

Uttar Pradesh

Population Policy



Government of Uttar Pradesh
July, 2000

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July, 2000

Department of Health and Family Welfare
Government of Uttar Pradesh

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Ram Prakash
Chief Minister



Government of Uttar Pradesh
Lucknow - 226001

Message

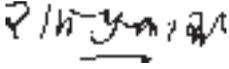


The population of Uttar Pradesh was about 5 crores at the turn of the century and is about 17 crores now. Today we are adding more than a crore of people every three years to our already over-crowded state. Unless we take effective steps, the population of UP will reach 44 crores in the year 2051. This is unsustainable and will bring to nought all developmental efforts and come in the way of meeting the aspirations of the people for a better quality of life.

In March 2000, when the Government of Uttar Pradesh started the process of developing a population policy, I had desired that this policy should aim to help people achieve their desired family size, bring about reduction in infant and maternal mortality rates, which are unacceptably high in UP, and streamline reproductive and child health services. I also felt the need to incorporate measures to facilitate the improvement in the status of women which is possible by providing avenues for education of girls and by concerted efforts to increase the age at marriage. One of the reasons why people in UP have large families is the lack of services, which in turn is due to inadequate resource allocation for health and family planning. To address this mammoth gap, we need to improve the efficiency of programme management, have effective inter-departmental coordination and also utilize other resources from the private sector like NGOs, co-operatives, corporate bodies and the private medical community. However, ultimately our efforts will be successful only if we can ensure people's participation through community involvement with the key role being played by the panchayats. Only by converting family planning into a people's movement can we see our dream of making every child and family healthy come true.

However, any policy is only as good as its implementation. Thus special emphasis has been laid on this aspect and a strong monitoring structure has been proposed. This will ensure that the design, implementation and monitoring of the family planning programme is in congruence with the needs of people in different regions of the state.

We are introducing this population policy in Uttar Pradesh on the occasion of the World Population Day with the hope that its adoption will contribute to building a modern Uttar Pradesh with an enhanced standard of living for its people.


(Ram Prakash)



Message



With a view to control the rapidly increasing population of the state, the state Government has evolved a population policy. The main objective of the policy is to bring down the total fertility rate to 2.1 by the year 2016, as well as, to meet the economic and social development needs. The population policy of the State is based on the basic principles contained in the National Population Policy declared by the Government of India in March, 2000. Expected improvement in the quality of life and development have not come through due to increasing population and the resultant pressure on natural resources. These aspects have been taken care of in the population policy.

The population policy would ensure community participation, enhancement in the marriageable age of women, empowerment of women, active participation of panchayats, government as well as non-government organisations, voluntary organisations, co-operatives and organised sector, private hospitals and nursing home etc. With a view to provide protection to the health of mothers and children, level of access and quality of services would be raised with regard to proper care of pregnant women, provision for safe delivery and child health. Participation of males would be increased in family planning programmes.

In order to have commitment and responsibility of the Government and community at every level 'State Population and Development Commission' would be set up under the chairmanship of Hon'ble Chief Minister, besides setting up the 'Population Stabilising Committee' under the chairmanship of the Chief Secretary. Similarly, Health and Family Welfare Committees would be set up at the district level to strengthen the inter-departmental co-ordination, and also improve access and quality of services to enhance the participation and accountability of people to the programme.

I am confident that with the implementation of the population policy, the economic and social development of the state and stability of population would gather the required momentum.

A handwritten signature in black ink, appearing to read 'Sardar Singh'.

(Sardar Singh)

Yogendra Narain,
Chief Secretary



Government of Uttar Pradesh
Lucknow - 226001

Message

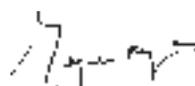


I am delighted that the Government of Uttar Pradesh has formulated a population policy for the state with a goal of reaching replacement level fertility by the year 2016. This is very timely because though in the last few years there have been some positive trends in Uttar Pradesh related to decrease in fertility, increase in contraceptive prevalence and the utilization of private sector for reproductive and child health services, these efforts need to be consolidated, up-scaled and focussed, to have wider impacts.

It is noteworthy that a participatory process has been followed in the development of this policy. A three-day workshop was held in Lucknow in March, 2000, in which more than 100 experts from all over the country, programme managers from the public and private sectors, representatives of international donor agencies and of different state governments gathered together to share experiences. Twenty nine papers were presented in this workshop and various issues were identified which the Government of Uttar Pradesh needs to tackle to achieve population stabilization. Further, a dialogue was established with prominent citizens not working in the reproductive and child health sector and their views, along with those of media representatives were also taken. On the basis of this collection of data and experiences, an expert group drafted the population policy document. Consultations were held with the Department of Health & Family Welfare, Secretaries of various developmental departments like education, women & child development, rural development, cooperatives, urban development and social welfare of the Government of Uttar Pradesh. The inputs of NGOs were also taken. The feedback received at various stages has been invaluable in making this policy an effective instrument for shaping the course of action for the coming years.

I would like to place on record my deep appreciation to various experts who participated in the exercise of formulating the Uttar Pradesh Population Policy. I would specially like to thank the members of the group set-up by the Government of Uttar Pradesh for drafting this policy. This group was chaired by Mr. V.K. Dewan, Principal Secretary, Medical Health & Family Welfare, Government of Uttar Pradesh. Ms. Aradhana Johri, Executive Director, SIFPSA, Dr. Bachchi Lal, Director General, Family Welfare, Dr. G. Narayana, Director, The POLICY Project, Mr. J.S. Deepak, Consultant, The POLICY Project, Dr. P.M. Kulkarni, Professor, Bharatiyar University and Dr. K. Srinivasan, Executive Director, Population Foundation of India were active members of the group.

I am of the firm view that any policy is only as good as its implementation. The detailed system of monitoring and review that has been laid out lends hope that this policy will be implemented with due diligence. This would be of vital importance, as I believe that only if Uttar Pradesh is able to achieve population stabilization at the earliest, can we provide a good quality of life to its people.



(Yogendra Narain)

Abbreviations

AD	Additional Director
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
APC	Agricultural Production Commissioner
ARI	Acute Respiratory Infection
CBR	Crude Birth Rate
CDR	Crude Death Rate
CHC	Community Health Centre
CMO	Chief Medical Officer
CNAA	Community Needs Assesment Approach
CPR	Contraceptive Prevalence Rate
DPEP	District Primary Education Programme
DUDA	District Urban Development Agency
DWCRA	Development of Women and Children in Rural Areas
FICCI	Federation of Indian Chambers of Commerce & Industry
FLE	Family Life Education
FP	Family Planning
GOI	Government of India
HDI	Human Development Index
ICDS	Integrated Child Development Services
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IFPS	Innovations in Family Planning Services
IMR	Infant Mortality Rate
IRDPA	Integrated Rural Development Programme
ISM	Indian System of Medicine

IUCD	Intrauterine Contraceptive Device
LAM	Lactation Amenorrhoea Method
MCDA	Model Cluster Development Approach
MCH	Maternal and Child Health
MIS	Management Information System
MMR	Maternal Mortality Rate
MO	Medical Officer
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NSS	National Service Scheme
NGO	Non Governmental Organization
ORS	Oral Rehydration Salts
PFI	Population Foundation of India
PHC	Primary Health Centre
PMU	Project Management Unit
RCH	Reproductive and Child Health
RTI	Reproductive Tract Infection
SIFPSA	State Innovations in Family Planning Services Project Agency
SO2-IS	Strategic Objective 2-Indicator Survey
SPDC	State Population Development Commission
SRS	Sample Registration System
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TFA	Target-Free Approach
TFR	Total Fertility Rate
TLC	Total Literacy Campaign
TRYSEM	Training Rural Youth for Self Employment
TT	Tetanus Toxoid
TLC	Total Literacy Campaign
UP	Uttar Pradesh
UPBEP	Uttar Pradesh Basic Education Project
VEC	Village Education Committee

Glossary

Anganwadi	A village-level centre under Integrated Child Development Services (ICDS) Programme
Dai	Traditional midwife
Gram Panchayat	Village-level local government
Mahila Swasthya Sangh	A group of women at village level created to discuss about various health and family planning issues every month
Nagar Palika/Parishad	Municipality/Corporation
Panchas	Members of Panchayat
Panchayat	Body of local government at village-level
Pradhan	Village-Head
Prajanan Swasthya Kendra	Reproductive Health Centre
Sarpanch	Panchayat Head
Zilla Parishad	District-level local government

Definitions

Crude Birth Rate	Number of Births per 1000 population in a given year
Crude Death Rate	Number of Deaths per 1000 population in a given year
Couple Protection Rate	Percentage of couples effectively protected by modern method of contraception
Infant Mortality Rate	Number of infants dying under one year of age in a year per 1000 live births of the same year.
Maternal Mortality Rate	Number of deaths of women while pregnant or during delivery or within 42 days of delivery due to any cause related to pregnancy and child birth per 1,00,000 live births in a given year.
Neo-natal Morality Rate	Number of infants dying within the first month of life (under 28 days) in a year per 1000 live births of the same year.
Peri-natal Mortality Rate	Number of still births plus deaths within 1st week of delivery per 1000 births in a year.
Post Neo-natal Mortality Rate	Number of infant deaths at 28 days to one year of age per 1000 live births in a given year.
Population Stabilization	A population with an unchanging rate of growth and an unchanging age composition, because of age specific birth and death rates having remained constant over a sufficiently long period of time.
Replacement Level Fertility	The level of fertility at which a cohort of women on the average are having only enough daughters to replace themselves in the population. A TFR of 2.1 is considered to be replacement level.
Sex Ratio	Number of females per 1000 males in a population
Total Fertility Rate	Average number of children that would be born to a woman if she experiences the current fertility pattern throughout her reproductive span (15-49 years)

Introduction

1.1 Background

Uttar Pradesh (UP) is the most populous state in India, with an estimated population of about 170 million as of March 2000 and a land area of 294,411 sq. km. One-sixth of the world's population lives in India and one-sixth of India's population lives in UP. Only three other countries of the world, China, the United States and Indonesia have populations larger than that of UP. The population density of the state at 578 persons per sq. km. is the fourth highest among major states in the country. The state, which spans most of the Indo-Gangetic plain of the country, has been the seat of ancient Hindu culture, religion and learning and has always played a prominent role in Indian political and cultural movements.

The present boundaries of the state came into existence with the reorganization of the states on a linguistic basis in 1956. For administrative purposes, the state has been divided into 83 districts, 294 tehsils, and 907 community blocks. There are 112,803 inhabited villages, 710 statutory towns, and 43 census towns. Nearly 19 percent of inhabited villages in India are in UP. As per the 1991 census, about 40 percent of the villages in UP had a population of less than 500 and another 26 percent of the villages had population in the range of 500-999. While the average population per village in UP is only 989, it is 1,829 in Andhra Pradesh and 2,325 in Tamil Nadu. Having a large number of small villages scattered all over the state is a major obstacle to the development of infrastructure

facilities and delivery of all types of services related to development sectors.

The major economic activity in the state is agriculture, and in 1991, 73 percent of the population in the state was engaged in agriculture and 46 percent of the state income was accounted for by agriculture. UP has retained its pre-eminent position in the country as a food-surplus state. The production of foodgrains has increased from 14.5 million metric tons in 1960-61 to 42.5 million tons in 1995-96 showing an average annual growth rate of 3.1 percent, which is much higher than the population growth rate. UP has witnessed rapid industrialization in the recent past, particularly after the launch of policies of economic liberalization in the country. As of March 1996, there were 1,661 medium and large industrial undertakings and 296,338 small industrial units employing 1.83 million persons. The per capita state domestic product was estimated at Rs 7,263 in 1997-98, and there has been some decline in poverty in the state. Yet nearly 40 percent of the total population lives below the poverty line.

The literacy rate in UP increased from 28 percent in 1981 to 42 percent in 1991. The differential between female and male literacy is very high. Male literacy in 1991 was 56 percent and female literacy, 25 percent. As per the latest survey estimates, the male literacy in 1999 was 73 percent and female literacy, 43 percent (NFHS II). The increase in overall literacy rate is due to persistent efforts made by the state government to enroll and retain

children in schools and to effectively implement the adult education programmes. The adult literacy rate (percent literate among those aged 15 and above) in the state has increased from 38 percent in 1991 to 49 percent in 1998, an increase of 11 percentage points in the seven-year period.

At the beginning of the 20th century, the population of UP was only 49 million and increased very slowly until 1951 (0.52 percent per annum) to reach 63 million. This was the period marked by high birth and death rates.

The population increased rapidly in the next five decades due to a faster decline in the death rate compared to the birth rate. The population of the state increased from 63 million in 1951 to about 170 million in 2000, an addition of 117 million in the last five decades compared to an addition of only 15 million in the previous five decades. The population of the state is increasing at 2.19 percent per year (SRS, 1998). This implies that the state at present is adding a population of 3.8 million every year and more than 10 million every three years.

Population Growth in Uttar Pradesh (1901-1991)

Year	Population (000s)			Sex Ratio	Density per sq.Km.	Annual Increase in Population (000s)	Annual Exponential Growth Rate
	Total	Male	Female				
1901	48,628	25,099	23,529	937	165		
1911	48,155	25,144	23,011	915	164	-47	-0.1
1921	46,672	24,452	22,220	909	159	-148	-0.31
1931	49,780	26,148	23,632	904	169	311	0.64
1941	56,535	29,641	26,894	907	192	676	1.27
1951	63,220	33,101	30,119	910	215	669	1.12
1961	73,755	38,638	35,117	909	251	1,054	1.54
1971	88,342	47,017	41,325	879	300	1,459	1.80
1981	110,863	58,819	52,044	885	377	2,252	2.27
1991	139,112	74,037	65,075	879	473	2,825	2.27

1.2 Fertility and Mortality

The crude birth rate (CBR) was 44.9 in 1971 and steadily declined to 32.4 in 1998. In rural areas, the CBR declined from 46.3 to 34.6 and in urban areas from 34.7 to 27.9 during the same period (SRS, 1998). The total fertility rate, which is the number of children a woman would have

on an average in her reproductive life, has been estimated to be over six until 1979 and declined rapidly to 4.3 in 1997-98. There are substantial rural-urban differences with regard to the total fertility rate. The age-specific pattern of fertility reveals a peak in the age group of 20-24 years for both urban and rural areas. The majority of births (56 percent) are of third or higher

order. A large proportion of these births is unwanted, as reported by mothers themselves, and could have been avoided.

The death rate declined sharply over the same period of time. The crude death rate estimated for the state was 20.1 in 1971 and declined to 10.3 in 1997. In rural areas the death rate declined from 21.1 to 10.7 and in urban areas from 13.1 to 8.2 (SRS, 1998). Much of this decline was due to sharp declines in the infant mortality rate, particularly after 1990. The infant mortality rate for the state was 182 per 1,000 live births in 1971 and declined to 114 in 1990 and further declined to 85 in 1997 (SRS, 1998). Nearly two-thirds of infant deaths are during the neonatal period. The child mortality rate that was 60.7 in 1986 declined to 39.2 in 1996 (NFHS II). As a result of the sharp decline in mortality rates, the life expectancy at birth increased from 43 in 1970-75 to 57 years in 1992-96. The life expectancy at birth was 45.4 for males and 40.5 for females in 1970-75 and increased to 57.7 for males and 56.4 for females in 1992-96 (SRS, 1998). During this period, the life expectancy at birth for males increased by 27 percent and for females, by 39 percent indicating the improving status of women in the state.

1.3 Contraceptive Use

There has been a substantial increase in the knowledge of contraceptive methods, particularly spacing methods, among married women in UP. The knowledge of pills increased from 65 percent in 1992-93 to 85 percent in 1998-99, of IUCD from 56 percent to 74 percent, and of condoms from 67 percent to 83 percent (NFHS I and NFHS II). In fact the contraceptive knowledge level in UP is one of the highest in the country. Use of contraception, however, is not commensurate with the knowledge levels.

The use of any method of contraception increased from 19.8 percent in 1992-93 (NFHS I) to 28.1 percent in 1998-99 (NFHS II)—an increase of 41 percent in a period of six years. There was some increase in condom and female sterilization method use while the proportion of pill and IUCD users remained more or less constant. UP has the highest proportion of spacing method users (30 percent) among modern method users compared to any other major state, except Punjab and West Bengal. There are major differentials in contraceptive method use in urban and rural areas of UP. While 45 percent in urban areas used any method of contraception in 1998-99, only 24 percent in rural areas were users. The rural-urban differentials remained the same. One of the causes of concern is the decline in acceptance of male sterilization, which was until the 1980s the predominant method used. Only 11 percent of total permanent method users were male sterilization method users in 1993-94 and this further declined to 4.5 percent in 1998-99. However, innovative efforts to improve the quality, demand and access dimensions of the programme in 15 Innovations in Family Planning Services Project (IFPS) districts of UP have clearly and decisively demonstrated that with concerted efforts contraceptive use can substantially be increased and that people are not averse to the use of contraception.

Unmet need for family planning is a measure of the extent to which married women desire to space or limit the number of children but do not do so because of various factors such as non-availability of easily affordable and readily accessible quality services and lack of consensus in the family. Married women in UP have consistently reported a large unmet need for family planning in recent years and the proportion of those with unmet need has increased over a period of time. In 1992-93, 32 percent wanted no more children and another

26 percent wanted a child after two or more years. In 1998-99, 38 percent wanted no more children and 18 percent wanted children after two or more years. The unmet need for sterilization has increased substantially in the past six years. In 1992-93, only 24 percent of women with two children did not want another child and this has increased to 37 percent in 1998-99 (NFHS I and NFHS II). The data clearly show that there is a huge untapped potential for family planning services, particularly for permanent methods.

1.4 Maternal and Child Health Care

The status of women in UP leaves much to be desired. The sex ratio as per the 1991 census was 879 females per 1,000 males as compared to 927 in the country as a whole. The mortality estimates for the period 1990-94 indicate that the expectation of life for females is lower than that of males. The maternal mortality ratio, which measures the extent of women dying due to maternal causes within 6 weeks of delivery, is the highest among all states. In 1997, there were an estimated 707 maternal deaths per 100,000 live births (SRS, 1998), almost eight times that in Kerala and 70 percent higher than the national average (436). Overall, 34 percent of women in the state are mildly anaemic, 14 percent are moderately anaemic and 2 percent are severely anaemic. However, of the children under three years of age having any degree of iron-deficiency anaemia, a lower proportion of female children (69 percent) compared to male children (73 percent) are anaemic (NFHS-II).

ANC services reach only half of the total pregnant women in UP. Percentage given two or more doses of tetanus toxoid (TT) injections increased from 37 percent in 1992-93 to 51 percent in 1998-99 (NFHS-II). The efforts made by the state government to reach more women

with TT services using a special campaign approach covering the entire state has resulted in a substantial increase in the proportion of pregnant women receiving two doses of TT injections. The proportion of pregnant women given TT injections increased from 46 percent in 1998 to 68 percent in 1999, and pregnant women who received two or more doses of TT injections increased from 42 percent to 59 percent (SO2-IS). The percentage of women who received iron and folic acid tablets increased only marginally from 30 percent in 1992-93 to 32 percent in 1998-99 due to constant disruptions in the supply chain (NFHS-II).

Another important aspect of maternal and child health is institutional deliveries and deliveries conducted by trained attendants. Institutional deliveries increased from 11 percent in 1992-93 to 17 percent in 1998 (NFHS-II). Trained personnel provide assistance to less than one-fourth of the total deliveries in the state (RCHS). More than three-fourths of deliveries are attended by untrained personnel in unhygienic conditions at home. Substantial efforts are required to improve the quality of maternal and child health care.

Fully immunized children increased substantially from 20 percent in 1992-93 (NFHS-I) to 42 percent in 1998 (RCHS) and at the same time, children not getting any vaccination declined from 43 percent to 30 percent. Deaths due to acute diarrhoea are a significant proportion of all deaths among children. Nearly all dehydration-related deaths can be prevented by prompt administration of rehydration solutions (ORS). Only 21 percent of mothers have ever used ORS packets or recommended home solutions to overcome problems of dehydration in 1992-93 (NFHS-I), and this has increased to 36 percent in 1998 (RCHS). Nearly 71 percent of all children under three years of age have iron-deficiency anaemia.

Nearly one-third of currently married women in the 15 to 44 age group have symptoms of reproductive tract infections and sexually transmitted infections (RTIs/STIs) as compared to only 21 percent of men aged 20-54 (RCHS). Awareness of AIDS and HIV is extremely low both among men (47 percent) and women (21 percent). UP has 166 AIDS cases and urgent steps need to be taken to prevent further spread of AIDS.

1.5 Regional Differences

On the basis of natural geographic considerations and cultural differences, the state is divided into five regions: Hill, Western, Central, Eastern and Bundelkhand (Southern)

with estimated populations in 1991 of 6 million (4.3 percent), 50 million (35.6 percent), 24 million (17.4 percent), 53 million (37.9 percent) and 7 million (4.8 percent) respectively. The population density varies from a high of 614 in the Eastern region to a low of 116 in the Hill region. Percent of urban population is the highest in the Western region (26 percent) and the lowest in the Eastern region (12 percent). The total literacy rate is the highest in the Hill region (60 percent) with 76 percent for males and 43 percent for females. The Eastern region has the lowest literacy rate of 39 percent, with a male literacy rate of 55 percent and a female literacy rate of only 21 percent. The sex ratio varies from 955 in the Hill region to 841 in the Western region.

Regional Differences in Uttar Pradesh

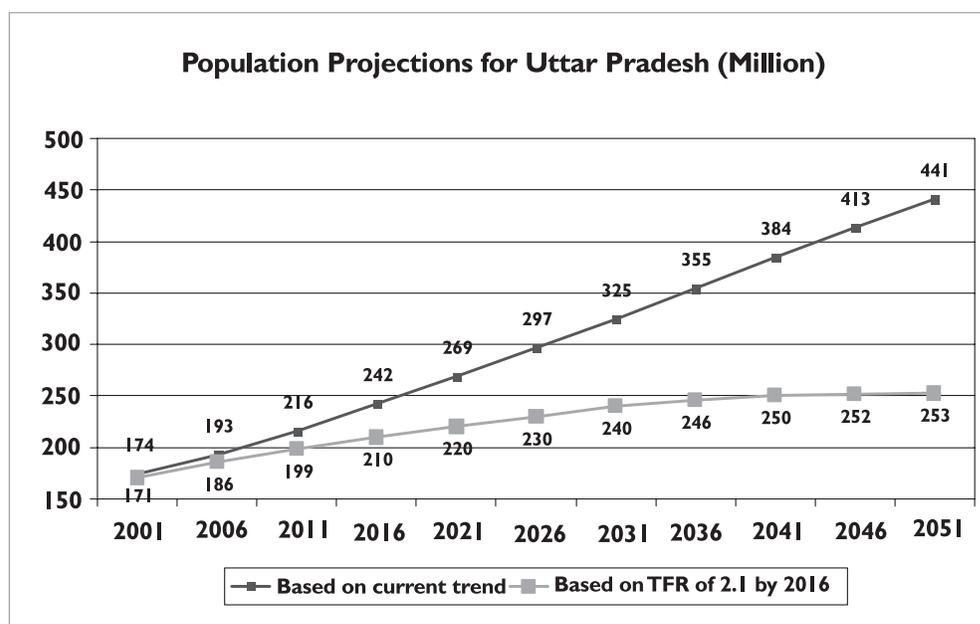
1991 Census	REGIONS					
	UP	Hill	Western	Central	Eastern	Bundelkhand
Area (in sq.kms)	294,411	51,124	82,191	45,834	85,844	29,418
Total Population (000s)	139,112	5,926	49,547	24,189	52,721	6,730
Density (per sq. km)	473	116	603	528	614	229
Number of villages	112,568	15,117	28,008	15,504	49,434	4,505
Number of towns	704	62	318	103	169	52
Percent urban population	19.8	21.7	26.4	23.7	11.6	21.3
Total literacy rate	40.9	59.6	42.0	42.5	38.6	42.3
Female literacy rate	25.3	42.9	30.3	28.3	20.9	23.9
Sex ratio	879	955	841	855	924	846
Fertility Indicators and Contraceptive Use (1995) –PERFORM Survey						
Crude birth rate	33.5	25.8	34.9	34.4	33.4	27.6
Total fertility rate	4.5	3.1	4.8	4.6	4.8	3.6
Contraceptive prevalence rate	25.1	48.2	29.3	22.9	18.8	34.6
Percent intending users among non-users	34.4	57.3	48.8	31.8	24.7	33.8
Percent Institutional deliveries	10.9	15.2	9.7	10.8	11.1	16.1
Percent of mothers reporting RTI	24.7	23.4	30.2	26.7	21.6	15.2

The Hill region has the lowest fertility followed by Bundelkhand region. The Western and Eastern regions have the highest fertility. Contraceptive use by any method is the highest in the Hill region (48 percent) and the lowest in the Eastern region (19 percent). The percentage of women who intend to use contraception either to limit or space children is very high in the Hill region (57 percent) and the lowest in the Eastern region (25 percent). The percentage of recent mothers reporting RTI is 30 percent in the Western region and 27 percent in the Central region. The Hill region with high literacy, low total fertility rate, and high use of contraceptive methods leads the other regions in terms of the demographic transition, closely followed by the Bundelkhand region. The Western region is marked by a relatively high female literacy rate, high contraceptive use, and also a very high proportion of intending users. However, the sex ratio in Western UP is very low, indicating the low status of women and also the high preference for sons. The Eastern and the Central regions have low literacy rates, low

contraceptive prevalence rates, and high fertility rates. Given these wide variations in fertility and contraceptive behaviour and other social development indicators, objectives and strategies for demand creation and service delivery have to be substantially different across regions. The Population Policy of UP recognizes and addresses these regional variations.

1.6 Need for a Population Policy

If the current fertility trends continue, the population of UP will be 216 million in 2011, 325 million in 2031, and 441 million in 2051 (PFI). In five decades, the population will increase by 270 million. **The density of the population will increase from the current 578 persons per sq. km. to 1,498 persons in 2051—almost a three-fold increase.** About 10 districts in UP would have more than 10 million people and another 18 districts will have more than 6 million. This huge increase in population will exert enormous pressure on natural resources and has the potential to frustrate all attempts to improve the quality of life of the people and



to achieve sustainable development. Therefore, there is an urgent need to develop people-friendly policies and strategies, to mobilize all possible resources in all sectors, and to energize the systems to reach replacement-level fertility by 2016 and to attain population stabilization as soon as possible thereafter.

The Population Policy looks at the issues related to population stabilization in a holistic, open and transparent manner. Population stabilization cannot be achieved without addressing the health issues related to women

and children. The status of women, gender equity, literacy, reduction of infant and maternal mortality, improved health and nutrition status of mothers and children have long been recognized as key determinants of fertility behaviour and are the central issues of population policy. To achieve replacement-level fertility, all development departments have to work in cohesion, and the synergy generated will not only help population stabilization efforts but also the objectives of various departments working to improve the quality of life of the people of UP.

Policy Objectives

2.1 The Mission

The mission of the Population Policy 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 stabilization and improvement of the health status of people, particularly women and children, are essential prerequisites to sustainable development.

2.2 Objectives

The main objective of the Population Policy is to reach replacement level of fertility of 2.1 by 2016. For this purpose, the contraceptive prevalence rate by modern methods must increase from 22 percent in 1998-99 to 52 percent in 2016. Fertility and contraceptive behaviour are inextricably inter-linked to infant and child mortality. To achieve population stabilization, there is an urgent need to reduce the infant mortality rate and also the maternal mortality ratio. The specific objectives of the Population Policy are given below.

2.3 Age at Marriage

To increase the median age at marriage for women from 16.4 years to 19.5 years by 2016 with the following specific objectives:

2.3.1 Increase awareness about legal age at marriage for males from 18 percent to 80 percent by 2011

2.3.2 Increase awareness about legal age at

marriage for females from 27 percent to 80 percent by 2011

2.3.3 Ensure that panchayats maintain records of all marriages in their jurisdiction

2.4 Reduction in Fertility

To reduce total fertility rate from 4.3 in 1997 to 2.6 in 2011 and further to replacement level fertility of 2.1 in 2016 with the following specific objectives:

2.4.1 Increase use of modern contraceptive methods from 22 percent in 1998-99 to 46 percent in 2011 and to 52 percent in 2016 by improving the demand, quality and access dimensions of the family planning programme

2.4.2 Substantially reduce unmet need for both spacing and terminal method use from 56 percent in 1998-99 to 20 percent in 2011 and to 10 percent in 2016

2.4.3 Increase the average age of the mother at the birth of her first child from the current 18 years to 20 years by 2011 and to 21 years by 2016 by promoting spacing method use among newly married couples

2.4.4 Encourage all couples with unmet need to use terminal or spacing methods based on their choice, and to substantially reduce the current unmet

need, increase the number of new users of sterilization services to at least 10 lakh couples and provide spacing services to 30 lakh couples per year by the year 2005

- 2.4.5 Develop region-specific strategies and service delivery systems for each of the five regions of UP

2.5 Reduction in Maternal Mortality

To reduce maternal mortality ratio from 707 in 1997 to 394 in 2010 and further to below 250 in 2016 with the following specific objectives:

- 2.5.1 Increase antenatal care (ANC) coverage from 46 percent in 1997 to 67 percent in 2006, to 78 percent in 2011 and to 90 percent in 2016
- 2.5.2 Increase TT coverage from 51 percent in 1998-99 to 80 percent in 2006, and to 90 percent in 2011
- 2.5.3 Increase deliveries attended by trained personnel from 22 percent in 1997 to 50 percent in 2006, to 65 percent in 2011 and to 80 percent in 2016
- 2.5.4 Increase institutional deliveries from 17 percent in 1997 to 35 percent in 2006, to 45 percent in 2011 and to 55 percent in 2016
- 2.5.5 Reduce mild and moderate anaemia among mothers from 47 percent in 1997 to 32 percent in 2006 to 23 percent in 2011 and to 15 percent in 2016
- 2.5.6 Eliminate severe anaemia among all women by 2011
- 2.5.7 Create a pregnancy-testing facility at each PHC and CHC by 2011

- 2.5.8 Strengthen the systems to identify pregnant mothers at risk and referral system to attend to high-risk cases

- 2.5.9 Introduce RTI and STI testing facilities and ensure availability of trained medical personnel to treat RTI and STI clients at all CHCs and PHCs by 2011

2.6 Reduction in Infant and Under-Five Mortality

To reduce the infant mortality rate from 85 in 1997 to 73 in 2006, to 67 in 2011 and to 61 in 2016 and to reduce under-five mortality from 125 in 1997 to 105 in 2006, to 94 in 2011 and to below 84 in 2016 with the following specific objectives:

- 2.6.1 Increase complete immunization of children from 42 percent in 1997 to 69 percent in 2006, to 85 percent in 2011, and to all children in 2016
- 2.6.2 Increase the use of oral rehydration salts or home-made solutions among those children suffering from diarrhoea from 36 percent in 1997 to 62 percent in 2006, to 76 percent in 2011, and to 90 percent in 2016
- 2.6.3 Eliminate severe malnutrition among children by 2011
- 2.6.4 Reduce mild and moderate anaemia among children from 65 percent in 1997, to 44 percent in 2006, to 32 percent in 2011 and to 20 percent in 2016
- 2.6.5 Reduce the incidence rate of acute respiratory infections (ARIs) among children by early identification of children with ARIs and by strengthening services at referral points

- 2.6.6 Ensure that 50 percent of all children receive all required doses of vitamin A by 2006 and 90 percent by 2016

2.7 RTI/STI and AIDS

To reduce STI and RTI prevalence and incidence substantially and to improve awareness of AIDS among men and women. The specific objectives are to:

- 2.7.1 Reduce substantially the proportion of women having STI and RTI symptoms from 32 percent in 1997 to 10 percent in 2011 and to 5 percent in 2016
- 2.7.2 Increase the awareness of AIDS among men from 47 percent in 1997 to 100 percent in 2011 and among women from 24 percent in 1997 to 100 percent in 2011

2.8 Regional-Level Objectives

In order to achieve the principal objectives of the Population Policy of UP, specific objectives are set for each region, taking note of the regional variations in demographic and social development.

2.8.1 Reduction in Fertility

To reduce the total fertility rate in the

- Western region from 4.6 in 1997 to 2.7 in 2011 and to 2.1 in 2016
- Central region from 4.4 in 1997 to 2.6 in 2011 and to 2.1 in 2016
- Eastern region from 4.6 in 1997 to 2.7 in 2011 and to 2.1 in 2016
- Hill region from 3.0 in 1997 to 2.1 in 2006 and to 1.6 in 2016

Objectives of Uttar Pradesh Population Policy

	TFR	CBR	CDR	IMR	MMR	CPR
2001	4.00	28.2	11.2	79.7	611	26.2
2002	3.95	27.9	11.0	78.4	587	26.9
2003	3.90	27.6	10.9	77.1	563	27.5
2004	3.80	27.1	10.7	75.9	539	29.1
2005	3.66	26.4	10.5	74.6	515	31.2
2006	3.50	25.8	10.3	73.3	491	33.5
2007	3.32	24.9	10.2	72.1	466	36.2
2008	3.14	24.1	10.0	70.8	442	38.8
2009	2.94	23.2	9.8	69.5	418	41.7
2010	2.76	22.4	9.7	68.3	394	44.2
2011	2.60	21.6	9.5	67.0	370	46.3
2012	2.46	20.9	9.4	65.8	346	48.1
2013	2.34	20.3	9.3	64.5	322	49.6
2014	2.24	19.7	9.2	63.3	298	50.7
2015	2.16	19.2	9.1	62.1	274	51.6
2016	2.10	18.8	9.0	60.8	250	52.1

- Bundelkhand region from 3.4 in 1997 to 2.1 in 2011 and to 1.9 in 2016

2.8.2 Reduction in Infant Mortality

To reduce the infant mortality rate in the

- Western region from 84 in 1997 to below 72 in 2006 to 66 in 2011, and to 60 in 2016
- Central region from 87 in 1997 to below 74 in 2006 to 68 in 2011, and to 62 in 2016
- Eastern region from 84 in 1997 to below 72 in 2006 to 66 in 2011, and to 60 in 2016
- Hill region from 66 in 1997 to below 57 in 2006 to 52 in 2011, and to 48 in 2016
- Bundelkhand region from 90 in 1997 to below 78 in 2006 to 71 in 2011 and to 65 in 2016

2.8.3 Increase in Contraceptive Prevalence

To raise the level of contraceptive prevalence in the

- Western region from 24 percent in 1997 to 36 in 2006 to 49 in 2011, and to 55 in 2016
- Central region from 19 percent in 1997 to 32 in 2006, to 45 in 2011, and to 51 in 2016
- Eastern region from 17 percent in 1997 to 31 in 2006, to 45 in 2011, and to 53 in 2016
- Hill region from 48 percent in 1997 to 59 in 2006, to 61 in 2011, and to 64 in 2016
- Bundelkhand region from 32 percent in 1997 to 47 in 2006, to 52 in 2011, and to 55 in 2016

Uttar Pradesh Population Policy: Objectives for RCH Indicators

	Any Institutional ANC Coverage	Deliveries by Trained Personnel	Immunization of Children	Use of ORS	Mild and Moderate Anaemia: Children	Mild and Moderate Anaemia: Mothers	
2001	55.3	25.0	34.2	54.0	47.4	56	40
2002	57.6	27.0	37.3	57.0	50.2	53	39
2003	59.9	29.0	40.3	60.1	53.1	51	37
2004	62.2	31.0	43.4	63.2	55.9	48	35
2005	64.5	33.0	46.4	66.2	58.7	46	34
2006	66.9	35.0	49.5	69.3	61.6	44	32
2007	69.2	37.0	52.5	72.4	64.4	41	30
2008	71.5	39.0	55.6	75.5	67.3	39	29
2009	73.8	41.0	58.6	78.5	70.1	37	27
2010	76.1	43.0	61.7	81.6	72.9	34	25
2011	78.4	45.0	64.7	84.7	75.8	32	23
2012	80.8	47.0	67.8	87.7	78.6	29	22
2013	83.1	49.0	70.8	90.8	81.5	25	20
2014	85.4	51.0	73.9	93.9	84.3	22	18
2015	87.7	53.0	76.1	96.9	87.2	21	17
2016	90.0	55.0	80.0	100.0	90.0	20	15

*All numbers are in percentages

Strategies to improve RCH Services

The goals of the Population Policy of Uttar Pradesh are ambitious and cannot be met by the efforts of the government alone. A multi-pronged approach is needed in partnership with different stakeholders. Opinion leaders, non-government organizations, cooperatives, private health sector, the organized sector, and other agencies have to play a major role in achieving the policy objectives. The strengths of all stakeholders will be fully harnessed and strong linkages between the government and other agencies will be established.

3.1 Strategies for Community Involvement

3.1.1 Age at Marriage

Nearly 64 percent of girls in UP marry before reaching the legal age at marriage. Low age at marriage not only contributes to the high fertility rate but also to the risks associated with early childbearing. Childbearing at a young age also contributes significantly to the infant mortality rate. An increase in the age at marriage is possible only when there is a major change in social values and attitudes towards the girl child.

- Services of advocacy groups such as religious leaders, community leaders and women's groups will be used to bring about changes in the values and attitudes of people, particularly in rural areas.
- Electronic media will be used to disseminate information on the legal age at marriage and also on the adverse consequences of early marriage on the health of adolescent girls.

- Those marrying before the legal age at marriage will not be eligible for any government job or for any job in government-managed organizations.
- Registration of marriages will be made compulsory and panchayats and urban local bodies will be entrusted with the responsibility for registering marriages.

3.1.2 Adolescent Education and Family Life Education

Family life education (FLE) will be provided to adolescent boys and girls. Family life education will cover planning for one's future and the importance of education, gender roles and responsible parenthood. Parents will be involved in some of the sessions to encourage positive parent-child communication.

- The Department of Health and Family Welfare in consultation with the Department of Education and other stakeholders will develop curricula appropriate to the cultural milieu and introduce a FLE programme in secondary schools and colleges.
- NGOs will be involved in FLE programme implementation for girls not attending schools, particularly in urban and rural areas.
- Parents and community leaders will be involved from the beginning and throughout the implementation of any adolescent FLE initiative to ensure social support. Orientation programmes will be organized to encourage parents to send their adolescents to the programme.

- Learning material appropriate for adolescent boys and girls on key topics will be generated and made widely available.

3.1.3 Empowerment of Women

Women bear the entire burden of childbearing and child rearing. Yet, in most cases, they have very little say in decisions about their own childbearing, when to have children, how many children to have, and whether to use contraceptives. If women had the choice, many would prefer to have fewer children than what they actually have. In many families, the role of women is largely confined to the kitchen and they do not participate in the process of decision making even on issues of vital importance to them and other family members. There is a need for reform to eliminate gender inequalities and a multi-pronged approach to empower women.

The Government of UP has already initiated a series of measures in this direction. In several development programmes such as the Integrated Rural Development Programme, Training Rural Youth for Self-Employment, *Jawahar Rojgar Yojana*, *Jawahar Gram Samridhi Yojana* and several other schemes, it has been made compulsory to have 30 to 40 percent women as beneficiaries. Nearly 50 percent of self-help groups in UP exclusively belong to women. In the three-tier panchayat system, 33 percent reservations have been made for women, and as a result, there are currently about 265,764 elected women panchayat members.

- 33 percent of all new jobs in the government sector or in organizations owned and controlled by the government will be reserved for women.
- 33 percent of all commercial establishments such as ration shops, which require

government licenses will be reserved for women.

- Education, particularly girl's education, is important to empower women. All efforts will be made to universalize primary education for girls and to retain girls in schools up to the secondary level. Special campaigns will be conducted to make the community aware of the importance of female education.
- Added emphasis will be given to formation of self-help groups exclusively for women, and the groups already formed will be further strengthened. Non-governmental organizations with development projects funded by the government will be encouraged to constitute self-help groups in their project areas.
- Women's milk cooperatives, currently in operation in 12 districts, will be extended to all districts, and exclusive women cooperatives will be formed to encourage participation of women in different economic activities.
- The strong bias of the society against girls is manifest in the preference for sons, and the extreme form of bias is reflected in the rising tendency of couples to opt for termination of pregnancies if the foetus is known to be female. A law has already been enacted to prevent such heinous practices, and all provisions of this law will be rigorously and strictly enforced.
- Women's polytechnics and working women's hostels will be opened in major cities in a phased manner to increase participation of women in secondary and tertiary sectors.
- All forms of gender bias in the provision of services to women will be eliminated by sensitizing personnel in different departments, particularly in the health and family welfare department.

3.1.4 Role of Panchayats in Programme Implementation

Panchayats have a constitutional responsibility for health, family welfare and education activities. Last year, the state government took active steps to devolve financial and administrative powers to the panchayats. It also declared the year 1999-2000 as the year of 'decentralization'. During this year, the state transferred the assets and functions of 12 departments, including family welfare to these elected bodies. The staff of eight departments have also been transferred to panchayats and designated as panchayat development officers. Today there are 61,054 panchayat development officers serving panchayats in UP, which have a total of 797,554 elected members. Out of these, 264,754 are women. An amount equal to 4 percent of state revenue has been devolved to panchayats and 7 percent to urban local bodies. With their vast reach and influence, panchayats are ideally suited for implementing the RCH programme at the grassroot level and bringing about convergence of service delivery at the village level.

The state government recognizes the overarching role that the panchayats can play in the implementation of the family welfare programme by converging services from a host of development departments and by using their influence to advocate the small family norm and create demand for services by mobilizing the community. However, panchayats need to be further strengthened and empowered to fulfil their role with respect to programme implementation, supervision and monitoring.

- Gram Pradhans and panchayat members along with panchayat development officers will undergo training and sensitization on a continuous basis to orient them to their role in the RCH programme. They also will be exposed to the range of

services being provided. Beginning with Gram Pradhans, all members of the Health and Welfare Committee and women panchayat members will be trained in the next three years directly or through distance learning methodology.

- Panchayats will be provided with IEC materials and support to carry out demand- generation activities and mobilize community members to avail themselves of immunization, antenatal care and family planning services.
- Panchayat meetings at all levels will begin with the review of reproductive and child health programme performance.
- Health and Welfare Committees of the panchayats would identify area-specific unmet needs for reproductive health services and develop village-level plans to provide these services.
- Funds under various development schemes would be utilized for maintenance of subcentres and for creating village-level health infrastructure like *apna ghar* (delivery centres) by imaginative dovetailing.
- Panchayats would be responsible for recording marriages in addition to births and deaths. This data would be shared with the grassroot-level workers to help them provide RCH services, including family planning.
- Of the total financial resources allocated to Panchayati Raj institutions, 10 percent will be earmarked for performance based disbursement; particularly for the performance in the areas of reproductive and child health services and female education.
- Every year each zilla, block, and gram panchayat would be appraised for its contribution to meeting reproductive, child health and family planning needs, and for recording marriages, births and deaths.

Those panchayats whose performance best meets clients RCH needs will be honoured by the Chief Minister and given special development grants for community assets.

3.2 Strategies to Involve Private Sector

3.2.1 Non-government Organizations

The Government of UP will encourage non-government organizations to implement innovative reproductive health programmes. Ability to mobilize and involve communities in development programmes is the major strength of non-government organizations. UP has several hundred non-government organizations. By providing financial and material resources and capacity-building opportunities to NGOs, community-based counselling and service delivery can be expanded rapidly to underserved rural areas and urban slums. The Society for Innovations in Family Planning Services Agency (SIFPSA) has supported several innovative NGO projects in the past five years and many of these NGOs have made impressive contributions to the RCH programme.

- NGOs not working in reproductive and child health programmes will be encouraged and provided with the resources to introduce RCH services in their programmes.
- NGOs that have successfully implemented innovative projects will be recognized and rewarded.
- NGOs will be linked to public sector service delivery systems to make the referral system more effective and to improve the quality of services.
- The supply system will be streamlined so that NGOs get an uninterrupted supply of contraceptives.
- Regular training programmes will be

conducted and new strategies will be evolved in partnership with NGOs to sustain the activities of NGOs.

3.2.2 Cooperatives

UP has 20,311 primary cooperative societies with 22.48 million members spread over sectors as diverse as agriculture, credit, handloom, dairy and sugarcane. Being economic platforms, with organizational strengths in rural areas and good understanding of rural markets, these cooperatives offer an opportunity for involving large networks of volunteers in the promotion of family planning and RCH services.

- Milk cooperatives will be used for service delivery using the model developed by SIFPSA. Their excellent logistics would be utilized for promoting referrals.
- Primary agriculture credit societies will be used as depots for both free and subsidized brands of contraceptives and as points for promoting RCH services.

3.2.3 Organized Sector

Liberalization of the economy with a human face requires corporate sector involvement in social development. As part of SIFPSA facilitated initiatives, individual industrial units and organized chambers of commerce have started providing RCH services to employees and their families and the community around them. These efforts by the corporate sector will be further expanded and strengthened.

- Large industrial units in both the private and public sectors will be involved in the delivery of RCH services. These industrial units have management strengths and excellent captive hospital facilities that could be used to provide clinical services to the rural and urban communities.

- Networks like railways and post offices with large rural outreach and a strong hospital set-up would be utilized for carrying messages on various RCH themes to remote areas. Because of their influence and acceptability in village communities, postmen will be trained to promote the small family norm and disseminate information.
- Chambers of commerce and industry such as FICCI, PHD and their affiliates would be requested to manage and implement RCH projects for the unorganized sector workers and small-scale industry workers.

3.2.4 Indigenous System of Medical Practitioners

UP has nearly 40,000 registered indigenous system of medical (ISM) practitioners belonging to the Ayurvedic, Unani and Homeopathic schools of medicine. There are perhaps an equal number of non-registered medical practitioners. A large proportion of rural population seeks health services from ISM practitioners because of their easy access and low cost. The potential of ISM practitioners to provide family planning services is immense.

- ISM practitioners, who are the first point of contact for health care in rural areas, will be trained to provide counselling and services related to family planning through district level training projects.
- They would be promoted as trained family planning counsellors and used as depots for free and priced oral contraceptives, condoms and other reproductive health products.

3.2.5 Private Health Sector

Given the huge task of providing services to a large number of eligible couples every year to reach replacement-level fertility, the public

health sector alone will not be able to cater to the needs of all. Partnership with the private sector is essential, particularly to provide quality clinical services. In UP, the private health sector is in its early stages of development. Government will initiate steps to expand the private health sector and also to utilize the facilities in existing health institutions.

- Private health institutions, meeting quality standards to provide sterilization and IUCD services, will be identified in each district.
- Private medical practitioners will be trained in providing quality family planning services.
- Wide publicity will be given to recognized institutions, and people will be encouraged to utilize services at these institutions.
- For private recognized health institutions, further support will be extended in the form of supply of equipment and other resources.

3.2.6 Contraceptive Marketing

Use of spacing methods in the state is very low. Of the total number of currently married women in reproductive age, only 6.4 percent use spacing methods. A large proportion of users of spacing methods depend on the private sector for fully priced or subsidized products. The dependence on the commercial sector has been gradually increasing. In 1992-93, 52 percent of oral contraceptive users depended on the private sector. This has increased to 74 percent in 1998-99. Similarly, more than 80 percent of condoms users are dependent on the commercial sector for supplies. Given this, contraceptive marketing has to play a major role in promoting the use of spacing methods, particularly condoms and oral contraceptives.

- The contraceptive marketing project launched three years ago to improve the sales of condoms in small towns and Category A villages in 28 districts of UP has achieved significant results. The new contraceptive marketing project launched in April 2000 will cover 25 percent of the villages up to D category in rural UP over the next three years. This will substantially increase the access to and use of condoms and oral contraceptives in rural UP.
- Innovative marketing approaches will be tried out to refine marketing strategies and to sustain marketing efforts.
- NGOs, cooperatives, and the organized sectors will be encouraged to introduce the element of social marketing in their projects.
- Linkages will be established with trained ISM practitioners to sell oral contraceptives and condoms.
- Marketing of other products like ORS packets, disposable delivery kits, vitamin A solution, and IFA tablets will be encouraged.
- of TT injections and 100 tablets of iron and folic acid (IFA) twice a year, following the special campaign approach in addition to the regular services at all service delivery points.
- Logistic systems related to the procurement and distribution of TT injections and IFA tablets will be streamlined.
- Antenatal check-ups will be conducted to identify pregnant women at risk and the referral system will be strengthened to serve these women.
- Supplementary nutrition will be provided to all pregnant and lactating women and an IEC campaign will be launched to promote healthy food habits.
- Postnatal check-ups will be done by ANMs at both subcentres and also during home visits.
- Infertility clinics will be opened in all district hospitals and services will be provided to couples having infertility problems.
- Maternal health care centres will be set up in all villages with more than 1,000 people, initially by involving community members and mobilizing resources from the community.
- Facilities and trained personnel will be made available at the CHC level to treat women with reproductive tract infections.

3.3 Strategies to Improve Access to and Quality of RCH Services

3.3.1 Maternal Health Services

Maternal health services, particularly antenatal care and postnatal care services, require special attention to reduce both maternal and infant mortality. A large proportion of women in both urban and rural areas are anaemic and are not protected against tetanus. The proportion availing of postnatal care services are also very low. Prophylaxis against nutritional deficiency would be able to save many lives.

- ANMs will register all pregnant women in rural areas in the first trimester with the help of periodic surveys.
- Pregnant women will be given two doses

3.3.2 Deliveries by Trained Personnel

Deliveries conducted by trained personnel are extremely low in UP. Most of the deliveries take place at home and are attended by untrained personnel. This has led to high infant mortality, particularly neonatal mortality and also maternal mortality. To reduce infant and maternal mortality, added emphasis will be placed on increasing institutional deliveries and the proportion of deliveries attended by trained personnel.

- The proportion of institutional deliveries will be increased substantially by encouraging women to avail of the facilities available at block PHC, CHC, and health institutions above the CHC level.
- In a phased manner, round-the-clock service centres will be opened in all health institutions with facilities to conduct deliveries.
- Panchayats will be provided funds to provide transport and other facilities for emergency delivery.
- Traditional birth attendants will be trained in all villages in conducting safe deliveries, and innovative approaches will be initiated to provide safe delivery kits to trained *dais*.
- Refresher training programmes will be conducted for trained traditional birth attendants on a regular basis.

3.3.3 Child Health Services

The reach of child health services and their acceptability have to be considerably increased in order to reduce infant mortality. Immunization of children against vaccine-preventable diseases, proper management of diarrhoea, treatment of acute respiratory infection and improved nutrition are the important measures that need to be strengthened further. There has been considerable improvement in the recent past in immunization coverage and in the use of ORS packets or home-made solutions in the case of diarrhoea.

- IEC campaign will be launched to create awareness about vaccine-preventable diseases and to encourage utilization of immunization services.
- Complete immunization of children will be given the highest priority and services of NGOs, community leaders, and other civil society organizations will be utilized to achieve complete immunization coverage of children.
- Mothers will be educated about the use of oral rehydration and home-made solutions, and social marketing of ORS packets will be encouraged.
- Facilities at PHCs and CHCs will be augmented to detect and treat children having acute respiratory problems.
- Supplementary nutrition will be provided to all children, particularly those from below the poverty line to eliminate all forms of nutritional deficiencies.

3.3.4 Sterilization Services

Sterilization services have a major role to play in the reduction of fertility. Demand for sterilization services is extremely high and has increased over time. The sterilization performance in the state has declined in the recent past, particularly after the introduction of the target-free approach. Health workers' visits to villages and their contacts with women to promote informed choice have also declined. There is an urgent need to streamline the service delivery systems to provide services to voluntary acceptors of sterilization methods.

- Integrated RCH camps conducted in select districts of UP have helped to improve access to and quality of services. RCH camps planned in advance and publicised through various media have substantially improved access to services. The camp approach may not be the best approach to provide high-quality services on a regular and continuous basis but, given the current service delivery situation in the state, is the best suited to reach those in need of services. The RCH camp approach will be further strengthened and expanded to cover the entire state.
- Sterilization camps, in addition to RCH camps, will be conducted in a systematic

and planned way in the entire state throughout the year.

- CHCs and PHCs will be upgraded to provide quality counselling and sterilization services.
- Visits of health workers to villages and households, particularly pregnant women, will be monitored and strict action will be initiated against those who are not making regular visits.
- All women who availed of medical termination of pregnancy (MTP) services and desired to limit their families will be counselled to adopt permanent methods.
- Panchayat members, NGOs, and personnel from other departments will be involved to mobilize additional resources to improve the quality of sterilization camps and to make each camp conducted in the state a major success.
- The frequency of camps will be increased and systems in place to organize camps will be streamlined.
- A pool of medical officers consisting of surgeons would be created at both the divisional and district levels to provide services at RCH and sterilization camps. This will enable Chief Medical Officers (CMOs) to ensure availability of clinical services at camps on an assured basis as per a predetermined calendar.
- Measures will be initiated to ensure follow-up services to all clients who received services at RCH/sterilization camps.
- A periodic review of the RCH/sterilization camp approach will be undertaken to identify areas that need to be strengthened, and all attempts will be made to strengthen the quality of services provided in the camps.

3.3.5 Involvement of Men

Involvement of men in family planning has sharply declined in the past two decades.

Vasectomy, once the most accepted method, has hardly any users now. Male participation is essential not only to increase the use of contraceptives but also to reduce the enormous burden the non-participation of men imposes on women. UP has already trained several medical officers to conduct no-scalpel vasectomy operations.

- More medical officers will be trained in conducting no-scalpel vasectomy operations, and male sterilization services will be made available in all CHCs and block PHCs in a phased manner.
- Special IEC campaigns will be launched to educate men about responsible parenthood and to encourage them to use family planning methods.
- Training curricula of health workers, supervisors, and medical officers will be modified to include material on involvement of men.
- Facilities will be provided at CHCs and PHCs to treat men having reproductive tract infections, and effective counselling services will be provided to prevent the spread of infection.

3.4 Strategies to Improve Service Delivery Systems

UP has a large unmet need for contraceptive services. This is primarily due to gaps in the existing health infrastructure and services and the lack of out-reach to remote areas and under-served groups. One of the main challenges for the family welfare programme in UP is to expand coverage of services by increasing their reach and improving their quality. The Government will endeavour to identify the strengths of the programme and build on them while at the same time removing weaknesses that impede its acceptance.

The roles, responsibilities, and accountability of different levels would be clearly charted out. The initiative at the state level would be to marshal resources from the Government of India and other sources, build capacity to implement the programme, and provide support for implementation activities. The district level would be the key unit of planning and programme design. At the village level, efforts would be made to identify specific unmet needs in the reproductive and child health programme and focus efforts of all departments to provide quality services. The service delivery system would have operational strategies geared to cater to the needs of rural as well as expanding urban areas. These strategies would be reviewed at regular intervals to ensure that they are implemented in an efficient manner and are continuously focused to meet client needs.

3.4.1 Contraceptive Service Requirements

To realize the goal of achieving replacement level fertility by 2016, the contraceptive prevalence rate will have to increase from the present level of 22 percent to 34 percent by 2006, to 46 by 2011, and to 52 in 2016. The percentage of couples protected by limiting and spacing methods will have to increase from the current level of 16 and 6 percent to 37 and 16 percent, respectively, in 2016. The increase in prevalence level calls for a substantial increase in the number of couples to be provided contraceptive services every year by the Department of Health and Family Welfare along with other partners.

The annual number of acceptors of limiting methods will increase steeply for some time

Uttar Pradesh: Contraceptive use to be achieved by 2016

Year	Couples of reproductive age (millions)	Contraceptive Prevalence Rate (Percent)			Couples to be provided contraception (millions)		
		Limiting	Spacing	Total	Limiting	Spacing	Total
2001	28.5	18.5	7.7	26.2	0.58	2.20	2.78
2002	29.4	19.0	7.9	26.9	0.64	2.37	3.00
2003	30.3	19.4	8.1	27.5	0.80	2.54	3.33
2004	31.3	20.5	8.6	29.1	0.98	2.79	3.77
2005	32.3	22.0	9.2	31.2	1.07	3.08	4.15
2006	33.3	23.6	9.9	33.5	1.22	3.39	4.61
2007	34.3	25.5	10.7	36.2	1.30	3.77	5.07
2008	35.4	27.3	11.5	38.8	1.30	4.14	5.44
2009	36.3	29.3	12.4	41.7	1.33	4.51	5.83
2010	37.3	31.0	13.1	44.2	1.21	4.84	6.05
2011	38.1	32.5	13.8	46.3	1.14	5.14	6.28
2012	38.8	33.8	14.3	48.1	1.08	5.41	6.49
2013	39.5	34.8	14.8	49.6	1.10	5.64	6.75
2014	40.2	35.6	15.1	50.7	0.96	5.86	6.82
2015	40.8	36.2	15.4	51.6	0.87	6.04	6.92
2016	41.5	36.5	15.6	52.1	0.89	6.17	7.06

before tapering off while in the case of spacing methods the annual number of acceptors will increase steadily.

State Level

- The annual number of limiting method acceptors should rapidly increase from the current level of less than 0.5 million to 0.6 million in 2001, 1.2 million by 2006, and reach a peak of 1.3 million in 2009.
- The annual number of couples to be provided spacing methods will be over 2 million in 2001, 3.4 million in 2006, 5.1 million in 2011, and 6.2 million in 2016.

Regional Level

Western Region

- The annual number of limiting method acceptors should increase to 194,000 in 2001, 432,000 in 2006, and reach a peak of 498,000 in 2009.
- The annual number of couples to be provided spacing methods will be over 1,058,000 in 2001, 1,482,000 in 2006, 2,062,000 in 2011 and 2,205,000 in 2016.

Central Region

- The annual number of limiting method acceptors should increase to 83,000 in 2001, 193,000 in 2006, and reach a peak of 220,000 in 2008.
- The annual number of couples to be provided spacing methods will be over 401,000 in 2001, 603,000 in 2006, 868,000 in 2011, and 978,000 in 2016.

Eastern Region

- The annual number of limiting method acceptors should increase to 211,000 in 2001, 501,000 in 2006, and reach a peak of 535,000 in 2009.
- The annual number of couples to be provided spacing methods will be over

442,000 in 2001, 900,000 in 2006, 1,796,000 in 2011, and 2,407,000 in 2016.

Hill Region

- The annual number of limiting method acceptors should be about 47,000 in 2001 and remain over 40,000 thereafter.
- The annual number of couples to be provided spacing methods will be 198,000 in 2001, 238,000 in 2006, 265,000 in 2011, and 288,000 in 2016.

Bundelkhand Region

- The annual number of limiting method acceptors should increase to 43,000 in 2001, and reach a peak of 53,000 in 2005.
- The annual number of couples to be provided spacing methods will be 105,000 in 2001, 171,000 in 2006, 242,000 in 2011, and nearly 300,000 in 2016.

3.4.2 Organization Structure

The Health and Family Welfare Department in UP has grown considerably over the years with the addition of more programmes and complexity in reporting relationships. Although most of these programmes are centrally funded they can be implemented efficiently in a large state like UP only if both financial and decision-making authority is devolved to the district level and below, and at the same time accountability for outcomes is clearly spelled out. A large and complex organization like the Health and Family Welfare Department can not produce the desired results with centralized systems. To make it more efficient the following measures will be undertaken:

- Job functions of all officers would be reviewed and rewritten to avoid overlaps, distribute work evenly, and to maintain a manageable span of control and unity of command.
- Decision-making authority, to the extent

feasible, would be decentralized to the regional, divisional, district and block levels and at the same time accountability of each level clearly spelt out.

- The offices of the divisional Additional Directors would be strengthened and made responsible for achievement of the expected levels of performance in their division. Their primary responsibility would be to supervise, monitor and provide assistance for all programme implementation activities in districts.
- Deputy CMOs who are area officers would be posted at the sub-divisional level and made responsible for the performance of all health institutions in their sub-division. It would be their duty to identify and organize resources from within their area for activities like RCH camps and special campaigns.
- The Government would strengthen the infrastructure at the PHC level (institutions covering 30,000 population) and make these PHCs independent units of programme management. All health workers in the additional PHC area will directly report to the Medical Officers in Additional PHCs. Medical Officers of Additional PHCs would also be given drawing and disbursement authority after necessary training and certification from the competent authority without insisting on a specific minimum length of experience.
- A pool of medical officers consisting of a few surgical operating teams would be created at both the divisional and district levels to provide services at RCH and sterilization camps. This will enable CMOs to ensure that clinical services are made available at camps on an assured basis as per a pre-determined calendar.
- The performance appraisal of all medical officers will mainly focus on their

contribution to meeting reproductive and child health needs of clients.

- The average subcentre population will be reduced from the current 7,000 to below 5,000 as per the GOI norm by creating more subcentres. This will substantially improve the access to health services in rural areas.
- District-level databases will be created, updated periodically, and utilized to develop district-specific strategies and action plans.
- Management information systems will be reviewed and redesigned to facilitate collection of adequate, complete and reliable information at all levels, to provide feedback on performance, and to encourage informed decision making.

3.4.3 Decentralization

While changes in organization structure are necessary to make the health department more effective and responsive, in a large state like UP with 83 districts, it is essential to decentralize the planning and programme design to the district level to make it more client-oriented, need-based and cost-effective in terms of service delivery. Through a consultative process involving workers and programme managers at various levels in the districts as well as panchayat members, NGOs, community leaders, and other stakeholders, the programme would be designed with the district as a unit of planning.

- This decentralized approach at the district level will help to tune the programme to the grass-root realities, develop management capabilities within the district, and increase the accountability of the programme to the local community.
- A district-level society with a Project Management Unit (PMU) would be set up in each district under the leadership of the District Magistrate to facilitate the flow

of funds from the state level to the district level and for monitoring activities and taking corrective action.

- These district societies would support, nurture and promote innovative activities and would further help in coordinating the work of government and non-government organizations.
- District societies with the assistance from the PMUs will prepare district action plans, strive to achieve inter-sectoral coordination at all levels, and ensure convergence of services, particularly at the village level.
- Of the total annual district plan funds, 10 percent will be earmarked and disbursed to those districts that have achieved reproductive and child health and female education programme objectives in a given year.

3.4.4 Urban Health Systems and the Role of Urban Local Bodies

Twenty percent of the population of UP, an estimated 35 million people, live in urban areas in the state spread over 704 towns and cities. Almost one-fourth of this population resides in slums, often unrecognized and unaccounted for by the government and thus deprived of basic education and health care facilities. By 2016, almost 30 percent of the state population would be residing in urban areas.

Unlike in the rural areas, where the health department has a wide network of primary health care facilities providing reproductive and child health services, the urban slums lack basic health infrastructure and outreach services. Thus, they are often bypassed even by national programmes providing immunization, safe motherhood and family planning services. The sparse health coverage provided by urban institutions like urban family welfare centres, health posts, and

maternity homes in cities is used more for emergencies and curative services. Often these facilities are far from their service area, poorly staffed, with inadequate space and supply of medicines and equipment. Urban local bodies like municipal corporations and nagar panchayats 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.

An urban woman on an average has 3.6 children but in urban slums the fertility levels are much higher and, in many cases, infant mortality rates reach close to those in remote rural areas. 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.

- Urban health posts with adequate space, equipment and trained personnel will be set up on the same pattern as primary health centres in rural areas. They would be responsible for providing door-to-door service in urban slums.
- All efforts will be made to involve all health infrastructure in urban areas, other than that of the state health department in the delivery of RCH and family planning services.
- An Additional Director (AD) in the Directorate of Family Welfare will be designated as AD (Urban) and would be responsible for coordinating with municipal corporations, nagar panchayats, and other departments/agencies to ensure the availability of supplies of contraceptives and reproductive health products like DDKs, ORS and IFA, and provision of training to municipal providers.

- Private sector organizations like NGOs, corporate bodies, and trusts would be encouraged and motivated to adopt *mohallas* and slums to provide the entire range of health care.
- All traditional birth attendants or *dais* in urban centres would be trained in elements of hygiene and safe delivery practices and for counselling for family planning. They would also act as depot holders for contraceptives.
- Innovative methods of social marketing would be used for promotion and making available contraceptives and health products in slums.

3.4.5 Linkages with Other Departments

A number of government departments, especially those working in the development sector, have considerable influence and infrastructure at the village level. While the Panchayat Raj system will be responsible for converging their services, these departments through their programmes can act as catalysts for the generation of demand for family planning and reproductive and child health services. For this purpose, each department could develop an action plan, and implement and monitor it on a regular basis. In order to develop this action plan, each department could set up a group with representatives from the family welfare department and an expert from outside to work out strategies, an implementing mechanism and a monitoring system.

Some of the major departments in the social sector would also have a role in providing services to supplement the services provided by the Department of Family Welfare. In order to ensure efficient delivery of these services and their linkage with the Health and Family Welfare Department, a group would be set up to monitor these activities at least on a

quarterly basis. This group would include the Secretary and Head of Department of the concerned department and the Director General, Family Welfare.

The role of each department, the action plan, and the specific activities to be carried out to attain population stabilization would be worked out by the department concerned within 3 months of the approval of the Population Policy.

3.4.6 Information, Education and Communication

Information, education and communication have a key role to play in creating demand for services, in promoting informed choice and in increasing awareness about service delivery points. Decisions to adopt family planning methods and also to seek health care services are based on a variety of factors. Communication has a major role to play in facilitating the informed choice at both familial and community levels. A series of measures will be initiated to effectively implement communication strategies.

- Region specific communication strategies will be developed and a variety of media such as print material, folk and electronic will be used to reach clients. Local cable networks will be used to convey appropriate messages.
- Health and family welfare personnel will be trained in interpersonal communication and counselling.
- All communication efforts will be coordinated with other development departments and integrated strategies will be developed to incorporate family planning messages in communication campaigns of all concerned departments.

3.4.7 Human Resource Development

Capacity needs to be built up in UP for the delivery of quality reproductive and child health services. Human resource development is, therefore, an important aspect that needs to be addressed. Training programmes not only help in enhancing technical skills of medical officers, para-medical staff, and programme managers but also help in changing the attitudes of service providers, both of which are crucial for quality improvement and client satisfaction. Management training is also essential for more efficient management of the programme. With the recognition of the need to expand channels for service delivery by involving the private and commercial sectors, it has become even more important to change mindsets and foster the team approach, whereby together everyone achieves more. Modern research, with newer technologies and improved ways of accomplishing tasks, also calls for a continuous need to upgrade skills and knowledge through updates and refreshers.

- An apex-level institution, the Centre for Management of RCH Programmes, would be set up at the state level to provide on-going technical assistance for training in both the government and non-governmental sectors. This institution will serve as a nodal point for identifying training needs, developing training curricula, drawing up training plans, training master trainers, conducting, monitoring and evaluating specific training programmes, and maintaining a data base. It will also assess the skills and competence of trained personnel from time to time and certify them as performing to standard.
- Induction training with emphasis on reproductive child health and public health issues would be made compulsory for all government personnel entering into service. Doctors as well as male and female supervisors will receive induction training at designated institutions at the state/divisional/district levels.
- Management training, including updates on financial procedures and matters relating to district plans, budgeting, hospital management, and MIS would be provided to all those posted in-charge of all health institutions at the PHC and above levels.
- Skill-based training would be given priority to ensure that personnel are able to provide good quality counselling and services. These would include training in clinical methods like minilaparotomy, abdominal tubectomy, laparoscopy, and no-scalpel vasectomy along with refresher training for the same.
- Paramedical staff would be trained in counselling skills to promote informed choice and in clinical skills for IUCD insertions.
- TBA training with emphasis on clinical practices related to safe delivery and hygienic practices will be expanded to ensure coverage of the entire state in the next three years, and supply of DDKs will be ensured using innovative marketing strategies.
- Infection-prevention training imparting hands-on learning to enhance knowledge and practice of disinfection, decontamination, and sterilization that involves all categories of service providers would be expanded to cover all health units.
- Capacity built up for training managers and staff of NGOs, cooperatives, panchayat members, and traditional medical practitioners would be further strengthened.
- Efforts would be made to ensure that

shortcomings in training programmes are identified and addressed on an on-going basis. Master trainers will be prepared and material for skill-based programmes would be regularly developed and updated, and the methodology for training would be participatory rather than pedagogical.

3.4.8 Improving Efficiency of the Logistic System

The proportion of spacing methods in total contraceptive use in UP is about 30 percent, which is one of the highest in the country. This adds sophistication to the family planning programme, but also makes it imperative to have an efficient system for forecasting, procurement, transportation, stocking of condoms, oral contraceptives, IUCDs and other RCH products. If for any reason there are stock outs at any level, spacing clients are likely to drop out, adversely affecting the programme.

- The government will reset expected levels of achievement for pills, condoms, and IUCDs, based on actual users of these methods and the proportion of unmet need likely to be converted to actual use rather than on the basis of reported distribution within a particular year. This will prevent over-indenting, over-reporting and wastage of spacing contraceptives.
- To achieve the goals of the Population Policy, systemic problems in the logistics system in UP will be addressed. A Logistic Management Cell in the Department of Family Welfare will be responsible for forecasting requirements of contraceptives.
- A logistics management information system would be developed and put in place at the earliest. This would include identification of appropriate and safe

storage space at railheads, divisional headquarters, and in districts to ensure effective buffer stock and timely distribution of contraceptives as per the identified needs.

- To ensure accountability for timely procurement and proper management of contraceptive stocks, an officer would be designated as Medical Officer (Logistics) in each district. MO (Logistics) would be trained in inventory management and would be responsible for ensuring proper flow of supplies within the district.

3.4.9 Involving Female Doctors from the Private Sector

The cultural preference of the people for female doctors to provide RH services and the shortage of such doctors is one of the major bottlenecks in the provision of quality RH services on a regular basis at CHCs/PHCs. SIFPSA has initiated an innovative scheme for hiring of female doctors from the private sector to serve at CHCs or block PHCs. This scheme, which has been adopted by the RCH project, will be extended to the entire state.

- CMOs would be responsible for identifying, contracting, and ensuring the transportation of these female doctors from their place of stay to the service sites and for making monthly payments to them. In districts where no private lady medical officer is available, the Additional Director of the division would be responsible for ensuring the availability of doctors from the divisional headquarters or nearby districts.
- Female doctors hired under this scheme would provide outdoor services, including gynecological check up, counselling for family planning, and diagnosis and referral for RTI and STIs. They would also insert IUCDs, perform sterilization

operations, and provide other services at RCH camps.

- These doctors would be trained through contraceptive technology updates and provided training for IUCD insertions and tubectomy, if necessary. The skills would be assessed every year to ensure that the doctors are performing to standard.

3.4.10 Quality of Care

After the adoption of the community needs assessment approach (CNAA), the “push element” in the family planning programme has been replaced by a “pull factor” in which quality of care is of prime importance. To achieve the goals laid out in the Population Policy, the state government will make all efforts to improve quality of care.

- The government will ensure the availability of services at various health facilities by making available doctors and health workers at these facilities. This would be done by improving residential facilities at PHCs and subcentres and posting of multi-purpose health workers in centres close to their homes.
- The period of posting doctors in rural facilities at the beginning of their service will be increased from 2 years to 5 years and made mandatory for confirmation and promotion.
- It will be ensured that medical officers and health workers providing family welfare services have the necessary technical competence and professional skills.
- Government facilities would be upgraded to have an appropriate environment, necessary equipment, consumables, medicines, and other items necessary to provide quality services.
- The mobility of medical officers and supervisors would be ensured by providing additional funds for POL and maintenance of vehicles.
- Follow-up services to clients who have accepted family planning methods and other RCH services will be strengthened and strictly monitored.
- Periodic surveys will be conducted to assess quality standards maintained at various health institutions and to prepare strategies to improve quality standards on a continuous basis.

3.4.11 New Technologies

The state government believes that an increase in contraceptive prevalence rate is a function of the number of modern methods of contraception available to people in the state. It will therefore take all steps to ensure the availability of a choice of modern methods. Sterilization services, both tubectomy and vasectomy, will be made available at all clinic sites, and providers and sites suitable for these will be promoted through the mass media. In addition, spacing services like IUCDs, oral contraceptives, and condoms would be promoted and provided at all facilities down to the subcentre. New contraceptive technologies like injectables are not yet available under the national family planning programme, though the Government of India has permitted NGOs to provide them with certain restrictions like the requirement of post-use surveillance. It has also allowed the commercial marketing of injectables.

- The state government will include materials related to new technologies such as injectables, new types of IUCDs, etc., their advantages and disadvantages, contra-indications, and side-effects in various curricula developed for training of government and non-government sector providers under the family planning programme.

- The state government in consultation with the Government of India will conduct operations research studies to examine the possibility of introducing injectables and other new technologies in family planning services provided by the state government under the national family welfare programme.
- An active dialogue will be initiated with the Government of India for wider availability of injectables and other new technologies through private, commercial, and government channels in the state.
- The state government will promote the indigenously developed non-hormonal, once-a-week pill 'Saheli' by providing marketing support under the contraceptive social marketing programme.
- The lactation amenorrhoea method (LAM) will also be offered as a method of spacing by training government and NGO workers for post-partum counselling.

3.4.12 User Charges

The Government is committed to providing health care to the people, especially those who cannot afford to pay for it. Further, since the paying capacity of a large proportion of the UP population is limited, the state government has to take the responsibility for providing hospital services at subsidized rates. This places a large burden on governmental resources and often in its desire to provide free health care and hospital services, the quality of services has to be sacrificed. To get over this problem, the state government has decided to introduce fees for services and user charges at various state government facilities. While health care will continue to remain subsidized to a large extent, the revenue earned from these user charges is expected to improve the quality of services at government facilities.

Fifty percent of the revenue from user charges will be retained at the earning medical facility and the rest will be deposited in the government treasury.

Policy Implementation

4.1 New Structures

The Population Policy sets out ambitious goals and plans out the broad strategy for the reproductive and child health programme in the state. However, the key to success lies in its vigorous implementation. In order to maintain and develop political commitment, generate a broad consensus on population-related issues, ensure inter-sectoral coordination, cater to the special requirements of different geographical regions, and provide direction to various initiatives at the state, regional and district levels, an appropriate implementation structure would be put in place.

4.2 State Population and Development Commission

The State Population and Development Commission (SPDC) will be the apex body that will oversee, guide, and review the implementation of the Population Policy. It will give policy directions, bring about multisectoral coordination, and ensure that the implementation of the policy is focused to meet the state's development and socio-economic goals. This commission will be presided over by the Chief Minister and will have the following members:

- Ministers in-charge of departments of Medical, Health and Family Welfare, Education, Women and Child Welfare, Rural Development, Finance, Planning, Youth Welfare, Labour, Agriculture, Cooperatives, Industries, and Social Welfare

- Leaders of the opposition in the Vidhan Sabha and Vidhan Parishad
- State presidents of recognized national and state political parties
- Deputy chairpersons of the State Planning Commission and 20-Point Programme Review Committee
- Mayors of all municipal corporations
- One Zilla Panchayat Chairman from each division
- Chief Secretary to Government of UP
- Additional Chief Secretary and Agriculture Production Commissioner, Government of UP
- Ten non-official members representing NGOs, cooperatives, the corporate sector, the trade unions, women's organizations, and the private medical community, with at least one representing each of the five geographical regions of the state
- Experts in the areas of health, communication, demography and programme management
- Principal Secretary, Department of Medical, Health and Family Welfare as Member Secretary

The Commission will meet at least twice a year and may co-opt other officers as members depending on need.

4.3 Committee For Population Stabilization

This committee will monitor the implementation of the Population Policy and coordinate the efforts of various departments

and agencies involved in it. It will also take all measures to ensure that the objectives laid out in the Population Policy are achieved in a time-bound manner. This committee would be chaired by the Chief Secretary and will have the following composition:

1. Additional Chief Secretary and APC
2. Principal Secretaries/Secretaries of concerned departments
3. Chief Executives of SIFPSA, UP Health Systems Project, State AIDS Control Society, RCH Project, Education for All Project, UP Land Development Project, UP Diversified Agriculture Support Project, and Pradeshik Cooperative Dairy Federation
4. Representatives of NGOs
5. Divisional Commissioners
6. Directors General of Health, National Programmes, Medical Education, Family Welfare, and Uttaranchal

The Principal Secretary, Medical, Health and Family Welfare Department will be its Member Secretary.

This Committee will meet at least once in three months.

4.4 Reproductive and Child Health Mission

In order to meet the special requirements of the different geographical areas of the state with reference to design of projects, behaviour change communication, monitoring and evaluation of interventions, involvement of the private sector, and improving the quality of the voluntary sterilization programme, a special three-member mission of technical experts would be set up to advise the Department of Family Welfare on a continuous basis. This RCH mission would

also address itself to the task of developing additional region-specific strategies.

4.5 District-Level Societies

To implement the RCH programme in districts, autonomous societies chaired by District Magistrates would be set up. These would have a mix of members from the government and non-government sectors and would be supported by a PMU. These would meet at least once a month to plan, coordinate, implement, and monitor programme activities.

4.6 Monitoring Systems

Considering its importance to the socio-economic development of the state, the Government will monitor the performance of the Reproductive and Child Health Programme at the state level. This monthly monitoring, by the Chief Secretary, would be done for each district, for indicators relating to family planning, child immunization, and antenatal care. Regions, divisions, and districts would be graded on an objective point scale, and feedback provided to them. Districts and officers showing good performance will be recognized. The performance of each district would be evaluated biannually with the help of a survey. All panchayats will be encouraged to keep a Population Information Display Board in a prominent place that contains information on population size, the number of births and deaths and other vital events in the panchayat area.

4.7 Additional Resources

The goals and objectives of the Population Policy are ambitious and will require additional resources for their achievement. Considering

their critical importance to the development of the state, the state government is committed to adequately fund the strategies mentioned in this document as well as all other efforts for population stabilization. As a token of its commitment, the government has decided to establish a Population Fund. The Committee

on Population Stabilization headed by the Chief Secretary will operate this fund.

In addition, efforts would be made to mobilize resources from the Government of India and through multilateral and bilateral reproductive and child health projects in the state.

Appendix A

Region-wise Tables on Policy Objectives

- Projected Population of Regions in Uttar Pradesh 2001-2016
- Fertility Goals of Regions of Uttar Pradesh 2001-2016
- Crude Birth Rate By Regions of Uttar Pradesh 2001-2016
- Crude Death Rate by Regions of Uttar Pradesh 2001-2016
- Infant Mortality Rate by Regions of Uttar Pradesh 2001-2016
- Contraceptive Prevalence Rate by Regions of Uttar Pradesh 2001-2016
- Total Couples to be Protected Each Year by Regions of Uttar Pradesh 2001-2016

Projected Population of Regions in Uttar Pradesh 2001-2016

Regional Population in Million						
	Western	Central	Eastern	Hills	Bundelkhand	State
2001	61.0	29.8	65.4	7.1	7.9	171.2
2002	62.1	30.3	66.6	7.2	8.0	174.1
2003	63.2	30.8	67.8	7.3	8.0	177.0
2004	64.4	31.3	69.0	7.4	8.1	180.1
2005	65.5	31.8	70.2	7.4	8.2	183.0
2006	66.5	32.2	71.3	7.5	8.2	185.8
2007	67.6	32.7	72.4	7.6	8.3	188.6
2008	68.6	33.2	73.5	7.7	8.4	191.3
2009	69.6	33.6	74.6	7.7	8.4	193.9
2010	70.6	34.0	75.6	7.8	8.5	196.5
2011	71.5	34.4	76.5	7.9	8.6	198.8
2012	72.4	34.7	77.4	8.0	8.6	201.2
2013	73.2	35.1	78.3	8.0	8.7	203.3
2014	74.1	35.4	79.2	8.1	8.8	205.6
2015	74.9	35.8	80.0	8.2	8.8	207.7
2016	75.7	36.1	80.8	8.2	8.9	209.7

Fertility Goals of Regions of Uttar Pradesh 2001-2016

Fertility Goals of Regions						
	Western	Central	Eastern	Hills	Bundelkhand	State
2001	4.3	4.1	4.3	2.5	3.1	4.0
2002	4.2	4.0	4.2	2.4	3.0	4.0
2003	4.2	4.0	4.2	2.3	2.9	3.9
2004	4.0	3.9	4.0	2.2	2.7	3.8
2005	3.9	3.7	3.9	2.2	2.6	3.7
2006	3.7	3.5	3.7	2.1	2.5	3.5
2007	3.5	3.4	3.5	2.1	2.4	3.3
2008	3.3	3.2	3.3	2.0	2.3	3.1
2009	3.1	3.0	3.1	2.0	2.2	2.9
2010	2.8	2.8	2.8	1.9	2.2	2.8
2011	2.7	2.6	2.7	1.9	2.1	2.6
2012	2.5	2.5	2.5	1.8	2.1	2.5
2013	2.4	2.4	2.4	1.8	2.0	2.3
2014	2.3	2.2	2.3	1.7	2.0	2.2
2015	2.2	2.2	2.2	1.7	1.9	2.2
2016	2.1	2.1	2.1	1.6	1.9	2.1

Crude Birth Rate By Regions of Uttar Pradesh 2001-2016

Crude Birth Rate						
	Western	Central	Eastern	Hills	Bundelkhand	State
2001	28.5	28.2	29.6	20.0	22.1	28.2
2002	28.3	27.9	29.3	19.5	21.4	27.9
2003	28.0	27.5	28.9	19.2	20.7	27.6
2004	27.6	27.1	28.4	18.9	20.0	27.1
2005	27.0	26.3	27.6	18.6	19.4	26.4
2006	26.4	25.6	26.9	18.5	18.8	25.8
2007	25.5	24.7	25.9	18.5	18.5	24.9
2008	24.6	23.8	24.9	18.5	18.2	24.1
2009	23.8	22.8	24.0	18.4	18.1	23.2
2010	22.9	21.9	23.0	18.3	18.1	22.4
2011	22.1	21.1	22.1	18.2	18.1	21.6
2012	21.4	20.3	21.3	17.8	18.2	20.9
2013	20.8	19.7	20.7	17.3	18.3	20.3
2014	20.1	19.1	20.0	16.7	18.3	19.7
2015	19.6	18.6	19.5	16.1	18.1	19.2
2016	19.2	18.2	19.2	15.5	17.9	18.8

Crude Death Rate by Regions of Uttar Pradesh 2001-2016

Crude Death Rate						
	Western	Central	Eastern	Hills	Bundelkhand	State
2001	11.0	11.5	11.6	8.7	11.4	11.2
2002	10.8	11.3	11.4	8.7	11.3	11.0
2003	10.6	11.1	11.2	8.6	11.1	10.9
2004	10.4	11.0	11.0	8.6	11.0	10.7
2005	10.3	10.8	10.8	8.5	10.8	10.5
2006	10.1	10.6	10.6	8.5	10.7	10.3
2007	9.9	10.5	10.4	8.5	10.6	10.2
2008	9.7	10.3	10.2	8.5	10.5	10.0
2009	9.6	10.1	10.0	8.5	10.5	9.8
2010	9.4	10.0	9.8	8.5	10.4	9.7
2011	9.3	9.8	9.6	8.5	10.4	9.5
2012	9.1	9.7	9.5	8.5	10.3	9.4
2013	9.0	9.6	9.3	8.5	10.3	9.3
2014	8.9	9.5	9.2	8.5	10.3	9.2
2015	8.8	9.4	9.1	8.5	10.2	9.1
2016	8.7	9.4	9.0	8.5	10.2	9.0

Infant Mortality Rate by Regions of Uttar Pradesh 2001-2016

Infant Mortality Rate						
	Western	Central	Eastern	Hills	Bundelkhand	State
2001	78.4	80.9	78.7	60.9	84.5	79.7
2002	77.2	79.6	77.4	60.0	83.2	78.4
2003	75.9	78.2	76.1	59.1	81.8	77.1
2004	74.6	76.9	74.8	58.2	80.5	75.9
2005	73.4	75.7	73.6	57.3	79.2	74.6
2006	72.1	74.4	72.3	56.5	77.9	73.3
2007	70.8	73.1	71.0	55.6	76.5	72.1
2008	69.6	71.9	69.8	54.7	75.2	70.8
2009	68.3	70.6	68.5	53.9	73.9	69.5
2010	67.1	69.3	67.3	53.1	72.6	68.3
2011	65.8	68.1	66.0	52.3	71.3	67.0
2012	64.6	66.8	64.8	51.5	70.1	65.8
2013	63.3	65.6	63.5	50.7	68.8	64.5
2014	62.1	64.4	62.3	49.9	67.6	63.3
2015	60.9	63.1	61.1	49.0	66.3	62.1
2016	59.6	61.9	59.8	48.2	65.1	60.8

Contraceptive Prevalence Rate by Regions of Uttar Pradesh 2001-2016

Year	Contraceptive Prevalence Rate																	
	Western			Central			Eastern			Hills			Bundelkhand			State		
Year	Limiting	Spacing	Total	Limiting	Spacing	Total	Limiting	Spacing	Total	Limiting	Spacing	Total	Limiting	Spacing	Total	Limiting	Spacing	Total
2001	17.2	10.6	27.8	15.2	8.0	23.2	17.5	3.9	21.4	39.6	14.7	54.3	29.6	7.8	37.4	18.5	7.7	26.2
2002	17.9	10.8	28.7	15.8	8.3	24.1	18.2	4.3	22.5	40.4	15.1	55.5	30.9	8.4	39.3	19.0	7.9	26.9
2003	18.7	11.0	29.7	16.6	8.6	25.2	18.9	4.7	23.6	41.2	15.4	56.6	32.1	9.1	41.2	19.4	8.1	27.5
2004	19.9	11.4	31.3	17.7	9.0	26.7	20.2	5.3	25.5	41.8	15.7	57.5	33.2	9.9	43.1	20.5	8.6	29.1
2005	21.5	12.1	33.6	19.5	9.8	29.3	21.9	6.0	27.9	42.4	15.8	58.2	34.4	10.5	44.9	22.0	9.2	31.2
2006	23.3	12.7	36.0	21.1	10.5	31.6	23.7	6.8	30.5	42.8	16.0	58.8	35.5	11.3	46.8	23.6	9.9	33.5
2007	25.3	13.6	38.9	23.0	11.3	34.3	25.9	7.8	33.7	43.0	16.1	59.1	36.3	11.9	48.2	25.5	10.7	36.2
2008	27.5	14.3	41.8	25.1	12.2	37.3	28.1	8.8	36.9	43.3	16.2	59.5	37.0	12.5	49.5	27.3	11.5	38.8
2009	29.5	15.0	44.5	27.1	13.1	40.2	30.1	9.8	39.9	43.6	16.2	59.8	37.5	13.1	50.6	29.3	12.4	41.7
2010	31.5	15.7	47.2	29.0	13.6	42.6	32.1	10.9	43.0	43.8	16.4	60.2	38.0	13.6	51.6	31.0	13.1	44.2
2011	33.2	16.1	49.4	30.6	14.1	44.7	33.5	11.9	45.4	44.1	16.5	60.6	38.2	14.2	52.4	32.5	13.8	46.3
2012	34.8	16.5	51.2	32.1	14.6	46.7	34.8	12.8	47.6	44.7	16.7	61.4	38.2	14.5	52.7	33.8	14.3	48.1
2013	36.0	16.6	52.6	33.2	14.9	48.1	35.7	13.6	49.3	45.1	16.9	62.0	38.3	15.0	53.3	34.8	14.8	49.6
2014	37.1	16.7	53.9	34.3	15.2	49.5	36.5	14.5	51.0	45.6	17.1	62.7	38.3	15.5	53.8	35.6	15.1	50.7
2015	37.9	16.7	54.6	35.0	15.2	50.2	36.8	15.2	52.0	46.1	17.2	63.3	38.4	16.0	54.4	36.2	15.4	51.6
2016	38.4	16.5	54.9	35.5	15.2	50.7	36.8	15.8	52.6	46.5	17.4	63.9	38.4	16.5	54.9	36.5	15.6	52.1

Total Couples to be Protected Each Year by Regions of Uttar Pradesh 2001-2016

Total Couples to Be Protected Each Year ('000s)																		
Year	Western			Central			Eastern			Hills			Bundelkhand			State		
	Limiting	Spacing	Total	Limiting	Spacing	Total	Limiting	Spacing	Total	Limiting	Spacing	Total	Limiting	Spacing	Total	Limiting	Spacing	Total
2001	194	1058	1252	83	401	483	211	442	653	47	198	245	43	105	148	578	2203	2781
2002	212	1112	1325	100	428	528	232	504	736	48	207	254	45	116	161	637	2367	3004
2003	272	1176	1448	117	458	575	311	562	873	47	215	263	48	128	176	796	2539	3335
2004	332	1265	1597	166	494	660	386	665	1051	47	223	270	50	142	192	981	2789	3770
2005	371	1365	1736	167	557	724	431	769	1200	46	231	277	53	156	209	1067	3079	4146
2006	432	1482	1915	193	603	796	501	900	1401	42	238	280	49	171	220	1218	3395	4612
2007	464	1619	2083	215	671	886	530	1050	1580	43	244	287	49	186	234	1301	3770	5070
2008	472	1751	2223	220	727	947	522	1209	1731	42	250	292	47	201	247	1303	4138	544
2009	498	1866	2364	208	789	997	535	1380	1916	41	255	297	44	215	259	1327	4506	5832
2010	464	1980	2444	196	829	1025	469	1544	2013	40	260	300	40	229	269	1209	4842	6051
2011	449	2062	2511	188	868	1056	428	1706	2133	44	265	309	32	242	274	1141	5142	6283
2012	420	2118	2538	183	907	1090	408	1857	2265	40	271	311	32	252	284	1083	5405	6488
2013	432	2169	2601	187	926	1113	411	2011	2422	40	275	316	31	263	294	1102	5643	6746
2014	387	2198	2585	161	949	1110	345	2156	2501	40	280	320	31	273	304	964	5856	6821
2015	353	2214	2567	153	973	1126	297	2289	2587	40	284	324	30	284	314	873	6045	6918
2016	362	2205	2567	157	978	1135	300	2407	2707	40	288	328	30	295	325	889	6173	7062

Appendix B

Linkages with other Development Departments

Several development departments have components in their programmes that directly or indirectly influence fertility behaviour and, as a result, determine the success of population stabilization efforts. Convergence of services at village level and coordination of programme planning and implementation mechanisms at the levels above village are crucial to achieving the desired results. Given this, the Health and Family Welfare Department will identify the key elements of each of the development programme in the state and prepare a detailed plan to integrate population stabilization activities with other development activities. Given below is a list of programmes implemented by the development departments in Uttar Pradesh.

Programmes of Rural Development Department

1. Employment Assurance Scheme

Though the scheme was launched in 1993 to provide assured employment of 100 days in lean agricultural season to unemployed unskilled rural workers, it has been restructured during 1999-2000. The scheme now will be implemented by Kshetra and Zilla Panchayats.

2. Jawahar Gram Samridhi Yojana

Jawahar Rozgar Yojana after restructuring is now being implemented as Jawahar Gram Samridhi Yojana. This scheme aims to create infrastructure facilities in rural areas and to strengthen facilities available. Entire amount of the scheme will now be transferred to

village panchayat who have been empowered to plan, approve and implement the projects themselves without any approvals from above.

3. Indira Awas Yojana

The scheme is being implemented in two parts: 80 percent of total funds are for construction of new houses for rural shelterless poor and 20 percent for shelter upgradation and conversion of *kuchcha* houses into *pucca* houses. During 1999-2000, a total of 71,886 houses have been constructed.

4. Rural Water Supply

This scheme funded by both the Government of India and the State Government aims to provide one hand pump for 250 persons in all rural habitations. So far about 10 lakh hand pumps have been installed and transferred to gram panchayats.

5. Swarn Jayanti Gram Swarozgar Yojana

This is a holistic approach covering all aspects of self-employment. It has come into existence after merging several schemes such as IRDP, TRYSEM, DWCRA, Improved Tool-Kits Programme, Ganga Kalyan Yojana and Million Wells Scheme. The scheme envisages organization of the poor into self-help groups, and their training, credit, technology, infrastructure and marketing. The main objective is to improve income levels of people below the poverty line. Nearly 30 percent of poor families will be covered in the next five years.

6. Basic Minimum Services

The broad objective of the basic minimum needs services is to ensure minimum infrastructure and facilities to improve quality of life of people in rural areas. Basic minimum services include safe drinking water, housing assistance, roads, primary health care, primary education, mid-day meal programme and public distribution system.

Department of Education

With a view to augmenting efforts towards improving the basic education scenario in the state, the Government of Uttar Pradesh undertook the UP Basic Education Project (UPBEP) in 17 districts in 1993 and later the District Primary Education Programme (DPEP) was launched in 1997 to cover another 22 districts. By expanding to another 38 districts under the third phase, almost the entire state has been brought within the ambit of accelerated primary education projects.

1. Working with Community on Girls' Education

Community involvement is crucial for achieving universal primary education. Both UPBEP and DPEP have been facilitating community participation and involvement with the help of grass-root structures such as the village education committee (VEC). There is a provision for at least three women members, one elected member of the Gram Panchayat, one nominated SC woman and one nominated mother in the committee. The main functions of VECs include enrolment, retention, supervision, construction and maintenance of school buildings, social mobilization for girls education etc.

2. Involvement of UP Mahila Samakhya

Apart from mobilization of women, the Mahila

Samakhya provides a range of educational opportunities for different age groups. Mahila Samakhya educational interventions include the Mahila Sanghas (women's collectives), Bal Kendras (children's centres for both boys and girls), Kishori Kendras (centres for adolescent girls), and Mahila Shikshan Kendras (women's literacy centres).

3. The Model Cluster Development Approach (MCDA) for Girls' Education

Specific pockets in the DPEP districts have very low female literacy rates. To tackle this problem it was decided to work intensively in two clusters of eight to ten villages in each DPEP district with the help of MCDA. Based on encouraging results, the project has been extended to 15 clusters in each DPEP district in 1999.

4. Non-formal Education and Alternative Schooling

The Government of Uttar Pradesh has been implementing the centrally sponsored non-formal education scheme in 576 blocks across the 83 districts in the state. This programme has extended the access to children who dropped out of school. A total of 58,241 centres have been set up in the state. Of these, 37,125 are exclusive centres for girls. Non-formal education in UPBEP districts is provided with the help of Siksha Ghar to reach out to the underprivileged children in the age group of 6-14.

5. Balika Shiksha Mission

The Government of Uttar Pradesh has launched the Girl's Education Mission in 1999 in order to provide equal educational opportunities for girls (6-14 years). The main objective is to provide equal access to all girls in all underserved areas and to ensure community participation to encourage girls' education.

Department of Women and Child Development

1. Mahila Samakhya

Mahila Samakhya covers 23 blocks in 10 districts of Uttar Pradesh. There are 1,435 vibrant and strong women's collectives called Sanghas. Sanghas take up a variety of activities ranging from changing traditional practices to carrying out development activities. Mahila Samakhya's main aim is to empower women so that the women attain a position of strength to carry on their collective agenda without a major need for any external inputs or impetus.

2. Integrated Child Development Services (ICDS)

The ICDS is designed to promote the holistic development of children under six years of age. Besides specific nutrition and health interventions, the pre-school education component is built into the programme. At present, the ICDS programme is operational in 550 blocks spread over 80 districts with 53,699 anganwadi centres. In all, 45.3 lakh women and

children derive benefit from the programme. The main services provided include supplementary nutrition, growth and weight monitoring, immunization services, health check up and education, referral services and pre-school education.

3. Scheme for Adolescent Girls

This scheme is being implemented in 99 development blocks. The main objective of the scheme is to provide supplementary nutrition, health education and skill training for adolescent girls. The adolescent girls below poverty line are the main beneficiaries.

4. Indira Mahila Yojana

The main aim of Indira Mahila Yojana is to create awareness among rural women in order to encourage them to participate in social and economic activities of the society. Initially the scheme was implemented in two districts and later extended to cover two more districts. A total of 2,780 women's groups were constituted and 30 block level societies were registered.