

Between Societal Aspiration and Individual Choice : Contraceptive Use in India

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It is now fifteen years since the Cairo Conference where the principle of reproductive rights and the right to informed choice in contraceptive use received universal endorsement. Ten years have also passed since India reinforced its commitment to the same principles through the National Population Policy, and it is perhaps an appropriate moment to review the changes in family planning related policy making and their consequences in India.

There have been many positive changes in this period. A quick review of the results of the National Family Health Survey between its first round (1992 -93) and its third round (2005 - 06) shows that there has been a 15% increase in contraceptive usage from 41 to 56%. If one looks at the increase over existing status of contraceptive usage in rural India during the same period the increase (37% to 53%) actually indicates an increase of nearly one and half times. Total fertility rates have declined substantially and in a large number of states it is below what is considered replacement fertility or a TFR of 2.1. If we take wanted fertility into account this figure across the country is actually 1.9, which means that the average number of children a couple/ married woman wants is less than 2, but she invariably ends up having more children because the couple is often unable to get the contraceptive of their choice. This indicates a failure of our family planning programme to reach all couples, and this is as high as one in five couples in states like UP, Bihar and Jharkhand. On the other hand in states like Himchal Pradesh and West Bengal the contraceptive prevalence is over 70% of all couples.

It may thus be argued that even without any centrally determined targets the family programme did not run aground. However the anxieties have continued, and there has been little attention paid to informed choice one on the cornerstones of the rights approach advocated by Cairo. Female sterilisation continues to be the most used method, mostly because it is the method most easily available or promoted. In states of northern India like UP and Bihar where the anxieties are more, camps continue to be the most common method of service delivery. Quality of care is easily compromised in camps and this has been repeatedly shown in studies. In addition, acceptors are rarely informed about alternatives or even about the side effects of any method and how to deal with them. Female sterilisation is not suited to young women, however, in Andhra Pradesh, a state well known to have achieved fertility transition, without attendant economic changes, the median age of women undergoing tubectomy is 23 years. This is not considered an appropriate age for tubectomy by any standards.

The overwhelming promotion and use to tubectomy as the contraceptive of choice for the relatively young reproducing population in India needs serious reconsideration. For one there is agreement among experts that the age and marital profile of the Indian population is changing. Thus there is need for contraceptives for young people, who may choose to delay first pregnancy and space the second. Tubectomy has nothing to offer these couples. There is also need to reconsider the fact that marriage may not be the exclusive domain of relationship requiring contraceptives. Even though there is a high proportion of child marriage in different

parts of the country, age at marriage is increasing both among men and women. It is necessary to recognise and address the contraceptive needs of men and women who are adults and in consenting relationships. We need to recognise that our parents and grandparents had begun sexual activity at an early age (probably their teens) , and it is ridiculous to restrict contraceptive access to our children at a similar or even higher age! One of the first steps that needs to be taken in step with march of time is to rename the programme from family planning to contraceptive care.

We need to re-examine our anxiety find simple solutions to complex situations. The continued dependence on tubectomy and current emphasis on the long acting copper T (Cu 380A), is probably due to the fact that they appear to provide a one-time solution. However as has already been pointed out contraceptive needs differ not only at different points in life but also according to the nature of the relationship, the autonomy of women and fertility intentions. We need also need to strengthen overall contraceptive counselling and inform all users of side-effects and contraindications. While the weakness of the service delivery system has been one of the reasons for the Supreme Court not allowing the introduction of long acting injectables like Depo Provera, the same weak system plays havoc on women who are undergoing sterilisation at well before the indicated age, without adequate asepsis and in non-salutary surgical conditions. Long term studies from the US indicate that sterilisation is not as other hand women undergoing tubectomy are said to have much higher rates of hysterectomy. This particular feature is now being observed in southern parts of India as well. Thus the focus needs to shift from protecting women through reducing their exposure to a particular method to protecting women through an overall strengthening of service delivery through comprehensive counselling counselling and quality service delivery.

However the policy direction seems to be much in the opposite direction. As recently as September 2007, the government increased sterilisation related incentives, worried about the declining trend in sterilisation. Even later, the Jan Sankhya Sthirta Kosh, Government promoted organisation, has started a competition among private providers for sterilisation services in the state of Bihar and Orissa under the 'Santhusti' Scheme. This may well end up violating the Supreme Court orders for maintaining quality during sterilisation operations, in addition to reintroducing provider incentives. The lack of policy support to promoting a basket of contraceptives, in the true sense of the term, and anticipating the contraceptive needs of the young population of the country has led to the unbridled promotion of emergency contraceptives by the private sector. Another disturbing policy trend in the international arena, has been to link population to climate change in some quarters. While the Government of India, has strictly stuck to the logic of per capita carbon emissions, some influential sources continue to link the two.

A review of contraception over the last fifteen years, clearly highlights the need to a re-articulation of the problem, identifying new programmatic priorities, strengthening service delivery in new ways and certainly increase the basket of choices. However in addition to all these changes, there needs to be a fundamental shift in the way contraceptive care is conceptualised, and that is the way it views men. In the heat of the campaign to prevent HIV infections, there was an aggressive promotion of condoms as an infection prevention agent. It

may well have succeeded in slowing the spread of the infection, however it has removed condom and male involvement from the domain of contraception (and trusted sexual relations) to the domain of risky sex and infection prevention. We now need to get men back into contraceptive care, but they need to be seen beyond targets of non-scalpel vasectomy. The design and delivery of contraceptive care programmes need to focus on respect, care, pleasure in addition to prevention of pregnancy and men's involvement needs to be central to all of this.