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BARRIERS TO THE BARRIER METHOD (AND MORE): ANALYSING ATTITUDES TOWARD CONTRACEPTIVES USAGE IN INDIA

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ABSTRACT

This paper attempts to discuss the societal narratives around contraception in India and problems in implementing successful contraception programmes. The history of contraception in India and the discourse surrounding it is explained in contrast to those very social narratives. This paper also reviews research by international and Indian medical organizations that establish the benefits of contraception in Indian context. The programmes introduced by Indian governments in the past have been analysed with a special emphasis on the harms and benefits of the contraception policy in the Emergency era. Recent government programmes that aim to increase awareness and availability of contraception indicate a positive shift toward increasing contraceptive access. This paper also analyses the role of non-governmental organizations, which have historically been the most significant contributor in facilitating on-ground positive change in sexual and reproductive health, specially for people from low-income backgrounds. Lastly, based on the research cited in the previous sections, this paper offers some policy recommendations aimed at improving mechanisms that attempt to increase contraception usage and awareness.

Keywords: Contraception, National Family Planning Program, tubectomy, ASHA

History of Contraception Usage in India

The history of contraception usage in India in its contemporary sense and the Indian societies' interaction with the idea can be traced back to Raghunath Dhondo Karve's publications in a Marathi magazine Samaj Swasthya starting from July 1927 (Rao, Mohan). Karve was a professor of Mathematics and a social reformer who hailed from Pune, Maharastra and was a pioneer in initiating birth control and family planning for the masses. In his writings, he continually discussed issues related to population control through use of contraceptives with the aim of improving society's overall well-being. He explained how the use of contraception would work toward preventing unwanted pregnancies and induced abortions. Karve proposed that the

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erstwhile government should take up a population control programme, but was met with opposition. Karve was not alone in propagating awareness about contraception; several political heavyweights such as Gandhi and Periyar gave their ideas on contraception and its relation to the process of nation building. However, these ideas were not necessarily practical or progressive; for example, Gandhi was the main opponent of birth control as he believed that self-control is the best contraceptives and state intervention would be detrimental to the end goal of sexual health. Periyar, on the other hand, saw birth control as a means for women to control their own lives.

In 1951, India became the first country in the developing world to create a state-sponsored family planning program, which was called the National Family Planning Program. The program's primary objectives were to lower fertility rates and slow population growth as a means to propel economic development. The program was tied to a series of five-year plans aimed at economic growth and restructuring which were carried out over 28 years, from 1951 to 1979. Over the course of this period, the preferred methods of birth control shifted from rhythm methods to an emphasis on sterilization and IUDs. An inverted red triangle, designed by Deep Tyagi in the 1960s, was adopted as the symbol of family planning in India. Since then, it has been adopted in other developing nations as well like Ghana, Gambia, Zimbabwe and Egypt. It is frequently placed on contraceptive products, such as condoms, diaphragms, spermicidal gel and IUDs (for instance, on the government-subsidized Nirodh condoms in India and Sultan condoms in Gambia).

The Indian Government also started taking foreign aid from non-profit bodies during the 1970s to counter the problem of awareness and availability of contraception. However, the planning methods adopted in the Emergency era specifically coerced people belonging to the lower castes and other minorities in order to reduce contraception costs, which are high due to wide-scale stigma around contraception and family planning. The fact that family planning could only be strictly implemented during the emergency era when political backlash was absent validates this argument. However, the merits of implementing strict family planning methods and contraception cannot be ignored. Over the course of the program, family planning in India resulted in a 19.9% decrease in birth rate where it has since stagnated at 35 births per 1000 persons(Rao, Mohan). By 1996, the program had been estimated to have averted 16.8 crore births (B.N. Saxena). This is partly in part to government intervention which established many clinics as well as the enforcement of fines for those who avoided family planning. The subsequent governmental family planning and contraception advocacy programmes have also born fruit. Contraceptive usage has been rising gradually in India. In 1970, 13% of married women used modern contraceptive methods, which rose to 35% by 1997 and 48% by 2009 (Mo, H.F.).

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Sociological Apprehensions around Contraception Usage - Prevailing Attitudes

In 2000, the contraceptive prevalence rate (CPR) among married women was 58% (Thulaseedharan, Jissa Vinoda). Contraceptive use in India is characterized by the predominance of non-reversible methods, particularly female sterilization, limited use of male-/couple-dependent methods, high discontinuation rates, and negligible use of contraceptives among both married and unmarried adolescents. Three out of four users rely on sterilization in India, which is – overwhelmingly – female sterilization. Sterilization accounts for roughly 85% of all modern contraceptive methods used. Although reported by a negligible minority, sterilization is the most common method used even among married adolescents. The central government has banned the use of quinacrine for female sterilization because of its harmful side-effects. Less than 7% of currently married women use the officially sponsored spacing methods (pills, IUD and condoms). The reported use of traditional contraceptive methods and male/ couple dependent methods is low.

According to the Open Access Journal of Contraception, in 2015, 62.2% of Indian women of reproductive age who are married or live with unmarried partners (in union) use modern contraceptive methods, compared with 36.1% in 1990 and 48.3% in 2000 . In absolute numbers, the number of women using modern contraceptive methods has doubled, from 58 million in 1990, to 124 million in 2015. Awareness of contraception lies at 92.5%. People are most aware about tubectomy (0.5%) followed by CuT (87.5%), condoms (50%), and then O.C. pills (12.5%). The most common contraceptive methods used in urban cities in India are condoms (20%) followed by tubectomy (12.5%) This is followed by injectable contraceptive and safe period, each of which constitutes 0.5% out of the total usage of all contraceptive methods.

Information dispensation is also a key part of analysing problems regarding contraception. A study conducted by Upadhye Children Hospital, quotes that 7.5% of women get information from the radio or the newspaper, 30% from hospital doctors, 25% from friends or relatives, and 7.5% had no source of information. According to the same study, 52.5% of women had no reason for the lack of contraception usage, 25% refrained from using due to myths or fears while 22.5% were not using contraceptives due to family pressure. Higher rates of sterilization are present among women who undergo lower levels of formal education than their more-educated counterparts. Contraception usage also varies according to region. States like Kerala and Andhra Pradesh show much higher rates of contraception than states like Uttar Pradesh, Bihar and Meghalaya. Interestingly, those who study for longer use contraception much lesser as a delay in getting married further postpones childbirth and sexual activity. According to Family Planning 2020, in 2017, there were 136,569,000 women using modern methods of contraception which

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prevented 39,170,000 unintended pregnancies, 11,966,000 unsafe abortions, and 42,000 maternal deaths.

There are several inferences that can be drawn from the aforementioned data. Working women, women living in urban areas and women with higher levels of education tend to use contraceptive methods at a higher scale. One can infer that women in urban areas and within the mid to high-income backgrounds have a larger control over their sexual activity, and consequently, their access to contraceptives and sexual health. Additionally, the high rates of female sterilization prove how the burden of contraception lies more on women than men. In spite of their cost and permanence, methods such as tubectomy are used more often than condoms in rural regions and villages where orthodox social stigma is most prevalent. Women have to undergo permanent anatomical change to prevail their reproductive rights when there are several other possibilities of contraception that are more accessible. Male-centric methods of contraception are generally safer and temporary but are still comparatively less, signalling a deep societal bias against women to bear more responsibility for contraception. Ironically enough, it is such biases that also increase the risk of sexually transmitted diseases for men as condom usage is significantly lesser.

Trends in Government Efforts to Promote Contraception Usage

India's state of Emergency, which lasted for twenty one months between 1975 and 1977, included a family planning initiative that began in April 1976, through which the government hoped to lower India's booming population growth. This program used propaganda and monetary incentives to – some argue – inveigle and even coerce citizens to get sterilized. People were promised land, housing, and money or approval on loans in exchange for being sterilised. Because of this program, thousands of men received vasectomies and even more women received tubal ligations, both of which are irreversible. However, the program focused more on sterilizing women than men. It also impacted families and households that belonged to the Scheduled Castes, an oppressed minority in India. After the Emergency was called off and Indira Gandhi failed to form a majority at the Parliament, all family initiatives received a strong backlash followed the highly controversial program.

However, recent family planning initiatives that were adopted at the inception of the twenty-first century include newly implemented government campaigns, improved healthcare facilities, increased education for women, and higher participation among women in the workforce, all of which have helped achieve lower fertility rates in many Indian cities. Nonetheless, this development is lopsided and several socially and economically backward regions remain unimpacted by these programmes. In 2017, Ministry of Health and Family Welfare launched

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Mission Pariwar Vikas, a central family planning initiative. The key strategic focus of this initiative is on improving access to contraceptives through delivering assured services, ensuring commodity security and accelerating access to high quality family planning services. According to official government circulars it aims at reducing India's overall fertility rate to 2.1% by the year 2025. Additionally, two contraceptive pills, MPA (Medroxyprogesterone acetate) under Antara program and Chaya (earlier marketed as Saheli) will be made freely available to all government hospitals. The contraceptives are safe and highly effective; the 'Antara' injectable being active for three months and the 'Chayya' pill for one week, both drugs will help meet the changing needs of couples and help women plan and space their pregnancies. Training of healthcare practitioners from all the states has been completed as well, with a pool of state and district level doctors and staff nurses being trained to support the roll-out. To help improve the supply and distribution of contraceptives, the Ministry had recently launched a new software, Family Planning Logistics Management Information System (FP-LMIS), designed to provide robust information on the demand and distribution of contraceptives to health facilities and ASHAs. Furthermore, the National Population Stabilisation Fund has started the Prerna Strategy, which aims at pushing up the age of marriage amongst girls; similarly, the Santushti Strategy aims to integrate private medical practitioners like gynecologists to provide accessible healthcare to women. A national helpline is also available to anyone who wishes to ask for advice on reproductive health, family planning, child health etc.

The Ministry of Health and Family Welfare also aims to achieve its goal of increasing modern contraceptive usage and ensure that 74% of the demand for modern contraceptives is satisfied by 2020, with continued emphasis on delivering assured services, generating demand and bridging supply gaps. Focus remains on increasing awareness and demand through a holistic communications campaign that has simultaneously been rolled out across all states of India.

Corporate Marketing Interventions

The government of India introduced the LPG (Liberalization Privatization Globalization) policy in 1991 which revolutionised the economic environment in the country. This lead to rapid expansion of the private sector and free market sentiment. Corporations started to expand, and their influence over the social and cultural lives of consumers increased multifold. It is within this socioeconomic background that contraceptives were introduced more dominantly into the market, primarily through wide-scale advertising campaigns and promotional efforts. The most astounding impact of these advertisements and campaigns their attempt to break into the market with narratives that strongly contrasted the orthodox social norms on sexual health and contraception. In a country where contraception is still viewed as an evil because it goes against

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traditional societal beliefs, corporations – ironically – played a major role changing the mainstream belief system.

I-Pill is an Indian brand that sells contraception pills for women to prevent fertilization post-coitus. On World Contraception Day, I-pill promoted the idea of couples making parenthood decisions and choices together with their campaign #TogetherInEveryDecision. The video features a couple in an everyday situation, but with one tiny variation: after an unwanted pregnancy, the husband is the one who panics and the wife is the calm one, is confident and is in control. The slight conflicting emotions last only for a while as the woman is able to reassure her husband, showcasing a bond between the two and a promise of being in it together for each other. This advertisement deviates from prevalent notions of men being the rational ones in a relationship and women being more emotional or anxious. There are other similar advertisements show women seeking advice from one another on matters related to unwanted pregnancies, propagating the idea of female solidarity and independence from men. Thus, when it comes to contraceptives, the advertising industry is involved in changing social norms for the better and promoting gender equality and justice.

However, corporations have had to go through several hurdles in terms of getting permits to play these advertisements. The stigma around contraception and political baggage acts as a barrier for corporations to receive approval from certifying authorities. The Drug Controller General Of India (DCGI) hac issued show-cause notices to Piramal Healthcare, Mankind Pharma and Morepen Laboratories for advertising their emergency contraceptive pill (ECP) on technical grounds. The technical advisory body for drugs had said ECPs may be advertised but it should clearly explain that the medicine should be used ‘only in emergency cases’ and not as a regular consumption, as was being made out in the advertisements. The body also said that such advertisements must make the consumer aware of the side-effects of the product. In response, the advisory board faced major criticism and backlash for interfering with attempts to increase contraceptive access to urban and suburban markets in India at a time when the population growth was a major public health crisis.

Nonetheless, these campaigns have boosted the growth of pharmaceutical companies. The Economic Times reported claims by The Pharmaceutical Wholesalers Association of 63% growth in this segment in value terms.. According to AC Nielsen, the emergency contraceptive segment grew by 245% in one financial year (The Economic Times). The condom industry in India is also growing at a rapid rate. Multinational brands like Durex have entered the Indian market to broaden their consumer base by tapping into the urban populations. The holding company of Durex, SSL International has also shifted the production of condoms from the UK to India for reasons including easy supply to high levels of demand.

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Conclusion: Policy Recommendations

Policy initiatives must essentially aim at increasing the awareness and outreach of contraception as awareness is the base upon which any policy change functions. The government must actively partner with NGOs, Corporate Social Responsibility initiatives and grassroot level activists to broaden awareness of contraception, especially amongst those who are lie at a social and economic disadvantage. It is important to provide and strengthen counter narratives to the populist belief that views contraception as evil and stigmatises sex education. Grassroot movements are already making positive impact in people's lives. However, these initiatives severely lack funding, which is another important point of intervention. Corporate firms that work in the healthcare sector – most notably pharmaceuticals – can spend their CSR efforts in a focused manner to sponsor underfunded grassroots advocacy work and thus increase contraceptive access in rural areas.

The government, too, can work toward financial accessibility of contraceptives in rural and low-income urban areas. For example, the government can introduce price caps and subsidies to condoms and contraceptive methods. International brands have hegemonized the Indian market for birth control. Profit motives make these commodities inaccessible to the large population of the nation that lives below the poverty line. Therefore, state intervention is required to put a cap on these prices or subsidise them. Moreover, health clinics should be set up in parts of rural India and make accessible procedures that often prove to be expensive, an example of which is abortion. Fulfilment of human rights requires that health-care facilities, commodities and services be of good quality, including scientifically and medically appropriate. This requires, among other things, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. Lastly, the government should leave no stone unturned to make sure the disparity in contraception methods evens out. As pointed earlier, the balance weighs heavily against women in India, who bear the burden of contraception and often through means such as the tubectomy, which is irreversible and cost-heavy. Alternatively, the government should promote other contraceptive methods, especially ones that tilt the responsibility more toward men, such as condoms, in order to begin addressing the inequality that women in India have been facing since time immemorial.

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