P.L.RAJ IAS & IPS ACADEMY

Building Bureaucrats Since 2006

6. NFHS-6 Report 2023–24 - From Demographic Targets To Reproductive Autonomy

The National Family Health Survey-6 (NFHS-6), covering the survey period 2023–24, presents a nuanced and in many ways contradictory picture of India's family planning landscape. On one hand, India's Total Fertility Rate has stabilised at 2.0 — below the replacement level of 2.1 — signalling the demographic success of decades of family planning investment. On the other hand, the internal composition of contraceptive use reveals persistent gender inequities, a regression toward unscientific methods, and a healthcare infrastructure still oriented around compliance targets rather than reproductive autonomy. The NFHS-6 marks a critical juncture - the demographic dividend is being captured, but the quality of reproductive choice available to Indian women — particularly in rural areas — remains deeply inadequate.

1.Understanding Key Concepts

Before examining the data, clarity on the conceptual framework is essential for both examination and policy purposes.

1. **Total Fertility Rate (TFR)** is the average number of children a woman would have during her reproductive years (15–49 years) if prevailing age-specific fertility patterns continued. It is the most widely used summary measure of fertility in a population.
2. **Replacement Level Fertility** is the fertility level at which one generation exactly replaces itself with the next — generally set at approximately 2.1 children per woman. The slightly above-2.0 figure accounts for child mortality before reproductive age, the sex ratio at birth, and the possibility that some women will not survive to reproduce. When fertility falls and remains below replacement level for a prolonged period, the population eventually begins to decline unless offset by immigration or population momentum from existing young age structures.
3. **Contraceptive Prevalence Rate (CPR)** is the percentage of women (or their partners) using any form of contraception at a given point in time, typically measured among married or in-union women aged 15–49 years. CPR is the headline indicator of family planning programme coverage.
4. **Modern Methods vs Reversible Methods -** This distinction is central to reading the NFHS-6 data correctly. Modern methods include all scientifically recognised contraceptives — both permanent (female sterilisation, male sterilisation) and temporary spacing methods (pills, IUDs, condoms, injectables, implants). Reversible methods refer exclusively to temporary methods that allow fertility to be regained after discontinuation — IUDs, condoms, pills, injectables, and implants. The distinction matters because a high CPR dominated by permanent sterilisation reflects demographic control, not reproductive autonomy. A high share of reversible methods reflects genuine choice, spacing agency, and gender equity in family planning.

2.Key Findings of the NFHS-6 Report

1. **Total Fertility Rate at 2.0 -** India's TFR has stabilised at 2.0 — marginally below replacement level. This represents a demographic milestone - India has crossed into sub-replacement fertility at the national level. However, this aggregate mask severe regional disparities, with northern states like

Bihar and Uttar Pradesh still recording TFRs well above replacement, while southern and western states have already entered very low fertility territory.

2. **Marginal rise in Contraceptive Prevalence Rate -** The overall CPR increased modestly from 66.7% in NFHS-5 to 69.1% in NFHS-6 — a positive directional trend reflecting expanded programme reach. However, the headline CPR number conceals more than it reveals about the quality and equity of contraceptive access.
3. **Female sterilisation dominance — the gender skew -** Female sterilisation remains the overwhelmingly dominant contraceptive method at 36.5% nationally, rising to 38.1% in rural areas. Male sterilisation, by contrast, accounts for a negligible 0.5%. This 73-to-1 ratio between female and male sterilisation is among the starkest manifestations of gender inequality in India's healthcare system. The permanent, irreversible physical burden of family planning — including surgical risks, recovery periods, and long-term health implications — is placed almost entirely on women, while male partners bear virtually no contraceptive responsibility.
4. **Reversible method deficit — the critical regression -** The most alarming finding in the NFHS-6 data is not the overall CPR but the shift within the method mixes. Reliance on modern, spacing-oriented reversible methods — pills, IUDs, condoms, injectables — declined from 56.4% in NFHS-5 to 52.7% in NFHS-6. Simultaneously, reliance on unscientific traditional tracking methods — calendar method, rhythm method, and similar approaches — spiked sharply from 10.3% to 16.4%. This is a troubling double regression - women are moving away from sterilisation (a positive development in terms of reversibility) but moving toward traditional methods rather than modern reversible alternatives. This suggests that the public health infrastructure has not yet developed the capacity to offer high-quality, sustained access to reversible methods at the community level.

3.Challenges That Demand Urgent Attention

1. **Early marriage and extended fertility windows -** Nationally, 20.1% of women aged 20–24 were married before 18 — the legal minimum age of marriage for women under the Prohibition of Child Marriage Act. In rural areas, this figure rises to 23.3%. Early marriage has two compounding reproductive consequences - it extends a woman's total pregnancy window by several years, and it reduces her negotiating power within the household on matters of contraceptive use, birth spacing, and family size. Child brides are structurally less able to exercise reproductive autonomy regardless of what contraceptive methods are theoretically available to them.
2. **Adolescent reproductive health emergency -** The NFHS-6 data reveals that 6.7% of girls aged 15–19 were already mothers or pregnant at the time of the survey — rising to 7.9% in rural India. This reflects the combined effect of child marriage, low contraceptive literacy among adolescents, inadequate access to age-appropriate sexual health information, and social pressure against adolescent girls accessing reproductive healthcare without family or partner permission. Adolescent pregnancy carries disproportionate health risks, including maternal mortality, anaemia, and obstetric complications.
3. **Target-driven public health infrastructure -** India's public health system, particularly at the primary healthcare level in rural areas, continues to operate with an implicit orientation toward permanent sterilisation as the easiest, cheapest, and most administratively convenient way to register family planning coverage. Large-scale sterilisation camps — while formally discouraged — remain a feature of the rural healthcare landscape. This orientation reflects a system designed around demographic targets and administrative metrics rather than individual reproductive health outcomes. It places

severe physical burdens on women, introduces surgical risks in settings with inadequate clinical infrastructure, and perpetuates the gender imbalance in family planning responsibility.

4. **Lack of true reproductive autonomy -** The shift away from female sterilisation has not translated into an upgrade toward modern, reversible scientific alternatives. Instead, women are reverting to traditional, unscientific tracking methods — which have significantly higher failure rates, provide no protection against sexually transmitted infections, and require active cooperation from male partners who frequently deny women contraceptive agency. This pattern reveals that the supply side of India's family planning programme is not yet strong enough to fill the gap left by declining sterilisation rates.

4.Government Initiatives

1. **Mission Parivar Vikas (MPV) -** Launched specifically for high-fertility districts across seven states — Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Jharkhand, Chhattisgarh, and Assam — the programme aims to improve access to contraceptives and spacing options through community health workers. MPV recognises that high-fertility pockets require targeted, intensive programmatic attention distinct from the national average.
2. **Expanded Contraceptive Basket -** The government has systematically added new spacing methods to the public health system's free supply basket. The Antara programme provides subcutaneous injectable contraceptives — effective for three months, administered by ASHA workers — while the Chhaya programme provides a non-hormonal weekly pill as an alternative to daily oral contraceptives. Both initiatives are designed to expand the reversible method mix available at the village level.
3. **Legal framework against child marriage -** The Prohibition of Child Marriage Act provides the legal basis for action against early marriage. Alongside it, schemes such as Sukanya Samriddhi Yojana and conditional cash transfer programmes tied to girls' education create financial incentives for families to keep daughters in school — the most durable intervention against child marriage.

Global Frameworks Contextualising India's Journey

1. **FP2030 (Family Planning 2030)** is a global partnership dedicated to ensuring that family planning systems are rights-based — prioritising individual reproductive choice and expanding access to a diverse basket of modern contraceptive options. India is a signatory partner to FP2030 commitments.
2. **International Conference on Population and Development (ICPD, Cairo, 1994)** represents the foundational paradigm shift in global family planning — from top-down, state-imposed demographic control targets to individual reproductive rights, maternal health, and gender equality as the organising principles of population policy. India's evolution from coercive sterilisation programmes of the 1970s to the current rights-based discourse reflects the influence of this paradigm shift.
3. **SDG 3.7 and SDG 5.6** mandate universal access to sexual and reproductive healthcare services and guarantee full reproductive rights by 2030, respectively, providing the international accountability framework within which India's family planning performance is evaluated.

5.Way Forward

1. **Prioritise girls' secondary education -** The single most powerful and sustained intervention against child marriage, adolescent pregnancy, and low reproductive autonomy is keeping girls in school through secondary education. Education delays marriage, builds negotiating capacity, and creates the economic independence necessary for genuine reproductive choice.

2. **Pivot systemic goals from compliance to choose -** Public health metrics, incentive structures, and resource allocations must shift decisively away from sterilisation numbers toward sustainable, non-coercive supply of reversible methods — IUDs, injectables, pills, and condoms — at the village level through ASHA workers and primary health centres. ASHA performance assessments should include the quality and diversity of contraceptive counselling, not just coverage numbers.
3. **De-stigmatise male contraception -** India's 73-to-1 gender imbalance in permanent sterilisation reflects patriarchal myths, inadequate information, and social stigma around vasectomies — despite the non-scalpel vasectomy being a simpler, safer, and quicker procedure than female tubectomy. Targeted awareness campaigns, community-level counselling, and male health worker networks are essential to redistribute contraceptive responsibility between partners.
4. **Strengthen adolescent reproductive health programmes -** Comprehensive, age-appropriate sexual and reproductive health education — integrated into school curricula — is essential to reduce the 6.7% adolescent pregnancy rate. Community-level adolescent health clinics (under the Rashtriya Kishor Swasthya Karyakram) must be adequately staffed and supplied.
5. **Upgrade rural health infrastructure -** Reliable, year-round supply of reversible contraceptives at sub-centre and PHC level — with trained personnel capable of counselling women on method options without coercion — is the supply-side prerequisite for any genuine shift in the contraceptive method mix.

Source - **https -//www.thehindu.com/news/national/what-is-lost-and-gained-in-nfhs-6/article71076595.ece**