

Dynamics of fertility and family planning among the urban poor in India: findings from NFHS 2, 3 and 4

Extended abstract:

Background :

India, as the rest of the developing world, is urbanizing rapidly. India's urban population nearly doubled from 217 million in 1991 to 285 million in 2001 to 377 million (31%) in 2011. It is expected to increase to 600 million by 2031 an increase of over 200 million in just 20 years (Government of India, Planning Commission, Twelfth Five Year Plan, 2012). Slums are home to 65.5 million persons which constitute about 17.4 percent of the urban population as per the 2011 census.

India's urban population grew by 31.8 per cent during the decade 2001-11 which is significantly higher than the rural population growth rate of 12.2 per cent. Accompanying this rapid pace of urbanization has been a fast growth in the population residing in slums. The decadal growth of slums has been 25.4 percent during 2001 and 2011.

Slums are characterized by crowded living conditions, unhygienic surroundings and lack of basic amenities such as garbage disposal facilities, water and sanitation. The near total absence of civic amenities coupled with lack of primary health care services in most of the urban poor settlements have an adverse impact on the health status of their residents. The health of the urban poor is significantly worse off than the rest of the urban population and is often comparable to the health conditions in rural areas (Agarwal et al., 2007).

Data and Methodology : We use data from the three rounds of the National Family Health Surveys (NFHS 2, 3, and 4) conducted between 1998-99 to 2015-16. Taking the bottom quartile of the urban sample as representative of the urban poor, we compare the (i) trends in health indicators of the urban poor from across the three rounds and (ii) trends in disparity in the indicators across the urban poor and rest of the urban population among fertility and family planning indicators.

Results :

We find that there has been a considerable improvement in the fertility and family planning indicators among the urban poor. The TFR has decreased sharply from 3.8 in 1998-99 to 2.8 in 2004-05 to 2.28 in 2014-15. While the TFR among the non-poor has reached below replacement level in NFHS-3 (1.84), there has been marginal dip in TFR (1.6) in NFHS-4. The disparity between the poor and non-poor has narrowed between the two time periods.

There has been a stagnation in the mCPR (Modern Contraceptives Prevalence Rate) among the urban poor (48.7 in NFHS-3 and 47.1 per cent in NFHS-4) and unmet need among the urban poor (14.1 in NFHS-3 and 13.3 per cent in NFHS-4). The use of spacing methods has improved among the urban poor (7.6 in NFHS-3 to 11.7 in NFHS-4), but there has been a deterioration in the use of limiting methods (41.1 in NFHS-3 to 35.3 in NFHS-4).

There has been a deterioration in the use of modern contraceptive methods (58 % in NFHS-3 to 52.3 in NFHS-4) and unmet need (8.3% in NFHS-3 to 12.1% in NFHS-4) among the rest of the urban poor. The relative stagnation of mCPR and unmet need among the urban poor and the

deterioration of these indicators among the rest of the urban population has resulted in the narrowing of the intra-urban disparity.

The adolescent fertility rate among the urban poor has declined from 103 in NFHS-3 to 63 per 1000 married women in the adolescent age (15-19 years) in NFHS-4. The indicator among the remaining urban population also declined from 42 to 26 between NFHS 3 and 4.

34.6 percent of births among urban poor are higher order (3 or above) and 33.5 percent of the births are closely spaced (less than 24 months). These birth characteristics are associated with higher incidences of neonatal and maternal mortality and higher rates of low birth weight and subsequent undernutrition (IIPS and ICF Macro, 2017). It is noted that in NFHS-4 unplanned births among the lowest urban quartile were 20.3 percent of all births, including unwanted (12 %) or mistimed (8.3%) compared with 17.1 unplanned births among the rest of the urban population.

In terms of initiation of use of family planning methods, in NFHS-4, we find that only 9.6 percent of users of contraception among the urban poor initiated FP when they had no children. Another 28.6 percent of urban poor users initiated FP after the first child. Over two-thirds of users of contraception initiated the use after the birth of the second or subsequent child. Although the initiation of family planning among the rest of the urban population is not encouraging either, they initiate FP at an earlier stage than the urban poor. It is also noted that the median parity at sterilization is 3 children among the urban poor and 2 children among the rest of the urban population. This indicates that among the urban poor sterilization which dominates the FP method mix is adopted at high parity which is associated with substantial risk of unintended pregnancies, which in turn drain the mother's health and nutrition.

It is also noted in NFHS-4 that 17.7 % of non-users of family planning have been ever approached by a health worker to talk about family planning. This indicates the relative neglect by the family planning program especially of short acting methods and of newly married and zero-parity couples. The drive of the program seems to be on permanent methods and more recently on post-partum methods of IUCD (MoHFW, 2016). The new methods of injectables and the weekly contraceptive pills are mired with supply issues and are yet to make a significant dent in method choice and CPR.

Discussion and Conclusion

While the decrease in TFR approaching replacement fertility might be comforting, the mCPR continues to plateau and the rates of teenage pregnancies, unwanted and mistimed pregnancies and closely spaced births continue to be high among the urban poor. This has implications on women achieving their reproductive rights and intentions as well as grave consequences on the health of the mothers themselves and their newborns.

The decline in TFR without an increase in mCPR has been attributed to - increased rate of spousal separation due to a) male migration for livelihood, b) an increase in marriages (and therefore first birth) at a later age, c) increased spousal separation due to migration, and d) a rise in abortions and emergency contraceptive use, and infertility (Abt Associates, 2016). The aspect of migration along with the reduced perceived risk of pregnancy is most relevant and critical with respect to the contraceptive requirements of the urban poor.

Owing to this infrequent—and often short term—contact, spouses of migrant men have distinct contraceptive needs that require customized behavioral and marketing strategies (Mahapatra et

al., 2020, Mukherjee et al., 2021). The FP needs of this group must be explored, validated, and addressed because the population of migrant workers will likely continue to grow with increasing urbanization. The proportion of married women reporting spousal separation due to work grew from five percent in NFHS-2 to 10 percent in NFHS-3 and 17.7 percent in NFHS-4 (Abt Associates, 2016).

India will need to address the contraceptive needs of its underserved populations, especially young women. This group, in particular, is in the most fertile years of the reproductive period yet reports low contraceptive use and is not ready for a limiting FP method. Accredited Social Health Activists (ASHAs) need to be incentivized to reach out to newly-married women and women without children and challenge the cultural norms of having children immediately after marriage through appropriate health behaviour promotion methods.

The focus is mostly on limiting methods and IUD, which are also accompanied with incentives for ASHAs, while for most of the young women who recently get married prefer short acting methods. Studies have noted that Oral Contraceptive Pills (OCPs) are the most popular method among this group and that supplies of short acting methods especially OCPs have been erratic both in the public and private sectors (Abt Associates, 2016). There is limited reach of the public sector in the slums and similarly vulnerable urban habitations, and the large reach of the private sector (including social marketing programmes) in urban areas. The private sector social marketing programmes should be leveraged and the reach of the public sector improved to meet the spacing needs of the urban poor.

Family planning seems to have taken a backseat with reduction in TFR. We note that frontline workers talk more about immunization rather than family planning during household visits. The increase in the rates of antenatal care, institutional deliveries, vaccination can be leveraged to promote family planning by integration of FP services during ante-natal and postnatal contact. The high rates of unmet need during the post-partum period can be addressed by promoting need based postpartum family planning services.

The urban poor also have deprived socio-economic conditions in terms of women's education, employment status, empowerment, social networks etc and have poorer access to entitlements in terms of aadhar cards, bank accounts and have poor living conditions. This further affects the health seeking behavior and compromises access to and utilization of services including family planning. In addition to addressing the immediate service gaps with regard to family planning services, the broader socio-cultural challenges and illegality associated with housing and habitations of the urban poor also need to be addressed for sustainable improvement in their health conditions towards fulfillment of SDG 11 and 3.

References

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