International Journal of Humanities and Social Science Invention (IJHSSI)
ISSN (Online): 2319 – 7722, ISSN (Print): 2319 – 7714
www.ijhssi.org ||Volume 11 Issue 12 December. 2022 || PP. 50-61

ICPD-1994 and London F2020 Has Changed India's Trajectory of Family Planning Programs

Abid Siraj
Research Scholar,
Rabindranath Tagor University, Bhopal, MP-India

Dr Usha Vaidya
Department of Humanities and Liberal Arts, Rabindranath Tagor University, Bhopal, MP-India

Dr Bharti Gaur
Independent Researcher and Trainer, Kota, Rajasthan-India

Abstract
Beginning in 1952, India was pioneered to start family planning as a fully government sponsored programs and has moved forward with many twists and turns. Although, most of the time, it has centered on sterilization. Focus on male sterilization in the 1970s, Integration of programs to ICPD-1994, SDGs, and targeted approach to increase the use of alternate contraceptive measures are some of the millstones of India's family planning approaches. This study is intended to gauge the impact of ICPD-1994 and FP-2020 on India's family planning and birth rate. In this study, NHFS survey data has been analysed using SPSS to compare indicators between given years. The result of the study shows that although India is in a continuous improvement phase, the rate of improvement has sharpened after the adoption and implementation of ICPD-1994 and FP-2020 measures. Recently, the use of temporary and Emergency contraceptives has widened along with its basket.

Key Words: *Family Planning Programs, Fertility Rate, Contraceptives, NHFS Survey*

Date of Submission: 01-12-2022 Date of Acceptance: 10-12-2022

I. Introduction

India's National Family Welfare program termed need for population control as "to lowering the birth rate to the degree necessary to stabilize the demographic at a comparable level with the needs of the national economy,".

In 1952, India was the first in the world to initiate a population control program to ensure equitable social development. The program has brought about many changes in both program policy and practices over its many years of existence. Goals of population stabilization, promotion of reproductive health, and reduction of maternal, newborn, and child mortality and morbidity are driving the current reorientation. The goal of this research is to examine India's family planning policies from a variety of angles, including how well they mesh with international efforts, and to assess the significance of critical international events like the "International Conference on Population and Development (ICPD)" and "Family Planning-2020", which are being studied here as well.

1. India's Family Planning Programs: A Review

As mentioned supra, the National Family Planning Programme in India began in year 1952. This marked a significant first step in the history of family planning in India and the world as well. India holds this distinction, as it achieved it before any other nation. Since its inception, there have been numerous policy formulation and implementation shifts within the family planning programme. In the 1975-77, when then-Prime Minister Indira Gandhi declared emergency and a very coercive sterilisation programmes by using all possible force available to then government disposal. After that, family planning program suffered tremendously in coming years. Many people, still, have bad memories and developed negative feelings toward the procedure.

Due to their positions as significant decision-makers in their families, men were singled out for special attention during the nationwide forced male sterilization camps during the Emergency in 1975–1977. However, vital, target-driven, incentivized family planning program emerged during this time(Balasubramanian, 2018). People were sterilized against their will and, in some cases, without their knowledge, drawing widespread criticism of the program. After the Emergency, a precipitous decline in the rate of vasectomies was seen.

Though government of India was in dmamage control mode by invoking first population policy. It was a document from government side to reinsure the population in general that emergency like policies and program will not going to come in near future.

In the 1990s, India made an effort to implement the policies discussed at the UN Population Conference in Cairo in 1994. Although the Indian government attended the ICPD-1994, which marked a global movement toward reproductive health and sexual health couple with target-free approach in family planning, though the target-oriented strategy still persisted in India(Basu, 2005). Improvements in children's and women's health and education and access to a range of birth control choices continue to be cited as the most effective strategies for achieving family planning goals (Sahay, 2017).

The next big step government of India took after 1994 ICPD, was to announce of the "National Population Policy in 2000", which intended to reduce fertility rates without establishing a precise goal. Public medical facilities were revamped to deal with promise made by the government of India in ICPD 1994 to provide right based sexual and reproductive health services. After that, new programs were established, and old ones were broadened to enhance India's already impressive family planning infrastructure. One of the fundamental tenets of the National Health Policy, which was implemented in 2002, and the National Rural Health Mission (NRHM), also introduced at that time, was family planning.

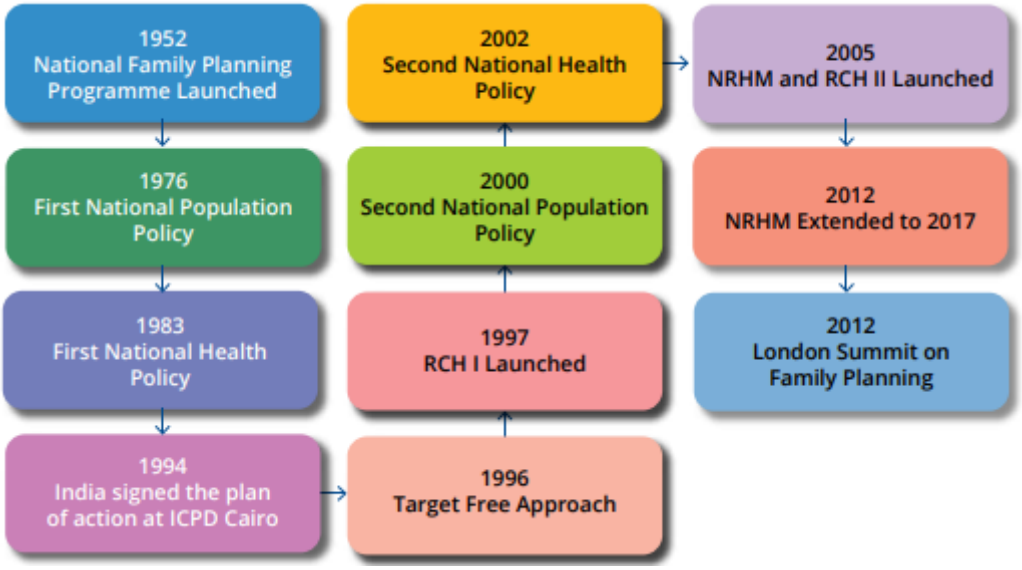

Figure 1: Milestones in Family Planning Programme in India (INDIA'S 'VISION FP 2020')

The National Population Policy 2000 stated that one of its aims was to maintain a population size that was sustainable for the economy. By 2012, the National Rural Health Mission, which began in 2005, aimed to reach a TFR replacement level of 2.1. However, the deadline passed, and the objective was accomplished. Retooled to achieve population stabilization and drastically reduce maternal, newborn, and child mortality and morbidity, the program has gone a long way from its inception. Following are a few examples of significant government policy initiatives r adaptation of certain international agreements in India:

1) International Conference on Population and Development
2) National Population Policy 2000
3) National Health Policy 2017
4) National Rural Health Mission 2005
5) National Health Mission
6) Millennium Development Goals
7) Sustainable Development Goals

2. Implications of These Policies

1) Male sterilisation was the most popular method of contraception in initial days of implementation of family planning program in India.But after emergency debacle it had lost impact factors as it used to be in family planning program. As a method of contraception, male sterilisation has seen its share decline from 8% to 1% in subsequent years.

2) As the prevalence of HIV/AIDS increased worldwide after the 1990s, condom use skyrocketed. Intrauterine contraceptive devices (IUDs) and injectable contraceptives are not viable alternatives to oral

contraceptives. This is due to the fact that no existing healthcare infrastructure can accommodate such procedures.

3) Due to inadequate medical infrastructure, female sterilisation has also been a subject of intense debate. The deaths of women in mass sterilisation camps are directly attributable to the sterilisation

When it comes to deciding which method of contraception to use, there is a significant knowledge gap. Only about one-third of users in India understand the benefits and risks of the many available contraceptive options (NFHS, 2005). Since the Indian government is the leading distributor of birth control, public funding for family planning is crucial for ensuring universal availability. However, with only 1.2% of GDP, India's public health spending is among the world's lowest. The World Health Organization (WHO) recommend to have at least 4 to 5 per cent of GDP share on health to maintain minimum level of healthcare delivery (WHO, 2000).

3. ICPD-1994

In 1994, 179 governments met in Cairo for the ICPD. They approved the "Programme of Action (PoA)" that put right based reproductive and sexual health care at the forefront of global and national development agenda.It was stated clearly in the PoA that

"The full and equal participation of women in civil, cultural, economic, political, and social life, at the national, regional, and global level, and the elimination of all forms of discrimination based on of sex, are priority objectives of the international community."(PoA, 1994)

i. Program of Action (PoA)

Universalization of accessible and affordable sexual and reproductive health services including sexually transmitted disease prevention, safe pregnancy and childbirth, and other aspects of reproductive health was main part of ICPD 1994 final program action plan. It was also acknowledged that, there is strong interconnectedness of the issues such as between women's empowerment and reproductive and sexual healthcarefor social and economic development.

In a first for an international policy document, it said that "reproductive health is a condition of complete physical, mental, and social well-being and not only the absence of sickness or infirmity, in all matters connected to the reproductive system."

1) Right to decide the number and spacing among chiddren.
2) Right to have a healthy and safe sex life.

The emphasis here is on a person's total well-being rather than just the absence of disease or death, expanding the scope of what it means to be healthy. The provision of full-spectrum reproductive health care, which the PoA strongly endorses, is a critical element of the agreement. Various aspects of reproductive health care that are strongly encouraged by the PoA include:

I. Family planning cafeteriaapproach.
II. Healthy pregnancy and safe delivery services.
III. Safe Abortion (wherever it is legal).
IV. RTI/STD/HIV testing and treatment.
V. Sex and hygiene-related education and counselling;
VI. The elimination of harmful practices such forced and child marriages, against women.

The International Conference on Population and Development (ICPD) at some extended got global consensus on reproductive and sexual health and rights are as human rights. By having reproductive and sexual health as human rights will eventually lead to women's empowerment, and help to have women's equality that is essential for ensuring the well-being and prosperity of all people.

ii. Impact of ICPD

Some scientists and politicians worried in the 1960s that rising populations would overwhelm Earth's resources, causing widespread starvation and the collapse of civilization. Others increased access to family planning services, and a select few took measures (often forced) to reduce birth rates.

A new international consensus on how to address population growth was represented in the ICPD's Programme of Actions. Rather than focusing on population targets, it firmly established that respect for the rights and dignity of persons was the most effective means of contraception by which people might achieve their desired levels of procreation. Nevertheless, governments understood importance of accessible and affordable family planning servicesas afundamental right for progress everywhere.The ICPD brought the idea of right based reproductive and sexual health, and women's empowerment as everyone's responsibility at CenterStage.

Since then, every year, the United Nations takes stock of sexual and reproductive health and rights status at the Commission on Population and Development constituted to review and suggestion corrective steps in ensuring these rights for individuals. These yearly assessments have shown how much still needs to be done. The pact has been in place for 26 years, yet much progress was made,rather been reversed.

Since 1994, globally, the number of people with access to modern contraception has increased by 25 percent, and so has the quality of family planning services as well. Nevertheless, availability of modern contraceptives methods has increased, but, still millions of women do not use them. Though, these women not to have any unintended pregnancies. Nevertheless, forecasts reveal that by 2050, the world's population may be 1.7 billion people, higher or lower depending on whether the average family size is 2.5 or 2.0 children (Figure 2).

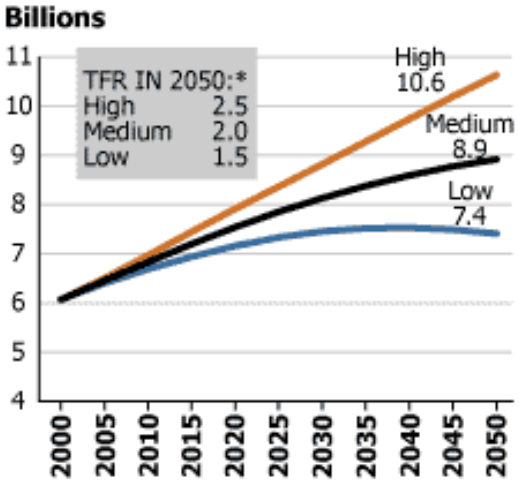

Figure 2: World Population Prospects

Total fertility rate (TFR) is count average number of children a woman would give birth during her entire reproductive age. To keep the population in check, the government generally used TFR as monitoring indicator and often fix quotas for state government to be achieved.

To maintain a stable population, India needs a TFR of 2.1, which is considered as a replacement level fertility rate of any given population. The fifth National Family Health Survey results show that efforts to reduce the population have been very successful. In India, the TFR has dropped from 2.2 in 2015–16 to an expected 2.0 in 2019–21. Five states have a replacement fertility rate of 2.1 or lower, but this varies widely across regions. NFHS-5 (2019–21) focused on the states that have high TFR, Bihar (2.98), Meghalaya (2.91), Uttar Pradesh (2.35), Jharkhand (2.26), and Manipur (2.17).

4. Family Planning 2020 (FP2020)

Ever since Cairo ICPD 1994, countries and donors drastically reduced their support for family planning initiatives in the recent past. Later, however, it was realised by the governments and international organization that reducing the high maternal, new-born, and child mortality rates may be facilitated by expanding affordability, accessibility, and availability of family planning services.

Considering this situation, the 'London Summit on Family Planning', also known as 'Family Planning 2020 (FP2020)', was convened in 2012. Its purpose was to renew international attention on the importance of family planning. It was set up as a governing body to oversee operations and ensure success. In order to evaluate the progress of the nation and make adjustments to the course of action if utilization levels remained constant or fell, these were required on a more frequent and expedient basis than the data provided by typical surveys. PMA2020, which stands for 'Performance Monitoring and Accountability 2020', was devised to provide accurate and timely estimates of the prevalence of modern contraceptive methods and unmet need in FP2020 priority countries such as India and Burkina Faso, Ghana, the Democratic Republic of the Congo, Ethiopia, Indonesia, Uganda, Kenya, and Niger.At the London Summit on Family Planning in 2012, access to contraception for 120 million additional women and girls in the world's poorest countries by 2020 was approved as an ambitious goal.

The critical focus of FP 2020 is:

I. Improving contraceptive access in priority countries with the adoption of modern contraceptive methods use
II. To enhance the basket of contraceptives by adding injectable and Post-partum Intra-uterine contraceptive devices.
III. Improving the quality of contraceptives services.
IV. Augmenting contraceptive demand through counselling and comprehensive campaigns,
V. Focused interventions in high fertility regions through a targeted approach.

a. Significance of FP 2020

Every six months to a year, PMA2020 conducts surveys to collect data on contraceptive usage and how demand, and supply chain working. The collected data would be used to navigate policies corrections and start innovative initiatives and pinpoint areas lacking and need improvement by FP2020 and governments.Women living in or near certain enumeration areas (EAs) are recruited and trained by PMA2020 to use smartphones to collect data on households and facilities, which is in turn uploaded to a cloud server.Multiple rounds of data collected by theseresident enumerators (REs). Each cycle occurred in within six weeks and each cycle always followed by an initial training of that round.

People, possessions, animals, houses built, and the state of water, sanitation, and hygiene (WASH) are all examples of data that can be collected from households. The female interview is open to women between the ages of 15 and 49 who are permanent family residents or at least lived one night before the interview. Family planning measures include currently what kind of contraceptive they are using and recall contraception used by them in the 12 months prior to the interview if they are not using any contraception at the time of interview.The data captured the "method information index," which includes questions such as whether she was given information about alternative methods, whether she was counselled about side effects and instructed on how she should deal if she experienced any side effects from the method. Several quality and variety indicators are quantifiable. The utilization of modern contraceptive methods, unmet family planning requirements, and socioeconomic status all represent constructed variables in the dataset.

In addition to questions about family planning, the household, female, and Social Development Program (SDP) questionnaires have few questions about water and sanitation. Round-specific WASH questions appear in both the household and female surveys. Some of the issues addressed such as access to clean water, disposal of human waste, incidences of diarrhea in children under five years of age, and menstrual hygiene. The PMA platform tries to chapturebreadth of topics related to maternal and child health, family planning, water and sanitation schistosomiasis, and nutrition. PMA 2020 is designed to generate national specific data. Though, some indicators are common across the board.

5. Study of Earlier Research

(Bongaarts & Blanc, 2015)Statistics on births and deaths in a country can help determine the average age of a mother when she gives birth. In developing countries, it has been observed that they lack of or inability to collect reliable vital statistics; therefore,getting areliable estimate of mean age at first birth for any child is not easy. Nevertheless, DHS could be one of reliable source of data to know the mean age of a women getting pregnant and delivering her first child in most of the developing countries including India. This study provides two methods that can be facilitate the calculation of an average age of mother at her first delivery by using data from the DHS. The first approach uses a weighted average of first birth rates within a single year across populations having reliable vital statistics. The median age of a mother at her first birth is the second statistic. The nations where childlessness is not rising, the two estimates from the most recent polls in 62 countries align quite well. Childless societies should, in theory, have fewer consensuses. The data support taking the initial approach. Moreover, these measuresare simple to compute and focuses on recent births, accuracy would be more than older markers. Because recall period could be tricky part. The average age of a country's first-born population can be estimated for the current time and compared with the estimations of other countries.

(Rana & Goli, 2021) From 1993 to 2016 and from 2016 upto2030, this study get deep into the effect of fulfilling the unmet need for family planning on overall indicators of maternal and child health related to family planning part.in India. This study make estimation very relevant to this issue that if state tries to meet the unmet need of family planning of its population result can be more promising. Data/methods: The paper used the sample registration system periodically released by Census Commissioner of India data, the national family health surveys, and the World Population Prospects. Using Spectrum's of renowned module that give correct projection related to family planning and demographic of given population, the outcomestrajectory of family planning initiatives in India from 1993 upto 2030 were evaluated in this paper. Results: population still don’t have quality accessibility issues in family planning servicesbetween 1993 and 2016, 56 million unintended births took place, unsafe was 7 million, and 1,67,000 women diesd due to pregnancy and delivery related issues. Any reduction in unmet for family planning by 5 per cent by end of 2030could result in avoidance of 41 million unwanted births, unsafe abortion 5 million. And top of that prevention of 124,000 maternal death. It was observed that between 1993 and 2016, the unmet need for family planning was decreased, that resulted in decrease of pregnancy of 27 per thousand married women, abortion reduced 1.8 per million married women, after adjusting risk in to infant mortality it was10 per 1000 live births, and under-five child morality by 15 per 1000 live births. If India would be able to reduce 5 percent in unmet need for family planning by 2030 it will have big impact on indicators such as, reduction in unintended births by 24 per 1000 married women, abortions by 1.6 per million married women, infant mortality, after adjusting risk, by 10 per 1000 live births, and on of major concern under 5-years child morality 14 per 1000 live births. This study concludes that India’s family

planning program has potential of a higher return on investmentand can help the country in achieving UN Sustainable Development Goals (SDGs) inlistingrelated to reproductive, maternal, and child health.

(Yadav et al., 2020). This paper review the family planning program in one of the most populus state on India 'Uttar Pradesh (UP)'. The paper used NFHS-4 data.It reveals that in UP unmet need for family planning is significantly high. Young adults between the ages of 15 and 19 and 20 to 24 have the most unmet needs. There is a dearth of information regarding unmet FP needs among slum dwellers aged 15–24. This research examined the factors contributing to the high unmet demand for FP services in India's urban slums in the state of Uttar Pradesh. Slums in India were analyzed using a cross-sectional design. One Urban-Primary Health Center (U-PHC) and two randomly chosen slums are located in each of Lucknow's eight Municipal Corporation zones. A total of 535 YMW were interviewed, with 33 from each of the designated slums being interviewed. The information was evaluated using a logistic model. Family planning services are needed by 55.3% of YMW. Forty-nine percent of unmet demands were related to space, while 14.5 percent were related to confinement. How to use contraceptive and availability of family planning services is important variable in meeting the unmet need for family planning; therefore, working on these variables with users is crucial for the program to address unmet need of men, women and community as whole. Sharing information related to family planning in order to create awareness help to reduce stigma/hesitation/shyness for contraception. People often worry about their health and the possible consequences when thinking about different approaches. The unmet demand for family planning services weresometimes linked one of or amalgamation of more than one factor such as to age, education, marital status, number of children, familiarity with birth control methods, attitudes toward contraceptive use, and access to an ANM. The high demand for family planning services is not being satisfied in the urban slum of YMW. Those in charge of programs meant to help young women of childbearing age have their high unmet family planning needs to be addressed should keep these factors in mind, as the results show they are essential.

(Patel et al., 2020)The country's youth can aid India's economic development and progress. Adolescent girls are highlighted as an essential demographic factor in accomplishing the Sustainable Development Goals (SDGs) and in mainstreaming gender equity across the SDGs through an examination of the inter-sectionalize and cross-cutting gender aspects. This article reviews the dataoffew important crucial indicators related to health, education, and domestic violence among adolescents by using secondary sources. These secondary sources comprises of the literature on adolescent girls and their health, educational, and violence-prevention efforts. The advancement of gender equality and sustainable development may be jeopardized if adolescent girls' data are not sex-disaggregated or do not include SDG indicators.

(Basu, 2005)any underdeveloped region/nation needs to focus on the growth of use of modern contraception methods by its population to reduce total fertility rate or reduce fertility rate to the replacement level. The paper suggests that conventional contraception methods user of birth control are often loose the interest in method and lack the motivation to exercise effective methods of fertility management. When looking at the demographics of contraceptive use in India, it appears that college educated urban women are the most likely to use these conventional contraceptives, and they are also the most influential users of these procedures. These women have ultramodern attitudes towards use of modern medicine and westernised body image, this study aims to contextualize this seemingly contradictory decision among urban, educated women within the context of the present developmental paradigm. At the end of the report, the authors speculate that the failure of population policy and contraceptive development is attributable, in part, to the adoption of traditional means of contraception by modern women.

6. Problem Statement

Since 1952 India's family planning programs have moved forward with many twists and turns. Although, most of the time, it has centered on sterilization. A vast spared PHC network was established to popularize this modern sterilization method, and a targeted sterilization campaign providing monetary incentives are some of the essential aspects. Focus on male sterilization in the 1970s, Integration of programs to ICPD-1994, SDGs, and targeted approach to increase the use of alternate contraceptive measures are some of the millstones of India's family planning approaches. The program has brought about changes in both program policy and practices over its many years of existence. Redirecting efforts are underway to improve reproductive health, lower mother, newborn, and child mortality rates, and accomplish population stability objectives. Many studies it has revealed that India continuously improved its position on various indicators. However, it misses the set target. However, in recent reports, it has been found that India has not only achieved some of its targets (at present birth rate is 2.0), but its improvement on various indicators has sharpened.

This study assumes that ICPD-1994 and FP-2020 have played an essential role in the improvement on family planning in India. Therefore, evaluating the impact of these two initiatives on total fertility and adaptation of modern family planning methods in India is imperative.

7. Methodology

a. Research Design

NFHS-1 used the data for 1990-92, just two years before ICPD. Starting from 1990 and subsequent surveys till 2020, these data have been used for comparative analysis of the different indicators. In this study, two separate analyses have been done.

1. **Impact of ICPD:** One for the fertility indicator, which provides a comparative view on the impact of the adoption of ICPD in India.
2. **Impact of FP-2020:** In the second analysis, data for the popularity and use of various contraceptive measures adopted by Indian women in age group of 15-49 years has been accounted for. This analysis gave a view on the impact of FP-2020.

b. Sampling Process

Using the present age-specific fertility rate as parameter, Total Fertility Rate (TFR) estimates the average number of children a woman gave birth in her entire reproductive age. In India, it is between 15 to 45/49 years of age. It is a conventional measure of the population from 15 to 49 when most women have children.

$$TFR = 5 \times \sum(ASFR)$$

$$\Rightarrow TFR = 5 \times \left(\frac{Total\ Number\ of\ Birth\ Women\ have\ during\ age\ 15-19}{Number\ of\ Women\ age\ between\ 15-19} + .. \frac{Total\ Number\ of\ Birth\ Women\ have\ during\ age\ 15-19}{Number\ of\ Women\ age\ between\ 15-19}\right)$$

The Crude Birth Rate (CBR),as a rough indicator,measures the births per 1,000 people per a particular midyear population estimate. The rate of natural increase in a given population depend upon subtracting of crude death rate from crude birth rate. In this calculation migration should not be counted.

$$Crude\ Birth\ Rate = \frac{\boldsymbol{Number\ of\ live\ births}}{\boldsymbol{Estimated\ midyear\ Population}} \times 1{,}000$$

TFR Formula has also been applied for sampling contraceptives used by women of different aged groups; however, the variable for such sampling was different.

c. Data collection

The data inputs in this research have been provided by sundry National Family Health Survey (NFHS) collected under the head of Fertility and Family Planning. Starting period from 1990 onwards. There are five such surveys have been conducted so far. NFHS obtains data three-year period preceding every survey. These three years were chosen to obtain recent information, minimize sampling variation, and reduce problems related to the displacement of births.

To access the impact of ICPD on data of total fertility rate and the crude birth rate has been taken into consideration. It has been observed that in all NFHS surveys among all reproductive age groups, the fertility rate in the age group of 20-24 across India have always been remained high. A separate comparison has been drawn for this group across the time horizon.

To evaluate the impact of FP-2020, data generated from women age group of 15-49 who are currently using modern contraception methods was used. As the basket of temporary contraceptives has diversified, this data has also been gathered for the recent survey. Collected data has been analyzed using SPSS, and comparative analysis has been drawn considering implementing year as the benchmark.

8. Result

a. Impact of ICPD

Each time they conduct a survey, the NFHS compiles estimates of the ASFR, TFR, and CBR for the three years prior. These three years were selected to minimize difficulties associated with shifting births from more recent years into previous ones, limit sampling variation, and acquire the most up-to-date information possible. As part of this study, we have compared TFR to CBR. Here, the age bracket with the highest fertility rate overall has also been taken into account. To frame this discussion, we will use India's 1999 acceptance of ICPD and its subsequent implementation under the National Population Policy 2000 as our starting point.

Table 1: TFR and CBR data for the NFHS survey

	1990-92	**1996–98**	**2003-05**	**2013-15**	**2019-21**
TFR (15-44 years)	3.39	2.85	2.66	2.18	2.0
CBR	28.7	24.8	23.1	19.0	17.80
TFR for the age of 20-24	0.231	0.210	0.209	0.184	0.165

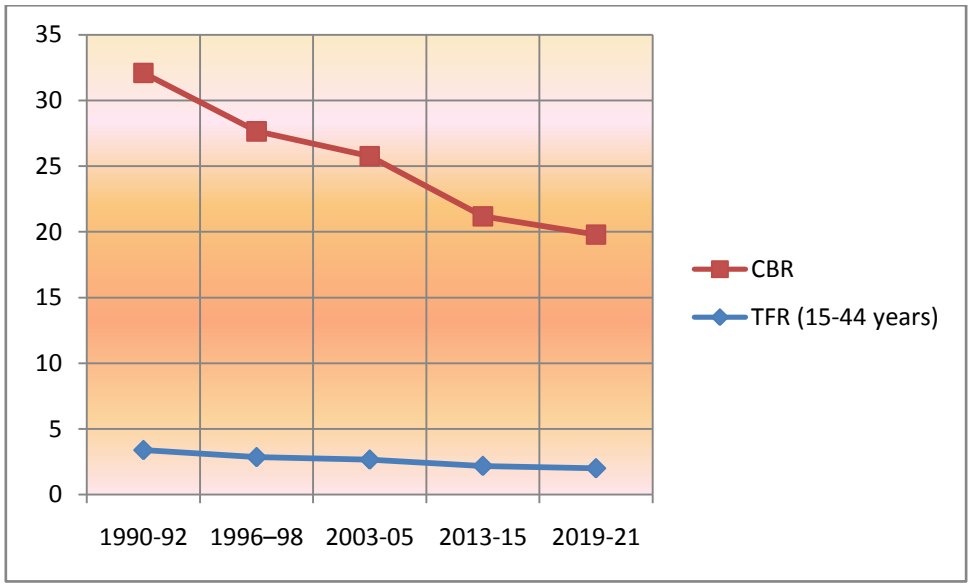

Figure 3: Graph depicting the fall in TFR and CBR

Interpretation: The figure-1 shows that although the decline in TFR and CBR is continuous, however, the after the adoption of ICPD in India in 1999, the decline has sharpened. It implies that the policy adopted has an impact on the decline of the fertility rate. These measures have helped the Indian fertility rate to reach its stipulated rate for population stabilization level of 2.1 in less than 20 years of policy adoption.

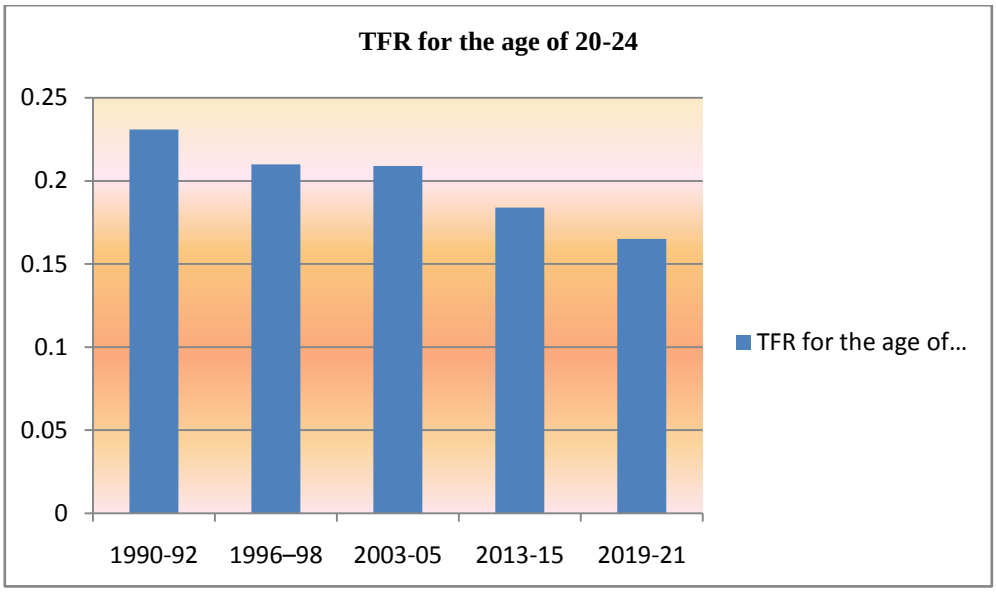

Figure 4: TFR for the Age group of 20-24

Interpretation: It has been observed that in all NFHS surveys among all age groups, the fertility rate in the 20-24 across India has always remained high. However, figure 2 shows that this group's corresponding decline in the fertility rate has also continuously declined. Suppose we synchronize this decline with educational, women's health awareness programs, etc. It confirms that these declines support these socio-demographic parameters.

b. Impact of FP-2020

Table 2: Indicators for Family Planning Method by married women in India

	1990-92	**1996–98**	**2003-05**	**2013-15**	**2019-21**
Unmet Need for Family Planning %	20	15.8	13.9	12.9	9.4
Use of any modern method of Family Planning	36	49	58	47.8	56.5
Use of Modern Temporary Contraceptive Method	6	8	9.8	11.2	11.4
Use of Sterilization	31	34	37	36.0	37.9

IMR (per 1000 live births)	79	68	57	41	35.2

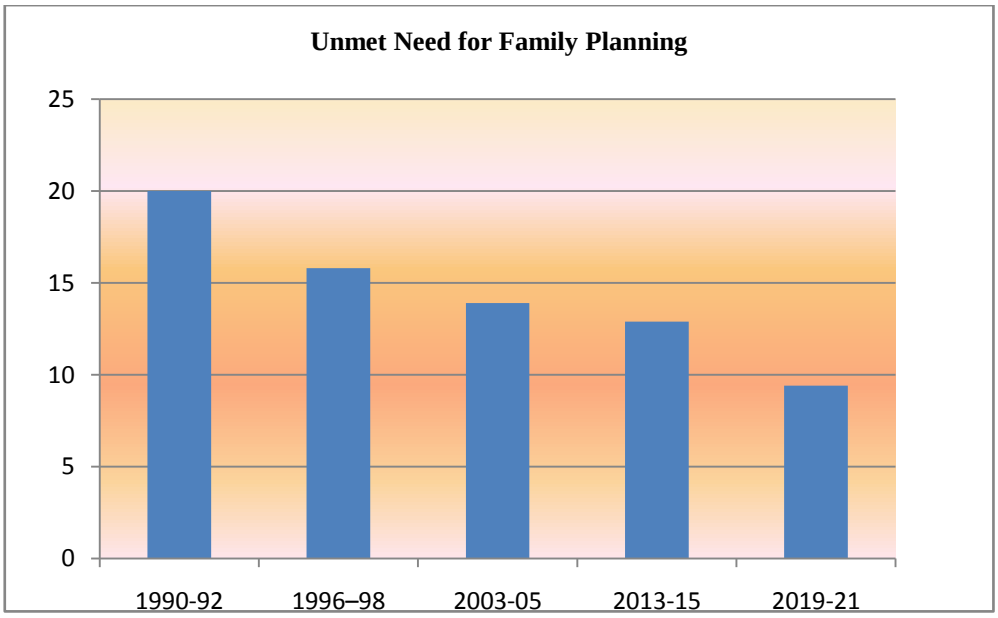

Figure 5: Unmet Need for Family Planning

Interpretation: According to table 2, 9 % women still have unmet need for family planning among currently married women. This is decrease significant from the 1990s, when the proportion was 20%. Since Family Planning 2020 (FP-2020) went into effect in 2013-2015, this decline has accelerated.

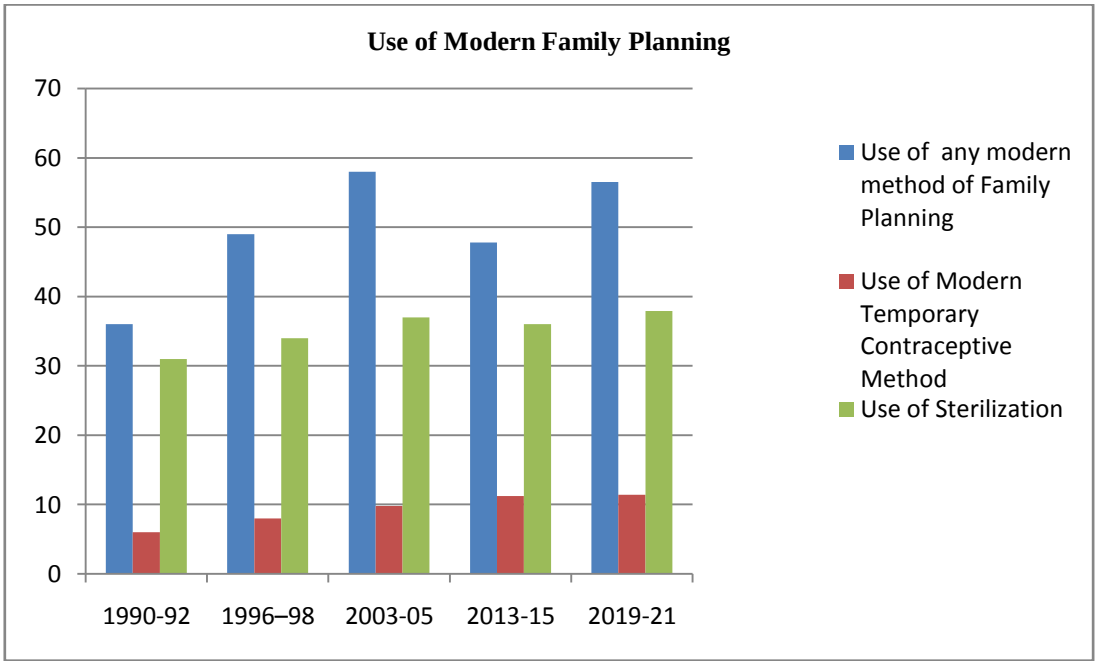

Figure 6: Use of Contraceptive

Interpretation: Between 2003-2005 and 2019-21, the modern family planning method utilised by married women remained unchanged at just below 60%. Although it fell to below 50% between 2013 and 2015
38% of married women use female sterilisation, making it the most popular modern contraceptive method. Nonetheless, it has remained unchanged due to the increased use of alternative methods, such as temporary contraceptives. It is also worth noting that since the desire to spacing in childbirth is getting popularise due to counseling, married women avoid using sterilization (a permanent form).

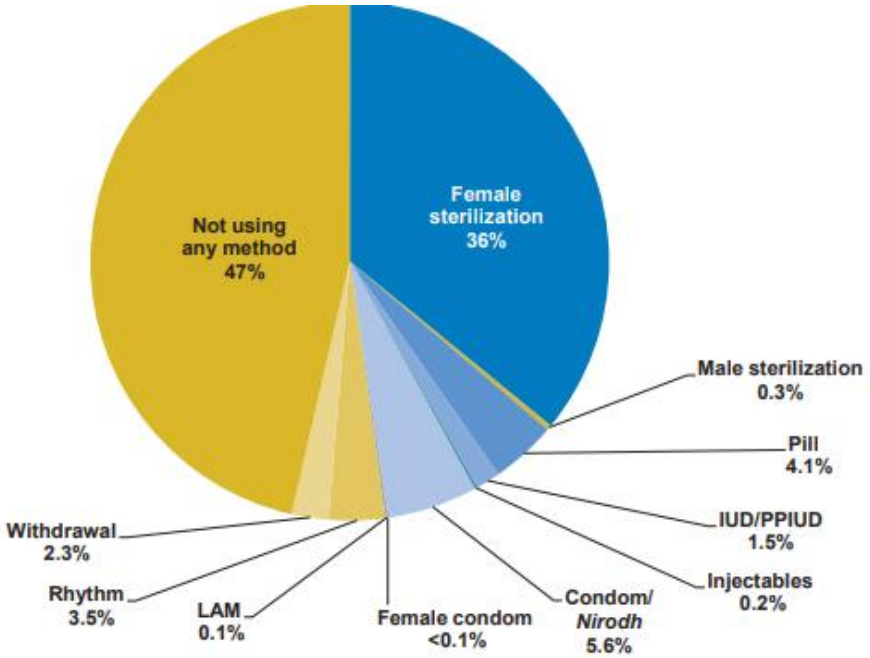

Figure 7: Use of temporary Contraceptives

Interpretation: In age between 15-49 years allmarried women, about 38% using sterilization. The condom used by male are 6 % and women oral contraceptive pill user are 4 per cent. Still 6 percent couples are using traditional method. Rhythm method is very among traditional contraceptive methods. It is worth to note that female sterilization is preferred method among women 19 %. Male partners are prefering to use condom i.e 12%.

9. Discussion

The National Population policy-2000 by Indiaput medium-term goal of reducing the TFR to a replacement level by 2010, the primary focus was to meet the unmet need for family planning mainly modern contraception methods. In this context, one among 14 national level socio-demographic goals are to ensure that all population of India have access to reliable information, proper counselling, and availability of quality services for fertility control and family planning at greater extend (MoHFW, 2000).

Some populations are more likely to experience infant and young child mortality than others. Compared to urban children, rural children in India had a 70% higher risk of dying before their fifth birthday. This is an increase from the 64% disparity seen in the most recent five-year period.

By these measures, 9 percent of India's women have an unmet need for contraception. As with the need to reduce births, the requirement to space them out is currently unmet (8 percent). The current contraceptive prevalence rate is 48%, meaning that still 25% of family planning need is not met. In Ideal case all women desired to opt for space or limit methods of family planning, there is huge gap between supply and demand.

Maternal Mortality Ratio (MMR)is the number of maternal deaths among women aged 15–49 per 100,000 live births. This statistic is derived from an annual tally of female deaths among sample household residents, specifically those occurring during pregnancy or within two months from Delivery or childbirth. Those are already using contraception have their reproductive health needs met. Unmet family planning needs consist of the total demand for family planning at a given time in a given population.

Unmet demand for spacing includes women who are ambivalent about having more children or who desire more children but are unsure when to have them. Women with an unmet need for limiting include those who are pregnant and do not wish to become pregnant in the near future, who have amenorrhea and do not wish to have any more children, or who are neither pregnant nor amenorrheic but do not use any form of family planning despite not wishing to have any more children.Having one's need for spacing met is defined as women reporting that they want or are unsure if they want another child when using a form of family planning. When a woman decides not to have more children after utilising a contraceptive method, she has satisfied her desire to limit. Keep in mind that "spacing" and "limiting" refer to the objectives of contraception, not the practise itself.

Birth control methods allow couples to control their reproductive output. Among married Indians aged 15-49, nearly all (99%) are familiar with at least one method of birth control. Among married couples, 42% of women and 48% of men are aware with emergency contraception method available in government and private as well. Interestingly, United States, only one-seventh of married women and one-eighth of married men are

familiar with the breastfeeding amenorrhea approach (LAM)(CDC, 2021). Women who started taking a contraceptive technique in the five years before the fourth poll were more likely to abandon it after only a year than males were. The primary motivation for stopping is trying to start a family (9%). Health services at public level are main source of providing modern contraceptives. Total 69% of its users are using services provided at primary level. The percentage of women who report ever having used a form of contraception is known as the contraceptive prevalence rate (CPR). 54% of married women between the ages of 15 and 49 have ever used some form of contraception. More than half of today's married women (55 %+) choose to adopt a contemporary approach. New techniques Injectable, intrauterine devices (IUDs/ PPIUDs), oral contraceptives, implants, diaphragms, foam/jelly, the morning-after pill, the lactation amenorrhea technique, condoms, and emergency contraception are all included. All married women age between15-49 witness a modest decline in the prevalence of contraception, from 56% in 2005-06 to 54% in 2015-16 (Table 2). Condom (Nirodh) use has climbed from 2% in 2005-06 to 12% in 2015-16 among sexually active, single men/women aged 15 to 49.

Although the rate of maternal mortality that may be prevented has decreased by 40%, it is still well above the target of 75 deaths per 100,000 live births set by the International Conference on Population and Development (ICPD) in Programme of Action. The damaging practices of female genital mutilation (FGM) and child marriage have also been met with broad action. There was a decrease from 49% to 31% in girls undergoing FGM in places where it was once common. However, because of rising populations, more women and girls are now affected overall. As far as sexual and reproductive health is concerned, we can accommodate almost everybody. All people, regardless of wealth, location, gender, sexual orientation, or handicap, now have enough information and necessary tools totake informed decisions about their sexual and reproductive health.

Currently, family planning programs are formulated under the National Health Mission. While the basket of choices for contraceptives has been expanded under the current initiatives, there is still an important aspect that needs to be added to the current discourse around family planning. Most family planning programs almost always put a burden on women. There needs to be a paradigm shift, and the existing programs must be reformulated to ensure that men and women are equally a part of the family planning discourse. That is to say, and those men should be held equally accountable too.

The recent NFHS-5 data also states that less than one in 10 men relies on condoms as a contraceptive. Male sterilization is safer and more accessible than female sterilization. Nevertheless, despite that, female sterilization is still the most preferred method of contraception among women. It has increased from 36% to 37.9% in the last five years. On the other hand, male sterilization still stands at only 0.3%. According to the NFHS-5 survey, 50% of men in states like Uttar Pradesh, Telangana, and Bihar believe thatit is women responsibility to use and know about contraception, not men. Another essential aspect still missing from the family planning landscape in India is that the conversation is almost always around population control and not women's health and reproductive rights. The conversation around family planning needs to shift from population control to women’s reproductive rights and access to sexual and reproductive healthcare.

Some states are taking steps in the right direction to encourage safer contraceptive methods. For instance, Odisha has introduced a family planning kit as a wedding gift for newlyweds. The state introduced this initiative under the NaiPahal scheme as a part of the National Health Mission.

The kit will have a list of items range from a book carrying methods of family planning and benefits of family planning, registration form of marriage, male condoms, female oral contraceptive pills, and home based pregnancy testing stiprs. While this is undoubtedly an unusual step, it is essential to understand that contraception and awareness about the same should not be limited only to married couples.

10. Conclusion

This article set out to examine the gender dynamics at play in Indian family planning in order to make sense of issues like the skewed distribution of the burden of providing birth control between men and women, the rising popularity of female sterilization, and the sometimes-forceful use of financial incentives to spread access to birth control. The article also analyses the Indian government's performance since the country gained its freedom. Family planning and reproductive governance remain important developmental priorities for the Indian welfare state. The question remains unanswered in this context: how policymakers should find a middle ground. Examining the family planning policy's sensitivity to gender, reproductive justice, and bodily autonomy is an essential and pressing task. Population management, high fertility rates, and unmet family planning requirements are all critical challenges that have only worsened in the last year due to the COVID-19 epidemic and should be factored into any policy decisions about family planning.

The goal of the FP2020 initiative, introduced during the 2012 “London Summit on Family Planning," is to increase access to modern contraceptive methods for 120 million women in the world's 69 poorest nations by 2020. To reach this aim, the annual growth rate of the use of modern contraceptives needs to increase from a projected 0.7 percentage points to 1.4 percentage points. In its pursuit of UHC, India has prioritized access to family planning services. India made progress in this area thanks to the National Rural Health Mission and the

National Urban Health Mission, now both have been merged with National Health Mission, the two components of the world's largest public health initiative.

According to the government's National Family Planning Program, various contraceptives are offered free of charge in India. There is a significant focus on long-acting techniques such as injectable MPA, IUCD (380A and 375), Female Sterilization (Minilap and Laparoscopic), and Male Sterilization in addition to the shorter-acting methods of condoms and oral pills. Post-pregnancy birth control methods are given significant attention (post-partum and post-abortion contraception). Counsellors trained in RMNCH+A are on hand to answer questions about your family planning options. Additionally, community health workers (ASHA) and auxiliary nurse midwives (known as ANMs) are present in every state, dispensing information on birth control options.

References:-

[1]. Balasubramanian, S. (2018). Motivating men: Social science and the regulation of men's reproduction in postwar India. *Gender & Society*, *32*(1), 34–58.

[2]. Basu, A. M. (2005). Ultramodern contraception: Social class and family planning in India. *Asian Population Studies*, *1*(3), 303–323. https://doi.org/10.1080/17441730500441178

[3]. Beninger, C. (2021). Reproductive Rights, UN Sustainable Development Goals and International Human Rights Law. In W. Leal Filho, A. Marisa Azul, L. Brandli, A. Lange Salvia, & T. Wall (Eds.), *Gender Equality* (pp. 1013–1025). Springer International Publishing. https://doi.org/10.1007/978-3-319-95687-9_48

[4]. Bongaarts, J., & Blanc, A. K. (2015). Estimating the current mean age of mothers at the birth of their first child from household surveys. *Population Health Metrics*, *13*(1), 25. https://doi.org/10.1186/s12963-015-0058-9

[5]. Chattopadhyay, S. (2007). *Tying tubes–'titrating'populations: The politics of female sterilization in India*. Workshop of the Irmgard Coninx Foundation, the Social Science Research Center, Berlin and Humboldt University. 15th–20th of February.

[6]. Cohen, S. A., & Richards, C. L. (1994). The Cairo Consensus: Population, Development and Women. *Family Planning Perspectives*, *26*(6), 272. https://doi.org/10.2307/2135895

[7]. Goli, S., James, K., Singh, D., Srinivasan, V., Mishra, R., Rana, M. J., & Reddy, U. S. (2021). Economic returns of family planning and fertility decline in India, 1991–2061. *Journal of Demographic Economics*, 1–33.

[8]. Heitmeyer, C., &Unnithan, M. (2015). Bodily rights and collective claims: The work of legal activists in interpreting reproductive and maternal rights in India. *Journal of the Royal Anthropological Institute*, *21*(2), 374–390.

[9]. International Conference on Population and Development. (1994). *Indian Medical Tribune*, *2*(16), 3.

[10]. Ker, J., Wang, L., Rao, J., & Lim, T. (2017). Deep learning applications in medical image analysis. *Ieee Access*, *6*, 9375–9389.

[11]. Patel, A., Banerjee, S., & Hans, A. (2020). Gender Equality and the Sustainable Development Goals: Focussing on the Adolescent Girls in India. In S. Hazra& A. Bhukta (Eds.), *Sustainable Development Goals* (pp. 79–93). Springer International Publishing. https://doi.org/10.1007/978-3-030-42488-6_5

[12]. Rana, M. J., &Goli, S. (2021a). The road from ICPD to SDGs: Health returns of reducing the unmet need for family planning in India. *Midwifery*, *103*, 103107. https://doi.org/10.1016/j.midw.2021.103107

[13]. Rana, M. J., &Goli, S. (2021b). The road from ICPD to SDGs: Health returns of reducing the unmet need for family planning in India. *Midwifery*, *103*, 103107. https://doi.org/10.1016/j.midw.2021.103107

[14]. Sahay, A. (n.d.). *Gender and Family Planning: A Close Reading of Forty Years of India's Family Planning Policies (1977-2019)*.

[15]. Turshen, M. (2020). Sexual and reproductive health and rights. In *Women's Health Movements* (pp. 191–229). Springer.

[16]. Undie, C.-C., Khosla, R., & Blanchet, K. (2017). *Improving family planning service delivery in humanitarian crises*. Population Council. https://doi.org/10.31899/rh4.1009

[17]. Yadav, K., Agarwal, M., Shukla, M., Singh, J. V., & Singh, V. K. (2020). Unmet need for family planning services among young married women (15–24 years) living in urban slums of India. *BMC Women's Health*, *20*(1), 187. https://doi.org/10.1186/s12905-020-01010-9

[18]. Yadav, K., Singh, B., & Goswami, K. (2009). Unmet family planning need: Differences and levels of agreement between husband-wife, Haryana, India. *Indian Journal of Community Medicine*, *34*(3), 188. https://doi.org/10.4103/0970-0218.55281

Abid Siraj, et. al. "ICPD-1994 and London F2020 Has Changed India's Trajectory of Family Planning Programs." *International Journal of Humanities and Social Science Invention (IJHSSI),* vol. 11(12), 2022, pp 50-61. Journal DOI- 10.35629/7722