

## **Family Planning and Contraceptive Use in India**

### *New Priorities, New Approaches*

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### **Introduction**

India started the first national family planning programme in the world nearly sixty years ago. Those were very different times with different realities. The life expectancy of the average Indian was more than thirty years less than it is today ( thirty five years to sixty seven years), the average number of children a woman had in her lifetime was about six and about more than one fifth of infants born did not see their first birthday. Contraceptive usage had begun earlier, but interestingly female sterilization, the most common contemporary contraceptive, did not exist as we know it today. Since then India's family planning programme has had a chequered history. From being a programme which was seen as being essentially supportive to a more robust maternal and child health programme it became so big that it overwhelmed the entire health programme in the size of its scope and budget as the fears of a 'population explosion' overwhelmed planners. From seeing development as the best contraceptive ( 1974), Indian policy makers moved to a radically different policy of forced sterilization within a very short time span ( 1975 – 77). Over time men's involvement in family planning fell and it became an entirely target driven numbers game where all government officials from the subordinate village school teacher to the District Collector being judged by the number of 'tubectomies' they delivered in a year (twenty point programme of the 1980's). Some degree of sanity was restored when post- ICPD ( International Conference on Population and Development, Cairo1994), India went into a target free, reproductive and child health regime ( 1996 -97), adopted a new National Population Policy (2000), which called for an integrated approach which transformed itself over the years into a more holistic National Rural Health Mission ( 2005). In the interim the spread of HIV/AIDS had introduced the new paradigm of dual protection with the consequences of unsafe sex being linked to both unwanted pregnancy as well as sexually transmitted infections. But somehow this concern remains isolated from mainstream health policy concerns in India today. In 2010 the family planning concerns were revisited by the National Parliament, after a long hiatus of thirty three years (since the Emergency) by holding a five and half hour discussion on the topic in early August. It is against this backdrop that this paper will explore some the new priorities and concerns around family planning and contraception.

### **The Need the revisit Family Planning**

A review of the discussions that took place in the Lok Sabha clearly indicates that the Malthusian fear of over population and food supply continues to dog our legislators. However within that overarching rubric there were some voices pointing towards the 'demographic dividend' and the 'population momentum' that are inevitable because of the higher birth and survival rates in the recent past due to better public health measures. This clearly indicates

that myths and misinformation around population issues continue even fifteen years after Cairo. The other 'fear' that seems to buttress this anxiety is India overtaking China and that the stabilization of India's population will be delayed by about 25 years (from 2045 to 2070). This point was highlighted by Indian Health Minister Mr Ghulam Nabi Azad during his presentation at the National Commission on Population during its meeting in September 2010. There is also a concern among some policy makers and bureaucrats that the efforts around meeting the Millennium Development Goals (MDG) and fulfilling NRHM objectives, the important task of Family Planning is being relatively ignored. Some experts at the global level are also trying to link family planning to the newest threats around Climate Change to create a new sense of urgency.

Family Planning policy making and implementation in India, with its emphasis on the eligible couple register has always remained silent about the contraceptive needs of single people and increasingly a large number of young people are delaying their marriage. Indeed delaying marriage is an acknowledged mechanism for reducing fertility! Unfortunately there is a policy silence on the contraceptive needs of young people who may not be in marriage. Similarly with the continued emphasis on surgical methods and on long term methods like the long acting Copper T, the contraceptive needs of young people, who today comprise the largest client group, remain acknowledged. The overall design and implementation of the programme has seen little change over the last two decades years. In many states targets continue at the district and sub-district levels. Permanent methods continue to be promoted by established and superannuated experts and camp based approach with an emphasis on surgical methods are promoted through newer agencies like the Jan Sankhya Sthirta Kosh in states like Bihar, leading to questions about informed consent, basket of choices and quality of care. Demand supply gaps and issues relating to commodity security continue to dog the programme at a practical level in many places.

### **Revisiting the Changes over the last six decades**

In the face of the new and recurring anxieties and concerns around family planning and contraceptive use it is necessary to review the changes that have taken place over the years which have substantially altered the context in which family planning and contraceptive use take place.

#### ***Changes in Fertility and Contraceptive usage***

- ⊙ Overall contraceptive usage has increased from about 13% in the 1970s to 41% in 1992-93 (NFHS1 – pre ICPD) to 56% in 2005 -06 (NFHS 3). For rural India this increase has been from 37% to 53%. The proportionate change during this period has been more in rural India .
- ⊙ Total Fertility Rate has declined from nearly 6 during the 1950's to 3.4 in 1992 -93 to 2.7 in 2005 -06. The total wanted fertility rate overall for the country is 1.9. This indicates that the overall the desire is for small families. A large number of states have already reached replacement fertility level of 2.1.

- ⊙ It is not surprising that unmet needs still continue to be high with an overall unmet need of 13% while in states like UP, Bihar and Jharkhand it continues to be over 20%. This indicates a large number of couples are unable to get the services to meet their needs.
- ⊙ In the last forty years contraceptive usage has increased four times on an average and in many states it has achieved rates around 70% which are as high as anywhere in the world. Contraceptive use is highest in Himachal Pradesh (73%) and West Bengal (71%). Female sterilization accounts for two-thirds of contraceptive use.
- ⊙ Women in India are more likely to use contraception if they already have a son. For example, 77 percent of women with two sons but no daughters use a method of family planning, compared with 53 percent of women with two daughters but no sons.
- ⊙ More than half of women who get sterilized have the operation before they reach 26 years of age. Early sterilization is particularly common in Andhra Pradesh, where the median age of sterilization is just 23 years.
- ⊙ The most commonly used spacing methods are condoms and the rhythm method (each used by 5% of currently married women).
- ⊙ Male sterilization is the least used method.
- ⊙ Only one-third of the users were informed about side effects and one quarter were informed what to do in case of side effects.

### ***Changes in global understanding and contests around population and family planning***

- ⊙ The 1950's was a time of nation building and like India many countries introduced national family planning programmes as a part of their nation building process. As changes in public health measures and medical technologies increased life expectancies Malthusian fears started predominating the global north (in the 1960s) and promotion of family planning became a routine part of international aid programmes. Increased understanding of human rights and rising assertion of the feminist movements challenged the assumption that family planning could be used as a nation building tool ( in the 70s and 80s) and the need for framing it within the concept of reproductive right of individuals and couples was universally acknowledged at the Cairo conference ( 1994).
- ⊙ Indian programming around family planning was influenced by global trends and the fear of the 'population bomb' has been systematically inculcated in the Indian public through a long tradition of 'population education', which has introduced this topic within school curriculum. Even after the policy changes many of the references have not been removed.
- ⊙ The fear of overpopulation had expressed itself in a series of incentives and disincentives in public policy and programming in India. These include a 'two-child

norm' mindset which expresses itself in a range of measures from maternity benefits schemes to participation in electoral politics to rationing of water for irrigation. While many states have reviewed legislation in tune with changed understanding on the issue, others continue to apply such measures.

- ⦿ Contraceptive provisioning is a contested area in India. Women's organizations and other progressive organizations have always called for following a policy which keeps women's interest at the centre. There have been more than one case of civil society approaching the courts for intervention. The Supreme Court has made more than one intervention which include banning of Quinacrine as a contraceptive, restricting use of Injectables and enforcing quality norms for sterilisation and instructing the introduction of a compensation scheme for failures and adverse outcomes.

### ***Changing demographics and changing needs***

- ⦿ When India gained independence the country's population was a third of what it is today but average life expectancy was also less than half at 32 years, the infant mortality rate nearly four times at 225 out of 1000 live births. Today we are concerned about a population of over one billion but rarely consider that this is perhaps due in great measure to the rapid decline in mortality rates leading to increased life expectancy.
- ⦿ In the last sixty years there have been major changes in family structure and composition. Families have become fragmented, the size of the family has become smaller, the age at marriage has increased and literacy both among men and women has increased. These changes have major consequences in reproductive decision making and contraceptive negotiations.
- ⦿ The Indian family planning programme is heavily dependent on permanent methods. These methods are most useful for couples who have completed their reproductive intentions, and offer little to those who would like to delay pregnancy. It is not surprising that according to NFHS 3 data the contraceptive use by age changes drastically from 13% among rural married women 19 years or younger to 55% for women 25 years or older and stagnating at 67% for women 30 years and above. Clearly the system is not able to meet the needs of young women, especially those below 25 years.
- ⦿ While age at marriage has increased across the country, the legal age at marriage continues to be violated with impunity across the country. In many states nearly half the girls who are 18years old are already married and a large proportion of them have become mothers. These contraceptive needs of such young couples remain acknowledged.
- ⦿ India is an increasingly becoming a young country. This means, that the proportion of young people is increasing as a proportion of the population, and our population pyramid is changing from an acute triangle to triangle on a rectangle or quadrilateral.

According to the last census in 2001 the proportion of population in the 13 to 35 years age bracket was 41% of the population. Over the last forty years there has been a ten percent increase in the population proportion of those in the age group 14 – 24 from about 27% of the overall population to over 30% of the population.

- ⊙ The spread of HIV/AIDS infection has clearly indicated the need to consider sexual activity beyond the strict confines of marriage and look at safety of sexual encounters. Unfortunately the contraceptive needs of many continues to be ignored where the family planning programme ignoring unmarried people, and the HIV prevention programme targeting sex workers, men who have sex with men and truckers

### ***Changes in Contraceptive availability***

- ⊙ When India started its family planning programme condoms and vasectomy were the most commonly employed method. Female sterilisation the most popular method today did not come into the system before the 1980's. Laparoscopic tubectomy, the predominant method used in camps became popular sometime later.
- ⊙ Today there are five main methods of contraception that are provided through the national family planning programme and they include the condom, the oral pill, the Copper T and male and female sterilisation. There have some changes in the technology used for most of these methods over the years. Condoms have become lubricated, pills have lowered their oestrogen content, Copper Ts are now available in two versions, and vasectomy has given way to non-scalpel vasectomy.
- ⊙ In addition to these methods there are a few more methods which are available in the market which include emergency contraceptives and the injectable contraceptive *Depo-provera*. Implants like Norplant and quinacrine have been outlawed in the country. Some non hormonal chemicals like centchroman (*Saheli*) and barrier foam methods like Nonoxynol (*Today*) are also available. Female contraceptives have also been introduced, but their use is exclusively in the context of infection prevention. There are other methods like diaphragm and cervical caps which are not easily available in India. A reversible male method called RISUG is under trial. Interestingly centchroman and RISUG have been developed by Indian scientists.
- ⊙ In addition to modern methods there are a number of traditional methods which now include some scientifically validated methods like LAM (*Lactation Amenorrhoea Method*), and the safe days method (*CycleBeads*).

### **Contraceptive Need, Choice or Compulsion?**

The history of contraceptives in the twentieth century makes very interesting reading. To start with the use of contraceptives was severely criticized by the doyens of society, leading to the movement around birth control or women's ability to control their reproduction. Margaret Sanger of the US was the most famous name in this movement and she was convicted as a criminal for distributing contraceptives. Later she was responsible for setting up the International Planned Parenthood Federation. On a different note, the idea of natural selection

in the context of the racist supremacy gave rise to the concept of eugenics, which was practiced through forcible sterilization among Jews in Nazi Germany, for blacks in the USA and among immigrants and Roma people in Europe. Malthusian concerns around development led to a different form of coercive practice by the state which reached its nadir in India during the Emergency. Sexual ignorance was another issue around which the twentieth century saw a revolution starting with Marie Stopes in UK exploring sex pleasure in marriage and Alfred Kinsey exploring the sexual behaviours of the American male and female. The sexual revolution of the sixties and thereafter was possible because of the widespread use of contraceptives like the pill and it was only after the incidence of genital herpes and later HIV that the issue of protection from STIs became a cause for concern.

Against this backdrop of different perspectives towards contraception, one can consider different aspects of a contraceptive which are considered desirable by different persons. A consensus list of desirable characteristics would read as follows:

- Very safe – no side effects and post use consequences
- Easy to use or administer and does not alter lifestyle, including sexual lifestyle because of its use
- No visits to hospital/ doctor/ provider
- Reversible – but this may not be desirable for those who have completed their reproductive intentions
- Effective – is completely failure proof
- Doesn't hinder pleasure- a very important consideration.
- Prevents infection

However even this list of desirable characteristics can differ under different circumstances like :

- Age– Contraceptive needs differ according to age and stages in one's life cycle. Hormonal methods, which are very effective, are not so safe at very younger and higher ages.
- Individual autonomy – in many situations women do not enjoy sufficient reproductive autonomy and may need methods which they can use without their communities or even their families becoming aware that they are using a contraceptive
- Nature of partner/ relationship – Stable relationships may need different kinds of contraceptive from occasional relations. Contraceptive usage ideally should follow from a joint decision making process, but inter spousal relationships in a deeply patriarchal world are hardly based on equality and mutual respect, affecting contraceptive choice.

- Family size intentions – clearly couples who desire a temporary suspension of childbearing require different methods from those who have completed their families.

The ability to identify one's needs and make choices also assumes that the person not only has information about the different methods available but access to them as well. A quick review of the global practice of contraceptive use provides a wide diversity of situations. Considering Western European countries as a yardstick one sees a diversity of practice between UK with permanent methods (both male and female) accounting for the bulk at more than 30% of contraceptive use to Germany where the pill (at 52%) predominates. Among the emerging economies injectables are the dominant method in South Africa while Brazil and India depend upon female sterilisation and in China the IUD is the most common. Interestingly in Japan the condom is the most popular method as is also the case in South Korea. Clearly different conditions influence the use of contraceptives in different regions and there is no ideal or desirable mix of methods which can indicate a state of complete fulfilment of contraceptive needs according to independent and autonomous informed choice.

### **Questioning Some Current Assumptions**

In the face of such overwhelming diversity of method mix in different countries and regions of the world it becomes difficult to question the existing situation in India. However even then some questions that may be posed about the current approach in India are as follows

- Is Female Sterilisation, the most common method safe, appropriate and method of choice in all situations?
- Does the Family Planning programme indeed provide a 'basket of choices'?
- Is there any value to keeping long acting hormonal methods out of the programme and not increasing the number of options available?
- Do we need more FP promotion and incentives in the face of continuing high unmet needs?
- Have we lost condoms to infection prevention?

We have already examined that female sterilization is certainly not a method of choice for young women because they may need temporary methods. In the face of a lack of choices many young women prefer to have two children in quick succession and then opt for an early tubectomy. In many states like Andhra Pradesh there are cases of women as young as 21 undergoing tubal ligation after having two children. Recent research indicates that tubectomy at very young age is undesirable and women under the age of 30 should be provided with other choices. Also the rates of hysterectomy tend to increase in women who have undergone tubectomy and this reality is also emerging in India. In addition, tubal ligation needs caution because it is abdominal surgery and poorly conducted operations (as in camp situations) lead to higher rates of infections, complications, failures and even death.

Contraceptive choices are limited in India. In practice the condom has moved out from use in 'trusted' relationships where contraception is the only concern to the realm of occasional relationship where infection prevention is the primary concern for the user. This shift in the use of condoms has also reduced the overall male responsibility for contraception. In this overall restricted environment it is necessary to review the legal restrictions on the use of injectables in India. Injectables like Net En and Depo Provera were subject to legal scrutiny in India because of safety concerns. Today there is more evidence available on the use of Depo Provera. According to papers published in peer reviewed academic journals it has some advantages ( eg. does not require daily application, can be used in women who are hypertensive, smokers, suffer from migraines – ie. who cannot use the pill) and some disadvantages ( eg. weight changes, mood effects, cycle disturbances, amenorrhoea and delayed return to fertility and above all loss of bone mineral density), like most other contraceptives. Considering the South Asian context the use of Depo Provera in India's neighbours is substantial with Bangladesh, Sri Lanka and Nepal all having 10.5% + rates of injectable use.

In the face of limited choices, the issue of high unmet needs is but natural. In states like UP and Bihar where the contraceptive rates are the lowest, the unmet needs are also highest. In such a situation it is perverse to continuing FP promotion and using incentives and disincentives, without making adequate provisions for information and services around a larger number of contraceptive alternatives.

### **Need for Demographic Reorientation**

India's family planning programme has always been demographically directed and figures like TFR ( Total Fertility Rate) of 2.1 and NRR ( Net Reproductive Rate) of 1 have for long been seen as the holy grail of demographic achievement. However current reality shows that while the TFR of 2.1 being eminently achievable, or already achieved in a number of states, the goal of population stabilization growing distant. This is because the phenomenon of population momentum has not been sufficiently explained and understood. A TFR of 2.1 with a large youthful population who continue to have sterilization as the most easily available option of contraception will lead to a very high momentum effect and the overall population growth rate will continue rise. And the desire for small families in India is more or less universal. The only way to reduce momentum is to space or increase the interval between childbirths, and sterilization as the only option in a mostly young population tends to have the opposite effect.

Another demographic imperative that needs consideration is the relationship between TFR 2.1 and NRR of 1. Experience across Asia has now shown that whenever there is a rapid decline in childbirth in the presence of steep gender differentials, there is a squeeze in the number of girls in any given population. Amartya Sen pointed this out as 'missing girls' in the early 90's. With the advent of technology the decline in sex ratio takes place through sex pre-selection and experience in different states in India shows that low TFR is compatible with very adverse sex ratios. The prevalence of such social phenomenon like 'son preference' may reduce the utility of purely numerical exercises.

A demographic construct which may require reconsideration is the very concept of population stabilization. Using a demographic transition model experts predict a transition across different phases, to this policy ideal of a 'stable' population. The Indian population is undergoing rapid economic growth and urbanization and one does not know how these are also going to affect family size and aspirations. Women's empowerment and autonomy is known to affect population growth, but now there are examples where women are challenging their reproductive roles. In most of Western Europe the growth rates are negative and population sizes are declining. Another fact that needs to be considered alongside is the issue of aging populations and dependancy ratios. A young population is productive, ie. it not only becomes an engine of economic growth but provides resources for the extremely young and elderly. As populations age, and reproductive rates reduce there comes a time when the productivity of the youth is no longer sufficient to support the needs of the elderly. Japan is close to reaching this stage. The US and many European countries are dealing with this problem by immigration, because their internal growth rates are not longer sufficient for their own needs. Internal migration in India is also known to be affected by xenophobia, but migration is often necessary. While this scenario may seem far-fetched in states like UP and Bihar they need to be considered for states like Kerala.

### **Next Steps**

The contextual assessment shows that the need for providing contraceptive services continues even after a relatively successful programme implementation of sixty years. However there have been radical changes in the context and these needs to be considered for re-strategizing. Broadly speaking the issue needs new prioritization, new allies and new directions in service delivery, and these are outlined below.

1. Firstly family planning and contraception has to be seen in the context of young people's needs. When considering family planning it needs moving beyond contraception into the domain of social issues like early marriage, childbirth, spacing, men's contraceptive use, partnership and gender equality as well as services like family life/ adolescent sexuality education. When considering sex and contraception the discussion needs to move beyond a limited family planning or infection prevention paradigm, and create a climate for accepting sexual health and contraceptive needs beyond marriage and address sexuality and pleasure along sexual violence and coercion.
2. Men have to be brought back into the family planning programme. And this cannot be through the provision of gun licenses for motivators of sterilization. Similarly men cannot become cannon fodder to young bureaucrats' desires to make or break world records. Unfortunately both these have been done in Madhya Pradesh and Uttar Pradesh in the recent past. Men have to be approached and involved as partners and carers, and not simply as targets for non scalpel vasectomy as is being done currently. We need to address men's interests as father/parent and spouse/partner to address issues like early marriage, spacing, and contraceptive use. The approach has to be within a gender equality paradigm. We will also need to address men's anxieties

about contraceptive use and failure (including women's anxieties) as well as their reproductive and sexual health needs. This may be done by identifying male leaders and ambassadors who have adopted these practices. These role models should be both from the community and from within the health system. One way to work with men is to engage a male volunteer to work alongside the ASHA to work with men (including young persons).

3. There is an urgent need to reorient policy makers and programme managers including politicians, bureaucrats and service providers about the changing context of family planning and contraceptives within a reproductive rights framework. It is ridiculous that in the twenty first century Indian legislators discuss the television both as a means of contraception and source for inflaming sexual urges. It is unacceptable that Indian policy makers continue with the practice of incentives and disincentives, changing with the times to provide consumer goods, gun licenses and even cars to promote sterilization.
4. The Family Planning programme needs to provide more alternatives and move beyond the tubectomy only approach that it has become bogged down with. It must be recognised that tubectomy is not a viable option for a large number of women who have contraceptive needs. Further, tubectomy among young women is not without risks. We need to conduct studies to carefully identify the various limitations of tubectomy performed under different circumstances (camp or fixed day or regular; mini-lap or laparoscopic). We owe this to the millions of women who have undergone tubectomy and may be suffering from some consequences as a result. We also need to introduce additional options, and the Supreme Court restrictions on Depo Provera may need to be revisited with an open mind and the currently available evidence. The 'basket of choices' approach needs to be strengthened within a community needs based approach. Temporary methods need to be widely available along with appropriate counseling services.
5. However all the changes suggested can only be successful if there is concomitant strengthening of service delivery. Family Planning / contraception should not be seen in isolation or as a vertical programme. It has to be integrated with MCH to develop a comprehensive Family Health programme. On the other hand it has to be part of a comprehensive sexual health initiative that has space for non family planning contraceptive use within health service delivery. Service providers need to be strengthened, including private and community based providers and they have to be accountable for strict quality and consent norms
6. Last but not the least we need to keep women's needs, concerns and participation at the centre of all planning and service delivery considerations. Gender equality has to be a cross cutting concern and all messages and approaches and service delivery mechanisms have to reinforce value of gender equality. At a practical level the practice of informed choice must be rigorously followed and adequate information about risks and advantages at all ages must be provided to all users, especially

women. More women controlled methods need to be made available for those who wish to use them- including diaphragm and jelly. Women's choices and satisfaction must become part of annual village planning and community monitoring processes.

