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## INTRODUCTION

Unprotected sexual intercourse on the fertile days of a woman's menstrual cycle can result in pregnancy. From time immemorial there have been attempts to separate sexual activity from reproduction. Various methods have been used in different cultural contexts. The traditional methods of regulating birth included periodic abstinence from sexual intercourse during certain festivals and particular seasons, or after the birth of a child (post-partum). Prolonged breast-feeding and social disapproval of sex after reaching a certain age also contributed to lowering birth rates. Sexual practices like *coitus interruptus* that involve ejaculating outside the vagina, herbal pessaries in the vagina, vinegar douches and a type of condom which is an equivalent of the modern one are also known to have been used.

Contraception or birth control refers to the range of methods used by women and men to prevent pregnancy. Every year several million dollars worth of research continues to look for the ideal methods of contraception, with several options being available for men and women today. Contraception is often called Family Planning, particularly so in our country. Through its Family Planning programme our government targets only married couples within conventionally defined family groups. This leaves out a large number of people who are sexually active and potential users of contraceptives, who then fall outside the ambit of government concern.

While contraception is a very personal decision that should ideally be taken together by the woman and man concerned, it has become a matter of public discussion in many countries where there is concern about population growth. If the growth is seen as being too rapid, couples are urged to use contraception when the state desires them to do so, such as after one or two children (China, India). Where the population is not growing fast enough to even replace itself (as in West Europe), there is pressure on women to have more children than they desire!

The ICPD resolution specifically says, "All couples and individuals (have the right) to decide freely and responsibly the number and spacing of their children, and to have the information, education and means to do so ... and to make decisions concerning reproduction free of discrimination, coercion and violence." (ICPD Principle 8, 7.3, 1994) Despite this, the mindset of 'choice' has not been widely internalised, and pressures continue to be applied from governments, religious leaders and donors.

Since the outcome of pregnancy is borne by a woman, it is important for them to be able to freely make contraceptive decisions. Control over one's body and the right to regulate fertility have been a cornerstone of the women's movement the world over. However, given the existence of gender disparities, women are often unable to negotiate contraception with their male partners. In many countries like India, state control over fertility ensures that women have little space to negotiate their rights over their bodies. Moreover, the types of contraceptive available or being researched might not be those with which women really feel comfortable or safe.

In this booklet we will try to get acquainted with the various methods of contraception available for both men and women, looking at their respective advantages and disadvantages. We will also examine the current issues and debates around contraception in India.

## SECTION ONE

### Contraceptive Options

#### What is contraception?

Contraception is a deliberate attempt to avoid pregnancy. Pregnancy occurs when the egg meets the sperm, and the zygote (the product of the sperm and egg meeting), attaches itself to the lining of the uterus and starts growing. Keeping this process in mind, there are basically five ways to avoid getting pregnant:

A. The most obvious method is to **avoid having sexual intercourse**. i.e. abstinence from any penis-to-vagina contact. A refinement of this method is to avoid penis-to-vagina contact during the fertile days of the woman's cycle (rhythm method, fertility awareness method).

B. Another simple method is to **prevent the egg from meeting with the sperm**. This includes the various barrier methods (male and female condoms, diaphragm and cervical cap) and the permanent methods - vasectomy (male sterilisation) and tubal ligation (female sterilisation).

C. A third way is to **prevent the woman from producing eggs and/or the man from producing sperm**. Examples of this include hormonal methods such as oral contraceptive pills, injectables and implants under the skin. The anti-fertility vaccines being developed for men and women would also fall into this category.

D. In yet another approach the **fertilized egg (zygote) can be prevented from implanting** (attaching) itself to the uterine wall. Examples include intra-uterine devices (IUDs) and non-steroidal pills.

E. The fifth way involves the **removing of the embryo even after conception** and implantation have taken place. Examples include induced abortion and abortifacient pills.

Thus, different contraceptives work in different ways to prevent pregnancy and each person should choose a method that suits her or his requirements without posing any danger to her/his health and life. Furthermore, this is not a decision one can make for one's entire life. As one ages or as the nature of one's sex life changes, one's contraceptive needs change.



### Factors to be kept in mind when choosing an appropriate contraceptive

The following factors should be borne in mind while choosing a contraceptive:

- The **effectiveness** i.e. what are the chances of getting pregnant
- Is the contraceptive **safe**, or are there any serious **side-effects**?
- Does it have any **long-term adverse effects**?
- Will it affect **breast-feeding**? Will the effect of the contraceptive be passed on in breast milk?
- Will it affect the health of **future children** the woman may bear?
- Whether it gives **protection from HIV** and other STDs
- Is the contraceptive method **reversible**, in case pregnancy is desired
- Whether the **male** partner is willing to take an active role in contraception
- Whether the contraceptive has special **contraindications** e.g. not to be used by women with irregular bleeding, or those with reproductive tract infections (RTIs)
- Whether **control** over the contraceptive is in the hands of the user, or is it dependent on the health service provider?

### Efficacy of Contraceptives

Each contraceptive method has a different efficacy i.e. how effective it is in preventing pregnancy. Effectiveness is measured according to a theoretical effectiveness rate, as well as the effectiveness in real life conditions. For instance, the oral contraceptive pill has a very high theoretical effectiveness, but if the woman forgets to take even a few pills, the effectiveness gets drastically reduced. The following table will help to get a comparative idea of the effectiveness of different contraceptive methods:

#### Contraceptive efficacy of different methods

##### Pregnancies per 100 women in first 12 months of use

Method	As commonly used	Used correctly and consistently
Norplant Implants	0.1	0.1
Vasectomy	0.15	0.1
DMPA and Net En Injectibles	0.3	0.3
Female Sterilisation	0.5	0.5
IUD (Copper T)	0.8	0.6
Breast Feeding (for first 6 months)	2	0.5
Combined oral pills	6-8	0.1
Condoms	14	3
Diaphragm with spermicide	20	6

Fertility Awareness	20	6
Female Condoms	21	1-9
Spermicides	26	6
No method	85	85

Source: The Essentials of Contraceptive Technology – A Handbook for Clinic Staff, John Hopkins Population Information Program, 1997

## **Brief description of different contraceptives**

### **A. Natural methods (Avoiding genital- to- genital contact, especially during fertile days)**

The safest and easiest way to prevent pregnancy would of course be by not having sex at all! The next best way would be to avoid genital-to-genital contact, without which sex can still be a pleasurable experience. For ages, women have known that it is possible to get pregnant only on a few days of the month. So, they have known that if sexual intercourse is avoided on those days, they can avoid getting pregnant. Today the following methods are available to avoid pregnancy without the use of any artificial means of birth control.

#### **1. The rhythm (calendar) method**

According to this method a woman is considered fertile after 10 days of the start of the menstrual cycle, hence sexual intercourse is avoided during these 10 days. The ‘safe period’ thus is considered to be the week during, before and after menstruation. This is an unreliable method because it does not take into account variations in the menstrual cycle. The rhythm method assumes that all women have 28-day cycles, and that ovulation occurs in the middle of the month. However, each individual woman has a different cycle length, and ovulation may take place at different times. It is only slightly better than using no method at all.

#### **2. Cervical mucus/Billings ovulation method**

Most women have some amount of secretion (mucus) from the vagina most times of the month. This is a perfectly healthy sign. The mucus varies in quantity, consistency and colour. It may be sticky and whitish at times, and at other times it may be slippery and transparent. The nature of this mucus varies with the stage of the menstrual cycle. Soon after menstruation, the mucus is usually scanty, relatively dry, thick, flaky and whitish. As an egg begins to ripen in one of the ovaries, the hormone oestrogen circulating in the body makes the mucus transparent, stretchy and slippery. The slipperiness and stretchiness is the maximum during ovulation and a day or so after. Thus, the slippery and stretchy kind of vaginal mucus is a woman's most useful and obvious sign of her fertile days. A woman can determine her fertile and infertile days by noticing the changes in the character of the cervical mucus by testing some of it on her fingers at about the same time everyday.

#### **3. Basal Body Temperature (BBT)**

A woman can also note her body temperature at the same time early every morning. The temperature of the body soon after sleep is called the Basal

Body Temperature. Towards the middle of the month, immediately after ovulation this temperature will rise significantly (about 1.2 degrees F) and stay that way until the next period. If this method is used exclusively, it necessitates avoidance of genital-to-genital contact in the entire period before the temperature rise, i.e. a period of about one to 16 days. Once ovulation has taken place, another one-two days are considered fertile. Thus, days on which sexual intercourse is 'safe' are relatively few. In addition, the daily trouble of taking temperature makes the method a cumbersome one.

#### **4. Fertility awareness method**

Fertility awareness is a method by which a woman can become aware of the cyclical changes her body undergoes every month. There are several signs in a woman's body which she can learn to recognise – cervical mucus, basal body temperature, changes in height and softness of the cervix, breast tenderness etc. A combination of these signs can help her recognise the period when she is most fertile, and use this knowledge to either avoid or achieve pregnancy.

With training in Fertility Awareness (from a person who has used the method, or has trained other women in FA), and some amount of practice, a woman can determine her fertile days with a fair amount of accuracy. The FA method needs special caution if:

- A woman has a reproductive tract infection which may cause changes in the mucus pattern.
- A woman is breast-feeding. Ovulation is delayed for some time after childbirth. The period of lactational amenorrhoea (absence of menstruation during breast-feeding) depends on whether there is complete breast-feeding, the nutritional status of the woman, and other factors. However, ovulation occurs before the first menstruation.
- A woman is approaching menopause. Menopausal changes cause a change in the menstrual cycle, and also the mucus patterns.
- A woman's partner is not co-operative about abstaining from sexual intercourse or using a barrier method during fertile days.

Used correctly and consistently, the FA method can be as effective as the condom. It is a safe, reversible method with no side-effects whatsoever. Awareness of the body processes and the reproductive cycle contributes to greater control over the body. The successful practice of FA requires the co-operation of the male and it can be a positive factor when men are made responsible partners in the process of fertility control.

#### **B. Barrier methods (methods that prevent egg from meeting sperm)**

Barrier methods work by literally forming a barrier between the sperm and egg. The following kinds of barriers are currently available:

##### **1. Male condom**

This is a cylindrical latex sheath worn over the penis during intercourse. It blocks the release of sperms into the vagina. It is unrolled onto the erect penis before any vagina-to-penis contact because long before ejaculation

occurs, the man may discharge a few drops of fluid which may contain sperm, or could transmit STDs. After ejaculation, the penis should be carefully withdrawn from the vagina so as not to spill any semen in or near the vagina. The condom is then unrolled and disposed off. A condom should never be used more than once. The male condom is one of the most effective and safe methods of contraception. It has no side effects on the man or the woman. Condoms are also highly effective in preventing AIDS and other STD's. Another advantage of the condom as a spacing method is that it is completely reversible. Condoms are the most widely available contraceptive.

### **Focussing on condoms**

Some people, especially men, feel that condoms reduce the spontaneity and pleasure of sex. In addition some people are allergic to latex rubber. If condoms are of poor quality, or have been stored too long, especially in a hot place, they may tear or leak. If there is not enough lubrication during sexual intercourse, or if the condom is incorrectly used, it may also tear e.g. if it is not rolled on smoothly. The reluctance on the part of many men to share the responsibility of birth control is a major reason why many men do not use condoms, even when they are so effective. However, if putting on the condom becomes part of sex play, it can even become a pleasurable activity. Considering that condoms are so safe, and have the added advantage of protecting against HIV and other STDs, it is worthwhile putting in a lot of effort encouraging men to use condoms.

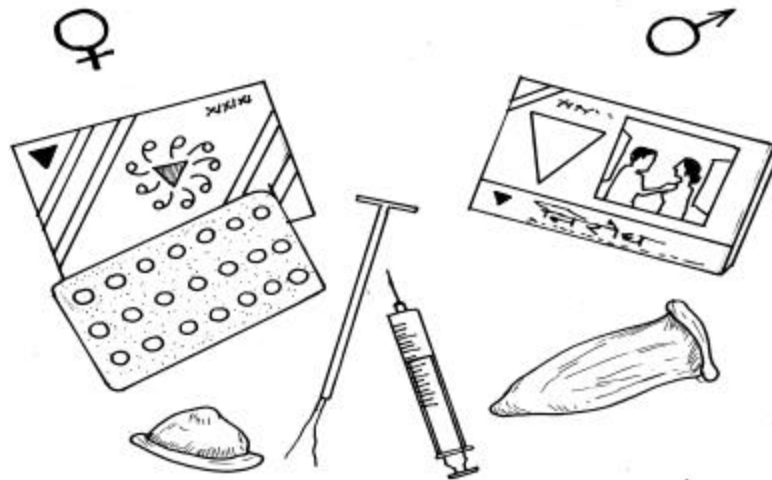
## **2. Diaphragm**

The diaphragm, invented in the nineteenth century, was a major breakthrough in giving women control over their fertility. The diaphragm is a circular, dome-shaped rubber disc with a firm rim inserted into the vagina to cover the cervix and block the entrance of sperm. The initial fitting of the diaphragm is done by a doctor/health worker, since the diaphragm is available in different sizes ranging from 2 to 4 inches, depending on the size of the upper vagina. Once the diaphragm of the right size is fitted, the woman herself inserts and removes it when necessary. It is filled with a spermicidal jelly or cream and placed right up inside the vagina until it covers the mouth of the uterus. It should be put in place before any sexual contact is made and left there for at least six hours after intercourse so that the spermicide can kill the sperms that are left in the vagina. Afterwards, it is removed, washed with soap and water, thoroughly dried and kept away until the next use.

The possible problems with the diaphragm include local irritation due to the spermicide or the diaphragm itself may push forward and cause cramps in the uterus or bladder of the urethra. For some women, this can lead to urethritis or recurrent cystitis. It should not therefore be used by women who are prone to urinary tract infections, or those who have a prolapsed uterus. However a significant advantage of the diaphragm is that it is in the control of the woman. The diaphragm, with proper awareness and training, has proved to be an effective and safe contraceptive. Its other advantages include that it has



no side effects. At present, the diaphragm is not easily available in India. A few women's organisations have experimented with importing and distributing it. The cost of one diaphragm is about Rs 400. While this may seem a bit expensive, it must be remembered that a diaphragm is reusable and lasts about three years if well maintained.



### **3. The cervical cap**

This is a thimble-shaped rubber cap that fits snugly over the cervix. Like the diaphragm, the cervical cap keeps sperm out of the uterus. The cap is designed to create an almost airtight seal around the cervical opening. Suction, or surface tension, hugs it close to the cervix. It is used with spermicide, which both inactivates sperm and strengthens the suction seal between the cap and the cervix. Unfortunately, the cervical cap is not available in India.

### **4. Female condom**

The female condom is a soft, loose-fitting sheath made of polyurethane, closed at one end. It works by blocking the release of sperm into the vagina. The condom is inserted into the vagina before sexual intercourse. A flexible polyurethane ring is located at either end of the device, one at the closed end that covers the cervix, and the other at the open end which remains outside the vagina. The ring outside the vagina adds to the protective effects of the female condom by creating a barrier between the labia and the base of the penis. The female condom should be inserted before any sexual contact is made. After intercourse it must be removed with care to prevent any sperm from spilling into the vagina, before the woman stands up. The female condom combines the features of a condom and a diaphragm. It is inserted into the vagina in much the same way as a diaphragm, without having to take care to directly cover the cervix. Like the male condom, the female condom can be used only once.

The female condom not only covers the vaginal walls but the cervix as well. As such, like the male condom it is not only an effective contraceptive for preventing pregnancy but is also an excellent safeguard against HIV and other STDs. Amongst its other plus points is that it can be inserted in

advance of intercourse, so that there is no need to interrupt intercourse. It comes in a standard size and does not need fitting by a doctor. The main disadvantage of the female condom is its cost. Another disadvantage is the embarrassing sound produced during sexual intercourse, and also the fact that it makes oral sex unpleasant. Since its outer ring covers the clitoris, many women find that it reduces their sexual pleasure and causes discomfort. The female condom is not readily available in India. Its use is mostly among voluntary organisations working on HIV/AIDS.

## **5. Spermicide**

Spermicides are chemicals applied into the vagina, which work by inactivating or killing the sperms. They are available in the form of foams, tablets (e.g. Today), jellies and creams (e.g. Delfen). The spermicide is inserted into the vagina with the help of an applicator immediately before sexual intercourse. They are not usually used on their own but could be used to increase the effectiveness of condoms or diaphragms. The lowest expected failure rate for spermicides used alone is 6%, while the typical failure rate is 26%. These spermicides do not generally have any serious side effects, though some women may experience genital irritation or allergic reactions.

### **Traditionally used methods**

A special note should be made of certain practices that are traditionally used. These methods are safe and without side-effects, but they have a low effectiveness. At best, they would slightly reduce the probability of getting pregnant as compared to using no method at all.

## **1. Breast feeding**

After childbirth, it takes some time such as a few months in most cases, for the woman to start menstruating again and ovulation to occur. This period during breast-feeding when there is an absence of menstruation is termed lactational amenorrhoea. It is prolonged in women who carry out 'complete breast-feeding' that is, when a woman nurses her baby on demand during day and night, giving exclusive breast-feed without any top-feed. During lactational amenorrhoea the chances of getting pregnant are reduced. However, it should be noted that ovulation takes place before the first menstruation. Hence, it is possible to get pregnant even without experiencing a menstrual period. In some regions of north India such conceptions are called "laam ka bachcha". Combining this method with Fertility Awareness greatly increases the effectiveness in preventing pregnancy.

## LAM – Lactational Amenorrhoea Method

LAM is considered a formal method of contraception by many authorities. Practicing LAM involves strictly following these guidelines:

- LAM is effective if the childbirth was less than 6 months back
- The baby should be exclusively breast-fed
- The baby should be fed at least once every 6 hours
- Menstruation must not have started

Many authorities claim that if these conditions are followed LAM is as effective as the condom

## 2. Coitus interruptus/ withdrawal

In this method, the penis is withdrawn from the vagina before ejaculation so that the sperm is not deposited inside the vagina. Withdrawal is not an effective method because the timing can go wrong, and contact with the vagina and vaginal lips may be difficult to avoid. Further, as soon as the erection appears a small amount of sperm is released, which can be sufficient to cause pregnancy.

## C. Methods that prevent fertilisation

### 1. Intra Uterine Device (IUD)

An IUD is usually a small, flexible plastic device that fits into the uterus. Most contain either copper or synthetic progesterone. The IUD is inserted in the woman's uterus through the cervix. Once it is in place, the strings (usually two) of the IUD extend down into the upper vagina. By inserting a finger into her vagina and touching the strings, a woman can check if the IUD is still in place.

The working of the IUD is not yet fully understood. IUDs (especially those that contain copper) cause an inflammation or chronic low-grade infection in the uterus. These changes may damage or destroy sperm or interfere with their movement in a woman's genital tract, making fertilisation impossible. IUDs may also speed up the movement of the egg in the fallopian tube, causing the egg to arrive in the uterus too soon to be able to join with sperm. Even if fertilisation does occur, the disturbance caused by the foreign body in the uterus prevents implantation.

The most commonly used IUD in India today is the Copper-T. These IUDs are used for about two to three years, after which they have to be changed. The IUD should be inserted inside the uterus by a doctor, during the menstrual period or soon after to ensure that there is no pregnancy at the time of insertion. The IUD is very effective as a contraceptive. However, it could have several side effects, some of them severe:

- Severe cramps and pain beyond the first three to five days after insertion.
- Heavy menstrual bleeding, or bleeding between periods, possibly contributing to anaemia.

- In rare cases, perforation (piercing) of the uterus wall. Embedding may also occur if the lining of the uterus grows around the IUD. Embedded IUDs cause more pain during removal, sometimes necessitating a D&C procedure (Dilation and Curettage).
- Pelvic Inflammatory Disease (PID), which is an infection in the uterine lining, uterine wall, fallopian tube, ovary, uterine membrane, broad ligaments of the uterus, or membranes lining the pelvic wall. Caused by a variety of infectious organisms including gonorrhoea and chlamydia, it is twice as likely to occur in women using IUDs as in women using no contraception.
- Ectopic pregnancy is more likely (with copper IUDs, there is a 3% chance) in women using IUDs. An ectopic pregnancy (pregnancy outside the uterus, usually in the fallopian tube) is a serious problem that can cause haemorrhage, and lead to infection, sterility and sometimes death (when emergency medical care is not available).
- IUDs should be chosen as a contraceptive after careful consideration. If one has never had a child, it is advisable not to get an IUD inserted. It is not appropriate for women prone to genital infections, those with a history of ectopic pregnancy, those suffering from severe dysmenorrhoea (painful menstruation) or women who are anaemic.

Most government health centres and hospitals pressurise women to get IUDs inserted immediately after a delivery or abortion. However, this can be extremely dangerous.



## 2. Non-steroidal pill - centchroman

Marketed in India by the brand name Saheli or Choice 7, non-steroidal pills work by accelerating the passage of the ova into the uterus. It works even if fertilisation has already occurred. Non-steroidal pills are promoted as an ideal contraceptive by the government. However, though not a hormonal pill it does change the estrogen-progesterone functions of a woman's body. Centchroman is also known to have caused ovarian cysts in some users.

## **D. Abortion**

An abortion is the ending of a pregnancy before full term, by expulsion of the foetus from the uterus. A spontaneous abortion or miscarriage is the natural termination (ending) of pregnancy. An induced abortion is also called Medical Termination of Pregnancy (MTP). Despite using contraceptives, a pregnancy may result. Or, pregnancy may be the result of rape, incest, or a coerced sexual encounter. In these situations, a woman may decide to have an abortion. From time immemorial, abortion has been used as a means of fertility control. External massage, performing arduous physical activity, scraping the uterus with a sharp object, consuming abortifacient (abortion causing) herbs and potions have been means by which women have attempted to end unwanted pregnancies. Many societies have imposed strict religious sanctions against abortion, viewing it as the taking away of life. Although abortion is still illegal in many countries, the women's movement the world over has articulated legal, safe, affordable and accessible abortion as a right. Induced abortion was legalised in India by the Medical Termination of Pregnancy Act, 1972.

During an abortion, the foetus and the placenta are removed through the cervix. Depending on the stage of the pregnancy, different methods of abortion may be used.

### ***(i) Suction:***

It is suitable for a six to eight-week pregnancy. In this method a cannula or tube that is connected to a suction pump is inserted through the cervix under either local or general anaesthesia. By suction, the foetal tissue is removed within a few minutes. It does not require a hospital stay.

### ***(ii) D&C (dilation and curettage)***

For pregnancies of 8 to 16 weeks, the cervix is dilated by a diluting rod and then the walls of the uterus are scraped clean with a curette, all under general anaesthesia.

### ***(iii) Induced labour***

For advanced pregnancies of about 16-20 weeks, usually a solution of saline, urea or prostaglandin is injected into the amniotic sac to cause premature labour and expel the foetus. This procedure is carried out under local anaesthesia and requires hospital stay of a day or two.

### How safe is an abortion?

If performed by an experienced doctor under hygienic conditions, an abortion can be safe. But it is safest within the first 12 weeks. If not carried out carefully, complications can arise. For instance, if an abortion is incomplete and some foetal or placental tissues remain inside, it could result in serious infection and severe bleeding. Other complications include blood loss, infection in the vagina and/or the cervix, perforation of the uterine wall and damage to the cervix. The trauma of having to undergo an abortion could lead to depression and other psychological problems.

Abortions should be considered a back-up method of fertility control, in the event of contraceptive failure or pregnancy due to coercion (for instance, rape). Repeated abortions are a health hazard. Abortions are not safe or legal after 20 weeks gestation.

Though government hospitals perform abortions free of charge, they lay down certain contraceptive conditions such as having the woman insert an IUD or Norplant or getting sterilisation done. This is unethical and illegal on the part of the government, and should be resisted.

#### ***(iv) The abortion pill***

Medical abortion is possible through the combined use of the drugs mifepristone and misoprostol and its use has recently been legalised in India. Mifepristone (also known as RU 486) is the anti-abortion pill but it has been found to be unreliable on its own and hence is followed 2 to 3 days later with a prostaglandin ( misoprostol). The RU-486 is effective in initiating abortion only in the first six to eight weeks of pregnancy. The abortion pill should be taken only under medical supervision, as it could cause uncontrolled bleeding. Some of the known side effects include uncontrolled vomiting and nausea, and severe bleeding that could lead to a collapse. It could take up to 12 days for abortion to take place and the woman could bleed all that while. Moreover, since RU-486 is effective only for very early pregnancy, it has not been studied as to what could be the impact on the foetus in case abortion does not occur.

### **E. Hormonal methods**

#### **Causing the woman not to produce eggs and/or the man not to produce sperms.**

Hormonal methods work by influencing the hormones estrogen and progesterone in the body and thereby stopping ovulation or sperm production. They also have the effect of thickening the cervical mucus (which prevents sperm from entering the uterus), and in some cases also cause changes in the uterus and fallopian tubes that prevents fertilisation. Hormonal methods disturb the delicate balance of hormones in the body. They may have serious side-effects and may impact various parts of the body other than just the reproductive system, i.e, they can cause systemic changes. However, government contraceptive providers promote them as an ideal contraceptive method because they are highly effective and easy to administer.

## Disadvantages of hormonal contraceptives

Women's organisations have highlighted the following specific disadvantages of hormonal contraceptives:

- (i) Effect on the functioning of the brain, causing headaches, dizziness, weight gain, anxiety, depression, tiredness, hypertension, decreased libido, digestion problems, vaginal discharge and soreness, skin problems and loss of appetite, among others. They also cause changes in cardio-vascular functioning (heart disease, stroke). The possibility of cancer risk has not been satisfactorily ruled out.
- (ii) Menstrual chaos: The high levels of hormones in the body can cause irregular bleeding, persistent spotting, heavy menstrual bleeding, prolonged periods or even total absence of periods.
- (iii) Return of fertility not certain: current research does not validate the assertion made by the government that a woman will promptly regain her fertility whenever she stops using hormonal contraception. Since these methods are being promoted as spacing methods, this is a serious concern.
- (iv) If a child is conceived due to failure of the method, or immediately after the woman stops using the method, or if hormonal contraception is used on a pregnant woman, the resultant child can have birth defects that may show up as late as puberty.
- (v) Hormonal contraceptives require close monitoring at every stage by trained personnel. This should be done before use, to discover any contraindications, during use to determine any adverse reactions, and after use to check for possible after-effects. Unfortunately, such basic facilities are often not available in Indian primary health centres and government hospitals.
- (vi) Besides the pill, hormonal contraceptives are long-acting e.g. injectibles (such as Net En and Depo Provera), implants such as Norplant, nasal sprays etc. Their effect can range from two-three months (injectibles) to five to six years (implants). Thus, even if a woman wishes to stop using the contraceptive, the effect of the hormone lingers in her body for some time after she stops. A further problem with long-acting hormonal contraceptives is that they place the control over fertility in the hands of the health-service provider rather than with the woman. Women's organisations the world over and in India, have been opposing the introduction of long-acting hormonal contraceptives not only because of their hazardous effect on health but also because of the potential for abuse inherent in these forms of delivering contraceptives.

### 1. Oral Contraceptives (OCs)

The 'pill' was heralded in the 1960s as a symbol of sexual freedom for women. It appeared to be a 100% effective, simple and wonderful alternative to the methods then available. Many women first heard about the dangers of the high-dose estrogen pill (blood clots, heart attacks, strokes, depression, suicide, weight gain, decreased sex drive) when they read Barbara Seaman's book, *Doctors' Case Against the Pill*, published in 1969. Efforts by women and consumer activists in the late 1960s led to modifications of the pill as well as special package inserts listing the possible negative effects and

complications. Because most of the negative effects are associated with high dosages of estrogen, drug companies reduced the estrogen content of the pill, and also began to develop progesterone-only pills. In the United States, Germany, and most countries in the West, the pill is available only by prescription. In India, however, OCs are available over-the-counter (OTC), i.e. without a doctor's prescription. Recently, vigorous "social marketing" strategies resulted in OCs being made available more freely, and through non-conventional outlets. When monitoring and follow-up is absent, treatment of side-effects and detection of complications is not possible.

### **Different oral contraceptives include:**

#### **Combined Oral Contraceptive (OC)**

Combined oral contraceptive pills contain two hormones, estrogen and progesterone, in different proportions. They prevent pregnancy primarily by inhibiting the development of the egg in the ovary by raising the level of estrogen at the beginning of the cycle. Today's low-dose combination pills (like Mala-D) are relatively safer than the high dose combination pill (like Ovral). However, combined OCs are not suitable for all women.

<b>Who should not use Combined OCs?</b>	<b>Who should not use progesterone-only pills?</b>
<p>Combined OC Pills are dangerous for women with the following conditions:</p> <ol style="list-style-type: none"> <li>1. Any disease associated with excess blood clotting – bad varicose veins, thrombophlebitis (clots in veins, frequently in leg), pulmonary embolism (blood clot that has travelled to the lung, usually from the leg).</li> <li>2. Stroke, heart disease, coronary artery disease</li> <li>3. Hepatitis or other liver diseases</li> <li>4. Heavy smokers</li> <li>5. Breast-feeding and less than six weeks after giving birth</li> <li>6. Pregnancy ended within the past three weeks: there may be an increased risk of thromboembolism during this period.</li> <li>7. Migraine headaches</li> <li>8. Moderate/severe hypertension (blood pressure 160/100 or more)</li> <li>9. Diabetes with certain vascular complications</li> <li>10. Liver tumours or liver cancer, cancer of the breast (or history of cancer of the breast)</li> <li>11. Women who are unable to take pills consistently and correctly. Forgetting pills in between the cycle could result in pregnancy.</li> </ol>	<p>Women with the following conditions should not take progestin-only pills:</p> <ol style="list-style-type: none"> <li>1. Unexplained vaginal bleeding</li> <li>2. Breast cancer</li> </ol> <p><b>Women with the following conditions should use progesterone-only pills only as a last choice:</b></p> <ul style="list-style-type: none"> <li>• Hepatitis</li> <li>• Jaundice</li> <li>• Cirrhosis of the liver</li> <li>• Benign or malignant liver tumours</li> <li>• Functional ovarian cysts</li> <li>• Cardiovascular complications</li> <li>• History of breast cancer</li> <li>• Women who are breast feeding</li> <li>• Women who are unable to take pills consistently and correctly. Forgetting pills in between the cycle could result in pregnancy.</li> </ul>



### **Progesterone-only pill**

While combined oral contraceptives stop ovulation, progesterone-only pills prevent pregnancy by increasing the thickness of cervical mucus, slowing down the motility (movement) of the sperm as well as the egg, and not allowing the uterine lining to develop properly. The pill has many advantages such as high effectiveness, convenience, no interference with sexual intercourse and proven reversibility. However, there are several unpleasant side-effects and long term effects which should be noted . These are highlighted in the box above.

### **2. Injectible Contraceptives**

Depo Provera (Depot Medroxyprogesterone Acetate) and Net En (Norethisterone Enanthate) are progesterone-only injectible contraceptives. The contraceptive effect of Depo Provera lasts for three months, and that of Net En for two months.

Injectibles seem to be a convenient method of birth control. However, there are many short-term side-effects and long-term health hazards associated with the use of injectibles. Since they are delivered in very high doses and their effects are long-acting, the seriousness of their side-effects far outweighs those of the pill. Much as the woman may want, the effect of injectibles cannot be withdrawn until it wears off in two-three months. Presently, injectables have not been licensed for introduction in the national Family Welfare programme. They were registered in 1994 for use only by private practitioners and for 'social marketing' by NGOs.

The health hazards associated with the use of progesterone-only injectibles include:

- Menstrual disturbances ranging from prolonged spotting and excessive bleeding to complete absence of bleeding
- Atherosclerosis – thickening of blood vessels and cardiovascular disease
- Thromboembolism – development of blood clots at unexpected sites, resulting in damage to heart, lungs and brain etc.
- Osteoporosis/loss of bone density, resulting in higher incidence of fractures
- Weight changes
- Other metabolic changes resulting in changes in sugar levels, depression, fatigue, loss of sexual desire etc.
- Return of fertility is not predictable (a serious limitation in a spacing method)
- Cancer risk – an unresolved issue
- Adverse effects on the foetus (in case of accidental pregnancy) have not been ruled out

### **3. Sub-dermal implant – Norplant**

Sub-dermal implants are a set of six rods of flexible silastic rubber capsules filled with the synthetic progestin levonorgestrel. Each rod is the size of a matchstick. The implant is usually inserted under the skin of the woman's forearm. Norplant is designed to last for up to five years. It can be removed

only by a surgical procedure by trained personnel.

This progesterone-only contraceptive works in three ways: by inhibiting ovulation, by thickening and decreasing the amount of cervical mucus, and by thinning the endometrial lining to prevent implantation.

Norplant is a highly effective and convenient contraceptive. Its use, however, is associated with several health risks common to progesterone-only contraceptives, similar to those of the injectibles. Many of these are seriously life-threatening, especially in a situation where proper monitoring and follow-up is not available. In August 1999, following cases filed in US courts, American Home Products Corp. which is the parent of Norplant-maker Wyeth-Ayerst Laboratories, was forced to pay over \$50 million to more than 36,000 women to settle claims that Norplant caused headaches, irregular menstrual bleeding, nausea and depression.

#### **4. Anti-fertility vaccine (under trial)**

Anti-fertility vaccines use the body's natural immune system to generate an immune response against hormones essential for pregnancy. The chosen reproductive cell is linked to a 'carrier' molecule like tetanus toxoid or diphtheria toxoid, so that the immune system perceives it as 'foreign' to the body. Vaccines aimed to create antibodies against the development of ova, sperm, and pregnancy hormones are currently under development. The most advanced of these is the anti-hCG (human chorionic gonadotropin) vaccine being developed at the National Institute of Immunology, New Delhi, as well as the World Health Organisation. Phase III clinical trials have been conducted on a three-month vaccine, but the efficacy is as low as 80%.

Since anti-fertility vaccines interfere with the immune system, their effects on any existing disease or allergy are yet to be fully determined. The reversibility has not been established beyond doubt – a serious limitation for a spacing method. If a woman takes the vaccine accidentally when she is pregnant, or there is contraceptive failure, the effects on the foetus have not been fully studied. Short term side-effects include fever, infection, pain and lesions at the site of vaccination, generalised rash, nausea and giddiness. Another serious concern, especially in the Indian context is the potential for abuse inherent in anti-fertility vaccines. Women can be vaccinated without their knowledge and consent. When medical technology is used to commit human rights violations, such technology needs to be questioned.

The International Campaign Against Hazardous Contraceptives and Coercive Population Policies (of which several groups in India are members) has been campaigning since 1993 to call a halt to research on anti-fertility vaccines.

#### **F. Permanent Methods**

Permanent methods in men and women involves permanently blocking or cutting off the tubes which carry the egg/sperm. With newer medical techniques, re-canalisation (rejoining of tubes) can be performed, but it is not always possible or successful, so these methods for all practical purposes are irreversible. Sterilisation is very highly effective. It is appropriate for people

who have attained the desired family size and are sure that they do not want any more children.

### **1. Vasectomy/ male sterilisation**

Vasectomy is a surgical method of sterilisation for men. It blocks the *vas deferens* in the male so that sperms cannot travel to the penis with semen. The man however continues to ejaculate and it does not affect his sexual libido or performance in any way. Adequate and sensitive counselling can help to alleviate anxieties about 'manhood' and sexual performance.

In 'no-scalpel' vasectomy, only a tiny hole is made on both sides of the scrotum to expose the *vas deferens* which is then cut, tied or clipped under local anaesthesia.

Vasectomy is a minor and simple surgery, but the man should rest for at least 48 hours after the operation, and should not lift any heavy objects for a week. One should resume sexual intercourse only after all signs of discomfort have gone, in any case not before a week. An alternative method of birth control must be used for at least two to three months after the operation, as sperm can live in the sperm duct for up to three months. In case the operation is followed by high fever, excessive or continued bleeding, swelling or pain, a doctor must be consulted immediately.

It is safer and simpler for a man to be sterilised because the male genitalia, unlike that of the female is external. Hence, vasectomy involves less interference to body organs and fewer complications. Recent studies indicate that men who have had a vasectomy may have an increased risk of prostate cancer. There are no other major long-term risks associated with vasectomy.

### **2. Tubectomy/ Female sterilisation**

Under this method a puncture or a small incision is made in the abdomen to gain access to the woman's fallopian tubes that are then cut, tied or clipped. This is done under local anaesthesia. It blocks the fallopian tubes in the female so that the eggs produced by the ovaries cannot unite the sperm. Female sterilisation is very effective if performed properly, though complications can and do arise. This could include infections, internal bleeding, perforation of the uterus and/or the intestines. It could also lead to heart problems, irregular bleeding, severe menstrual pain, and the need for repeated D & Cs or even a hysterectomy. A doctor should be immediately considered in such a case. Proper precautions need to be taken before and during sterilisation. One needs to rest for about 48 hours after the operation. Normal activity can be resumed within two to three days but one must not lift heavy objects for about a week. Sexual intercourse can usually be resumed after a week.

The risks of tubectomy are the same as those for any major abdominal surgery – cardiac irregularity, cardiac arrest, infection, internal bleeding, perforation of a major blood vessel. These risks increase manifold when tubectomy is performed in settings where due care is not taken, for example in Family Planning 'camps' where a huge number of women are sterilised. Mobile camps are even more problematic since the possibility of monitoring

and follow-up does not exist. Laparoscopic techniques may involve specific problems such as internal burn injuries or punctures to other organs or tissue, skin burn, puncturing of the intestine, perforation of the uterus, and carbon dioxide embolism (which may cause immediate death)

### **Emergency contraception or Morning after pill**

After unprotected sex, emergency oral contraception can prevent pregnancy. It is also called the morning-after or post-coital contraception. It is of particular relevance in situations where a woman has been forced to have sex against her will (rape), a condom has broken or unplanned sex has taken place. Emergency contraception can be used only up to 72 hours (three days) after the occurrence of unprotected sex. Four standard dose or low-dose oral contraceptives such as Mala-D or Mala-N can be taken for emergency contraception. A morning after pill consisting of the drug levonorgestrel has also been introduced in the Family Planning programme, two of which should be taken within four days of unprotected sex.

Its side-effects include nausea, vomiting and disruption of the next menstrual period. It is not very clear how emergency contraception works. It is thought to prevent ovulation, and may also contribute to disrupting fertilisation if it has already occurred. However, it is not 100 % effective. The average chance of pregnancy due to one act of unprotected intercourse in the second or third week of the menstrual cycle is 8%, and after emergency contraception it gets reduced to 2%.

It is important to remember that in case emergency contraception does not work, the chances of birth defects in the foetus cannot be absolutely ruled out. Hence, it is important to be very cautious in the use of emergency contraception, ensuring there is adequate backup of legal and safe abortion services.

## SECTION TWO

### Issues And Debates In India

#### Contraception or Family Planning ?

The government of India has always used the term Family Planning in its various programmes to such an extent that many service providers equate it with contraception. However, this is not the case. Family Planning takes place only within the framework of the family, where the two partners make conscious decisions about the number of children desired, the timing of conception and the spacing of children. Ideally, the health of the mother and child, emotional and psychological state of the mother, financial condition of the family and emotional care that can be given to the children should all be taken into account. Contraception, on the other hand, is the need of other categories of people too who are sexually active.

#### Those whose contraceptive needs get ignored by Family Planning

A significant number of sexually active persons fall outside the pattern of monogamous heterosexual marriage and may need contraception.

**Those with relations outside marriage:** Contraception is probably more important in heterosexual relations outside of marriage (rather than within it) for preventing conception, STD's, especially HIV and the medical and social consequences attached to them. Such relationships include pre and extra-marital sex.

**Sex workers:** They comprise the most frequent users of contraceptives, being vulnerable to pregnancies as well as HIV/AIDS and other STD's. However they are not targetted by the government as prospective users of contraceptives.

**Adolescents:** Adolescent sexual activity, though presumed by many to be non-existent, is a definite reality. Teenagers unfortunately are denied access to information about contraceptives and access to them. As a result teenage abortions are very common.

**Single men and women:** Many sexually active single men and women do not fall into the traditionally defined target groups. The numbers of such people is increasing in our society because of factors like delay in the average age for marriage for both men and women, and with people deciding not to get married for various reasons.

**Men and women who are attracted to the same sex:** Gay and lesbian people who may or may not be married are not even recognised by the authorities, and no efforts are made to give them information and access to contraceptives. In fact, there have been instances (the Tihar Jail episode of 1996) in which certain groups of people like prisoners were denied access to condoms when they were found to engage in homosexual activities.

**Already sterilised person and childless couples:** The government keeps out men and women who have been sterilised, are newly married or otherwise do not have a child. Their names are struck out of the Target Couples register. These persons, however, are still vulnerable to HIV/AIDS and other STDs.

### **Male responsibility and participation in contraception**

When contraception was first promoted in India, condoms and vasectomy were relatively more popular than contraceptive methods for women. But following the Emergency 'excesses' when men were coerced into vasectomy, the health system became reluctant to address men on the topic. As a result it is women who have been almost exclusively targeted by the state. Both men and women have come to consider this a natural trend. Only after the Cairo Conference did the issue of male participation in Family Planning come to be discussed openly once again. However, in a society as patriarchal as ours it will take a lot to change the established trend.

In popular imagery, the man who has undergone vasectomy is seen to be impotent or emasculated. This dissuades many potential acceptors. Condoms too have been popularly discredited as depriving sex of pleasure. With both these methods conveniently out of the way, men have withdrawn from the entire realm of taking responsibility for their fertility behaviour. So much so that government programmes often distribute condoms to the wife, reinforcing the view that contraception is the woman's responsibility.

The issue now is not about finding a more convenient and effective contraceptive method for men, but of how to change the popular mindset. The government has started promoting no-scalpel vasectomy, but the results are far from satisfactory. There has to be much greater emphasis on the responsibility of the husband and father, not only in the popular media but also through systematic training and reorientation of health department functionaries right from the top level to field workers.

### **Reproductive rights and contraception**

The International Conference on Population and Development (ICPD) 1994, known popularly as the Cairo Conference, is considered to be a watershed in the field of population and development. Many ground-breaking decisions were taken here, and these are proving to have a long-term impact. The understanding that emerged from Cairo with respect to contraception and reproductive rights was: The individual should have rights to -

- Access to services and information
- Highest quality of care
- Reproductive Health choices free of coercion and violence

In India however, it is Family Planning services that are provided instead of contraceptive services and that too only to limited potential users. Provider-biases are common. For example, persuading couples with two or more children (with at least one being a male child, as this would then be the 'desired' family size) to adopt a terminal method of contraception. Another bias by health workers is to try to persuade only women, considered a 'soft target', to undergo sterilisation, rather than reaching out equally to men. Nor is women's health a consideration. There is a conflict of goals between a woman's need for birth-control and the state's interest in population control and as a result women's rights are marginalised.



### **Government services for contraception – A review**

The government through its Family Planning programme is providing free contraceptive services of five different methods: condoms, IUDs, oral contraceptive pills, tubectomy and vasectomy. These are available at the PHCs of every development block, some of them also being available with the ANM (Auxiliary Nurse Midwife) at her sub-centre in the village. Examining the government services in India in accordance with the ICPD charter brings to light the following:

***Access to services and information*** -Access to complete and unbiased information and to proper services regarding contraception when desired is a basic reproductive right. Men and women should know about the various contraceptive options available to them and the relative merits of each method, without any information being withheld, before they take a decision. In practice, however, the government machinery is frequently involved in promoting particular methods, and the client is hardly ever provided accurate information to make her/his choice.

***Quality of care*** – Quality of care comprises a number of interlinked factors. These include the respect shown by the service-provider towards the client, competence of the service-provider, availability and accessibility of the appropriate service and availability of follow-up support. The lack of quality care, however, is clearly evident in the kind of service made available to millions of women in India through the peripheral service delivery system. Service providers are often inappropriately trained technically, the client not treated with respect and follow-up support absent when required. These are just a few examples from a list that can be endless.

### Comparison of Quality of services at Sterilisation camps

Year	State		Description
1994	Gujarat	10 camps 275 women	OT temporary in some places, lighting and ventilation poor. Lack of cleanliness. No facility for scrubbing hands, equipment old and in poor condition. Emergency medicines lacking. Women not given OT clothes. Embarrassing exposure of clients Instrument sterilization inadequate. No post operative follow up.
1995	MP	7 camps 82 women	Camps organized in school buildings. Makeshift OT in most places. OT had cobweb and dust on the walls. Gloves not changed after each operation. Outreach camps had no electricity and had to draw electricity from Jeep batteries for operating the laparoscope. Lamps and candles used for lighting. In all five camps number of providers outnumbered clients. Clients had to wait for 4 or 5 hours before doctors came.
1995	UP	3 Camps 30 women	No stretchers to remove post operative patients. OT facility depended on whether the camp was conducted in a PHC, CHC or Post partum centre. OT facilities at the PHC were inadequate. No pre-operative information or support provided to clients Time between pre-operative medication and sterilization hurried. Inadequate time given for sterilization of laparoscope
2002	UP	10 Camps 253 women	OT tables makeshift. Pre and post operative areas inadequate. Only one location had all recommended back up facilities. Clients not provided with OT clothes. Surgeon and assistant had clean OT clothes in 2 places. Infiltration anaesthesia given along with premedication outside the OT at variable interval before surgery Bicycle pump and bulb of BP instrument used for pumping air into the abdomen for laparoscopy. Laparoscopic ligation completed in 2 to 5 minutes per case No pre operative or post operative monitoring.

***Contraceptive choices and freedom from coercion*** - The Indian Family Planning programme was well known for being target-oriented through offering incentives and establishing punishment regimes. However, its policy has changed since the Cairo Conference took place. In April 1996 the Central Government adopted the Target Free Approach, subsequently renaming it the Community Needs Assessment approach. Unfortunately, this change has not



been internalised and many state government and service-providers continue with reproductive targets and incentives. Tubectomies still remain the order of the day, and incentives have been increased manifold in several states.

### **Violence, gender and contraception**

Contraception is an area in which gender-based violence occurs on women within the family and also by service providers. In Indian society with its wide gender disparities, it is doubtful whether women can negotiate contraceptive use with their partners. It may be difficult for the woman to insist that her male partner take up responsibility and use contraception. This is true both within and outside marriage. When men do not want to use a contraceptive, they can also force their woman partner not to use one, regardless of whether the woman wants a child or not. The result is that women are often saddled with an unwanted pregnancy or an induced abortion. In cases of abortion the woman must face a host of other complications. Another form of violence associated with the issue of contraception is the pressure on women to bear male children, because of which they must go through several unwanted pregnancies in order to have a son.

Coercion and violence with regard to contraception takes different forms in the case of government health services. Many government centres or service-providers insist before an abortion is conducted that the woman agrees to IUD insertion. They may also insist on sterilisation or IUD insertion when she comes to deliver a child. Then there is the pressure on the woman by the service-provider to adopt a particular method. The absence of proper contraceptive information and services leads many women to bear more children than they want. Going through unsafe abortions is also a form of violence.

### **Provider control versus user control**

If one is viewing contraception from the rights perspective, a debate on control is essential. Provider controlled contraception refers to those methods where dependence on the service provider is high, for instance injectibles, permanent methods and implants. Several countries have used such methods for ensuring population control. On the other hand, user-controlled methods give the user autonomy and the ability to choose to become pregnant, which population control regimes are keen to regulate. Provider controlled methods also imply that the provider is accessible and supportive in case of complications and if side-effects occur. However, these become difficult to ensure where the health service delivery mechanism is weak.

## SECTION THREE

### **Implementing a Contraceptive Programme**

There is a great unmet need for contraception in India. It is crucial to enable women to take informed decisions about birth-control so that they do not undergo needless pregnancies and abortions. Programmes focussing on contraception are thus essential to provide women in remote and marginal areas access to contraceptive information and services. But care needs to be taken to follow a model that allows all potential users access to this information and services. Also, one needs to respect the client's right to free and informed choice. While it is important that for monitoring the programme targets are set, or more correctly, indicators estimating change established, these should not be given greater importance than the communities needs. The Community Needs Assessment Approach lays down the principles of generating the contraceptive needs of the community in partnership with it. One needs to improvise and devise actual ways of doing so.

Service-provision is a key element that needs to be taken care of because once the needs have been generated it would be fatal not to provide the services. Despite the popular notion that government supplies of condoms are used as balloons by village kids, there is definitely a demand- supply gap at the community level. Today, most communities clearly express the need for contraception and the main factor that stops them from achieving the desired family size is often the lack of services. Many organisations have resorted to a social marketing approach where instead of providing free contraceptives, the organisation assists the community in accessing cheap but reliable contraceptives from the market.

### **Some features which could be included in a contraceptive programme**

1. It should be part of a holistic reproductive health package rather than being a stand-alone contraceptive programme
2. It should actively promote male participation and involvement in contraception
3. The programme should be integrated and include IEC and service provision
4. The IEC should be geared to reduce gender disparities in the community especially with regard to contraception
5. Information provided about different contraceptives should be unbiased and include both merits and demerits. There should be no hidden agenda as far as methods are concerned
6. Spacing methods should be especially promoted
7. There should be provisions for confidential counselling services
8. Women should be empowered for contraceptive negotiation
9. Services should include systematic follow-up care
10. The programme should not ignore the contraceptive needs of other

people who are not strictly eligible couples

### **Contraceptive Research**

Contraceptive research is of three kinds- Research for developing new contraceptives, research or field studies to determine their efficacy, side-effects and acceptability and finally research into contraceptive needs and experiences. Thus, the research could be biological or social. While many research laboratories are involved in biological research to find the ideal contraceptive, NGOs are involved in social research by either testing the contraceptive's efficacy and acceptability or by studying the community's needs and experiences. In either type of research the organisation must ensure:

- Full regard for ethics, insisting on informed consent for any type of testing
- Promote research on male contraceptive methods
- Promote qualitative research on knowledge, attitudes and experiences of different client groups regarding contraceptive use

### **Advocacy**

Contraceptives are a very important issue in a country like India that is so concerned with its population. There are five methods of contraceptives being promoted through the family welfare programme. A few others were tried but not introduced following serious protests against some that were not considered safe in the prevailing circumstances. Constant vigilance by citizens' organisations is needed to ensure that the contraceptive needs of the poor are properly met through the government system. Some of the issues around which this vigilance may be maintained are:

- Quality and reach of government services
- Demand for more women- friendly and non-invasive safe contraceptives
- Monitoring new contraceptives being tried and promoted, from the point of view of safety.

Details of advocacy campaigns around contraceptives are provided in *Booklet 3 Changing Paradigms : RH Policy and Advocacy*

### **Organisations Working On Contraception And Family Planning**

As mentioned earlier, a large number of organisations are working in the area of Family Planning. Many are supported by the government. The government norm earlier was to fund programmes that focussed exclusively on Family Planning, but in the last few years the nature of the programmes has changed. The term now being used is Reproductive and Child Health, with the emphasis however remaining on Family Planning and Contraceptive prevalence.

## Mother NGO Scheme

The Mother NGO scheme is promoted by the Department of Family Welfare, in the Union Ministry of Health and Family Welfare. Under this scheme NGOs are invited to send projects for becoming Mother NGOS. Mother NGOs are to be those that will support grassroots NGOs both financially and technically to implement RCH programmes on the ground. Each Mother NGO will look after a few districts in the state, supporting grassroots NGOs in there. The selection of Mother NGOs is to be done by screening applications from national NGOs as well as recommendations from local Government authorities. Under this scheme a large number of Mother NGOs have already been appointed in various districts. They in turn are in the process of identifying grassroots NGOs for implementing RCH projects. To get further details regarding the Mother NGO scheme please contact:

The Joint Secretary,  
Department of Family Welfare,  
Ministry of Health and Family Welfare  
Nirman Bhawan,  
New Delhi 110001

Some large autonomous organisations promote Family Planning through community based interventions, such as the Pariwar Seva Sansthan and the Family Planning Association of India. Other organisations like JANANI and Population Services International work on promoting contraceptives through the social marketing approach.

In the state of Uttar Pradesh a massive multi-million dollar project called State Innovations in Family Planning Services Agency (SIFPSA) is funded by the USAID. Innovations in Family Planning Services (IFPS), an initiative of USAID also promotes family planning programmes through the state government, NGOs, corporate houses and cooperatives. A large number of international agencies too are involved in training on different aspects of family planning and contraception in the country. These include CEDPA, Engender Health, PATH and INTRAH/PRIME.

Some organisations work on the advocacy aspect of family planning. These include Forum For Women's Health (FFWH) , Jagori, Saheli, Healthwatch UP Bihar and Sama. Some of the advocacy campaigns related to Family Planning have been resisting the introduction of injectibles and implants, ensuring the quality of care of sterilisation operations. Other organisations involved in research around the issue include Centre for Enquiry into Health and Allied Themes (CEHAT), Population Foundation of India, Population Council, International Centre for Research on Women (ICRW), Centre for Operation Research Training (CORT), ORG- MARG, Foundation for Research in Health Systems (FRHS) and Foundation for Research in Community Health FRCH.

Some of the addresses of the organisations referred to above are given below:

<b>Engender Health</b> 50,M, Shantipath, Gateway –3 Niti Marg, New Delhi-110021(India) Phone- 91(011) 2461-2841,2467-3733 2688-3497	<b>PATH</b> 53, Lodhi Estate, Sangha Rachna Building, Ground Floor New Delhi-110003 (India) Phone- (91-11) 2463-5745/2463-1235
<b>Centre for Operation Research Training(CORT)</b> 402, Woodland Apartment, Race Course circle, Vadodra, 390007 (Gujarat) Ph. No.- 091-265-2336875, 2341253 Email-cortresearch@sify.com	<b>Population Council</b> Zone 5A, Ground Floor, India Habitat Centre, Lodhi Road, N Delhi 110003 Tel- (91-11-2)464-2901/2,4008/9.
<b>Centre for Enquiry into Health and Allied Themes (CEHAT)</b> Sai Ashary, Aram Society Road, Vakola, Santacruz (East) Mumbai – 400055(Maharashtra) Tel- 91-(022)26673571,26673154 Email- cehat@vsnl.com	<b>JANANI</b> Reshmi complex, P&T Colony, Kidwaiपुरी Patna- 800001, India Ph-+91-612,2537645 Email- patna@janani.org
<b>Centre for Development and Population Activities (CEDPA)</b> C-Block House No-1 Hauz khas. New Delhi – 110016 Ph. No.- -91(011) 51656781 - 8	<b>Population Services International</b> C-445 Chittaranjan Park, P.O. Box 7360, New Delhi 110019, Ph-(011)-91-11 - 2627-8375 Email- psi@psi.org
<b>Foundation for Research in Community Health (FRCH)</b> 84/A R.G Thadani Marg, Worli, Mumbai Ph.no.-022- 24932876/ 4934989 Email- frchbom@bom2.vsnl.net.in	<b>State Innovations in Family Planning Services Agency (SIFPSA)</b> Om Kailash Towers, 19, Vidhan Sabha Marg, Lucknow 226001 Phone-(91-522) 2237497/2237498 Email- sifpsa@satyammail.com
<b>Foundation for Research in Health Systems ( FRHS),</b> 7,Shrividhi Apartments, 182, Azad Society, Ahmedabad-380015, India Ph.no.- : (079) 6740437/6746279 Email:- frhsahdad1@sancharnet.in	<b>Population Foundation of India</b> B- 28 Tara Crescent, Qutab Institutional Area, New Delhi – 110016. Ph – 011- 26867080. Email – prema@popfound.org
<b>International Centre for Research on Women (ICRW),</b> 42, 1 <sup>st</sup> floor, Golf links New Delhi –110003 Phone:- 2465-4216 Email- info@icrwindia.org	<b>PRIME/INTRAH</b> 50,M, Shantipath, Gateway –3 Niti Marg, New Delhi-110021(India) Phone- 91(011) 2461-2841,2467-3733 2688-3497 Email- intrah@giasdl01.vsnl.net.in
<b>Healthwatch UP Bihar</b> C- 1485 Indira Nagar, Lucknow – 226016, UP, India Ph – 91-522-2310747, 2341319. Email – hwupb@yahoo.co.in	<b>SAMA</b> G-19, 2nd Floor, Marg No. 24, Saket. New Delhi 17 Ph- 011-26562401, 55637632 Email- sama_womenshealth@vsnl.net

## SECTION FOUR

### Resource Section

**Books And Reports** - Some of the books and reports that we found useful in preparing this booklet are:

1. Balasubrahmanyam Vimal, "Contraception – As if Women Mattered"; Centre for Education and Documentation, 1986.
2. Bell Ruth et al. 'Changing Bodies, Changing lives': A Book for Teens on Sex and Relationships. New York : Vintage Books, 1987 (updated 1998).
3. Bhate Kamaxi et al (eds.), In Search of Our Bodies: A Feminist Look at Women, Health and Reproduction in India. Shakti, Bombay, 1987.
4. Billings Evelyn and Ann Westmore, "The Billings Method," Harmondsworth: Penguin 1980.
5. Boston Women's Health Book Collective, "Our Bodies, Ourselves: For the New Century"; Simon and Schuster, New York, 1998.
6. Burns August, Ronnie Lovich, Jane Maxwell and Katharine Shapiro; Where Women Have no Doctor- A Health Guide for Women; A Hesperian Foundation Book, 1997
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**Videos:** There are a large number of videos that deal with contraception or more correctly, Family Planning. A number of these are produced by the Government. Below is a list of films that deal in a critical way with the issue of contraception.

1. Something Like a War, Deepa Dhanraj: A Film documenting excesses in population control, sterilization and hazardous contraceptives like Norplant.
2. The Legend of Malthus, Deepa Dhanraj: A Film analysing the myths of “over population” propagated by Malthus.
3. The Human Laboratory, Horizon Films: A film about the Anti-Fertility Vaccine and Norplant, documenting the use of women as guinea-pigs for medical research.
4. Vaccination Against Pregnancy, Ulrike Schaz: A film about the Anti-Fertility Vaccine and its hazards for women.

Video films as well as a complete catalogue of available films can be obtained from:

<b>1. Jagori,</b> C – 54, South Extension Part II, New Delhi-110049 Tel.-011- 26257015/2625-7140 Email- jagori@spectranet.com Web site- <a href="http://www.jagori.org">http://www.jagori.org</a>	<b>2. Netwaves,</b> C/o KP Sasi, 139, 10 <sup>th</sup> A Cross (IInd Floor), J.P. Nagar, Phase I, Bangalore, 560 078 Tel. 26553117
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### Resource Organisations

There are a number of resource organisations on Contraception and Family planning. We have tried to categorise these into those that can provide technical information and support and those that provide support for an alternative perspective.

Technical support may be obtained from:

#### **Parivar Sewa Sansthan (PSS)**

An affiliate of Marie Stopes International, it is probably best known for the Marie Stopes Clinics and for providing cheap and safe abortion services. It also runs comprehensive Family Planning programmes in various areas.

28, Defence Colony,

New Delhi – 110024

Phno. –(011) 24332585,24336337,24336710

Email- parivarseva@vsnl.com

Web site- [www.parivarsevasanstha.org](http://www.parivarsevasanstha.org)



**Family Planning Association of India (FPAI)**

FPAI is one of the oldest NGOs in the sphere of Family Planning and contraception. It has branches in all states. It carries out comprehensive programmes addressing all aspects of Reproductive Health.

Bajaj Bhavan, Nariman Point,  
Mumbai – 400021, India  
Tel- (91) –22-22029080/22025174  
Email- fpai@viasbm01.vsnl.net.in  
Web site- <http://www.fpai.org>

**UNFPA**

This UN body is exclusively devoted to the Reproductive Health agenda. It produces a lot of material on the issue, particularly related to statistics from all over the world.

Country Representative,  
UNFPA,  
55, Lodhi Estate,  
New Delhi 110003

Office of the **Chief Medical Officer** in every District. It can provide information, contraceptive services and the IEC materials produced by the Government from time to time

**VHAI and state VHAs**

Alok Mukhopadhyay, Executive Director,  
VHAI,  
40 Institutional Area, Behind Qutab Hotel,  
New Delhi 110016

Organisations promoting an alternative perspective include:

**FORUM FOR WOMEN'S HEALTH**

FFWH is a campaign group working on women's health. It has worked on the campaign against hazardous contraception and coercive population control.

c/o Swatija Manorama,  
9 Sarvesh,  
Govind Nagar, Thane (East),  
Maharashtra, 400 603

**JAGORI**

This women's group documents health-related issues and participated in the campaign against hazardous contraceptives. Resource material, training material and video films on women's issues and health are also available with it.

**SAHELI**

This autonomous women's group has been involved in the campaign against hazardous contraceptives and coercive population control for over 15 years. It has also raised issues of ethics in medical research and informed consent. It has produced reports, newsletters and other material in English and Hindi.

**SAHELI**

Unit Above Shop 105-108,  
Defence Colony Flyover Market (Southside),  
Defence Colony,  
New Delhi 110 024  
Phno.(011) 24616485  
Email- saheli@indiatimes.com.

**Useful Websites:**

<b>International</b>	<b>Indian</b>
Population Action International - <a href="http://www.populationaction.org/">www.populationaction.org/</a>	CEHAT - <a href="http://www.cephat.org">www.cephat.org</a>
UNFPA - <a href="http://www.unfpa.org/">www.unfpa.org/</a>	Department of Family Welfare - <a href="http://www.health.nic.in">www.health.nic.in</a> .
International Planned Parenthood Federation - <a href="http://www.ippf.org">www.ippf.org</a>	Family Planning Association of India - <a href="http://www.fpaIndia.com/">www.fpaIndia.com/</a>
Johns Hopkins University Center for Communication Programs - <a href="http://www.jhuccp.org">www.jhuccp.org</a>	Jagori - <a href="http://www.jagori.org/">www.jagori.org/</a>
Population Reports <a href="http://www.infoforhealth.org/pr/">www.infoforhealth.org/pr/</a>	Janani <a href="http://www.janani.org">http://www.janani.org</a>
Family Health International - <a href="http://www.fhi.org">www.fhi.org</a> .	Pariwar Sewa Sansthan - <a href="http://www.parivarsevasanstha.org">www.parivarsevasanstha.org</a>
IWHC <a href="http://www.iwhc.org/">http://www.iwhc.org/</a>	SAHAYOG – <a href="http://www.sahayogindia.org">www.sahayogindia.org</a>
Marie Stopes International - <a href="http://www.mariestopes.org.ok">www.mariestopes.org.ok</a>	SIFPSA - <a href="http://www.sifpsa.org">www.sifpsa.org</a> .
WGNRR <a href="http://www.wgnrr.org">http://www.wgnrr.org</a>	UNFPA India <a href="http://www.unfpa.org.in">http://www.unfpa.org.in</a>
PATH - <a href="http://www.path..org">www.path..org</a> . RHO- <a href="http://www.rho.org">www.rho.org</a>	Voluntary Health Association of India <a href="http://www.vhai.org">www.vhai.org</a> .

**Booklet prepared by -**

***Research and Text – Alok Srivastava, Jashodhara Dasgupta, Abhijit Das***

***Additional text and review – Laxmi Murthy***

***Illustrations - Ganesh***

***Layout - Deepak***

UNDERSTANDING REPRODUCTIVE HEALTH

A Resource Pack

This Resource Pack is an introduction for those who wish to learn about different facets of Reproductive Health. Reproductive Health as a concept is relatively new and , despite the name, is not exclusively a ‘health’ subject. In its ambit it involves social sciences, medical sciences, women’s issues, human rights, population sciences, demography and so on. Thus it could be of relevance to individuals with a wide range of interests. Reproductive Health is an issue of interest to Government planners and managers because of the overwhelming concern for population. Reproductive Health is also a matter of great interest to the NGO sector, because of their concern for the health of women. Concern for women, their rights, well being and health is the underlying theme for the entire Resource Pack.

This Resource Pack has been designed as a series of booklets so that the interested reader may straight-away refer to the issue of her/his interest. The matter and presentation of the material in the different booklets has been kept simple as well as provocative as it is meant for the first-time user. Each booklet has been divided into four sections - the first dealing with theory and concepts, the second with issues of relevance, the third on best practices in the field. Keeping the interest of the practitioner in mind there is also a small resource section at the end of each booklet.

The booklets in this pack are as follows -

Booklet 1	<b>An Introduction to Reproductive Health</b>
Booklet 2	<b>Understanding Numbers</b> : Population and Demography
Booklet 3	<b>Changing Paradigms</b> : RH Policy and Advocacy
Booklet 4	<b>Exploring New Frontiers</b> : Reproductive and Sexual Rights
Booklet 5	<b>Maternal health is still important</b>
Booklet 6	<b>The Promise of better health</b> : Women’s Health
Booklet 7	<b>Beyond Family Planning</b> : Contraception
Booklet 8	<b>The Emerging Agenda</b> : Adolescents
Booklet 9	<b>Forging new partnerships</b> : Men’s Health and Responsibility
Booklet 10	<b>Coming to terms with reality</b> : HIV/AIDS and STDs
Booklet 11	<b>Acknowledging ourselves</b> : Sex and Sexuality
Booklet 12	<b>Women have Minds Too!</b> : Exploring the interface between Reproductive Health and Mental health
Booklet 13	<b>Taking a stand</b> : Violence, Women and Health
Booklet 14	<b>Data Digest</b>

**KRITI Resource Centre  
for  
Women's Health , Gender and Empowerment**

The KRITI Resource Centre, is involved in providing training support, production and distribution of material, and engaging in creative partnerships with other institutions to strengthen their work of empowering women at the grassroots level, enabling women to lead healthier lives. The primary activities of the KRITI Resource Centre for Women's Health, Gender and Empowerment are as follows

**TRAINING** - KRITI has considerable experience and expertise in trainings related to Women's Health and Gender and has provided training support to over 100 organisation as well as Government projects and departments in the states of UP, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Delhi, Rajasthan, Haryana and Himachal Pradesh. The Resource centre has been involved in partnerships with other gender training organizations like JAGORI, IWID, and the South Asian Network of Gender Trainers (SANGT).

**PRODUCTION AND DISTRIBUTION OF LEARNING AND COMMUNICATION MATERIAL** - *KRITI is also involved in designing and producing appropriate material for the special needs of those involved in working with communities on these issues. Much of the material is in Hindi. Copiously illustrated material has also been produced keeping grassroots needs in mind. For the practitioners KRITI has produced newsletters, field manuals, training manuals and kits, briefing kits and information sheets on various relevant issues.*

**RESEARCH AND DOCUMENTATION** - *KRITI Resource Centre engages in field level documentation, to get a more holistic understanding of women's health and the socio-economic conditions that influence it. Some of the studies it has conducted and participated in include a study of traditional birthing practices, Abortion and women's health in rural areas of Uttarakhand, customs and practices around menstruation, the possibility of HIV/AIDS, implementing the Target Free Approach in Family welfare programmes in UP, quality of care of health care service in UP, violence against women and so on.*

**ADVOCACY** - *The resource centre is also actively involved with advocacy on the issues of Women's Health and Population Policies and Violence against Women. It is closely working with other networks and organisations working on these issues.*

**SERVICES PROVIDED BY KRITI RESOURCE CENTRE**

- ❖ Library and documentation centre
- ❖ Books, posters and other materials
- ❖ Training and internship
- ❖ Support for developing gender sensitive community based interventions/training programmes







**Kriti Resource Centre**

C-1485, Indira Nagar  
Lucknow - 226016, U.P., India  
Phone - (0522) 2310747, 2341319  
email - [kritirc@sahayogindia.org](mailto:kritirc@sahayogindia.org)  
Website : [www.sahayogindia.org](http://www.sahayogindia.org)