INDIAN JOURNAL OF DEVELOPMENT RESEARCH AND SOCIAL ACTION ISSN :- 0973-3116
VOLUME 17• NUMBER 2 • JULY-DECEMBER 2021 • PP. 161-174

Need for Policy Shift In Family Planning Programme In India

Dr. Kamna Srivastava

ABSTRACT

It is widely acknowledged that improving population health is both an important way of promoting productivity and economic growth and a goal in and of itself. Ironically, India was the first country to introduce family planning programmes in 1952, and it has since changed techniques in response to international conferences such as those in Mexico, Cairo, and Beijing, with mixed results. The fact remains that the government cannot successfully limit family size, provide health services, and promote development on its own. India's demographic parameters, future fertility transition, and population stabilisation will be largely determined by changes in the four largest states, namely Uttar Pradesh, Bihar, Madhya Pradesh, and Rajasthan, which account for roughly 40% of the country's population. These states have often been described as "Backward" or "Bimaru" states. There has been unequal burden of family planning on women as there has been shifting of focus from men to women. Against this backdrop, present paper purports to review the performance of family planning in India

Introduction

India's demographic parameters, future fertility transition, and population stabilisation will be largely determined by changes in the four largest states, namely Uttar Pradesh, Bihar, Madhya Pradesh, and Rajasthan, which account for roughly 40% of the country's population. These states are frequently referred to as "backward" or "BIMARU." Despite having immense natural resources and personnel, the populace remained at lower levels of development in practically all areas. Because of its abundant human and natural resources, the state has the ability to lead India's economic and social development. One of the major factors that has hampered the efficient exploitation and utilisation of Uttar Pradesh's resources is the state's population pressure. Without reaching appropriate demographic goals and population stabilisation, the state will struggle to achieve sustainable development. For India, the demographic shift is both a challenge and an opportunity. The country will have a battery of huge productive and reproducing populations, which will provide an opportunity. The aim is to create synergy between India's continuing

1. Assistant Prof., Department of Economics, University of Lucknow, Lucknow

demographic, educational, economic, and technological transitions so that population stabilisation and sustainable development may be achieved more quickly (Singh, and Singh, 2006). By 2050, India is expected to surpass China as the world's most populous country. India is a developing country with insufficient resources to feed an ever-increasing population. The population growth rate is faster than Brazil's population growth rate. If current trends continue, the population will explode. Ironically, India was the first country to introduce family planning programmes in 1952, but it has had poor success in adjusting policies in response to international conferences such as Maxico, Cairn, Beijing, and others. The fact remains that Government alone cannot successfully restrict family size avail health services and bring development. There is a need of collaboration with voluntary agencies, grass root level leaders and the masses (Singh, 2003).

Family Planning

The Family Welfare Department, Ministry of Health and Family Welfare, Government of India, New Delhi, has a complicated organisation that has evolved over time. New projects and programmes, including as MCH, CSSM, and RCH, have been added to the basic core of family planning programmes. The Maternal and Child Health (MCH) component was added to the 7th Plan (1984–89), with an emphasis on the health requirements of women in reproductive age and children under the age of five, as well as providing contraception and spacing services to desiring married couples. Similarly, in 1992, the World Bank and UNICEF collaborated to develop the Child Survival and Safe Motherhood (CSSM) Program, which aimed to boost the maternal and child health component of the National Family Welfare Program. Management of acute respiratory tract infections, diarrhoea care, and emergency obstetric services were all part of the CSSM. It was the first real attempt to bring together concerns related to morbidity, mortality, and infant quality of life. At the 1994 Cairo International Conference on Population and Development, it was recommended that the participating countries develop a single RCH programme. The goal of RCH was to deliver need-based, client-centered, demand-driven, high-quality, and integrated health care to population stabilisation beneficiaries. India's RCH programme includes I undesired fertility prevention and management, (ii) pregnancy and childbirth management, (iii) RTI and STD prevention and management, (iv) child survival through immunization, diarrhoea and acute respiratory illness control, and infant care, among other things. As part of the 2000 national population policy, community-based organisations (Panchayats, NGOs, Youth Clubs, and SHGs) were given a key role in the implementation, monitoring, and management of RCH programmes at the grassroots level. In conjunction with the continuing Integrated Child Development Scheme, village self–help

groups will be used to organise and provide basic services for RCH. The community and for the community will provide an integrated and coordinated service delivery package for basic health care, family planning, and maternal child health-related services at village levels. The participation of NGOs in the implementation of RCH programmes was encouraged.

The historical Bhore Committee was created by the Indian government in 1943 to examine the country's health state and provide recommendations for the future. The Bhore Committee, which was remarkably affected by the deliberations of the Beveridge Committee in England, which gave rise to the country's National Health Service, presented far-reaching recommendations guided by two overarching ideas. First, health care services were the obligation of the state; second, everyone should have access to comprehensive health care regardless of their capacity to pay. Preventive services were stressed, with an emphasis on rural areas and a relationship between health and general development, in the blueprint for the growth of health services that was outlined, both in the short and long term. More than half of the budget for the First Plan was set aside for the construction of hospitals and clinics, and 40% of the overall budget was set aside for medical education and training. As part of the Community Development Program, primary health centres were to be built. The launch of what are known as unipropose, vertical programmes for the control of malaria, small pox, filarial, leprosy, cholera, and venereal diseases was made possible by the First Plan. During this time, India was the first country in the world to implement a family planning programme. While acknowledging the importance of mother and child health, it was to be treated as an integrated part of general health care. The control programmes were transformed into the National Malaria Eradication Programme in the Second Plan, thanks to international agencies' encouragement. It was envisaged that malaria would be eradicated by 1966. The operational strategy for the family planning programme over the first two plan periods, again inspired by international agencies, was the clinical approach. The Third Plan witnessed the coming to the fore recommendations of the Health Survey and Planning Committee, known in popular parlance as the Mudaliar Committee. The committee noted that the primary health care system that had evolved so very haltingly, bear no resemblance to that visualized by the Bhore Committee. The committee recommended the upgradation of existing services. Following a series of small pox eradication campaigns, the National Tuberculosis Program was established in 1962. This eventually paid off, despite the fact that when India ultimately eradicated smallpox in 1975, it had not only invested far more resources than had been expected. The speed of the family planning programme was significantly boosted in the Fourth Plan, with over 1000 mobile service units supplementing family welfare centres for vasectomy. The sterilization

rate peaked at 3.1 million in 1972–73. Two-thirds of them took part in summer camps. As the Fifth Plan established this new paradigm, the echoes of such transformations echoed in India. The major goal, according to the report, is to provide vulnerable groups with basic public health services, including family planning and nutrition.The year 1975 enters the annals of the history of public health in India for two reasons. First in this year, India finally declared small pox free. Second, the year witnessed the declaration of emergency which facilitated the passage of the draconian National Population Policy of April 1976 which called for a direct assault on the population problem. In 1977, the government announced the implementation of the recommendations of the Srivastava Committee as a scheme for strengthening rural health care services. In this year, Community Health Volunteers Scheme was inaugurated as a step towards repositioning people's hands on a war footing. In 1980, 'Health for All', An Alternative Strategy was adopted. This strategy routed in the community, provided adequate, efficient and equitable referral services, integrated and promoted preventive and curative aspects and combined the valuable elements in our culture and tradition with the best elements of the Western System. The Sixth Plan adopted a long–term demographical goal of reducing the net reproduction rate of one by all the states of the country by 2001. It acknowledged the necessity for poverty elimination, advances in infant and child survival, female interary, and nutrition in order to achieve this goal. As a result, throughout the plan period, there was a greater emphasis on female sterilisation, often in surgical camps. Tuberculosis, leprosy, and UIP, all of which were included in the 20 Point Programme, were given targets to meet, but the CHV project was buried without fanfare. Despite the failure to reach the targets set out in the Sixth Plan for rural infrastructure development and communicable disease management, the Seventh Plan commends the growth of specializations and super specialties to address the serious health challenge of no communicable illnesses. During this time, a natural AIDS control programme was launched with a soft credit from the World Bank of US $ 84 million and technical assistance from the World Health Organization. A separate organization, the NACO, was consequently set up. The Eighth Plan document again notes the depressingly familiar inability to meet the goals of the previous plan in control of communicable diseases, in achieving the family planning goals. During this period, AIDS control began to assume increasing importance, not so much because it was assessed as a major public health problem epidemiologically, but because funds began flowing from international agencies. The Ninth Plan stated that reduction in the population growth rate has been recognized as one of the priority objectives during the Plan period. The priorities in the Plan were started to be to meet the felt needs for contraception, and to reduce the infant and maternal morbidity and mortality so that there was a reduction in the desired level of fertility. During this period,

two important policy documents were announced, first the National Population Policy, significantly announced before, the second, the National Health Policy (Planning Commission, 2001).

Three of the eight Millennium Development Goals directly related to health have developed as international agreement on reducing indices/deaths due to communicable and avoidable diseases. Using the 1990s as a baseline, the three goals and targets that must be met by 2015 are: I reduce under five (infant/child) mortality by two-thirds; (ii) reduce maternal mortality rate by three-quarters; and (iii) combat human immunodeficiency virus/ acquired immune deficiency syndrome (HIV/ AIDS), malaria, tuberculosis (TB), and other diseases not only by halting but also by reversing Increased access to health care for women and children, elimination of childhood diarrhoea deaths by 2010, effective targeting of undernourished children, restructuring malaria workforce to reduce incidence by 50%, and improved diagnosis and treatment of tuberculosis are all part of India Vision 2020.It also seeks to address the state of under equipped, under staffed and under financed health care infrastructure and suggests increasing public spending from 0.8 per cent to 3.4 per cent of gross domestic product.

Food hygiene, access to clean air and water, and good sanitation are all important aspects of effective public health interventions. Local requirements should be considered while designing public policy, as decentralisation and devolution of authority will give local bodies a larger role. Addressing specific public policy issues at the state, district, or block level does not negate the central government's involvement. It necessitates the Centre taking a more proactive approach to eliminating inequities across states and ensuring adequate regulatory and monitoring procedures. In poorer areas, the number of NGOs and community-based organizations (CBOs) is lower. To assure their availability in remote locations, there is a need to increase the number of care providers and develop adequate working circumstances. The Government of India's Ministry of Health and Family Welfare (MOHFW) is establishing a Reproductive Child Health (RCH) Program throughout the country.. For this purpose, it is absolutely essential to obtain knowledge of the existing situation at different levels of health facilities in the country. A facility survey at district level will help in assessing the availability of trained staff, equipment and supplies and their utilization at Primary Health Centres (PHCs), Community Health Centres (CHCs), First Referral Units (FRUs) and District Hospitals (Ram Chandran, 2002). Though, RCH programme has been implemented in India with vigour and spirit. However, there is paucity of literature on RCH programme and particularly community participation in the RCH services.

Female Centric Family Planning

In poor nations, an estimated 225 million women want to delay or stop having

children but are not utilising any form of contraception. Condoms and other family planning measures, such as birth control pills, can help prevent HIV and other sexually transmitted infections. Contraception and family planning lessen the need for abortion, especially dangerous abortion. People's rights to choose the number and spacing of their children are reinforced by family planning. Family planning/contraception saves women and children's lives by preventing unplanned pregnancies. Family planning allows parents to have the number of children they want and to space their pregnancies out. It is accomplished through the use of contraceptive techniques and infertility treatment. The ability of a woman to choose whether or not to become pregnant has a direct impact on her health and happiness. Family planning allows for the spacing of pregnancies and can help young women who are at risk of health problems and mortality from early childbirth postpone their pregnancies. It prevents unplanned pregnancies, including those in older women who are more vulnerable to pregnancy-related risks. Women who want to limit the size of their families can do so via family planning. Maternal mortality appears to be higher in women who have more than four children, according to research. Family planning minimizes the need for risky abortions by lowering the rate of unplanned pregnancies.

Closely spaced and ill-timed pregnancies and births lead to some of the world's greatest infant mortality rates, which can be avoided with family planning. Infants whose moms die as a result of childbirth are at a higher risk of death and illness. Family planning helps HIV-positive women avoid unplanned pregnancies, resulting in fewer infected newborns and orphans. Condoms, both male and female, offer dual protection against unplanned pregnancies as well as STIs such as HIV. People can make informed decisions about their sexual and reproductive health with the help of family planning. Family planning provides women with the option to further their education and engage in society, including paid work in non-family groups. Furthermore, having smaller families allows parents to devote more time and attention to each child. Children with fewer siblings are more likely to complete their education than those with many siblings. Adolescents who are pregnant are more likely to have kids who are born prematurely or with low birth weight. Neonatal mortality is higher among babies born to teenagers. Many pregnant adolescent females are forced to drop out of school. This has long-term consequences for them, their families, and their communities. Slowing unsustainable population increase and its detrimental effects on the economy, ecology, and national and regional development initiatives are all dependent on family planning.

Family planning should be widely available and easily accessible to anybody who is sexually active, including adolescents, through midwives and other qualified health providers. Midwives are educated to give locally available and culturally acceptable contraceptive techniques (where permitted).

Counseling and some family planning measures, such as tablets and condoms, are also provided by other qualified health practitioners, such as community health workers. Women and men must be referred to a clinician for procedures such as sterilization. Men use contraception in such a small percentage of the population that it places a significant responsibility on women to utilise Family Planning Method. Male condoms and sterilisation are the only modern contraceptive techniques available to guys (vasectomy). India's family planning programme has been dogged by a "vertical strategy" rather than focusing on other issues from the start. Poverty, education, and public health care are all factors that influence population growth. Due to the influx of international assistance for family planning programmes, there has always been a foreign intervention in the design of family planning programmes in India without taking into account the country's actual socioeconomic conditions. Indira Gandhi, India's Prime Minister, attempted but failed to launch a forced sterilisation programme in the early 1970s. Officially, men with two or more children were required to undergo sterilisation, but it is suspected that many unmarried young men, political opponents, and stupid, poor men were also sterilised. In India, this initiative is still recognised and condemned, and it is accused for instilling a public hostility to family planning, which has impeded government programmes for decades. After the crises, the focus of the family planning programme switched to women because sterilising men was politically costly. The world's first governmental population stabilisation programme, the national family planning programme, was begun in 1951. The initiative was projected to have prevented 16.8 crore births by 1996. India was the first country in the world to implement a family planning programme in 1952. In India, the Ministry of Health and Family Welfare is in charge of developing and implementing family planning policies. In India, an inverted Red Triangle represents family planning health and contraception services. The program's aims are geared toward achieving the objectives outlined in many policy papers. While India's fertility rates are improving, there are still sections of the country with substantially higher fertility rates. The fertility rate in India has been declining for a long time, having more than halved between 1960 and 2009. From 5.7 births per woman in 1966 to 3.3 births per woman in 1997 and 2.7 births per woman in 2009, the rate has steadily decreased. The TFR (total fertility rate) was reported to be 2.9 births per woman in 2005. Since then, the country has seen a continuous reduction, reaching a current rate of 2.3 births per woman (as of 2014).

Twenty Indian states have fallen below the 2.1 replacement rate and are no longer contributing to population growth in the country. As of 2017, India's overall fertility rate was 2.2. Bihar, Uttar Pradesh, Meghalaya, and Nagaland are the four Indian states with fertility rates above 3.5. Bihar has the highest fertility rate of any Indian state, at 4.0 births per woman. The knowledge and

acceptance of family planning methods are vastly different. Despite having a high level of knowledge of modern methods of contraception (97%) and knowing at least one technique, only 49% of married women of reproductive age currently utilise them. Despite a government-sponsored, planned family planning programme, the results are far from ideal. India must be concerned about the 51% of individuals who do not utilise contraception.

The achievement of family planning goals is largely due to women's cooperation. Despite public awareness campaigns and incentives to encourage male sterilisation, males are hesitant to undertake the easy vasectomy operation, which is a less invasive non-therapeutic procedure than tubectomy. Only tubectomy was able to meet the Family Welfare Department's goals, thanks to women's willingness to undergo the family planning treatment. In a patriarchal society, women are automatically considered to be in charge of family planning. Despite the fact that the prevalence of contraception has dropped in numerous states, a trend analysis of the most recent National Family Health Survey suggests that women are obligated to be responsible for keeping family numbers limited.The latest round of National Family Health Survey (NFHS) 2015-16 data shows a declining trend of modern contraceptive use among married people. The data released for 35 states so far reveals that 13 out of these show a falling trend of modern contraceptive use.

One of the most important indices for determining the state of family planning is the contraceptive prevalence rate (CPR). It refers to the percentage of married women in the reproductive age group (15-49 years) who or their partners are currently using at least one form of contraception. Lower CPR has been shown to have negative consequences on a country's demography as well as the overall health of women and children. While the usage of contemporary contraceptives is declining in a lot of states – such as sterilizations, IUCDs (intrauterine contraceptive devices), oral contraceptive tablets, condoms, and so on – there is a striking discrepancy in contraceptive uptake by women and men in every state. Male involvement in reproductive health and family planning has recently been recognized as a crucial area for the total reproductive well-being of the couple by reproductive health programme designers, policymakers, and population researchers.Non-involvement of males in such areas contributes to major initiatives failing to achieve their desired objectives. To implement effective programmes to include men, it is therefore essential to first understand whether men are at all interested to be part of reproductive health programmes, and the barriers that they face while accessing services and how best can these be overcome. Despite almost two decades since the call to involve men actively in such programmes, men still feel ignored or are missing from such initiatives in India and other developing societies. As described in the above sections, there is enough evidence indicating the unmet need for comprehensive male

involvement in community-based Sexual and Reproductive Health (SRH) programmes which is essential for the well-being of the couple, since, in Indian communities, more so in rural India, men are gatekeepers and influencers in all decision making.

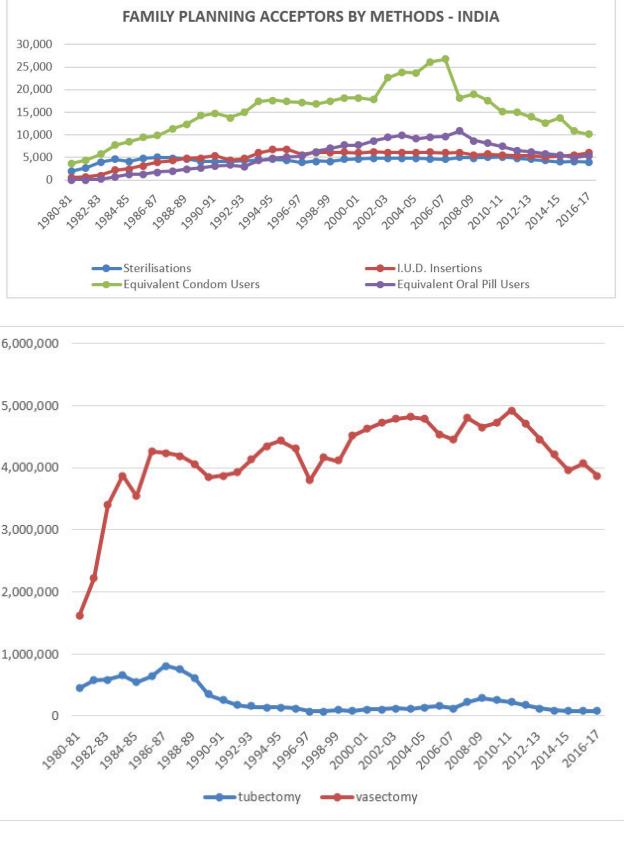
Performance of Family Planning

As on 1st March, 2011 India's population stood at 121 crore comprising of 62.3 crore (51.5 percent) males and 58.7 crore (48.5 percent) females. India, which accounts for world's 17.5 percent population, is the second most populous country in the world next only to China (19.4%).Of the 121 crore Indians, 83.4 crore (68. 9 percent) live in rural areas while 37.7 crore (31.1 percent) live in urban areas. The contribution of Uttar Pradesh to the total population of the country is 16.5 percent followed by Maharashtra (9.3 percent), Bihar (8.6 percent), West Bengal (7.5 percent) and Madhya Pradesh (6.0 per cent). These six most populous states in the country account for 55 percent of the country's population (Govt. of India, 2017). The Crude Birth Rate declined from 29.5 in the 1991 to 25.4 in 2001 and further declined to 20.4 in 2016. The CBR is higher (22.1) in rural areas as compared to urban areas (17.0) in 2016. Bihar recorded the highest CBR (26.8) and Andaman & Nicobar Islands the lowest (11.7). Bihar (26.8), Assam (21.7), Chhattisgarh (22.8), Haryana (20.7) Jharkhand (22.9), Rajasthan (24.3), Madhya Pradesh (25.1), Uttar Pradesh (26.2), Meghalaya (23.7), Dadra & Nagar Haveli (24.5) and Daman & Diu recorded higher CBR as compared to the national average. The CBR is higher in rural areas as compared to urban areas in all States/UTs except Kerala, Goa, Sikkim, Dadra & Nagar Haveli, Daman & Diu and Puducherry. . At the national level, 76.2 children were born per thousand women aged 15-49 years in 2015. This number varies from 60.8 in urban areas to 83.8 in rural areas in 2015. The General fertility rate (GFR) is consistently higher in rural population as compared to urban population. Among the bigger States, GFR varies widely from 53.0 in Kerala to 104.0 in Bihar. The GFR is higher in 8 bigger States viz. Assam (80.2), Bihar (104.0), Chhattisgarh (83.5), Haryana (78.5), Jharkhand (86.6), Madhya Pradesh (96.2), Rajasthan (91.7) and Uttar Pradesh (99.5) as compared to national average (76.2) in 2015. The Total fertility rate (TFR) has declined from 2.8 in 2006 to 2.3 in 2015 which accounts for a decline of about 17.9 percent . The TFR in rural areas has declined from 3.1 in 2006 to 2.5 in 2015 whereas the corresponding decline in urban areas has been from 2.0 to 1.8 during the same period. Among the bigger States, West Bengal has the lowest TFR of 1.6 and the highest TFR recorded is 3.2 for Bihar. Thirteen States out of 22 bigger States have achieved the replacement level of fertility i.e. TFR of 2.1 in 2015 viz. Andhra Pradesh (1.7), Delhi (1.7), Himachal Pradesh (1.7), Jammu & Kashmir (1.6), Karnataka (1.8), Kerala (1.8), Odisha (2.0), Maharashtra (1.8), Punjab (1.7), Tamil Nadu (1.6) , Telangana (1.8), Uttarakhand (2.0) and West

Bengal (1.6). With the exception of Kerala where the TFR is same for both rural and urban Population (1.8) during 2015, in all other bigger States the rural TFR is higher as compared to urban TFR. However, the difference is marginal in Andhra Pradesh, Delhi, Karnataka, Punjab,Tamil Nadu and Uttarakhand (Govt. of India,2017)

According to the latest SRS estimates, the Maternal Mortality Ratio (MMR) of India was 167 per one lakh live birth (2011-13) as compared to 178 in 2010-12. Some states like Kerala (61), Tamil Nadu (79), and Maharashtra (68) have made remarkable progress in 2011-13 while some others are lagging behind. The MMR is the highest in Assam (300) closely followed by Uttar Pradesh / Uttarkhand (285) and Rajasthan (244). Kerala is the best performing State with MMR of 61. Prevailing high maternal morbidity and mortality has always been cause of concern. Available data from SRS indicate that the major causes of maternal mortality are haemorrhage, sepsis, abortion, hypertensive disorders and obstructed labour (Chart 1) .

Chart1: Gender Wise Performance of Sterilization in India



According to the latest data, the total number of family planning acceptors in India decreased by 0.16 percent between 2015-16 and 2016-17. The data revealed that condom is the most preferred method of family planning while sterilizations the least adopted means. The number of couples adopting various methods for family planning, including spacing methods in 2016-17 was found to be 25.5 million with 10.1 million preferring condoms to any other means. The total number of family planning acceptors in India has shown a gradual decreasing trend after 2007-08. About 3.94 million people underwent sterilization during 2016-17. . The number of sterilization has decreased by 2.08 lakhs (5.0 percent) in 2016-17 as compared to 2015-16. Of the total sterilizations conducted, vasectomy (male sterilization) comprised only 1.9 percent .Of the total number of sterilisations, Andaman & Nicobar had the highest percentage of vasectomies (30.5 percent) in 2016-17 while no vasectomy has been reported in the state/ UT of Mizoram and Lakshadweep (Govt. of India, 2017).

The number of vasectomies carried out in almost all bigger states is quite insignificant as compared to number of tubectomies . Of the total tubectomy operations carried out in the country, 36.4 percent reported accounts for Laparoscopic tubectomies during 2016-17. Laparoscopic Tubectomies are more prominent in Himachal Pradesh (87.5 percent) followed by Madhya Pradesh (84 percent), Rajasthan (79.7 percent), Tripura(73.7 percent), Assam (71.7 percent), Uttar Pradesh (69.3 percent), Uttarakhand (61 percent), Nagaland (58.8 percent), Delhi (57.8 percent), Jammu & Kashmir (57.8 percent), Daman & Diu (53.6 percent) and Dadra & Nagar Haveli (52.3 percent). At the national level, the number of IUD insertions during 2016- 17 showed an increase of 7.76 percent as compared to 2015-16. The bigger States showing increase in performance during 2016-17 are Andhra Pradesh, Assam, Chhattisgarh, Gujarat, Jharkhand, Maharashtra, Odisha, Rajasthan, Jammu & Kashmir, Uttar Pradesh and West Bengal while usage has gone down in Bihar, Haryana, Karnataka, Kerala, Madhya Pradesh, Punjab, Tamil Nadu and Telangana. According to the available data, the number of equivalent condom users increased marginally from 4.42 million in 2015-16 to 4.57 million in 2016-17 under free distribution scheme but under Social Marketing Scheme, it has decreased from 6.5 million in 2015-16 to 5.6 million in 2016-17. Overall, the condom users has decreased from 10.9 million in 2015-16 to 10.1 million in 2016-17. The increase in condom users under free distribution during 2016-17 has been observed in 9 major states viz. Andhra Pradesh, Assam, Bihar, Gujarat, Haryana, Karnataka, Kerala, Odisha, Tamil Nadu, Telangana and West Bengal as compared to 2015-16. The significant observation is that the number of takers of free condoms increased by 3.4 percent in 2016-17 as compared to previous year whereas in 2015-16. However, the number of users has decreased in the case of Social Marketing Scheme. During the year 2016-17, 3.47 million oral pill users were worked out under free distribution scheme as against 3.3 million in 2015-16. Among major

States, Andhra Pradesh, Assam, Gujarat, Haryana, Jharkhand, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, Telangana, Uttar Pradesh and West Bengal have reported increased number of oral pill users in 2016-17 as compared to 2015-16 under free distribution scheme while in respect of other major States, there was drop in the number of users. Under social marketing scheme, the oral pill users have also improved and increased from 1.65 million in 2015-16 to 1.99 million oral pill users during 2016-17. Overall, the oral pill users increased from 4.97 million in 2015- 16 to 5.45 million during 2016-17.

Maternal and Child Health Programmes have aggressively promoted institutional deliveries in India. Out of 20.6 million deliveries reported in 2016-17 more than 18.6 million deliveries were reported institutional which account for 90.3 percent of total reported deliveries as compared to 88.4 percent in 2015-16. The percentage of institutional deliveries steadily increased from 81.7 percent in 2011-12 to 90.3 percent in 2016-17. States/UTs reported with an achievement of more than 90 percent institutional deliveries in 2016-17 include Andhra Pradesh (98.5 percent), Chhattisgarh (92.1 percent), Gujarat (98.9 percent), Haryana (92.5 percent), Jharkhand (90.5 percent), Karnataka (99.6 percent), Kerala (99.9 percent), Madhya Pradesh (91.1 percent), Maharashtra (99.1 percent), Odisha (92.4 percent), Punjab (95.1 percent), Rajasthan (96.9 percent), Tamil Nadu (100 percent), Telangana (99.3 percent), West Bengal (92.6 percent), Arunachal Pradesh (93.0 percent), Delhi (93.9 percent),Goa (99.9 percent), Jammu & Kashmir (92.5 percent), Sikkim (98.4 percent), Tripura (90.3 percent), Andaman & Nicobar Islands (97.5 percent), Chandigarh (99.6 percent), Dadra & Nagar Haveli (99.5 percent), Daman & Diu (99.4 percent), Lakshadweep (100.0 percent) and Puducherry (100.0 percent) . Female sterilization remains the most popular modern contraceptive method. As per NFHS IV ,2015-16 , among currently married women age 15-49, 36 percent use female sterilization, followed by male condoms (6 percent) and pills (4 percent). Six percent use a traditional method, mostly the rhythm method. Among sexually active unmarried women, female sterilization is the most commonly used method (19 percent), followed by male condoms (12 percent). The contraceptive prevalence rate among currently married women age 15-49 decreased slightly, from 56 percent in 2005-06 to 54 percent in 2015-16 . Use of contraceptive methods is the lowest in Manipur, Bihar, and Meghalaya (24 percent) and the highest in Punjab (76 percent). Among the states, a relatively low proportion of currently married women use contraceptive methods in all of the smaller states in the northeast region except for Sikkim and Tripura, as well as Goa. Among the union territories, the use of contraceptive methods is the lowest in Lakshadweep (30 percent) and the highest in Chandigarh (74 percent). Almost seven in 10 (69 percent) modern method contraceptive users obtained their method from the public health sector. The rest of the users of modern methods obtained their method from the private health sector including NGO

or trust hospitals/clinics (24 percent) and other sources (6 percent), including shops, their husband, friends, and relatives. A lower proportion of ,urban users (58 percent) than rural users (76 percent) obtained their method from the public health sector. The public health sector is the major source of female and male sterilization and IUDs/PPIUDs, whereas the private health sector is the major source of pills, injectables, and condoms/Nirodhs. Two-thirds of currently married women age 15-49 have a demand for family planning; 11 percent want to space births, and 55 percent want to limit births. As per report of NFHS, 2015-16 , 54 percent of currently married women are already using a contraceptive method either to space or to limit births, and therefore have their need met. However, 13 percent of currently married women have an unmet need for family planning, including 6 percent who have an unmet need for spacing births and 7 percent who have an unmet need for limiting births. If all currently married women who want to space or limit their children were to use a family planning method, the contraceptive prevalence rate would increase from 54 percent to 66 percent. The total demand for family planning among currently married women age 15-49 in India decreased slightly from 70 percent in 2005-06 to 66 percent in 2015-16. The unmet need for family planning was almost the same in NFHS-3 and NFHS-4 (IIPS, 2016).

The current policy of Government of India under NHM is to encourage institutional delivery which is an important step in lowering the maternal mortality. However, home based deliveries are still prevalent in the country though the number is decreasing over the years. According to the data available on HMIS Portal, the number of deliveries conducted at home has come down to 19.9 lakhs in 2016-17 from 38.8 lakhs in 2011-12. It is observed that medical attention provided to new born at home has significantly increased over the years. The percentage of newborns visited within 24 hours of home delivery has increased from 62.3 in 2011- 12 to 67.4 percent in 2016-17. To provide safe abortions, most countries have enacted laws whereby only qualified gynaecologists / doctors and approved clinics / hospitals can perform abortions under certain laid down conditions. , During the period of 2016-17, 7, 32,349 MTPs were performed as against 7,02,403 in 2015-16. Maharashtra with 1, 95,343 MTPs tops the list in bigger States while Telangana is at the bottom of the ladder (2435). .

Conclusion

Despite a five-decade history, India's family planning programme has unable to achieve replacement level fertility. As a result, efforts are currently being made to rethink the programme in order to establish and implement priority strategies for accomplishing programmatic goals. In India, there is a substantial unmet demand for couples to limit their family size and space their births. However,

the national programme has so far failed to provide them with a variety of contraceptive options. It is critical to increase service quality in order to convey the underlying principle of informed contraceptive choice. To assist clients to attain their reproductive goals, context-specific, focused techniques are required to provide method choice. The problem of high unmet contraceptive need among young couples, particularly married adolescents, must be addressed immediately. Both fertility and mortality have been declining at a slower rate. As a result, it is critical to concentrate efforts and resources in these states. People's numerous reproductive health needs should be addressed through integrated programmes that are more effective and efficient. Because son preference is still prominent in India's patriarchal society, such integrated programmes must be created with a gender lens. As spouses strive to obtain their ideal family composition, son preference leads to larger households. There are a number of intriguing contraceptive technologies in the works right now. However, in order for these technologies to be effectively delivered by service providers and accepted by clients, scientists developing them must collaborate with professionals involved in programme planning and implementation, and all stakeholders must understand the needs and perspectives of end-users of these technologies. Over time, the focal point of family planning strategies has shifted from males to women. There has been drastic decline in the share of male sterilization in total sterilization of family planning cases while number of family planning acceptors has increased significantly over the period. Thus, there is increase use of family planning methods by women in India.

References

IIPS (2016) National Family Health Survey, IV , 2015-16, International Institute of Population Sciences, Mumbai

Planning Commission (2001), Report Of The Subgroup On Public Health, Govt. Of India, July 2001.

Ramchandra, P. (2002), Health Nutrition, Population Vision 2020, IN: Indian Vision 2020, Planning Commission, Govt. of India.

Ramchandran, S., (2003), Women Status Effect On Family Size, IN: Dimensions of Researches in Indian Anthropology by (Ed.) Sahay and Singh, Sereals Pub. Delhi.

Singh S. K. and Singh A. K. (2006), Reproductive Child Health in North East Region, Serials Publication Delhi.

Singh, U.P. (2003), Trends Of Mortality among Bhoxa Tribe of Uttaranchal, the Oriental Anthropologist, Vol. 3 (1), Jan.