup>

The government of India supports the idea of a relatively broad contraceptive method mix, currently offering mainly oral contraceptive pills, condoms, intrauterine contraceptive devices

(IUCDs), and male and female sterilisation. Injectable contraceptives have been introduced on a pilot basis and are now being considered for government approval. Additionally contraception

based on fertility awareness—such as the standard days and lactational amenorrhea methods—have also been encouraged on a limited basis in Jharkhand and Uttar Pradesh.

In urban Uttar Pradesh, female sterilisation is the most prevalent method of contraception, with 19 percent using this method, followed by 17 percent using condoms, 3.2 percent oral contraceptive use, 3 percent of IUCD use, and 0.5 percent male sterilisation.<sup>[3]</sup> See Table 2 for the family planning performance for Uttar Pradesh, as reported by the State Action Plan.

**Table 2. Selected Provision of Long-Acting and Permanent Methods in Uttar Pradesh 2007–2010**

Methods	2007–08	2008–09	2009–10 (until Dec 09)	Expected by March 2010
Vasectomy	5,940	11,132	6,603	25,000
Tubectomy	465,951	468,381	217,809	530,000
IUCD	1,943,474	2,105,501	1,059,116	2,200,000

Source: National Rural Health Mission, Department of Family Welfare, Uttar Pradesh, *State Action Plan, Uttar Pradesh, 2010–2011*. Available online at [www.upnrhm.org/uploads/rti/PIP201011Final.pdf](http://www.upnrhm.org/uploads/rti/PIP201011Final.pdf)

A large percentage of women in Uttar Pradesh exceed their fertility goals, especially poor women. Unmet need for family planning in urban Uttar Pradesh is 15 percent, with 9 percent in need of a limiting method and 6 percent in need of spacing methods.<sup>[3]</sup>

### The Indian Family Planning Programme: Historical Background

As the first programme of its kind, the Indian family planning programme began with a modest effort to provide contraceptive services at the clinic level in the early 1950s. The main methods at that time were male and female sterilisation and condoms.

After the Bengal famine, concerns were voiced about population growth and the widespread need for affordable and acceptable health care and family planning services. In 1946, the Bhore committee report recommended a national programme for family planning; the planning process got underway in the early 1950s, officially beginning the Indian family planning programme. In the early 1960s, it

had become clear that an exclusive focus on clinic-based services was too limited. Extension services were added in the mid-1960s with male and female family planning workers joining the existing maternal and child health staff of primary health centres.

In the 1950s and 1960s, the concept of the primary health centre became the cornerstone of the planners' approach toward providing basic health and medical services to a population suffering from a vast array of epidemic and other diseases. The planners committed themselves to establishing one primary health centre per community development block (each representing a population of 60,000 to 100,000) and saw the centre as the focal point for a range of communicable disease control programmes, particularly malaria and smallpox eradication schemes. With commitment from the government of India to provide contraceptive services and information, family planning became another essential component to each centre's preventive health and medical activities.<sup>[4]</sup>

Although conceptualised as an educational approach, the family planning extension services became dominated by a target- and incentives-driven strategy that, in the 1970s, involved family planning staff but also revenue workers and police. This approach led to the so-called “Emergency Period” (from 1975 to 1977) when large vasectomy camps forcibly sterilised men and generally provided poor-quality services. India’s first population policy, issued in 1976, gave states the right to make family planning compulsory after a couple had three children, and set punishments for employees who did not achieve vasectomy targets. These aggressive policies contributed to the downfall of Indira Gandhi’s government and were replaced by a revised population policy in 1977 that rejected compulsory sterilisation, and emphasised education, motivation, and consent. In the early 1980s, the focus on sterilisation was reduced by introducing spacing methods; when sterilisation was provided, emphasis shifted from male to female sterilisations. In spite of these changes, the time-bound, target-oriented approach was revived and enhanced by a vigorous promotion of incentive payments.<sup>[5]</sup>

In the early 1990s, new directions emerged in India’s policies that placed family planning in the context of social development, female education, and high-quality contraceptive services. The passing of the 72<sup>nd</sup> and 73<sup>rd</sup> Constitutional Amendment and the Panchayati Raj and Nagar Palika Acts in 1992 started a process of decentralisation that made the family planning programme the responsibility of elected, village-level government representatives.<sup>[5]</sup> In 1996, the government of India removed method-specific contraceptive targets,<sup>[6]</sup> and one year later, the first Reproductive and Child Health (RCH) Programme was adopted, incorporating the new approach to population and development articulated at the 1994 International Conference on Population and Development held in Cairo. The programme integrates interventions previously delivered through the Child Survival and Safe Motherhood Programme and family planning services, adding services for reproductive tract and sexually transmitted infections. The aim is to provide client-centred, need-based, high-quality services to

enhance the quality of reproductive life as well as population stabilisation.

### **The National Population Policy (NPP), 2000**

After several years of deliberations India adopted its National Population Policy in 2000. Continuing the pattern already adopted in the RCH Programme, the NPP 2000 is framed broadly within the spirit of the Platform of Action of the 1994 International Conference on Population and Development held in Cairo. The NPP 2000 considers stabilising the population as “an essential requirement for promoting sustainable development” and “affirms the commitment of government towards voluntary and informed choice, and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services.”

The policy places population concerns within the context of health—especially maternal, reproductive, and child health—while emphasising the need to focus on poverty alleviation, the empowerment of women, child health and survival, and gender-based and broader social determinants of health. A dominant theme is the need for “convergence of service delivery at the village levels,” i.e., integrated efforts among all relevant services and programmes, such as health and family welfare and education.

NPP 2000 has three broad objectives. Its immediate objective is “to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care”; its medium-term objective is “to bring the TFR [total fertility rate] to replacement levels by 2010, through vigorous implementation of inter-sectoral operational strategies”; and the long-term objective is “to achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection.” In the same year that the NPP 2000 was adopted, the Population Commission was created to translate the new policy into action.

The focus of the NPP 2000 is clearly on rural areas, however, in the section on underserved population groups, the document notes the need to pay special attention to urban slums.

#### **Uttar Pradesh Population Policy, 2000**

In introducing the Uttar Pradesh Population Policy (UPPP) in July 2000, the Minister of Family Welfare and Maternal and Child Welfare stated that the policy is based on the same broad principles as those articulated in the national policy. The state policy's mission is "to improve the quality of life of the people of Uttar Pradesh with unequivocal and explicit emphasis on sustainable development measures and actions. Population stabilisation and improvement of the health status of people, particularly women and children, are essential prerequisites to sustainable development."

UPPP 2000 has the following goals:

- Increase the median age at marriage for women from 16.4 years in the late 1990s to 19.5 years by 2016;
- Reduce the total fertility rate to 2.6 births in 2011;
- Reduce the maternal mortality ratio from 707 pregnancy-related deaths per 100,000 births in 1997 to 394 in 2010, and to fewer than 250 in 2016;
- Reduce the infant mortality rate from 85 deaths among infants under one in 1997, to 73 by 2006, 67 in 2011, and 61 in 2016.

UPPP 2000 recognises the problems of the urban population and seeks to develop primary health infrastructure in urban areas. It has provisions for partnerships with urban local bodies, private providers, and nongovernmental organisations to provide reproductive and child health services to the slums. The policy provides a vision for establishing urban health posts with adequate staff and equipment, on the same pattern as primary health centres in rural areas.

To achieve its objectives, the UPPP 2000 identified several specific strategies covering community participation; involvement of the private sector; improvement in, access to, and quality of reproductive and child health services; and

improvement of service delivery systems by decentralising decision making and involving other development departments.

#### **Reproductive and Child Health Programme, Phase II (RCH II), 2005–10**

In 2005, a second phase of the Reproductive and Child Health Programme was initiated. Its vision is to achieve the outcomes that were envisioned in the Millennium Development Goals and in a variety of India's policy statements such as the NPP 2000, the Tenth Five-Year Plan document, and the National Health Policy of 2002. While RCH I established the basic goals for a reproductive health and client-centred approach, RCH II plans to deepen the policy commitments made to equity of health outcomes, addressing disparities between women and men, between socio-economic groups, between more-advanced and less-advanced states, and between the urban poor and the urban nonpoor. RCH II focuses on the poorest states, including Uttar Pradesh.

In its institutional mechanism, RCH II addresses some of the lessons learned from RCH I, leading to greater emphasis on "state-specific planning, targeting the vulnerable, demand-side stimulation, strengthening systems, health and population outcomes, and flexible financing."

#### **National Rural Health Mission (NRHM), 2005–12**

The National Rural Health Mission was launched in 2005 with the purpose of making necessary corrections in the basic health care delivery system. Its goal is to "improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women, and children." Although most of the interventions and budgetary allocations of the NRHM are for the rural areas, there was recognition that increasing urbanisation puts great pressure on urban health services. One of the objectives of the NRHM therefore is to improve the health status of the urban poor by ensuring that each city has one urban health post for every 50,000 people. Among the planned interventions for the urban areas are a baseline health facility assessment in the slums and in the 14 major cities of the country, and the

organisation of monthly health and family planning outreach camps.

One of the programmes under the NRHM is the *JananiSurakshaYojana*, which seeks to reduce maternal mortality by promoting institutional deliveries. It provides cash benefits to all women below the poverty line who deliver in a health facility in eight disadvantaged states, including Uttar Pradesh. The number of institutional deliveries has increased significantly as a result of this programme.

### The Growth of India's Urban Areas

The main focus of the Indian family planning programme has been on the rural areas. The NPP 2000 devotes relatively little space to the discussion of urban needs. While emphasis on the rural areas was justifiable in the early years, India's extraordinary urban growth in the past four decades—with the associated increase in the urban slum population—demands attention to the health and family planning needs of the urban poor. India's

entire population at the time of independence is approximately the same as the current population of India's urban areas. If India continues to grow as anticipated, the country will have an additional 250 million people in the next 20 years.<sup>[7]</sup>

### The Need for Attention to the Urban Poor in Uttar Pradesh<sup>[8]</sup>

With a population of 175 million, Uttar Pradesh is the largest state in India. The state's urban population comprises 21 percent of the total population and about one-third of these people are estimated to be below the poverty line. Uttar Pradesh has the largest number of urban poor of any Indian state and ranks low in several social indicators. There are stark differences in the health status between urban poor and nonpoor populations. Moreover, not all poor people are equally vulnerable; assessments show that residents of the poorest slums have a lower health status than that of other slum residents.

**Table 3. Reproductive and child health indicators in three urban economic groups in Uttar Pradesh**

Indicator	Urban low	Urban medium	Urban high
Three ANC check-ups	9.1	27.3	59
Deliveries at home	85.3	71.7	39.3
Total fertility rate (TFR)	3.74	3.09	2.55
Modern contraceptive use	21.3	40.1	54
Under-five child mortality	130.6	104.5	37.3

Source: Government of India and UHRC, 2006.

Some policy documents have clearly recognized the need for attention to the urban poor; for example, the *UPPP 2000* states:

...The urban slums lack basic health infrastructure and outreach services. Thus, they are often by-passed even by national programmes providing immunisation, safe motherhood and family planning.... Urban local bodies like municipal corporations and *nagarpanchayats* are also expected to provide health care, but resource scarcity restricts them to only providing sanitation services. NGOs and private trusts are also few and far between. There is consequently an urgent need to develop infrastructure in urban areas to provide reproductive and child health care and outreach services and involve the elected urban local

bodies to take the lead in coordinating these services.<sup>[9]</sup>

However, the *State of Urban Health in Uttar Pradesh* states that, "in spite of a clear mandate at the policy level, this has not been translated into effective programmes which have had significant impact on the health of the urban poor."<sup>[8]</sup>

### National Urban Health Mission (NUHM)

The need for attention to urban areas was recognised in India's Tenth Five-Year Plan, which called for building urban health projects, and also the RCH II, which articulated the need to address disparities between urban poor and nonpoor. Similarly the 11<sup>th</sup> Five Year Plan (2007–2012) has devoted significant attention to urban health, calling for the creation of a National Urban Health Mission.

According to the plans, the National Urban Health Mission will “improve the health status of the urban poor, particularly the slum dwellers and other disadvantaged sections, by facilitating equitable access to quality health care through a revamped public health system, partnerships, community based risk pooling mechanisms with the active involvement of urban local bodies.”<sup>[10]</sup> The NUHM has not yet been implemented.

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### Notes

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