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Achieving Uttar Pradesh's Population Policy Goals through Demand-based Family Planning Programs: Taking Stock at the Mid-point

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EXECUTIVE SUMMARY

This report describes progress in achieving the goals of the Uttar Pradesh (UP) Population Policy adopted in 2000, the implications of alternative fertility and mortality trends during the next decade, and strategies and program initiatives recommended by national and state policymakers and other experts.

To assess progress in implementing the UP Population Policy and to show how fertility trends would affect maternal and child health and socioeconomic development, the USAID | Health Policy Initiative, Task Order 1, analyzed data from the National Family Health Survey (NFHS-3) conducted in 2005–06. The project conducted the analysis using the FamPlan, DemProj, and RAPID models within Spectrum, a modeling system that uses computer software to generate projections and estimates showing the results of policy alternatives.

The project presented the results of the analysis at two roundtable meetings held in India in December 2007. At the Lucknow meeting, participants generated recommendations for new initiatives in UP's Reproductive and Child Health Program to help move the state closer to the goal of population stabilization. The major recommendations were to

Women waiting at a reproductive and child health camp in Agra.

- Make communication strategies more focused and strategic;

- Strengthen community participation;

- Stimulate private sector involvement and public-private collaboration;

- Make postpartum family planning a standard service;

- Ensure contraceptive security; and

- Produce higher quality data and analysis.

During the second meeting in New Delhi, senior policymakers from the Ministry of Health and Family Welfare further discussed meeting unmet need through repositioning family planning within the overall package of reproductive and child health interventions in UP. Mr. G.C. Chaturvedi, Mission Director, National Rural Health Mission, facilitated the roundtable discussion. Participants deliberated on the state-specific interventions identified during the Lucknow roundtable and then generated targeted actions to ensure contraceptive security, strengthen communication strategies, and increase community involvement in decisionmaking. These actions include

- Increase the availability of maternal health, reproductive health, and child health services by having round-the-clock services in a minimum of 10 percent of primary health centers, as is being done in other states;

- Conduct a study on the acceptability of the multi-load copper intrauterine device;

- Expand the choice of family planning methods available; and

- Improve access to high-quality services by having fixed days for sterilization instead of periodic sterilization days.

Participants agreed that further dialogue on these actions is needed, as well as the UP government's formal commitment to implementing them. If these actions are implemented, the total fertility rate in the state should decline, thereby making important progress toward achieving the Population Policy goals of UP and India.

ABBREVIATIONS

ASHA	accredited social health activist
FP	family planning
GDP	gross domestic product
IIPS	International Institute for Population Sciences
IMR	infant mortality rate
MMR	maternal mortality ratio
MWRA	married women of reproductive age
NFHS	National Family Health Survey
NGO	nongovernmental organization
RH	reproductive health
SIFPSA	State Innovations in Family Planning Services Project Agency
TFR	total fertility rate
UNFPA	United Nations Population Fund
UP	Uttar Pradesh
USAID	United States Agency for International Development
WHO	World Health Organization

I.   INTRODUCTION

This policy brief describes progress in achieving the goals of the 2000 Uttar Pradesh (UP) Population Policy, the implications of alternative fertility and mortality trends during the next decade, and strategies and program initiatives recommended by national and local policymakers and other experts.

To assess progress in implementing the UP Population Policy and to show how fertility trends would affect maternal and child health and socioeconomic development, the USAID | Health Policy Initiative, Task Order 1, analyzed data from the National Family Health Survey (NFHS-3) conducted in 2005–06. The project conducted the analysis using the FamPlan, DemProj, and RAPID models within Spectrum, a modeling system that uses computer software to generate projections and estimates showing the results of policy alternatives.

Woman in Patholi village in Agra, Uttar Pradesh.

The project presented the results of the analysis at two roundtable meetings held in India in December 2007. During the first meeting in Lucknow, UP's capital, participants discussed progress toward achieving the goals of the UP Population Policy and the Reproductive and Child Health Program. They also discussed the remaining challenges, particularly the high unmet need for family planning, as well as appropriate interventions to address these challenges. Ms. Nita Chowdhury, the Principal Secretary for Health and Family Welfare, led the meeting; and Mr. Rajeev Kapoor—UP Mission Director, National Rural Health Mission; Secretary for Health and Family Welfare; and Executive Director of the State Innovations in Family Planning Services Project Agency (SIFPSA)—moderated the roundtable discussion. Other senior officials attending were Dr. Rajender Kumar, Director of Maternal and Child Health; and Mr. C.B. Prasad, Additional Director, National Rural Health Mission. More than 60 stakeholders attended, including representatives from the Directorate of Health and Family Welfare, UP Health Systems Development Program, SIFPSA, Medical College, nongovernmental organizations (NGOs), academia, and international agencies. USAID was represented by Ms. Sheena Chhabra, Health Systems Division Chief; and Dr. Loveleen Johri, Senior Reproductive Health Advisor.

The second meeting, held in New Delhi, brought together nine senior officials from the Ministry of Health and Family Welfare to discuss the interventions for UP that were identified during the Lucknow meeting. The group met at the office of Mr. G.C. Chaturvedi, Director of the National Rural Health Mission. Attendees included the following ministry officials: Mr. Amarjeet Singha, Joint Secretary; Dr. M.S. Jayalakshmi, Deputy Commissioner; Dr. S.K. Sikdar, Assistant Commissioner; Mr. S.K. Das, Additional Director General, Dr. Keerthi Malviya, Assistant Commissioner, Family Planning; and Mr. Praveen Srivastava, Director, Statistics. Ms. Chhabra and Dr. Johri of USAID also attended.

II.   PROGRESS IN ACHIEVING THE POPULATION POLICY GOALS

The UP Population Policy aims to improve the quality of life of the state's inhabitants through population stabilization. The major goals focus on reaching replacement-level fertility (2.1 children per woman) by the year 2016 and improving maternal and child health (see Box 1). To date, progress toward attaining these goals has been mixed.

Based on data from the NFHS-3 conducted in 2005–06, UP is on target to reach the child health goals and has made progress toward the maternal health goals. However, the state has made limited progress in addressing the unmet need for family planning. The data indicate the following:

- **Significant progress toward achieving infant and child mortality goals.** The death rates of infants and children under the age of five in UP have declined substantially in the past decade. The current infant mortality rate (IMR)—which represents the number of infant deaths per 1,000 live births—is 74.3, while the under-five mortality rate is 109. If rates of improvement can be duplicated during the next decade, UP will reach the 2016 goals set in the UP Population Policy (see Figure 1).

- **Considerable improvements in maternal mortality.** UP's maternal mortality ratio (MMR)—which represents the number of deaths to women due to pregnancy and childbirth per 100,000 live births—was 517 in 2003. While important declines in maternal mortality occurred during 1997–2003, the pace of progress will need to be escalated in order to reach the goal of reducing maternal deaths to below 250 per 100,000 births by 2016 (see Figure 2).

- **Stagnating fertility decline.** UP's total fertility rate (TFR)—which represents the average number of lifetime births per woman by the time she reaches age 50—dropped significantly in the early 1990s, but the pace of the decline has leveled off since then (see Figure 3). The TFR is currently 3.8 children per woman—far higher than the Population Policy goal of 2.1 children per woman by 2016, which represents the number of children needed to replace their two parents under low mortality conditions.

Figure 1. Trends in infant and child mortality to 2006 and reduction in mortality needed to reach the Population Policy goals in 2016
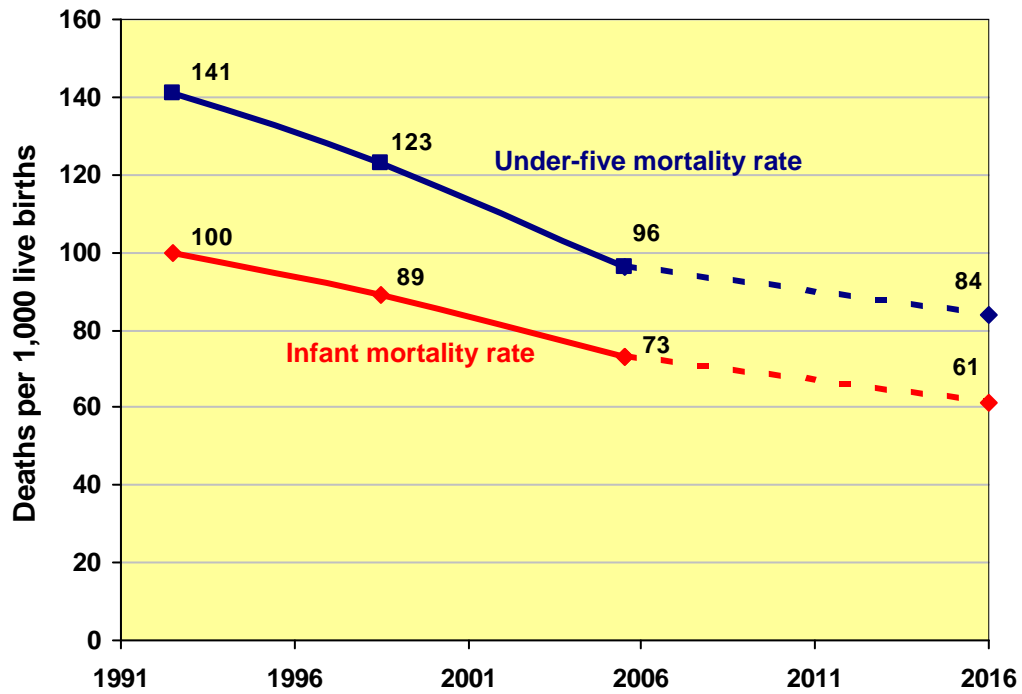
Sources: NFHS-1, -2, and -3; DemProj and FamPlan model projections for 2006–2016

Figure 2. Trends in the maternal mortality ratio and reduction in mortality needed to reach the Population Policy goals in 2016

Source: India Sample Registration System

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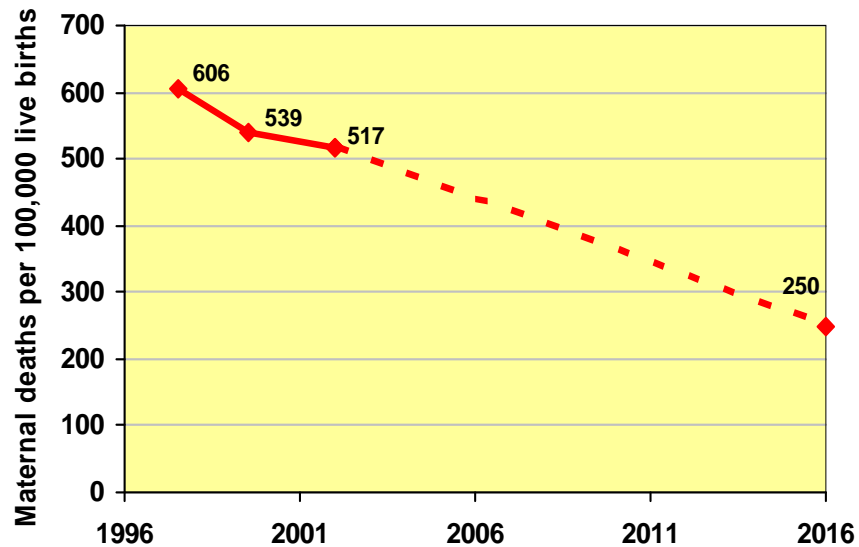
Figure 3. Trends in fertility to 2006 and decline in fertility needed to reach the Population Policy goals in 2016
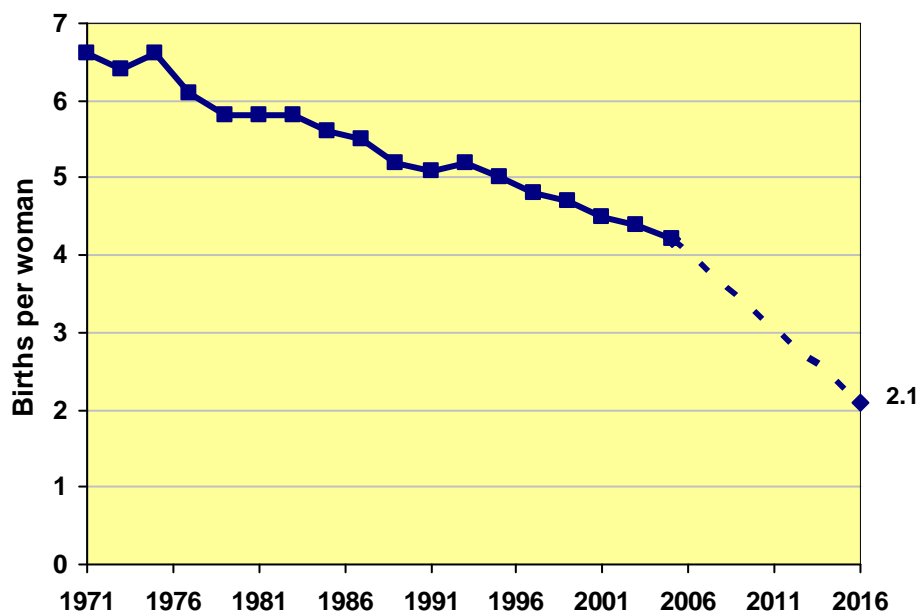
Sources: NFHS-1, -2, and -3; DemProj and FamPlan model projections for 2006–2016

Population projections for India and States (2006) anticipate that UP's population of 186.8 million people in 2007 is likely to grow to 218 million by 2016. UP is currently the most populous state in India and will remain so for at least the next two decades. In addition, maternal and child mortality levels remain high in UP, compared with the national average and levels in other states (Technical Group on Population Projections, 2006).

III.   THE BENEFITS OF ACHIEVING THE UP POPULATION POLICY GOALS

Achieving the UP Population Policy goals requires reducing UP's high unmet need for family planning. One in five (21%) married women have an unmet need, which is defined as the proportion of women who want to delay or limit childbearing but are not using any family planning method (traditional or modern). The population and family planning projection scenarios developed by the Health Policy Initiative assumed two different paths for fertility and family planning use based on unmet need (Health Policy Initiative, 2007):

- Under the **Constant Scenario**, unmet need remains constant through 2016. The current fertility level and the proportions of various contraceptive methods used ("contraceptive mix") will continue to remain at current levels well into the future.

- Under the **Zero Unmet Need Scenario**, unmet need is gradually met and eliminated by 2016. Increased use of modern family planning methods will lead to fertility levels in line with the UP Population Policy.

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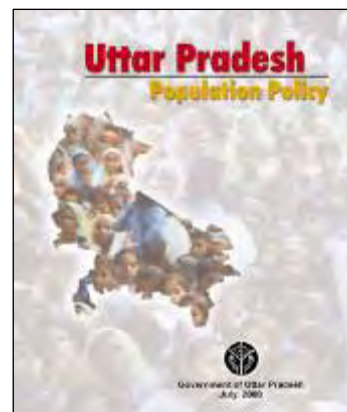
Local and international experts examined these projections to determine the potential benefits of achieving the goals of UP's Population Policy by reducing unmet need. Two main types of benefits were discussed: (1) enhanced child and maternal survival, achieved family size, and reduced childbearing risks; and (2) improved opportunities for socioeconomic development of the population.

Desired Family Size Achieved, Childbearing Risks Reduced, and Maternal and Child Survival Enhanced

Achieved family size. Although the current TFR is 3.8 children per woman, UP couples want to have smaller families—on average about 2.3 children (based on data from the NFHS-3, 2005–06) (see Figure 4). The Population Policy aims to help couples achieve their desired family size, which is close to the replacement fertility goal of 2.1.

Figure 4. Achieving the fertility goal will help couples achieve their desired family size

Source: NFHS-3, fact sheet http://www.nfhsindia.org/pdf/UP.pdf
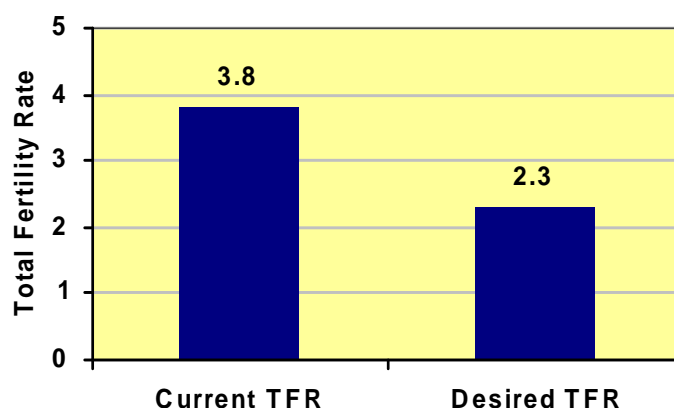
Reduced childbearing risks. High-risk births are major causes of illness, disability, and premature death among mothers and children (UNICEF, 2004; WHO, 2004). High-risk births are defined as those that are spaced less than two years apart or born to mothers who are younger than 18 or older than 34 or who have more than three children (NFHS-3, 2007). Analysis of the NFHS-3 data indicates that about half (51%) of births in UP fall under one or more higher risk pregnancy categories due to the mother's age, repeated childbearing, and/or short birth intervals:

- *Too early* (when the mother is younger than 18 years old): 12 percent

- *Too late* (when the mother is older than 34 years old): 25 percent

- *Too often* (when the mother has had three or more births): 40 percent

- *Too soon* (when a birth occurs less than two years after a previous birth): 24 percent

Similar categorizations of mothers by risk category are not readily available because information on mothers who have died is often inadequate. The evidence for elevated risk for mothers comes from a study in rural Bangladesh that found that women with higher parity (meaning lifetime number of births per woman) had higher maternal mortality than women with fewer children (Chen et al., 1974). Other studies have supported these findings (WHO, 1994; UNFPA, 2003).

Figure 5 confirms that the highest infant mortality rates in UP occurred among babies belonging to high-risk groups. Infants born to women under age 18 and those spaced fewer than 24 months after a previous birth were more likely to die before their first birthday, compared with those born to older mothers or at longer birth intervals. In regard to family size, the first birth has the highest risk of death in the first year of life, closely followed by the fourth or higher birth.

Figure 5. Infant mortality rate by risk categories
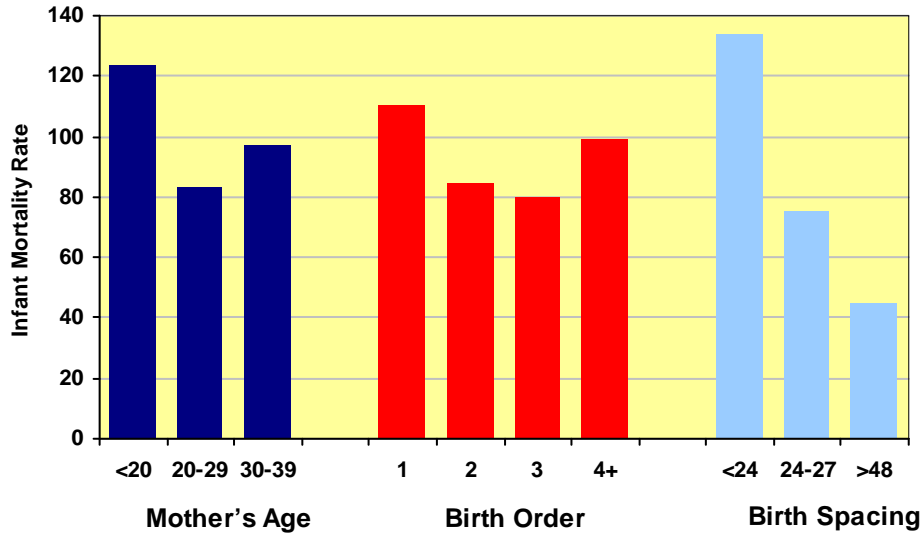
Sources: NFHS-2 and -3

Experts estimate that the widespread use of family planning could lower maternal mortality ratios by 20 percent and infant mortality rates by as much as 25–30 percent in developing countries. Spacing pregnancies farther apart can help women affected by anemia and malnutrition to become healthier and better prepared for pregnancy in the future and thus to have healthier babies. For women for whom pregnancy poses substantial health risks and for those who do not want any more children, voluntary sterilization can be an option to prevent pregnancy permanently.

If UP decreased the unmet need for family planning, fertility would also decline to near replacement level by 2016. Reducing the TFR is likely to reduce the number and proportion of high-risk births, with the latter estimated to decline from 51 percent in 2006 to 39 percent in 2016. If high-risk births were to decline to 39 percent of all births in 2016, then the child survival goals of the UP Population Policy would be exceeded (see Figure 6).

Figure 6. Recent declines in infant and child mortality and projected declines associated with the reduction of high-risk births
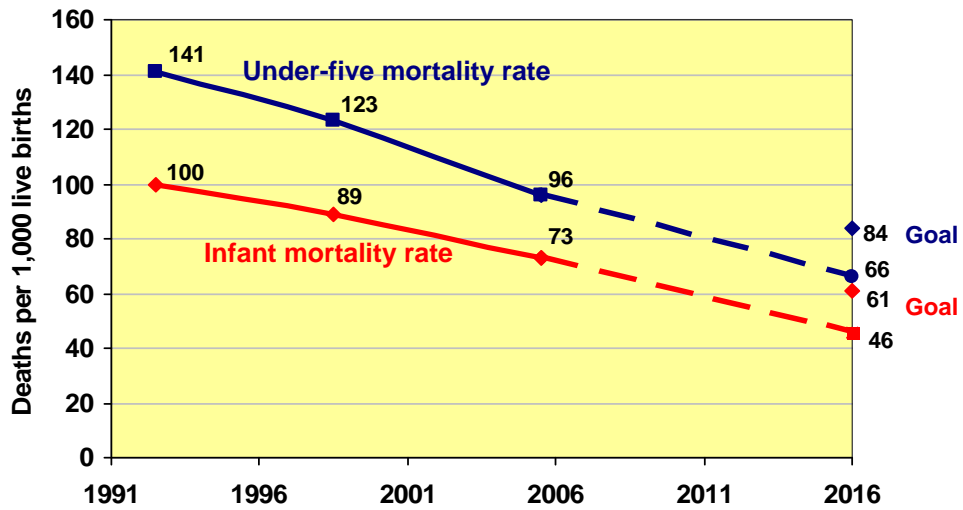
Sources: NFHS-3; DemProj and FamPlan model projections for 2006–2016

Data from India's Sample Registration System show some improvement in maternal mortality in recent years. However, greater efforts will be needed to accelerate the rate of decline if UP is to achieve its Population Policy goal of fewer than 250 maternal deaths per 100,000 births by 2016. If the proportion of high-risk births declined to 39 percent of births in 2016, maternal mortality would also drop, and UP could achieve its Population Policy goal for fewer maternal deaths (see Figure 7).

Figure 7. Maternal mortality ratio for 1997–2003 and projected decline associated with the reduction of high-risk births

Source: India Sample Registration System

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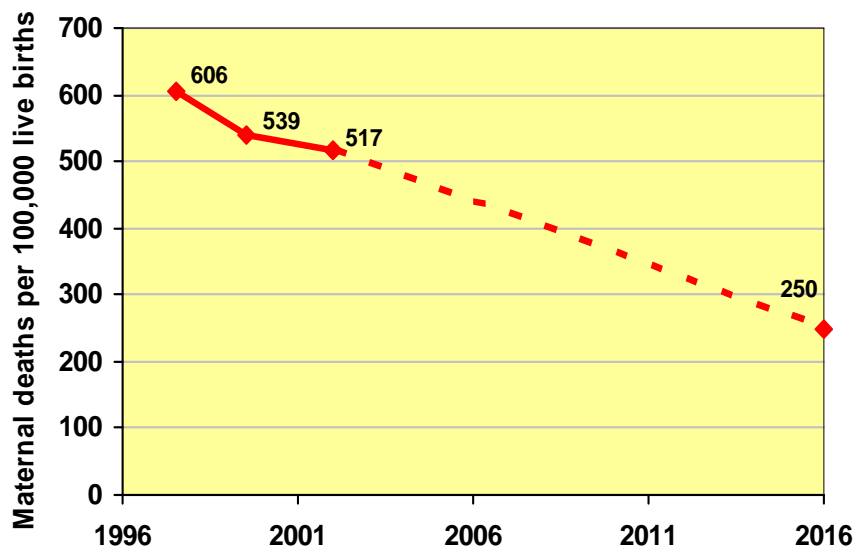
In summary, meeting unmet need for family planning reduces fertility rates, leading to improvements in women's and children's health. These improvements could be observed within a decade if unmet need was eliminated by 2016.

Improved Opportunities for Socioeconomic Development

UP has numerous challenges in furthering socioeconomic development. Many of these challenges are shaped or exacerbated by high fertility and rapid population growth. Focusing on the Constant and Zero Unmet Need scenarios discussed during the roundtable meetings, the Health Policy Initiative conducted an abbreviated RAPID analysis to examine some of the socioeconomic implications of the two population projections.

As shown in Table 1, if the current trends continue, UP will have to make even larger investments in education and health services to meet the needs of the 234 million people projected for 2016. In contrast, if half of the women in UP were to use modern contraceptive methods, average family size could decline to 2.3 children per woman in 2016, thus making future investments in education and health services more manageable. The changes made in the next few years will set the stage for even greater savings within two decades if the projections are extended to 2026.

Table 1. Comparison of two RAPID Model projection scenarios for UP

Socioeconomic Indicators	Projection Scenarios			
	Zero Unmet Need 2016	Constant 2016	Zero Unmet Need 2026	Constant 2026
Education Requirements				
Children in primary school-going ages (in millions)	38	40	29	51
Primary students (in millions)	24	26	18	33
Primary teachers required	473,000	503,000	363,000	642,000
Recurrent primary school expenditures required (US$, billions)	$1.11	$1.18	$0.85	$1.51
Health Service Requirements				
Doctors required (constant service ratio)	44,000	47,000	48,000	58,000
Nurses required (constant service ratio)	70,000	75,000	77,000	93,000
Health centers required (constant service ratio)	33,000	36,000	37,000	44,000
Recurrent health expenditures (US$, billions)	$5.7	$6.1	$6.3	$7.5
Demographic Indicators				
Total population (in millions)	219	234	241	290
Dependency ratio (Population ages 0–14 and 65+ for every 100 ages 15–64)	55	65	42	67
Population 0–14 years old (in millions)	66	81	56	100

Source: DemProj and RAPID model projections using UP government data

A comparison of the two projection scenarios shows that if current fertility and family planning levels remain constant, UP's population could reach 234 million in 2016. However, if UP achieves the goals of the Population Policy by 2016, the total population would be about 219 million—on par with the 218 million stated in the government's 2006 projection (see Figure 8). Achieving the Population Policy goals fosters significant potential for families in UP to achieve their socioeconomic aspirations and for the state to make progress toward achieving its development objectives. The outlook for socioeconomic development would be much brighter—fewer children requiring primary schooling, fewer teachers and health providers needed, and lower public sector expenditures just to maintain current levels of education and health services. The potential savings could be tapped to improve the quality of health and education services.

Figure 8. Projected UP population growth based on current fertility ("Constant") and the attainment of Population Policy goals ("Zero Unmet Need")
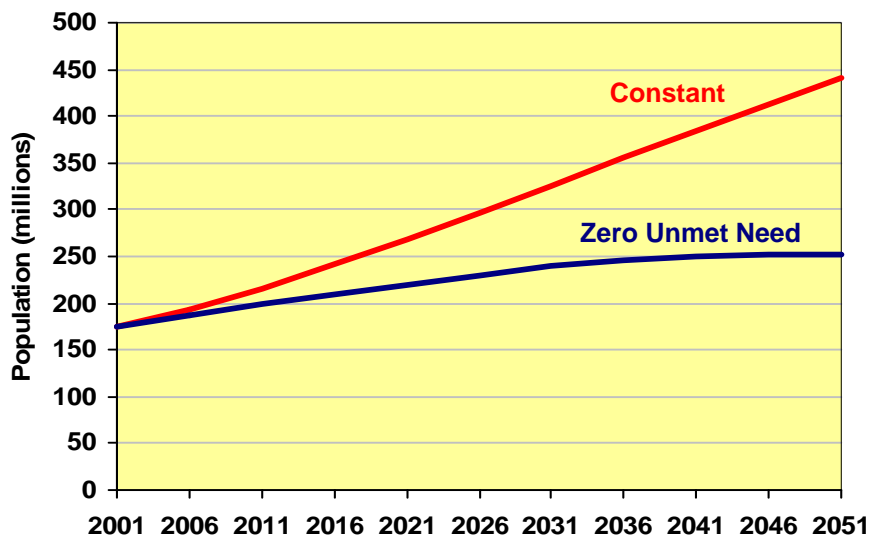
Sources: DemProj and FamPlan model projections 2006–2051

Additional socioeconomic benefits can be realized if the ratio of working-age people to dependents (the young and old) remains relatively high. If unmet need is eliminated by 2016 and fertility reaches replacement level (Zero Unmet Need scenario), the proportion of the population in the young dependent ages (0–14 years old) becomes smaller (see Figure 9). This implies fewer young children needing basic health and nutrition services, as well as primary schooling. At the same time, the proportion of the population in the prime working ages (15–64 years old) becomes larger. If the Population Policy goals were achieved through decreased unmet need for family planning, UP's dependency burden would be lower.

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Figure 9. Achieving the goals of the Population Policy will produce a more balanced age distribution

Zero unmet need by 2016

Male
Female
75-79
60-64
45-49
30-34
15-19
0-4

Constant unmet need thru 2016

Male
Female
80+
70-74
60-64
50-54
40-44
30-34
20-24
10-14
0-4
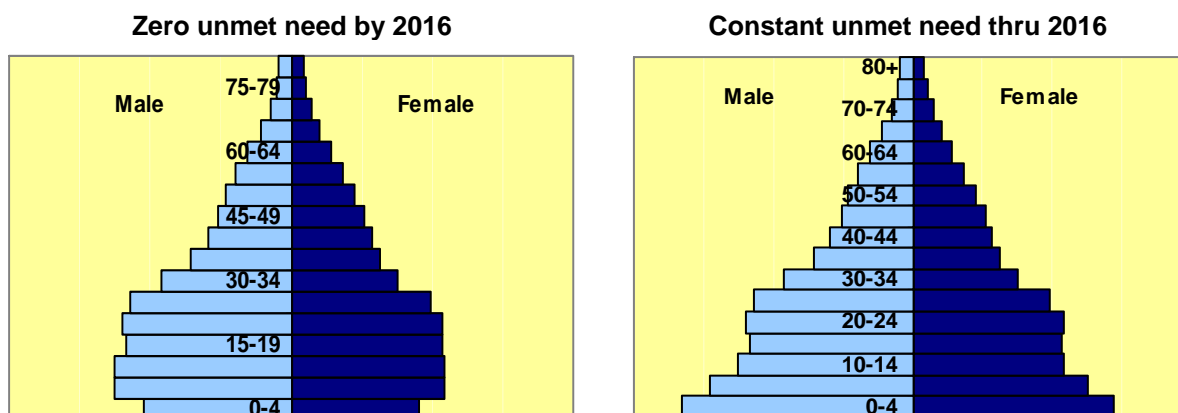
Source: DemProj and FamPlan model projections for 2006–2016

Declining fertility was a key factor in the Asian "economic miracle." For example, Thailand's total fertility rate fell from 6.4 children per woman in 1960 to 3.5 in 1980 and then to 2.3 in 1990—only a decade later. During this period, GDP per capita rose from US$332 in 1960 to US$798 in 1980 and US$1,427 in 1990. Modern economies are dependent on a smaller, highly productive labor force rather than a larger labor force of unskilled workers—emphasizing the capacity of the population rather than sheer numbers. Meeting unmet need will lead to a decline in fertility, which means that more resources will be available for education and health services and for agricultural modernization. With declining fertility, countries can generate higher levels of savings and investment to drive economic development.

IV.   CHILDBEARING PREFERENCES AND NEEDS

Reaching the goals of the UP Population Policy will require efforts to decrease unmet need in order to decrease fertility. UP's Reproductive and Child Health Program has improved and expanded family planning services over the past decade. Nevertheless, two important client-focused challenges need to be addressed: (1) high unmet need for family planning and (2) a mismatch between demand and method mix.

High unmet need for family planning. Unmet need is defined as the proportion of women who want to delay or limit childbearing but are not using any family planning method (traditional or modern). Based on the NFHS-3 data, one in five (21%) currently married women in UP had an unmet need for family planning in 2005–06; 12 percent of women surveyed did not want any more children; and an additional 9 percent wanted to delay their next birth at least two years but were not using family planning (see Figure 10). Thus, almost 8 million UP couples are not using family planning but want to limit fertility or space births.

Figure 10. Percent and number of married women who wish to limit or space future births but are not using contraception
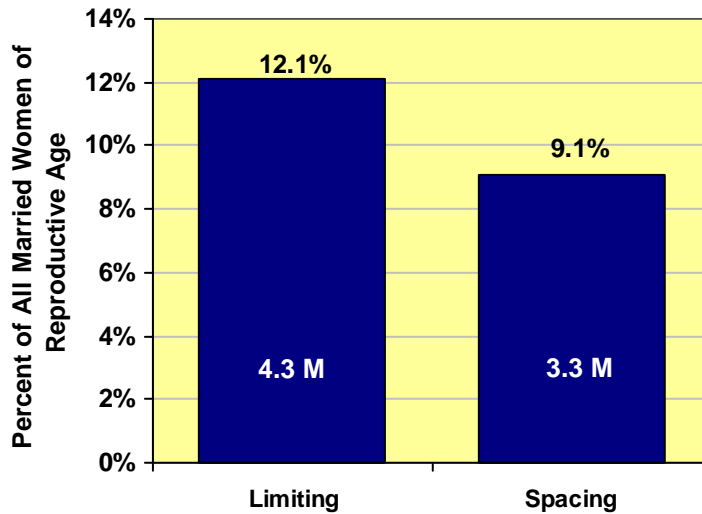
Source: NFHS-3

The current high level of unmet need suggests great potential for increased family planning use. If current users of traditional family planning methods were to shift to modern methods, current users of modern methods were to continue to use them, and all potential users were to choose modern methods, use of modern methods could rise to 64 percent (see Figure 11). This level is greater than the 52 percent goal for use of modern methods by 2016 in the UP Population Policy. In summary, achieving 52 percent modern family planning use is attainable.

Figure 11. Potential for greater use of modern family planning methods
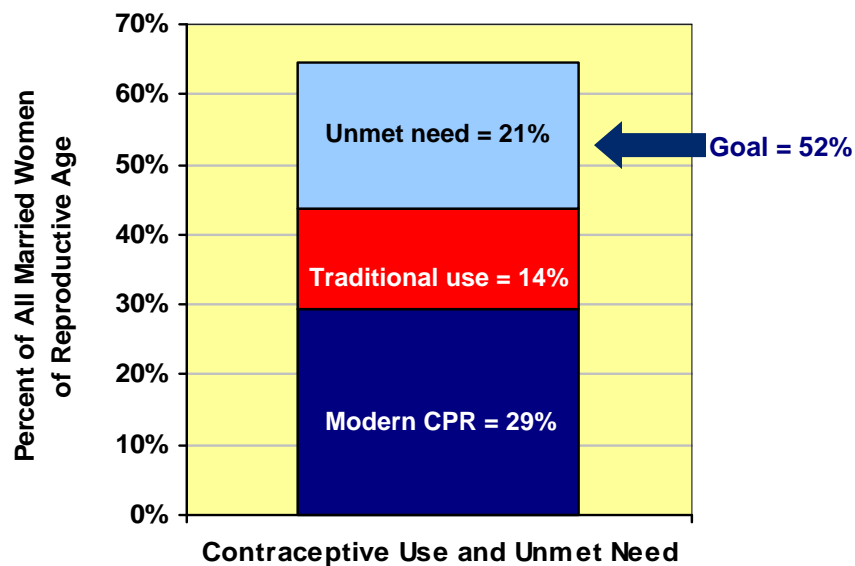
Sources: NFHS-3 and UP Population Policy

Mismatch between demand and method mix. Three in five current family planning users wish to limit future births, while two in five current users wish to space future births. However, the mix of family planning methods being used does not match these profiles (see Figure 12). While 38 percent of married women of reproductive age (MWRA) say they want to limit future births and are using an FP method, about half (54%) of these women are using female sterilization while the rest are using spacing methods such as condoms or pills. A large proportion of current FP users are using traditional methods (primarily rhythm) that have high failure rates and thus are ineffective for spacing and limiting births.

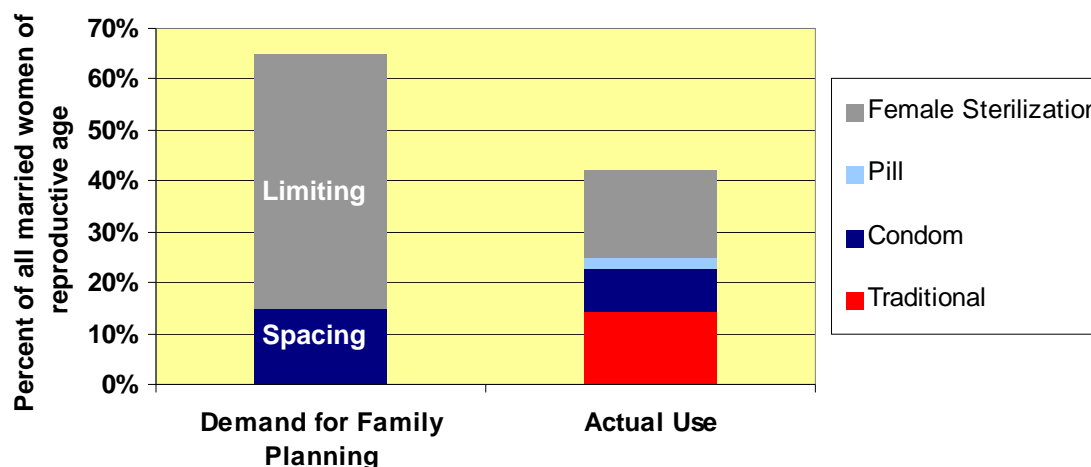**Figure 12. Percent of married women wishing to limit or space births and current contraceptive use by method**

Source: NFHS-3

Women in UP, as in other states of India, tend to select from a small number of FP methods. Female sterilization is the most popular FP method and is used by 17 percent of MWRA. The condom is next in popularity and is used by 9 percent of MWRA. Other modern methods—the pill, IUD, male sterilization, and injectable—combined are used by less than 4 percent of MWRA. Traditional methods, mainly rhythm, are used by 14 percent of MWRA.

The specific reasons for the high unmet need and the mismatch in demand and method mix cannot be determined from available NFHS data for UP. However, NFHS data for India nationally and data from around the world point to the following as the main reasons for non-use of contraception among women at risk of unintended pregnancy (UNFPA, 2004):

- Lack of accessible family planning services, especially for those living in rural and remote areas

- Shortages of commodities, materials, equipment, and providers, especially trained ones

- Concerns about health or fear of contraceptive side effects

- Lack of method choices appropriate to the situation of the woman and her family

- Clients' lack of knowledge about the availability, effectiveness, and safety of contraceptive choices

- Lack of spousal, family, or community support

- Insufficient counseling or follow-up (e.g., those experiencing side effects must be counseled on proper use, dosage, or method-switching)

- Financial constraints

- Actual or perceived religious opposition

V. RECOMMENDED POLICY ACTIONS AND STRATEGIC DIRECTIONS FOR UP

At the meeting in Lucknow, UP policymakers and other key stakeholders recommended specific strategies and interventions to address the main barriers to accessible, high-quality family planning services; to ensure a demand-driven Reproductive and Child Health Program; and to move UP closer to population stabilization. More than 60 stakeholders attended, including high-level officials from the UP Ministry of Health and Family Welfare, the National Rural Health Mission, public health agencies, NGOs, and academia. The stakeholders adopted the following recommendations:

Make communication strategies more focused and strategic. UP must develop and implement more focused communication strategies to reach the target populations with relevant and appropriate information.

- Considering the importance of sociocultural factors, the key audiences for communication should include mothers-in-law and husbands—the main decisionmakers at the household level. Health-related messages—such as "mothers-in-law care," "family planning saves children's lives," or "modern contraceptives can prevent unsafe pregnancies"—need to be created to reach these specific audiences.

- General communication strategies should also emphasize the socioeconomic benefits of family planning, such as allowing mothers and fathers to work and save money so that their children can attend school and family members can have a better future.

- Many women who use traditional methods for birth spacing experience high rates of unintended pregnancy due to method failure, incorrect use, or inconsistent use. Health providers need to provide women using traditional methods with complete and accurate information on correct use of these methods, as well as information on modern contraceptive methods so that they can make an informed choice.

> "The communication efforts should be intensified and whatever amount of money and time is required should be provided so that couples who want to adopt a family planning method should be reached with correct information and services."
> ~ Ms. Nita Choudhary, Principal Secretary, Health and Family Welfare, UP

Strengthen community participation. UP must strengthen community participation and fine-tune strategies to identify and sensitize local leaders in the communities. This is especially important in communities where local groups oppose family planning. Such groups might launch campaigns to block the implementation of family planning policies or programs or prevent segments of the population from availing of family planning information and services. Other community members might not be well-informed about the benefits of family planning and sources of contraceptive methods.

- The Reproductive and Child Health Program can broaden its outreach by involving community leaders to mobilize local groups in mass information campaigns about the benefits of family planning to families and the community.

Village women seeking information about reproductive health vouchers in Agra.

- Community leaders can foster the active participation of household members, particularly mothers-in-law and husbands, who are often the ones who make family planning decisions. Much can be achieved if these key household members are involved in community campaigns aimed at wider appreciation of the benefits of family planning for maternal and child health.

- Involving community leaders and representatives in dialogue with UP policymakers and other stakeholders is also important in identifying and addressing barriers to access and in promoting community ownership of the Population Policy goals. Various stakeholders should also be involved in assessing and implementing policies and programs.

Stimulate private sector involvement and public-private collaboration. The private sector should be engaged more fully, as it encompasses NGOs, cooperatives, commercial entities, and private health providers.

- The policy environment to determine and address the disincentives to private sector involvement in family planning services must be reviewed and barriers to their active engagement removed.

- To expand the role of the private sector in family planning, the Reproductive and Child Health Program must identify the different market segments for family planning services and assess the capabilities and reach of service delivery mechanisms and providers.

- The Reproductive and Child Health Program should also work to build partnerships with NGOs and other private groups on a large scale that reach out to the poor and other vulnerable populations with family planning services.

- Cooperatives—especially those in the agricultural, manufacturing, and service sectors—need to be involved so they can help disseminate family planning information and provide support services to their members.

- Large commercial or manufacturing establishments with in-company health services are also potential partners in increasing access to family planning services.

Make postpartum family planning a standard service. "Jannani Suraksha Yojna," which encourages women to deliver in health facilities, is a highly popular program under the National Rural Health Mission in UP and has succeeded in increasing the number of institutional deliveries. This program can serve as a model for the integration of postpartum family planning as a standard service within delivery institutions in UP. These programs can also reach women during their stay at the health facilities, provide them with family planning information, and motivate them to consider using family planning. Doctors, nurses, and accredited social health activists (ASHAs) can

Villagers gathered for a discussion on vouchers in Agra.

all play a role. The postpartum setting is also an opportunity to reach out to husbands and mothers-in-law, as one or both usually accompany the woman for delivery.

Ensure contraceptive security. "Contraceptive security" means that all people are able to choose, obtain, and use high-quality contraceptives whenever they want and need them. The roundtable discussions reaffirmed the importance of ensuring the timely supply of services and commodities to achieve the goals of the Population Policy. Participants emphasized the provision of high-quality family planning information, counseling, products, and services through various channels, including public institutions, the network of ASHAs, and nongovernmental service delivery organizations.

- Contraceptive choices must be expanded. The NFHS-3 data and the Health Policy Initiative analysis showed that the current contraceptive method mix does not match the needs of women and couples. The family planning program must develop a strategy to provide men and women all over UP with a broader array of contraceptive method choices.

- The Reproductive and Child Health Program must ensure that family planning services are accessible. Women who are poor or living in remote areas have difficulty accessing services due to limited clinic opening hours or lack of information on the days or times that the services are available. Roundtable participants stated that more regular provision of services in health clinics is needed.

- Other barriers to continued family planning use must be removed. Pill users, for example, receive only a one-month supply; roundtable participants recommended a three-month supply.

This woman used vouchers to obtain antenatal and postnatal care in Agra.

Produce higher quality data and analysis. The identification of specific family planning needs requires statistical and health systems that provide high-quality, region-disaggregated data on basic population and health information. Moreover, information on gender, caste, religion, language, and other socioeconomic factors is needed to effectively develop targeted communication, service, and outreach strategies and interventions.

At the second meeting in New Delhi, senior policymakers from the Ministry of Health and Family Welfare further discussed meeting unmet need through repositioning family planning within the overall package of reproductive and child health interventions in UP. Participants deliberated on the state-specific interventions identified during the Lucknow roundtable and then generated targeted actions to ensure contraceptive security, strengthen communication strategies, and increase community involvement in decisionmaking. These target actions include the following:

- Increase the availability of maternity, RH, and child health services by having round-the-clock services in a minimum of 10 percent of primary health centers, as is being done in other states.

- Conduct a study on the acceptability of the multi-load copper intrauterine device. (This IUD is not currently available in UP's public health services. Medical specialists believe that it has fewer side effects than other IUDs. If the study confirms this finding, adding the multi-load IUD to the state's array of FP methods could attract more users and encourage use over 3–5 years, thus reducing the risk of infection associated with IUD removal under field conditions in UP.)

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- Expand the basket of family planning methods available under UP public services in order to offer more method choice. (Methods that are not currently offered include female condoms, the multi-load copper IUD, pre-loaded Copper T380A IUD packages, emergency contraceptive pills, and the standard days method. Pre-loaded IUDs reduce the risk of infection from insertion and, thus, are recommended by medical specialists.)

- Improve access to high-quality services by having fixed days for sterilization instead of periodic sterilization days. (This change would increase women's confidence in the availability of services and also decrease the long waiting times that are associated with periodic sterilization days. Physicians providing sterilization services often arrive late at service sites and thus cannot provide services to all the women waiting for them.)

These recommendations are consistent with the National Program Implementation Plan for reproductive and child health services during 2005–2010 (Government of India, 2005).

Participants agreed that further dialogue on these actions is needed, as well as the UP government's formal commitment to implementing them. If the actions achieved their desired results, the total fertility rate in the state would likely decline, thereby making important progress toward achieving the Population Policy goals of UP and India.

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