



Are the present reversible methods of contraception a true basket of choice for Indian women?

I understand that India as a country is still focussed on population control that aims to reduce women's fertility. There is growing emphasis to make available multiple contraceptive choices that suits the individual and the varied family planning needs of women and couples. While birth spacing and limiting births are important aspects of women's health, managing the unwanted pregnancies and protecting the reproductive rights of women is equally more important. I would say it is the need of the hour, given that fertility levels in some states are at or below replacement levels.

I speak here from my experiences of interacting with several rural women in South India, from Thanjavur district of Tamil Nadu. This was part of my doctoral studies. These are women from diverse caste and class groups who have experienced an induced abortion, without ascertaining the sex of the foetus and some of them have also experienced spontaneous abortion and still birth.

I saw a section of young women of diverse caste and class backgrounds who clearly felt the need for spacing between births for various reasons. Reasons such as their birthing experience (if not so good), the traumatic contexts of strained relationships during childbirth and postpartum due to lack of care and support necessitated the thought of postponing another immediate conception. For instance, postpartum care from the parents or in-laws and/or financial ability to spend for food and medical care by the husbands was unavailable for many. A few of them simply wanted to devote quality time and energy to the existing child prompted them to desire for some space before another possible pregnancy.

Only a small number of them (usually those from higher castes and classes status who accessed private health care services) were told about the contraceptive pills as an option to take up. The rest of them had not heard from the health care providers about safe sex practices in the post-partum period; the possibility of conceiving during the breast-feeding phase; and contraceptive options available to prevent conception. The women who went for their first delivery to medical college or the government headquarters hospitals were inserted with Intra Uterine Device (IUD) post-partum, without their consent and prior intimation. Thus, women have had little knowledge during this phase of their life (immediately after the first delivery). Therefore, when they became pregnant soon after a previous delivery, many women either decided to have an induced abortion or continued the unwanted pregnancy. I clearly see the lack and failure of contraception counselling predominantly in the public-sector health facilities, but also in much of the private health sector for women during the post-partum period.

Secondly, while women are well aware after experiencing a second pregnancy (irrespective of continuing or discontinuing that pregnancy) about the IUD and sterilisation, their awareness about the contraceptive pills was low. I believe it is because the grass root providers in the region who perceive that contraceptive

pills could not be used beyond a period of six months. The misconception about pills along with a perception among providers that lower caste and class women may not comply with regular contraceptive pills, neglect conversation about the pills among women in these communities. Infact I found the grassroot providers issuing the contraceptive strips provided by the government to adolescent and young women who have menstrual regulation problems.

From my informal conversation with providers at all levels both frontline workers and medical doctors, I sensed their acceptance of the phenomenon of successive childbirths followed by sterilisation. The frontline workers always target women with more than three children for either sterilisation or IUD insertion. One of my respondents made a laughing and a sarcastic comment, 'that madam (frontline worker) is always worried about if the women in her block have got their periods or not. Nothing else concerns her'. This statement is about the emphasis given to institutional deliveries and registering at the earliest for antenatal visits. The women's reality is beyond these boundaries of state policies, and many women wanted to space their consecutive pregnancies.

Many women have very restricted physical mobility until they have two children. When the first child is three to four years old, that is the first-time women gain physical mobility wherein they drop them to the school or take them to the near-by health centre. Until then, either the parents or in-laws or husband accompany them. This situation does not allow women to interact with others (especially women of same age group) outside the family either to share or ask about their concerns/doubts. Similarly, women do not have the autonomy to spend the money earned by their husbands without proper consultation. I personally witnessed several times when these women had no money and had to wait for their husbands to fetch them some vegetables and ingredients for cooking on an everyday basis. Most of the women are not allowed to go for jobs outside home. Some days when the men do not have any income, they need to seek a loan from the regular shop from where they buy the cooking ingredients. In this entire picture, women had no role other than waiting for their menfolk in order to cook something for the family. One has to come to hold amidst this large picture, the dependence of women financially to make a visit to the hospital or to spend for herself to seek healthcare. It was the lack of knowledge accompanied by the financial and physical immobility, they are left with no choices to determine their reproductive decision.

Third, there were yet another group of women who have had two or more children and desperately wanted to stop childbearing. Their husbands or families do not agree to the same. While the sterilisation or an abortion compulsorily demands a husband's consent in the present service provision (although not necessary according to protocols), a contraceptive pill or an IUD procedure does not demand the same. But I found many women given the lack of awareness about contraceptive pills, and fear of IUD left with no choice. Their fear is not addressed at any point. There are also a few of them who have tried using a IUD and have ended up with health problems and others continuing with mild health issues. There are a few other women who would not mind using them but are denied IUD given their health condition or because their husbands suspect their fidelity.

There are women who believe that sterilisation is the best option after successive childbirths. Some of them who have gone against their husband's wishes, thinking it could be an ultimate solution, have been denied service due to poor health, mainly anaemia. I found many such women. Some of these women said, apart from the health condition, the providers in the public sector are also adding a new protocol, where the women should have a copper-T inserted which shall be removed just before the sterilisation procedure. This is a pathetic situation for women amidst the strong patriarchal domination of men who decide for the women. These women eventually are ending with frequent induced abortion episodes. The men do not use

condoms, and one of the women's husband said, "earlier they use to keep condoms in a box in front of the PHC. It's been a few years I have not seen it available. Where is the money to go and buy every now and then madam? I might think instead I will buy a milk packet for tea that day".

I also found difficulty encountered by women to go and have the IUD inserted on the third or fourth day following the beginning of the menstrual cycle, even if their husbands consented informally. The reasons were as simple as the child is sick or there would be debt repayment crisis or the women would not even have enough money to travel to the health facility. Beyond these if they have a IUD inserted there would be others to scare them and make her remove it, even if there are no side effects experienced. The lack of information about the method chosen for them to even clarify others' mis-interpretation.

In the growing push for injectable contraceptives, I see both good and bad signs. If women have to make a regular visit to health centres once in three months, I foresee the constraints and pressure it could pose on women. In a context where pill and IUD are not true choices for women, how would women look at injections? Any injection in the perception of women in rural area are seen as immediate working mechanisms, strong and effective compared to pills and tonics. Some of the common conditions when using depot medroxyprogesterone acetate (DMPA) are said to increase bleeding or unexpected bleeding or spotting especially during the first 3 months of use; decrease, stopping, or infrequent bleeding; headaches, dizziness, abdominal pain, mood changes, diminished sex drive, and weight gain. Some of these are experienced even with IUD's. How would women associate and compare the overall contraception availability and conditions with DMPA vs IUD vs pills. Would the informed choice procedure of presenting the information to the user be possible for the grassroot workers to allow women to take up DMPA as an alternative to IUCD?

The government has so far given less importance to reversible contraceptives. Now, there is impetus for the DMPA, which are provider controlled technologies. While the government is so keen on rolling out injectibles, why not other reversible contraceptives such as the diaphragm which are more women centred safe technologies? The basket of choice may possibly increase but in reality, many women do not see the pill and the IUD as options suitable to them. Then how could one relate the marginal addition as wider expansion of available choice? There is also a need to expand the frontline workers' knowledge and advocacy about natural methods and the various temporary methods available out of which women may be able to choose. Further the total absence of promoting condoms has been a major neglect by the family welfare programme. The universal promotion of one method over another will not truly address the informed choice of contraception in the current scenario. There is a need to better understand women's difficulties and barriers to using reversible methods of contraception and to provide them both with a broader array of choices that meet the varied needs of different women, along with necessary information and access to hassle free pre-post contraceptive services and support from the health care system.

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