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Changing family planning scenario in India: An overview of recent evidence

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Changing family planning scenario in India:

An overview of
recent evidence

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New Delhi, India



**Changing family planning
scenario in India:
An overview of recent evidence**

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Abstract

Over the decades, there has been a substantial increase in contraceptive use in India. The direction, emphasis and strategies of the Family Welfare Programme have changed over time. However, meeting the contraceptive needs of considerable proportions of women and men and improving the quality of family planning services continue to be a challenge. The 1990s witnessed a growing recognition of this, and several innovative policy and programme initiatives have been launched to address these issues. This paper reviews and synthesises evidence from surveys and studies conducted in the 1990s and thereafter on contraceptive use dynamics and the unmet need for contraception in India. The paper also discusses some of the barriers that hindered the success of the programme and sheds light on new initiatives to address these, and assesses their impact if any. The paper makes suggestions for areas that need further programme and research attention.

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Caveat

Information is, happily, in a state of fluidity. Since writing the original draft of this paper, new information and data have been published and have shed new light on contraceptive use dynamics in India. As far as possible we have tried to update the paper, but recognise that there will always be gaps, and perhaps whole areas of importance that have not been addressed. We would be grateful for any further relevant information and will try to incorporate it in the next publication.



1 Introduction

The Family Welfare Programme in India has experienced significant growth and adaptation over the past half century since its inception in 1951. During this period, financial investments in the programme have substantially increased and service delivery points have significantly expanded. Services administered through the programme have been broadened to include immunisation, pregnancy, delivery and postpartum care, and preventive and curative health care. The range of contraceptive products delivered through the programme has widened. Multiple stakeholders, including the private sector and non-governmental sector, have been engaged in providing contraceptive services. Of late, the programme has been integrated with the broader Reproductive and Child Health Programme. The couple protection rate has quadrupled from 10 per cent in 1971 to 44 per cent in 1999 (MOHFW 2000). Notwithstanding these achievements, several issues continue to haunt the programme and many goals remain under-achieved: a significant proportion of pregnancies continue to be unplanned; the contraceptive needs of millions of women remain unmet; several sub-population groups including adolescents and men continue to be neglected and under-served; and contraceptive choice remains conspicuous by its absence, as is quality of care within the programme.

Recognition of the changes worldwide and the challenges that are faced by the programme has led to the development of several new policy initiatives. Recently, the programme focus has shifted away from vertical family planning services towards the provision of comprehensive integrated reproductive health care at all levels of the health sector (Pachauri 1995). Providing a backdrop of the changing policy environment, this paper reviews and synthesises recent evidence on contraceptive use dynamics and the unmet need for contraception in India. While discussing some of the barriers that hindered the success of the programme, the paper sheds light on new initiatives to address these and assesses their impact if any. However, it may be mentioned that it is too early to make any definitive assessment of the impact and data for making such an assessment are limited. The review concludes with a discussion of critical programmatic and research issues to be addressed in order to improve quality of services and meet clients' needs. This review draws on national surveys and small-scale studies carried out primarily in the 1990s, and as far as possible new information and data are incorporated.



2 Changing policy and programme environment

The Family Welfare Programme in India was launched with the objective of reducing birth rates to the extent necessary to stabilise population at a level consistent with the requirements of the national economy. The programme has since evolved through a number of stages, and has changed direction, emphasis and strategies. During the first decade of its existence, family planning was considered more a mechanism to improve the health of mothers and children than a method of population control (Visaria 2000; Visaria and Chari 1998). Clinic-centred family planning service delivery, along with health education activities, were promoted during this period. Over time however, the primary focus of the programme became the achievement of demographic goals.

With growing concerns about the rate of population growth and its adverse effect on the pace of social and economic development, the Third Five-year Plan period (1961–66) marked a subtle shift in the emphasis of the programme from the welfare of women and children to the macro objective of population stabilisation (Visaria and Chari 1998). At the same time, an extension-education approach replaced the original clinic-centred approach, and the programme was integrated with health services. During 1965–75, the programme was further integrated with the maternal and child health programme. This period also witnessed the introduction of time-bound method-specific targets within the programme.

As is well known, the target-oriented approach became highly coercive during the Emergency period (1975–77).¹ The National Population Policy 1976 called for a “frontal attack on the problems of population” and inspired state governments to “pass suitable legislation to make family planning compulsory for citizens” and to stop childbearing after three children, if the “state so desires” (Srinivasan 1998). The backlash of the coercive approach compelled subsequent governments to stress the voluntary nature of family planning acceptance. The Population Policy 1977 clearly underscored that “compulsion in the area of family welfare must be ruled out for all times to come,” and emphasised the need for an educational and motivational approach to make acceptance of family planning completely voluntary. However, in the 1980s, the time-bound, target-oriented approach was revived and efforts to encourage the use of reversible methods were initiated. Incentive

¹ In June 1975, the Congress Party, which was in power at the Centre, declared an Emergency.



payments were vigorously promoted during this period, leading to the violation of women's rights in some cases (Visaria 2000).²

The 1990s witnessed dramatic changes in the family welfare policy and programme in the country. The passing of the 72nd and 73rd Constitutional Amendments and the Panchayati Raj and Nagar Palika Acts in 1992 set in motion the process of democratic decentralisation, and brought the Family Welfare Programme, legally, in the domain of panchayati raj institutions.³ In addition, several factors including stagnation in the Family Welfare Programme, organised pressure from multiple constituencies to bring issues of quality and choice into the programme, and the recognition of inherent constraints in the programme contributed to changes in policy approach (Visaria, Jejeebhoy and Merrick 1999). The International Conference on Population and Development in 1994 and the Beijing Women's Conference in 1995 further catalysed the process of policy change. In 1996, the government took the radical decision of abolishing method-specific contraceptive targets that had been used to guide, monitor and evaluate the programme for decades, replacing it with what was initially called the Target-free Approach, where health workers' case loads would be determined by needs identified at the community level, rather than centrally-assigned. In 1997, to avoid misconceptions and to direct the programme more towards addressing clients' needs, the Target-free Approach was renamed as the Community Needs Assessment Approach, and decentralised participatory planning was initiated.⁴ The government has provided broad guidelines for conducting community needs assessment and has given states the responsibility for working out the practical details of implementation.

The Reproductive and Child Health Programme, which was launched in 1997, espouses the principles of client satisfaction and high quality comprehensive and integrated health services. It seeks to integrate services for the prevention and management of unwanted pregnancy, the promotion of safe motherhood and child survival, and the prevention and management of reproductive tract infections and sexually transmitted infections. The programme aims to expand services to meet the needs of hitherto under-served and neglected population groups, including adolescents, and economically and socially disadvantaged groups, such as urban slum and tribal populations. It envisages utilising and upgrading the existing health infrastructure to deliver these services. To make the programme a people's programme, the new approach champions local needs-based,

² Incentive payments were first introduced in Tamil Nadu in 1959 as compensation for loss of wages to acceptors of vasectomy. Such incentives were also given nationally, though to a limited extent, during the 1960s and 1970s to acceptors of sterilisation and IUD.

³ A Panchayat is an elected body of representatives that carries out village administration.

⁴ The Target-free Approach was interpreted by some health care providers as "work-free".



decentralised, participatory planning and monitoring, and seeks to involve several stakeholders, including non-governmental organisations (NGOs), the private sector, panchayati raj institutions and civil society in more meaningful ways to move the new agenda forward (MOHFW 1997).

The new approach represents a dramatic change in the culture of the Family Welfare Programme (Pachauri 1999), and for the first time in the history of the programme in India, attention has been focused on gender concerns. The Reproductive and Child Health Programme seeks to address gender issues impinging on women's health by improving quality of care, including promoting better interaction between providers and clients; increasing the availability of female health care providers at the primary health care level; addressing neglected concerns of women such as reproductive tract infections; addressing the needs of neglected population sub-groups such as adolescents; organising gender sensitisation training for stakeholders; encouraging male involvement in reproductive health; and facilitating women's and men's participation in programme monitoring through client feedback (World Bank 1997).

The Reproductive and Child Health Programme has been carried out with varying intensity and clarity in different parts of the country. Preparations for launching the second phase of the Reproductive and Child Health Programme are currently under way.

The National Population Policy, adopted in February 2000, further legitimised the paradigm shift to client-based services. The National Population Commission was set up in May 2000 to guide the translation of policy rhetoric into programmes. In March 2001, an Empowered Action Group was set up by the Government of India to facilitate focused efforts to promote the Reproductive and Child Health Programme in the states of Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Orissa, Chhattisgarh, Jharkhand and Uttaranchal which have been lagging behind in a number of socio-demographic indices.⁵ Several state governments have also framed state-specific population policies thereby broadening the policy discourse within the states.

The National Population Policy provides a policy framework for achieving the twin objectives of population stabilisation and promoting reproductive health within the wider context of sustainable development. The immediate objectives of the National Population Policy are to address the unmet need for contraception, the limitations in health care infrastructure and the shortages in health personnel, and to provide integrated service delivery for basic reproductive and child health care. In the medium term, the National Population Policy aims to achieve the goal of

⁵ Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Orissa, Chhattisgarh, Jharkhand and Uttaranchal are sometimes referred to as the Empowered Action Group (EAG) states.



bringing the total fertility rate to replacement level by 2010 (MOHFW 2000). The National Population Policy has delineated twelve strategic themes to achieve these objectives, including decentralised planning and implementation, convergence of service delivery at the grassroots, empowering women and encouraging male involvement, meeting the unmet need for family welfare services, addressing the needs of disadvantaged and under-served population groups, and forging public–private partnerships.

The National Population Policy affirms the government’s commitment to the provision of quality services, information and counselling, and expanding contraceptive method choices in order to enable people to make voluntary and informed choices. Disincentives have not been included in the Policy, though several promotional and motivational measures are to be implemented at the community and individual level. Unlike in the past, these incentives are not just for sterilisation but have been linked to poverty, delayed marriage, antenatal and delivery care, birth registration, birth of a girl child and immunisation (Pachauri 2000). These include, to list a few, rewarding and honouring Panchayats and Zilla Parishads for exemplary performance in universalising the small family norm, achieving reductions in infant mortality and birth rates, and promoting literacy with completion of primary schooling; providing cash incentives to mothers who have their first child after 19 years of age; and rewarding couples below the poverty line who marry after the legal age of marriage, register the marriage, have their first child after the mother reaches the age of 21, accept the small family norm, and adopt a terminal method after the birth of the second child (MOHFW 2000).⁶ However, it is a cause of great concern that some of the policies adopted by the states espouse strategies and mechanisms that are diametrically opposed to the principles of equity and equality that the new National Population Policy entails. In their urgency to reduce population numbers, some states, including Andhra Pradesh, Madhya Pradesh, Maharashtra and Rajasthan, have articulated several open or “veiled” disincentives (Pachauri 2001). The population policy of Madhya Pradesh, for example, advocates debarring individuals marrying before the legal age at marriage from seeking jobs, getting admission in educational institutions and applying for loans. The policy also calls for debarring individuals with more than two children from contesting local body elections (Government of Madhya Pradesh 2000). These policies will negatively affect women who hardly play a role in deciding the age at which they are married or the number of children they bear (Qadeer 2000).

These new policy and programme initiatives articulate laudable principles and goals. The challenge lies in translating these principles into reality.

⁶ A Zilla Parishad is the apex body at the district level within the three-tier panchayati raj system in India.



3

The contraceptive scenario

Over the decades, contraceptive use has been increasing in India. At the same time, there is a substantial unmet need for contraception. The contraceptive scenario is also characterised by the predominance of non-reversible methods, limited use of male/couple-dependent methods, substantial levels of discontinuation, and negligible use of contraceptives among both married and unmarried adolescents. As will be seen in the following discussion, there are wide regional variations in all these aspects.

Contraceptive use

Official statistics report that 87 million eligible couples, out of an estimated total of 171 million eligible couples, were effectively protected against conception by various contraceptive methods in the year 2000 (MOHFW 2003a). Data from National Family Health Survey (NFHS)–2 indicate that nearly one-half of currently married women were using some method of contraception in 1998–99. Contraceptive prevalence increased with age except at the older ages (8 per cent among adolescent girls vs. 67 per cent among women aged 35–39 years), with education (43 per cent among illiterate women vs. 57 per cent among women with a high school education), with standard of living (40 per cent among women from households with a low standard of living index vs. 61 per cent among women from households with a high standard of living index), and with number of living children (5 per cent among women with no living children vs. 68 per cent among women with three living children) (IIPS and ORC Macro 2000). Similarly, at each parity, current use was lower among women with no sons than among women with one or more sons, with a maximum differential at parity three, indicating that strong son preference prevails in India (at parity three, 38 per cent of women with no sons vs. 62 per cent with one son and 75 per cent with two sons). Most of these differentials have persisted over time (Visaria 2000). Contraceptive prevalence varied widely among the states, from less than 30 per cent in Meghalaya, Bihar and Uttar Pradesh to more than 60 per cent in Delhi, Haryana, Himachal Pradesh, Punjab, West Bengal, Maharashtra and Kerala.

A comparison with data from NFHS–1 (IIPS 1995) reveals an 18 per cent increase in contraceptive prevalence during the six-and-a-half years between the two surveys. Although contraceptive



prevalence differs among the states, there has been an overall increase in contraceptive use in almost all states during the 1990s. The exceptions are Goa, Jammu and Kashmir, and Meghalaya. The north-eastern states of Nagaland and Arunachal Pradesh recorded the maximum increase (by 133 per cent and 50 per cent, respectively). Among the four large northern states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh, all except Bihar recorded increases ranging between 21 per cent and 42 per cent during this period. A preliminary comparison of data from the Reproductive and Child Health Survey–1 (1998–99) and the first phase of the Reproductive and Child Health Survey–2 (2002), reflecting changes after the introduction of the Community Needs Assessment Approach and the Reproductive and Child Health Programme, also indicate an increase in contraceptive use in all the major states, particularly Uttar Pradesh, Madhya Pradesh and Himachal Pradesh (MOHFW 2003b).⁷

Method-mix

A “cafeteria approach,” whereby clients are provided with a choice of contraceptive methods, has been adopted by the Family Welfare Programme since the 1960s. However, it is well documented that, until recently, the emphasis of the programme remained skewed towards promoting non-reversible methods, particularly female sterilisation. Hence, not surprisingly, female sterilisation continues to be used by the majority of contraceptive users in India. Nationally, data from NFHS–2 show that sterilisation accounted for 84 per cent of the contraceptive prevalence rate due to modern methods and 75 per cent of overall current contraceptive prevalence (IIPS and ORC Macro 2000). Although reported by only a negligible minority, sterilisation was the most commonly adopted method even among married adolescents in India. A review of data on contraceptive behaviour of adolescents in Asian countries shows that India is the only country where such a pattern prevails (Pachauri and Santhya 2002).

The predominance of sterilisation is observed in almost all states (see Table 1). For example more than 90 per cent of modern contraceptive method users are sterilised in all the southern states and Bihar, and the situation is most skewed in Andhra Pradesh, where 97 per cent of all modern method users are sterilised. The exceptions include Delhi, Punjab and a few north-eastern states where fewer than three in five users of modern methods are sterilised (IIPS and ORC Macro 2000). A comparison with data from NFHS–1 (IIPS 1995) indicates that the same pattern prevailed throughout

⁷ The first phase of the Reproductive and Child Health Survey–2 conducted in 2002 covered only one-half of the districts in each state. The comparative picture presented here is based on the data pertaining to the districts covered in both the rounds.



Table 1: Contraceptive prevalence rate (modern methods), all India and states

States	Service statistics 2000			NFHS 1992-93			NFHS 1998-99		
	Total	Sterilisation	Spacing	Total	Sterilisation	Spacing	Total	Sterilisation	Spacing
India	46.2	29.0	17.2	36.3	30.7	5.5	42.8	36.1	6.8
Delhi	27.0	17.0	10.0	54.6	23.2	31.3	56.3	28.6	27.7
Haryana	49.4	32.3	17.1	44.3	34.7	9.6	53.2	40.8	12.5
Himachal Pradesh	46.9	34.8	12.1	54.4	45.8	8.6	60.8	52.4	8.4
Jammu & Kashmir	14.4	12.1	2.3	39.7	29.7	10.0	41.7	30.7	11.1
Punjab	65.5	35.2	30.3	51.3	34.0	17.3	53.8	30.9	23.0
Rajasthan	36.1	22.9	13.2	30.9	27.7	3.3	38.1	32.3	5.8
Madhya Pradesh	45.9	28.0	17.9	35.5	31.5	4.0	42.6	37.9	4.7
Uttar Pradesh	38.0	17.3	20.7	18.5	13.1	5.5	22.0	15.6	6.4
Bihar	21.2	16.7	4.5	21.6	18.6	2.9	22.4	20.2	2.2
Orissa	37.6	26.5	11.1	34.6	31.6	3.0	40.3	35.6	4.7
West Bengal	32.2	27.2	5.0	37.3	30.6	6.7	47.3	33.8	13.5
Arunachal Pradesh	14.0	9.7	4.3	19.3	10.7	8.6	32.8	20.7	12.2
Assam	15.2	12.3	2.9	19.8	14.4	5.4	26.6	16.7	10.0
Manipur	17.8	11.3	6.5	24.1	13.8	10.3	25.9	15.5	10.3
Meghalaya	4.7	2.8	1.9	15.1	10.0	5.1	15.5	6.5	9.1
Mizoram	34.6	28.9	5.7	52.9	44.6	8.3	57.1	45.3	11.7
Nagaland	8.2	6.3	1.9	13.0	6.4	6.5	24.2	12.3	12.0
Sikkim	21.5	14.8	6.7	–	–	–	41.4	24.8	16.6
Goa	23.9	21.1	2.8	37.9	30.5	7.3	35.9	28.2	7.7
Gujarat	52.8	35.4	17.4	46.9	41.0	5.9	53.3	45.3	8.1
Maharashtra	49.3	40.0	9.3	52.5	46.2	6.4	59.9	52.2	7.6
Andhra Pradesh	52.8	44.5	8.3	46.5	44.7	1.8	58.9	57.0	1.8
Karnataka	56.3	44.8	11.5	47.3	42.5	4.8	56.5	52.2	4.4
Kerala	39.6	34.5	5.1	54.4	48.3	6.1	56.1	51.0	5.1
Tamil Nadu	50.4	39.3	11.1	45.2	39.5	5.7	50.3	46.0	4.3

Sources: Planning Commission, 2002; IIPS, 1995; IIPS and ORC Macro, 2000



the 1990s. At the state level, the percentage share of non-reversible methods in current prevalence increased in Delhi and Arunachal Pradesh, declined in Punjab, West Bengal, Assam and Meghalaya, and remained almost the same in the other states.

Nationally, the use of natural family planning methods was reportedly low, accounting for just 10 per cent of current contraceptive use. Among the states, the use of natural methods was relatively common in West Bengal, Assam, Manipur, Punjab, Sikkim and Goa. In West Bengal, more than one in four current users were using a natural family planning method.

Use of male/couple- dependent methods

In India, gender inequalities favour men and sexual and reproductive health decisions are usually made by them. Therefore, there is a growing realisation that unless men are reached, the Reproductive and Child Health Programme, including family welfare efforts, will have limited impact (Pachauri 1997). Direct evidence on the use of male methods is scarce as men have been excluded from most of the national surveys, and small-scale studies exploring the contraceptive behaviour of men are limited. Data from NFHS-2, based on the responses of currently married women, show that one in ten currently married “couples” were using male/couple-dependent contraceptive methods (condoms, vasectomy, withdrawal and periodic abstinence) in 1998-99, which translates into 21 per cent of total current contraceptive prevalence. The use of male/couple-dependent methods was as low as 2-3 per cent of currently married couples in Mizoram, Bihar and Karnataka, and as high as 23-28 per cent of currently married couples in West Bengal, Delhi and Punjab (IIPS and ORC Macro 2000).

Small-scale studies of women and men also reflect the limited use of male/couple-dependent methods. For example, in a study of women in the slums and villages in Maharashtra, male-dependent methods accounted for less than 10 per cent of total contraceptive prevalence (Kanitkar and Kulkarni 2002). In a study of married men in the tribal areas of Maharashtra, male/couple-dependent methods accounted for 16 per cent of overall contraceptive use (Balaiah et al. 1999). However, another study of married men in Uttar Pradesh reports that one in three current users were using either condoms or male sterilisation (Carolina Population Centre 1997).

During the six-year period between NFHS-1 and NFHS-2, the use of male/couple-dependent methods remained the same (IIPS 1995; IIPS and ORC Macro 2000). At the state level, all the southern states recorded a decline, ranging from 21 per cent to 46 per cent in the proportion of currently married couples using male/couple-dependent methods during the 1990s. Among the



four major northern states, while Madhya Pradesh and Bihar recorded a decline, the proportion of couples using male methods increased in Uttar Pradesh and Rajasthan. Data specifically on the use of condoms reveal that only a small minority (3.1 per cent) of currently married couples were using condoms. Condom use was typically low in almost all states, except Delhi and Punjab, where 18 per cent and 14 per cent, respectively, of currently married couples were using condoms. During the 1990s, according to survey data, condom use increased marginally from 2.4 per cent in 1992–93 to 3.1 per cent in 1998–99. Despite the introduction of “no-scalpel” vasectomy and campaigns to promote male involvement in family planning and reproductive health, the acceptance of vasectomy remained negligible—2 per cent of currently married couples nationally. In fact, during the 1990s, the acceptance of vasectomy declined substantially (by 44 per cent) nationally, a pattern established during the post-Emergency period.⁸

Contraceptive practice among the unmarried

Available evidence suggests that a substantial proportion of unmarried adolescent boys and girls are sexually active, placing them at risk of unintended pregnancy and sexually transmitted infections. A review shows that 15–30 per cent of adolescent boys and up to 10 per cent of girls in India were sexually active before marriage (Jejeebhoy and Sebastian 2003). Little is known about the contraceptive behaviours of unmarried adolescents. Demographic and Health Surveys and other national surveys have largely excluded this group and only a few small-scale studies have explored the contraceptive behaviours of unmarried adolescents. Because relatively few unmarried adolescents report being sexually active, data on contraceptive use from these studies may not accurately reflect their contraceptive behaviours. These studies indicate, however, that a large majority of unmarried, sexually active adolescents do not use any contraceptive method. Those who report practising contraception often use natural methods, which are more difficult for adolescents to use consistently and effectively because they require accurate knowledge of the reproductive cycle and active cooperation of the partner (Pachauri and Santhya 2002).

According to a review of studies on premarital sexual behaviour among adolescent boys in India, the vast majority had engaged in unprotected sex, even with commercial sex workers (Jejeebhoy 1996). A study of male students in Mumbai reveals that 43 per cent of sexually experienced students never used a condom, and 45 per cent had used a condom only occasionally (Abraham

⁸ The coercive approach used to promote vasectomy during the Emergency period resulted in a backlash against vasectomy across the country and the method did not gain popularity thereafter.



and Kumar 1999). Yet another study of adolescent males in a slum setting in Uttar Pradesh shows that 58 per cent of sexually experienced males reported ever having used a condom during any act of intercourse, 32 per cent reported condom use in relations with sex workers, and 56 per cent in relations with a friend or relative. Protection against pregnancy appears to motivate most condom use (Awasthi, Nichter and Pande 2000). Similarly, in a study of unmarried and married men in Orissa, 19 per cent of sexually active unmarried men reported condom use during the last sexual act. Among those who reported condom use, 61 per cent mentioned prevention of pregnancy as the main reason for use, indicating that condom promotion efforts aimed at young men should stress the dual protection properties of condoms (Collumbien, Das and Campbell 2001). These findings highlight the need for innovative strategies to reach out to unmarried young people with better information and services.

Contraceptive discontinuation and switching

As contraceptive use increases and becomes a more established behaviour, prevalence is no longer a sufficient marker of programme success (Jejeebhoy 1990). Contraceptive continuation may become more important than acceptance in increasing contraceptive prevalence (Jain 1989). An analysis of contraceptive continuation rates and the reasons why women discontinue using contraceptive methods could provide important information about the adequacy of services provided. As the Family Welfare Programme in the country is currently making vigorous efforts to shift its emphasis from non-reversible methods to reversible methods, and expand service delivery beyond the bounds of the public sector, information on contraceptive discontinuation and switching assumes greater significance. Data on contraceptive continuation/discontinuation, switching and failure are, however, limited.

In India, as the vast majority (66 per cent) of ever users are sterilised, only a small proportion of ever users have the option of discontinuing use (IIPS and ORC Macro 2000). Nationally, data from NFHS-2 show that one in ten currently married women who have ever used a contraceptive method (which translates into about one in three [29 per cent] ever users of reversible methods) had discontinued use at the time of the survey. Though the desire for a child was cited as the main reason for discontinuation (30 per cent), the fact that more than one-third reported method-related reasons such as method failure, side effects and inconvenience highlights the need for improved quality of services.

The data also show that younger women (15–24-year-olds) were more likely to discontinue using contraceptives compared to older women (see Table 2). Younger women were also more likely to



Table 2: Percentage of currently married, non-pregnant women reporting contraceptive discontinuation by selected background characteristics and reasons for discontinuation

Characteristics	Percentage discontinuing use ¹	Reasons for discontinuation				
		Method failure	Side effects ²	Unsuitable method ³	Wanted child ⁴	Others ⁵
Age						
15–24	20.9	4.2	16.1	8.9	48.3	22.4
25–34	9.3	4.5	22.9	10.3	33.6	28.7
35+	7.8	4.2	29.2	12.2	11.2	43.2
Residence						
Urban	11.0	3.7	25.7	8.6	30.5	31.5
Rural	9.8	4.7	21.8	11.5	30.0	32.0
Educational status						
Illiterate	8.7	5.8	22.8	14.2	27.7	29.5
Primary	9.5	5.5	25.5	8.5	28.0	32.5
Secondary+	12.5	2.6	22.4	8.1	33.2	33.6
Caste						
Scheduled caste/tribe	9.3	4.5	20.7	14.7	33.3	26.9
Non-Scheduled caste/tribe	10.4	4.3	23.8	9.4	29.5	33.1
Region						
South (south+west)	7.9	2.3	22.9	6.6	36.6	31.5
North (north+east)	11.3	4.9	22.8	11.4	27.5	33.4
North-east	18.1	3.2	32.8	15.1	26.5	22.4

Source: Based on NFHS–2 data

Notes:

¹ The denominator used is non-pregnant, currently married women who ever used a contraceptive in each category

² The method created menstrual or health problems, resulted in lack of sexual satisfaction or weight gain

³ The method was inconvenient to use, or hard to get, or cost too much, or the woman did not like the method or lacked privacy for use

⁴ Wanted to have a child or wanted to replace a dead child

⁵ Husband away or an unspecified reason



mention desire for a child, but less likely to mention side effects, as their main reason for discontinuation. However, younger women were no more likely than older women to discontinue use due to method failure or difficulty in accessing a suitable method. Notably, contraceptive discontinuation was comparatively higher in the northern and north-eastern states, particularly the latter, than in the southern states. Moreover, women who discontinued using contraceptives in the northern and north-eastern states more frequently reported difficulty in accessing a method or inconvenience in using a method as reasons for discontinuation, compared with women in the southern states.

Information on method-specific discontinuation rates from small-scale surveys shows, not unexpectedly, higher discontinuation rates for pills and condoms than intra-uterine devices (IUDs). Estimates derived from data on contraceptive history over a three-year period in Uttar Pradesh show that four-fifths of the IUD users continued use for up to 20 months and only 50 per cent of pill users continued for up to 10 months (Zhang, Tsui and Suchindran 1999). A prospective study of women using IUDs and oral pills in Gujarat reveals that 43 and 62 per cent respectively discontinued the method by the end of the twelfth month, and after eighteen months, the proportion discontinuing the method increased to 62 and 73 per cent respectively (Gandotra and Das 1996). The tendency to discontinue use appears to be more common in rural areas than in urban areas. For example, in a study of IUD users in Karnataka, 50 per cent of the rural users, compared to 30 per cent of the urban users, discontinued use within one year of acceptance (Bhat and Hasalkar 1996).

It is important to assess whether women using a contraceptive method switch to an alternative method immediately after discontinuing the method they have been using. However, information on patterns of contraceptive switching in India is sparse. As with contraceptive discontinuation, the option of contraceptive switching is limited as many ever users had never used any other method before sterilisation (IIPS and ORC Macro 2000). An analysis of data on future use of contraception available from NFHS-2 sheds light on the intended pattern of switching among current discontinuers and indicates that one-third intend to use another method within 12 months from the time of the survey, another one-third intend to use a method sometime later, and the rest do not intend to use any method at all. While nearly one-half (46 per cent) of the potential contraceptive switchers plan to use female sterilisation, one-fifth plan to switch to pills, one-tenth to condoms, and another one-tenth to natural family planning. Among discontinuers who intend to switch to a method within 12 months, the choice tends to be more in favour of reversible methods (48 per cent for modern reversible methods, 10 per cent for natural family planning methods and 33 per cent for non-reversible methods). A prospective follow-up study of IUD and oral pill users in Gujarat shows that about one-third of those who discontinued IUD use after 12–18 months did not switch to any



other method, one in ten switched to female sterilisation, one in twenty to natural methods, 3 per cent to oral pills and 3 per cent to condoms. Among oral pill discontinuers, while over one in four did not switch to any method, the tendency was to switch to other spacing methods like IUDs or natural methods, followed by a terminal method (Gandotra and Das 1996).



4 Unmet need for contraception

Despite improved availability and access to contraceptive services, a substantial proportion of pregnancies in India are unplanned (mistimed or unwanted). It is estimated that if all unwanted births could be eliminated, the total fertility rate would drop to the replacement level of fertility. Data from NFHS-2, for example, show that 21 per cent of all pregnancies that resulted in live births in the three years preceding the survey (including current pregnancies) were unplanned—12 per cent mistimed and 9 per cent definitely unwanted (IIPS and ORC Macro 2000). In all likelihood, this is an underestimate of unintended pregnancies because longitudinal survey data reveal women's tendency for ex post revision of their preferences in favour of the wantedness of existing children (Bankole and Westoff 1998). Moreover, a substantial proportion of unintended pregnancies may be terminated through induced abortion. Estimates show that about 6.7 million induced abortions take place annually in India (National Commission on Population 2002). Several studies report that the desire to limit family size and to space the next birth are the main reasons for abortion mentioned by the majority of abortion seekers (Ganatra 2000). These findings provide clear evidence of the substantial unmet need for contraception among women in India.

The concept of unmet need for contraception, originally coined to reflect the discrepancy between fertility preferences and contraceptive use (Casterline and Sinding 2000), has evolved over time. Conventionally, currently married women who are not using any contraceptive method but who do not want any more children, or who want to wait two or more years before having another child, are defined as having an unmet need for family planning. It has been suggested that that the concept of unmet need be expanded to include women's future fertility preferences; potential clients other than married women, including unmarried women and men (whether married or unmarried), and women who are dissatisfied with their current method or are using an inappropriate method; and qualitative as well as quantitative dimensions of care (Bruce 1990; Dixon-Mueller 1993; Dixon-Mueller and Germain 1992). Following the recent shift in the reproductive health paradigm, in India too, researchers have called for an expansion of the concept to reflect "the extent to which women are achieving their reproductive intentions in good health" (Ravindran and Mishra 2001). The conventional concept, however, continues to guide programme design in the country.



Magnitude

By the conventional definition, NFHS–2 reports that 16 per cent of currently married women have an unmet contraceptive need—8.3 per cent for spacing and 7.5 per cent for limiting—which translates into one-fourth of women who wish to space or limit births. It is estimated that if all women who say they want to space or limit their births were to use family planning, the contraceptive prevalence rate would increase from 48 per cent to 64 per cent of currently married women (IIPS and ORC Macro 2000). Based on the current population of 1,027 million married women, this implies that approximately 40 million married women have an unmet need (National Commission on Population 2002). While the needs of the vast majority of women who wish to stop childbearing are being satisfied, the needs of women who wish to delay or space childbearing remain largely unsatisfied. For example, it is estimated that the needs of 86 per cent of women who wish to stop childbearing are addressed by the existing services, compared to the needs of 30 per cent of women who wish to delay their next pregnancy.

What is disturbing is the finding that the current programme is addressing only a small part of the contraceptive demand of young women, particularly those who are yet to begin or are still in the process of forming their families (see Table 3). Young women are more likely to have an unmet need for contraception. Data from NFHS–2 indicate that 25 per cent of young women, compared to 17 per cent of women aged 25–34 years and 7 per cent of women 35 years and above, had an unmet need for contraception (IIPS and ORC Macro 2000). When translated in terms of young women who wish to space or limit births, this implies that the existing service delivery system is addressing the contraceptive needs of only 44 per cent of young women. Among women who have not given birth, the contraceptive needs of only 25 per cent of women are satisfied. In addition to the strong programme emphasis on sterilisation until recently, this may be partly due to the neglect of young women by the programme that perceives a contraceptive need among young people only after they have completed their family formation. Evidence is emerging, however, that young couples, despite community norms that favour a first child soon after marriage, would prefer delaying the first birth until they have spent more time together to know each other better (Haberland, McGrory and Santhya 2001).



Table 3: Percentage of married women with an unmet need for contraception by selected background characteristics

Characteristics	Unmet need			Met need			Total demand			% demand satisfied		
	Spacing	Limiting	Total	Spacing	Limiting	Total	Spacing	Limiting	Total	Spacing	Limiting	Total
Age												
15–24	21.0	4.5	25.3	7.1	13.1	20.0	28.1	17.6	45.3	25.3	74.4	44.2
25–34	5.8	10.8	16.5	3.7	52.1	55.4	9.5	62.9	71.9	38.9	82.8	77.1
35+	0.6	6.4	7.0	0.4	63.9	64.1	1.0	70.3	71.1	40.0	90.9	90.2
Residence												
Urban	6.7	6.7	13.4	5.2	53.1	58.2	11.9	59.8	71.6	43.7	88.8	81.3
Rural	8.9	7.8	16.7	2.9	42.1	44.7	11.8	49.9	61.4	24.6	84.4	72.8
Educational status												
Illiterate	7.9	8.8	16.5	1.5	40.9	42.1	9.4	49.7	58.6	16.0	82.3	71.8
Primary	7.9	6.5	14.3	2.7	51.9	54.4	10.6	58.4	68.7	25.5	88.9	79.2
Secondary+	9.5	6.0	15.4	7.3	48.3	55.5	16.8	54.3	70.9	43.5	89.0	78.3
Cash employment												
Worked for pay	5.5	6.1	11.5	2.2	53.0	55.0	7.7	59.1	66.5	28.6	89.7	82.7
Worked without pay	7.0	7.0	14.0	1.5	46.2	47.5	8.5	53.2	61.5	17.6	86.8	77.2
Not worked	9.8	8.2	17.9	4.4	41.5	45.6	14.2	49.7	63.5	31.0	83.5	71.8
Caste												
Scheduled caste/tribe	8.7	8.2	16.5	2.6	40.5	42.9	11.3	48.7	59.4	23.0	83.2	72.2
Non-Scheduled caste/tribe	7.9	7.4	15.5	3.9	46.8	50.4	11.8	54.2	65.9	33.1	86.3	76.5
Mass media exposure												
Exposed	7.8	6.1	13.9	1.8	35.2	36.5	9.6	41.3	50.4	18.8	85.2	72.4
Not exposed	9.2	9.7	18.8	4.7	51.4	55.9	13.9	61.1	74.7	33.8	84.1	74.8
Spousal discussion												
Discussed	9.9	12.5	22.4	9.1	40.4	49.3	19.0	52.9	71.7	47.9	76.4	68.8
Not discussed	8.0	6.4	14.4	2.3	46.0	48.0	10.3	52.4	62.4	22.3	87.8	76.9
No. of living children												
0	13.9	0.2	14.1	3.8	0.7	4.6	17.7	0.9	18.7	21.5	77.8	24.6
1–2	13.0	5.4	18.2	6.7	38.0	44.5	19.7	43.4	62.7	34.0	87.6	71.0
3+	3.2	11.1	14.2	0.8	61.5	61.8	4.0	72.6	76.0	20.0	84.7	81.3
Region												
South (south+west)	6.7	4.2	10.9	2.8	56.0	58.7	9.5	60.2	69.6	29.5	93.0	84.3
North (north+east)	9.4	9.6	18.8	3.8	38.2	41.6	13.2	47.8	60.4	28.8	79.9	68.9
North-east	9.4	10.3	19.2	7.7	34.6	41.4	17.1	44.9	60.6	45.0	77.1	68.3

Source: Based on NFHS–2 data



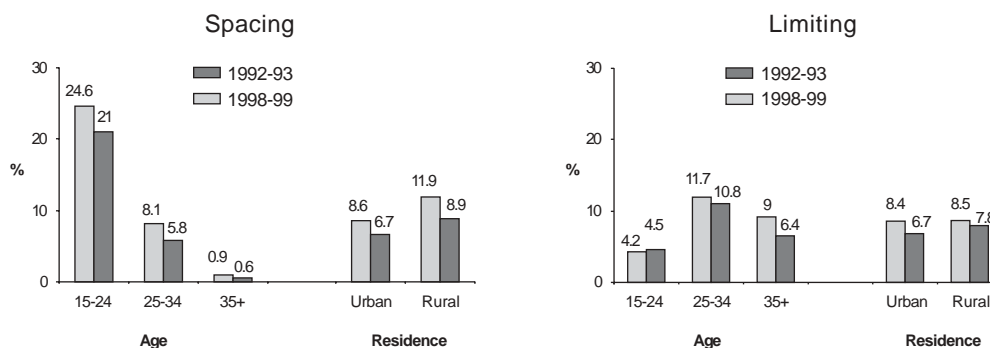
There are pronounced regional differences in the proportion of women with an unmet need for contraception. NFHS-2 data show that the level of unmet need was higher in the northern and north-eastern states than in the southern states — 19 per cent vs. 11 per cent. There are substantial differences in unmet need within each region as well. In the southern states, for example, 8 per cent of married women in Andhra Pradesh had an unmet need for contraception, compared to 17 per cent in Goa. Similarly, the level of unmet need in the northern states ranged from 7 per cent in Punjab to 25 per cent in Bihar and Uttar Pradesh. In the north-eastern states, unmet need ranged from 16 per cent in Mizoram to 36 per cent in Meghalaya (IIPS and ORC Macro 2000).

National and regional trends

Nationally, the proportion of women with an unmet need declined marginally (by 19 per cent) during the six years between NFHS-1 and NFHS-2 (IIPS 1995; IIPS and ORC Macro 2000). The decline was more pronounced in the case of unmet need for spacing (25 per cent) than for limiting (12 per cent). The trends in unmet need for spacing and limiting for different age groups, as shown in Figure 1, indicate that the decline was concentrated in the group of women 35 years and above and the least decline was reflected in the younger age group.

A comparison of state-level estimates of unmet need for contraceptives in 1992-93 and 1998-99 shows that the level of unmet need declined in the majority of the states, ranging from as low as 2 per cent in Bihar to 54 per cent in Haryana. However, the north-eastern states, except Assam, recorded an increase in the level of unmet need during this period. While the level of unmet need increased marginally (by 9 per cent) in Manipur, it increased substantially (by 41 per cent) in Meghalaya.

Figure 1: Trends in unmet need for spacing and limiting



Source: IIPS, 1995; IIPS and ORC Macro, 2000.



It is important to bear in mind that individuals move rapidly in and out of the unmet need state, making the subgroups with an unmet need a moving target (Jain 1999; Robey, Ross and Bhushan 1996; Westoff and Bankole 1998) Moreover, unmet need is determined by a combination of factors including the extent of exposure to the risk of pregnancy, the efficacy of contraceptive practice and intentions about childbearing (Westoff 1988).

5

Barriers to meeting contraceptive needs

The Family Welfare Programme has been successful in spreading the message of the small family norm, improving contraceptive acceptance and reducing fertility rates but its achievements have been modest. While contextual and structural factors (high levels of illiteracy, poor access to sources of knowledge, poverty, and gender- and non-gender-based disparities) are partly responsible, the direction, emphasis and strategies followed hitherto in the Family Welfare Programme have largely contributed to the limited success of the programme. There is an increasing recognition of various barriers to promoting contraceptive choice and meeting contraceptive needs in the country. Several measures to address these have been launched in recent years. The following sections discuss some of these barriers, measures proposed or currently under way, and emerging evidence on the extent to which these measures have succeeded in promoting contraceptive choice and addressing unmet need.

Limited knowledge

As is known, the small family norm is widely accepted (the mean ideal family size reported by young people is currently 2.5 children) and general awareness of contraception is universal (99 per cent of currently married women in the reproductive age group were aware of at least one contraceptive method). However, awareness of reversible (modern or natural) methods is relatively limited among both women and men. Nationally, for example, only 71 per cent of currently married women were aware of condoms (IIPS and ORC Macro 2000). In some major states including Andhra Pradesh, Karnataka, Madhya Pradesh and Orissa, fewer than three in five currently married women were aware of condoms. What is more disturbing is the finding that awareness of specific reversible methods, which are more suitable for young women, is even more limited among younger women compared to older women. For example, only three-fifths of married adolescents were aware of condoms, compared to nearly three-fourths of women aged 20–34 years (Santhya and Jejeebhoy 2003). Also disturbing, particularly in the context of increasing premarital sexual experience among unmarried boys and girls, is the evidence from small-scale studies that a substantial proportion of unmarried boys and girls lack contraceptive knowledge (Bhende 1994; Kumar et al. 2000).



Knowledge of contraception, as usually measured in national surveys, is unlikely to reflect a familiarity with and understanding of contraceptives adequate to lead to use. Of equal importance as awareness of contraceptive methods is knowledge of where these methods can be obtained, what the main side effects are and how to use the selected method correctly (Bongaarts and Bruce 1995). Evidence from a number of small-scale studies in various parts of the country indicates that inadequate knowledge of contraceptive methods is a reason for not accepting family planning (Levine et al. 1992; Roy et al. 1991). Incomplete or erroneous information on where to obtain methods and how to use them is strongly associated with unmet need (Viswanathan, Godfrey and Yinger 1998). Studies assessing correct, adequate and timely knowledge of contraceptive methods among women and men are limited, but suggest that a small proportion have complete and timely knowledge of various contraceptive methods. For example, a study of married men in Gujarat reports that knowledge about the correct use of condoms was low; only a small minority knew about when to put on a condom, how to use it properly and that it should not be re-used (Sharma et al. 1997). In a study of men in rural Maharashtra, while 92 per cent were aware of condoms, only 29 per cent knew about its correct use (Balaiah et al. 1999). A small-scale study conducted in Karnataka reports that while 56 per cent of women and 61 per cent of men interviewed were aware of reversible methods, a much smaller proportion—31 per cent of women and 52 per cent of men—was aware of at least one service outlet for reversible methods (Rajaretnam and Deshpande 1994).

Qualitative studies also report that in many cases, men and women who were aware of contraceptive methods did not have timely knowledge, especially during the initial years of their married life (Haberland, McGrory and Santhya 2001; Levine et al. 1992; Santhya, McGrory and Haberland 2001). For example, in-depth interviews with first-time pregnant women and first-time recently delivered mothers in Vadodara; and Kolkata reveal that they did not have contraceptive knowledge prior to becoming pregnant; had they had such knowledge, they may have delayed the first pregnancy:

...we talk, so one day he [husband] told me this [wanted a child after 2–3 years]. I also told him that I want a child after 2–3 years. But he told me that he did not know how not to have a child so he would ask someone, but then next month I came to know that I was pregnant. (18-year-old first-time pregnant woman in Vadodara; Haberland, McGrory and Santhya 2001)

Moreover, several studies report that misconceptions are common among women and men, particularly related to the side effects of contraceptive methods (Balaiah et al. 1999; IIPS 2001a; Parveen et al. 1995; Population Council 2002; Sharma et al. 1997).



There is clearly a need to increase correct and timely knowledge about contraceptives among women, men and community leaders through clinic- and community-based programmes. Information, education and communication (IEC) efforts need to be strengthened, and integrated within the training of all health providers. The Reproductive and Child Health Programme recognises the importance of IEC efforts in promoting a demand for services, including family planning services, but the lack of adequate collaboration between the health sector and IEC units is reportedly rendering these efforts ineffective (Population Council 2002). Similarly, the experience of a scheme to involve Zilla Saksharata Samitis in IEC activities pertaining to the Reproductive and Child Health Programme shows that operationalisation at the ground level is a huge challenge.⁹ Under this scheme, these samitis are encouraged to utilise local resource persons and institutions from the district to design and deliver IEC programmes on reproductive and child health in the local language. This scheme is currently in different phases of implementation in 227 districts in the country and 22 Zilla Saksharata Samitis have completed these activities (MOHFW 2002a). An evaluation of the scheme in a number of districts in Gujarat shows that the involvement of Zilla Saksharata Samitis and IEC functionaries, who are to play a vital role in this venture, is completely missing. These educational activities are mainly organised by the staff of the primary health centres with some support from the local Panchayat (Gandotra and Das 2001).

Gender inequalities and limited male involvement

Within the patriarchal set-up in India, women have relatively little power. Young women are particularly powerless, secluded and voiceless in matters relating to their own lives, and are constrained from exercising choice in sexual and reproductive matters. Nationally, data from NFHS–2 shows that only one in two ever-married women participated in decisions about their own health care (IIPS and ORC Macro 2000). The role of the husband has been noted in several studies of decision-making related to the use of contraception, especially during the early years of marriage (Acharya and Surender 1996; Barua and Kurz 2001; Dharamalingam 1995; Ghosh 2001; Haberland, McGrory and Santhya 2001; Jejeebhoy and Kulkarni 1996; Ravindran 1993). Most couples do not discuss with each other when to have their first child, birth spacing or contraception (Gupta, Jain and Sen 2001; IIPS and ORC Macro 2000; Khan and Patel 1997). Nationally, for example, fewer than one in five currently married women reported discussing family planning with their husbands (IIPS and ORC Macro 2000). Studies also show that most men approve of

⁹ Zilla Saksharata Samitis are independent, autonomous bodies registered under the Societies Registration Act to help in implementing the National Literacy Mission at the district and village level.



contraception only after having a second or third child (Khan and Patel 1997), and that husbands' approval of a particular method is critical (Parveen et al. 1995).

Given that men dominate in reproductive health matters, promoting shared responsibility and the active involvement of men in safe and responsible sexual relationships, family planning, safe motherhood and responsible parenthood is critical. The National Population Policy and the Reproductive and Child Health Programme recognise this synergy, but men's roles have not been properly defined in government programmes. There have been some efforts to promote the use of male methods such as vasectomy and condoms, and initiatives to re-popularise vasectomy, including IEC campaigns and training of surgeons in "no-scalpel" vasectomy, have been launched in several states (MOHFW 1999). Though these efforts have proved successful in some districts in Andhra Pradesh, a similar change has not occurred in most other states (Planning Commission 2002).

Male health workers could play an important role in promoting male involvement in reproductive and child health. However, two-thirds of primary health centres in India do not have a male health worker (IIPS 2001b). Moreover, the Reproductive and Child Health Programme document offers no clear guidelines on the role and responsibilities of male health workers (Prakashamma 1999). Karnataka's experience shows that involving male health workers in the community needs assessment process can be problematic. Male workers in the state, who traditionally focus on malaria and tuberculosis screening and follow-up, viewed reproductive and child health as the domain of the female worker (Murthy et al. 2002). The Reproductive and Child Health Programme must take cognisance of this fact and redefine the role of male health workers and impart suitable training to them.

Limited efforts to involve men in reproductive health matters have been carried out by a few NGOs. These NGO experiences have demonstrated that men are potentially interested in becoming more supportive and involved in reproductive health programmes. The challenge is how to encourage more such efforts while, at the same time, finding the means to incorporate what NGOs have learned in the design and implementation of public programmes. It is encouraging that such collaborations are emerging. For example, in Maharashtra, Foundation for Research in Health Systems has been working with the state government to develop interventions to include men in reproductive health services and provide education to adolescent boys within a government programme (Raju and Leonard 2000).

Many studies report that reproductive decision-making often is beyond the control of young women and their husbands (Barua and Kurz 2001; Piet-Pelon, Rob and Khan 1999; Ravindran



1993; Santhya, McGrory and Haberland 2001), and it is the extended family's decision on what is permissible that influences the husband/couple's decision. Access to appropriate contraception is frequently thwarted by the family and peer pressure. Hence, it is also important to engage other gate-keepers, including senior men and women in the family and influential people in the community, in reproductive health programmes.

Limited informed choice

The public sector essentially provides five contraceptive methods—two forms of tubectomy (laparoscopy and minilap), vasectomy (including “no-scalpel” vasectomy), IUDs (Copper T200), oral pills (combined) and condoms. Efforts to broaden the basket of choices have been under way, including clinical trials to assess the safety and efficacy of available methods such as estrogen-progestogen combination injectables, vaginal rings and long-acting IUDs, and the development of new methods of male and female fertility regulation (Puri 1998). As part of expanding contraceptive choice, the government has introduced emergency contraceptive pills in the Reproductive and Child Health Programme (MOHFW 2002b). However, most women and men, particularly those who rely on the public sector—indeed 76 per cent of current users of modern methods relied on this sector (IIPS and ORC Macro 2000)—do not have access to a wide range of contraceptives. Methods that are perceived as less effective, including pessaries, spermicides and diaphragms, or that are controversial, including injectables and implants, are either dropped or not introduced in the public programme or are given low priority by health workers. The recently introduced emergency contraceptive pills are currently available through medical officers only at the district and sub-district level (Mallik 2003).

Not only is access to a wider choice of methods limited, but providers also often do not assist women and men to exercise their right to contraceptive choice by offering them complete and accurate information about the variety of methods available. Nationally, for example, data from NFHS-2 show that only 15 per cent of users of modern contraceptive methods who were motivated by providers, friends or others were informed about at least one alternative method. Private and NGO sector health workers were more likely to inform clients about alternative methods than were public sector health workers (28 per cent vs. 19 per cent) (IIPS and ORC Macro 2000). Providers have a distinct bias towards sterilisation (Visaria 2000). Several small-scale studies of clients and providers conducted in the early 1990s report that most women were informed about female sterilisation and only a minority were told about reversible methods (Barge and Ramachandar 1999; ICMR 1991; Khan, Patel and Chandrasekhar 1993; Khan, Gupta and Patel 1999; Khan, Patel and Gupta 1999; Murthy 1999; Ravindran 1999; Roy and Verma, 1999; Verma and Roy 1999; Visaria 1999). In a qualitative study in rural Karnataka, medical officers were reported to



have asked investigators why couples should be told to use reversible methods if they voluntarily accept sterilisation (Rajaretnam and Deshpande 1994). This bias seems to have been carried over to the clients. For example, a large majority (65 per cent) of women who intend to use contraception reported that they intend to use female sterilisation (IIPS and ORC Macro 2000).

Evidence from a growing number of studies suggests that pre-acceptance counselling of clients on how the method works, what the expected side effects are and how to manage the side effects is typically lacking or limited in the Family Welfare Programme across the country (Foo and Koenig 2000). Nationally, data from NFHS-2 indicate that only 22 per cent of users of any modern method were informed of its possible side effects at the time of accepting the method (IIPS and ORC Macro 2000). Similarly, data from the Reproductive and Child Health Survey-1 report that only one-third of sterilisation users (35 per cent), fewer than one-half of IUD users (46 per cent) and fewer than one-fourth of pill users (23 per cent) were informed of the side effects before accepting the method. The provision of pre-acceptance counselling was lacking or limited even in those states where contraceptive prevalence was relatively high such as Kerala and Tamil Nadu (IIPS 2001a). Hence, not surprisingly, data from NFHS-2 show that among those who discontinued use at the time of the survey, more than one-fourth (29 per cent) reported side effects and other method-related concerns as reasons for discontinuing use (IIPS and ORC Macro 2000). Small-scale studies on reasons for contraceptive discontinuation conducted in various parts of the country, including Gujarat, Karnataka, Madhya Pradesh, Maharashtra, Orissa and Uttar Pradesh, also reiterate these findings (Bhat and Hasalkar 1996; Bhatnagar et al. 1988a; 1988b; Gandotra and Das 1996; Kanitakar et al. 1988; Kanojia et al. 1996; Khan, Patel and Chandrasekhar 1990; Prabhavati and Sheshadri 1988; Rao 1990; Schaap 1993). In most of these studies, more than half of women discontinuing use of IUDs and oral pills reported side effects as the reason. There is, however, evidence that if women are informed earlier about the side effects that they might experience in the first few months of method use, continuation rates will improve significantly (ICMR Task Force on IUD and Hormonal Contraceptives 1994; Prabhavati and Sheshadri 1988).

Available evidence on users' perspectives/client acceptability of various methods, though limited, suggests that many of the reversible methods that are not currently being promoted are acceptable to women in rural and urban areas (Rajgopal et al. 1989; Ravindran 1995). For example, in a feasibility study of user perspectives on the desirability of including the diaphragm among other contraceptive methods, 8 per cent of study participants accepted the diaphragm, and all users, irrespective of their educational level, reported that they thought the method was appropriate and easy to use (Ravindran 1995). Twice as many married adolescents accepted the diaphragm as compared to older women. Similarly, evidence is emerging that if provided with complete information



on all available contraceptive methods, women do make an informed choice overriding provider bias. For example, in a study where 8,077 potential clients were provided with detailed information on various methods, including IUDs, oral pills, condoms, sterilisation and Norplant, the majority (80 per cent) opted for reversible methods irrespective of their literacy status and only 17 per cent accepted sterilisation. While Norplant was the first choice of the provider for 35 per cent of the women, only 5 per cent of women preferred and accepted Norplant (Baveja et al. 2000).

The Government of India's radical decision to remove Centre-driven targets for family planning has been perceived by many as a small but right step towards furthering informed choice, and thereby reproductive rights. Facilitating informed choice is envisaged as a strategic measure in the Reproductive and Child Health Programme and the National Population Policy 2000. Though the new policy formulations are path-breaking in bringing the language of choice and rights into national discourse, the mechanisms to translate the rhetoric into action are not clearly defined, and the strategies delineated contravene the ethos of choice and rights. In the revised target-free manual, for example, a system called "client segmentation" is used to guide a client's method choice. Client segmentation, in fact, places a woman into a category that will determine which method she is to be offered rather than offering the woman all the necessary information about the menu of contraceptive choices available to her and allowing to make an informed decision (Visaria, Jejeebhoy and Merrick 1999).

Early assessments of health care providers' efforts to promote informed contraceptive choice after the launching of the Target-free Approach and the Reproductive and Child Health Programme indicate mixed results. Some improvements in the provision of information on contraceptive choice have been reported in qualitative studies conducted in Uttar Pradesh and Gujarat.

I got a Copper-T inserted by an auxiliary nurse-midwife.... In fact, first, she told me to use Nirodh and [she also told me] if it did not work, then I take oral pills and if I cannot eat oral contraceptive pills, or happen to forget, then accept Copper-T. I have taken the decision on my own. (CORT 1998)

Similarly, studies in Tamil Nadu and Karnataka reveal that women are being provided with more family planning information (Murthy et al. 2002; Visaria and Visaria 1999). In contrast, evidence from Andhra Pradesh and Madhya Pradesh suggests that health workers continue to tell women what method they should choose rather than asking them their preference (Kalway, Rawat and Srivastava 1999; Prakashamma 1999). As one female health supervisor commented:



...we are now supposed to give them a choice, like those available in the market, and let them choose whatever they want. But if we keep talking and give them counselling and tell them all the information about the different methods, no one may want to accept sterilisation or any method. (Prakashamma 1999)

A more recent study conducted by Population Council in Andhra Pradesh, Madhya Pradesh and Maharashtra also reports that women were rarely told about a range of methods—fewer than one in ten women in Andhra Pradesh, and one in five women in Madhya Pradesh and Maharashtra, reported having been informed about more than two methods. Women who do not have any children were not told about any method. Moreover, even though most of the providers are trained to provide counselling for condoms, oral pills, IUDs and female sterilisation, few providers informed clients how a method works, how to manage side effects and the danger signs that warrant medical attention. A review of IEC materials in these states indicates that information to enable contraceptive choice was either scanty or non-existent. The materials included only benefits but not side effects and sometimes contained “command” messages that take away the element of choice, such as “get sterilised after having one child” (Population Council 2002).

Limited access to and availability of services

Over the decades, there has been considerable expansion and strengthening of the health care infrastructure, and family welfare services are now an integral part of services provided by primary, secondary and tertiary care institutions across the country. Currently, about 137,271 subcentres (1/4579 population) and 22,975 primary health centres (1/27364 population) in rural areas, and 871 health posts and 1,083 family welfare centres in urban areas provide family planning services at the grassroot level (Planning Commission 2002). Access to contraceptive methods has increased significantly, and only a negligible minority of women (4 per cent as per NFHS–2 data) perceived availability, accessibility or cost as major impediments to using contraception. Yet, in practice, access to and availability of services are critical issues of concern. Gaps in infrastructure, manpower, equipment and supplies at the primary health centre level remain. A recent survey of health facilities across the country reports that most primary health centres were not adequately staffed: almost one in ten was functioning without any doctor and 80 per cent did not have a female medical officer. The situation was particularly grim in Orissa, Rajasthan and Uttar Pradesh where 95 per cent or more primary health centres did not have a female medical officer. Nearly one-half of primary health centres did not have an auxiliary nurse-midwife; in states such as Orissa, Uttar Pradesh and Bihar, 87-94 per cent did not have an auxiliary nurse-midwife (IIPS 2001b).



Where workers are available, they are generally poorly trained and have little knowledge of the methods they are to provide (Foo and Koenig 2000; Jejeebhoy and Kulkarni 1996). The facility survey referred to earlier reveals that only 16 per cent of primary health centres had physicians trained in conducting sterilisation, and only two-third had at least one paramedical staff trained in IUD insertion (IIPS 2001b). While female health workers in many studies reported that they had received training in IUD insertion, the majority did not feel confident about actually inserting an IUD in field settings or showed little awareness of the precautions to be taken (Visaria 2000). A survey in Maharashtra observes that only one-third of the 80 health workers had correct knowledge of oral pills and only 43 per cent could give adequate advice on a method convincingly (Roy et al. 1991). It is encouraging that the Reproductive and Child Health Programme has laid greater emphasis on skill upgradation and gender sensitisation training, and a nationwide reproductive and child health training programme has been launched to upgrade the skills of health providers and managers to deliver the reproductive and child health package of services. However, it is a matter of concern that a mid-term review of the training component of the Reproductive and Child Health Programme notes that the modules and training focus more on the technical areas of service delivery and give little importance to the newer focus areas, such as gender sensitivity, life-cycle approach, client focus and quality of services, which are the pillars underlying the paradigm shift (Mavalankar 2002). It has also been pointed out that lack of state ownership of training programmes, and inadequate technical support by the collaborating centres, have significantly affected the quality and pace of training (World Bank 2000). The draft Programme Implementation Plan of the Reproductive and Child Health Programme–2 also recognises the limitations of the existing training programme (MOHFW 2003b)

Health or family planning workers are required to regularly visit each household in their assigned areas to provide information related to health and family planning, counsel and motivate women to adopt appropriate health and family planning practices, and deliver other related services. However, data from NFHS–2 indicate that only 13 per cent of women had received a home visit from a health or family planning worker during the 12 months preceding the survey, and women without any children were least likely to receive a home visit. Only 11 per cent of women who were visited at home reported that they received family planning services (IIPS and ORC Macro 2000). State-level data show that fewer than 2 per cent of women in several states, including Punjab, Haryana, Delhi, Arunachal Pradesh, Nagaland, and Jammu and Kashmir, received a home visit from a health or family planning worker in the 12 months preceding the survey. Only in four states—Gujarat, Mizoram, Tamil Nadu and Maharashtra—had at least a quarter of women received such a visit. Several small-scale studies also reveal significant shortcomings in the frequency and regularity of outreach services, the time devoted by workers to such activities and the length of time spent



with clients (Foo and Koenig 2000). Additionally, outreach services are reported to be almost non-existent in remote and tribal areas (Murthy 1999). Moreover, health workers at the community level are often looked upon with distrust, and identified as interested only in recruiting “cases” for family planning (Jejeebhoy and Kulkarni 1996; Ravindran 1993). A number of studies show that the introduction of the Target-free Approach/Community Needs Assessment Approach, however, has reportedly enabled front-line health workers to gain a more positive image in their communities (Murthy et al. 2002; Sathyanarayana and Kar 2001; Sen, Gurumurthy and Sudarshan 1999):

...earlier we felt that we were beggars, begging women to come for an operation. Women behaved as if they were doing us a favour. Now I don't feel that way. I feel that I give them the services they need. (Murthy et al. 2002)

The Reproductive and Child Health Programme recommends that women who do not deliver in institutions receive three postpartum visits, during which they are to be given an abdominal examination, and provided advice on family planning, breast feeding and baby care. Data from NFHS-2 show not only that postpartum check-ups are almost non-existent but also that family planning is given the lowest priority among the various components of postpartum care (IIPS and ORC Macro 2000). Nationally, fewer than one in five non-institutional births was followed by a postpartum check-up. Among those who received a postpartum check-up, only 27 per cent of mothers received family planning advice, compared to 43 per cent receiving advice on breastfeeding and 46 per cent receiving advice on baby care. Adolescent mothers and women delivering for the first time were less likely than older women to receive advice on family planning. Notably, mothers received advice about family planning during postpartum check-ups for only 14 per cent of first births, although these women are more likely to need advice on birth spacing and contraception. Clearly, health workers and other providers tend to overlook adolescents and young women until they are further advanced in their reproductive careers.

Stock-outs and erratic supplies of reversible contraceptives make it unrealistic to expect providers to offer clients a choice of methods. The survey of health facilities referred to earlier reports that only 56–61 per cent of primary health centres had some stocks of condoms, IUDs and oral pills on the day of the survey. The situation was worse in states like Bihar, Orissa and Uttar Pradesh where fewer than one-fifth of primary health centres had some stocks of these methods (IIPS 2001b).

Though the overall situation is far from satisfactory, many new initiatives and the restructuring of existing measures have been successful in improving access to and availability of contraceptive and other reproductive health services. Of particular interest are initiatives by NGOs and experiments



with public–private partnerships. The social marketing and social franchising of selected reproductive health services by Janani, a registered society in Bihar, is one such example. Combining a strong market-based approach with a community-based distribution system, Janani has been able to provide quality family planning services at an affordable price in rural areas (Gopalakrishnan et al. 2002). Janani’s experiences have clearly shown that couples are willing to adopt family planning methods and pay for quality services that are easy to access (Mangal and Narayana 2001). An evaluation conducted in 2001 reports that the system has been successful in attracting illiterate and nulliparous women, population groups often overlooked by public sector providers (Sulzbach et al. 2002). The Innovations in Family Planning Services project in Uttar Pradesh is yet another example of successful delivery in areas with little or no access to reproductive and child health services. The project has contributed to increased regular contact with clients, improvements in contraceptive method-mix and use of temporary methods. A survey of married women in the reproductive age group in five project districts reports that about two-fifths of women had met with a community health worker in the six months prior to the survey (Levitt-Dayal 2002). In comparison, NFHS–2 data for Uttar Pradesh show that only 3 per cent of women received at least one home visit by a health worker in the 12 months prior to the survey (IIPS and ORC Macro 2000).

Poor quality of services

It is now widely acknowledged that the quality of family planning services is generally poor. Several studies report that little consideration is given to interpersonal interactions (Gupta 1993; Levine et al. 1992; Mavalankar and Sharma 1999; Ramachandar and Barge 1999; Ravindran 1999; Ramanathan, Dilip and Padmadas 1995). Women are often treated as ignorant and incapable of intelligent action. Service providers tend to disregard women’s need for privacy, and are uncaring about women’s dignity. As discussed in a previous section, pre-acceptance counselling and check-up are conspicuous by their absence. Post-acceptance follow-up services are also limited, especially in the case of reversible methods. Nationally, for example, data from NFHS–2 show that three in four sterilisation users and two in five users of other modern methods received follow-up services (IIPS and ORC Macro 2000). Data from the Reproductive and Child Health Survey–1, however, indicate that a much smaller percentage of women (only one in four) received a follow-up visit from a health worker after accepting the method—27 per cent in the case of sterilisation, 13 per cent for IUD and 7 per cent for pills. In many states, fewer than one in ten women reported receiving a follow-up visit (IIPS 2001a). It is commonly observed that auxiliary nurse-midwives do not maintain their registers adequately to follow up users, and lack a clear idea of how many have continued/discontinued the method (Foo and Koenig 2000).



Though long ignored as an issue within reproductive health care in India, there is a current programmatic shift towards incorporating quality of care within public sector services. To improve the quality of services, the Reproductive and Child Health Programme emphasises the need to assess client needs and perceptions, sensitise and orient health workers about the new ethos, involve the community including panchayati raj institutions in setting priorities and monitoring the quality of services, setting quality assurance guidelines and conducting refresher training for skill upgradation (World Bank 1997). However, moving beyond rhetoric to actually implementing change has not yet been noticeably achieved in many parts of the country. Assessments in various states in the early days of the implementation of the Reproductive and Child Health Programme show that not all programme managers and policy makers are convinced about the new emphasis on quality and choice. For example, an assessment in Karnataka reports that all officials believed that targets were the only way to ensure efficient functioning of auxiliary nurse-midwives and better implementation of the programme: “Monitoring is always in terms of figures and numbers, we first look at the numerical targets and then we look at the quality of work” (Sen, Gurumurthy and Sudarshan 1999). This clearly highlights that the concept of quality orientation is alien to health care providers at all levels.

To date, limited progress has been made in involving panchayats in the Reproductive and Child Health Programme and profound inter-state differences prevail. States like Kerala have embarked on decentralised planning and monitoring programmes utilising panchayati raj institutions, and have devolved powers and finances to these institutions. In some other states, panchayati raj institutions are mainly involved in planning and monitoring without devolution of powers and finances, and in others, panchayati raj institutions have not started participating in the programme (Planning Commission 2002).

Similarly, early assessments show that the Community Needs Assessment Approach is yet to become fully operational in many parts of the country and its implementation varies across districts within each state, as well as across states (Narayana and Sangawan 2001). Many states continue to impose targets, setting local goals based on the previous year’s centrally-assigned targets (Visaria and Ramachandran 1999). Incidents where NGOs, under government–NGO partnership, were forced to set targets, use district/state-level indicators and not permitted to follow the Community Needs Assessment Approach have been reported (Sudarshan 2002). In many states, the involvement of women and other stakeholders in community needs assessment was reported to be minimal. Moreover, the data generated using community needs assessment have not yet been properly used for setting local goals (Das and Sathyanarayana 2001), nor have they been used for making midcourse corrections (Planning Commission 2002).



6

The way forward

Though the Family Welfare Programme has experienced significant growth and modification over the past half century, pregnancies continue to be unplanned and the unmet need for contraception remains substantially high. Important sub-groups, such as adolescents, are neglected or under-served, the vast majority of contraceptive users are sterilised, contraceptive choice is conspicuous by its absence and the quality of care is limited within the programme.

The 1990s witnessed a growing recognition of the challenges faced by the programme, which led to the development of several new policy initiatives. These initiatives mark seminal changes in the way that health and family welfare issues are viewed in the country. The language of gender equality, equity, women's empowerment, choice, client satisfaction and quality of services has been brought into discussions around women's health. Several programmatic initiatives in moving forward the policy agenda have been taken up.

Early assessments of the impact of the new policy and programme initiatives suggest some improvement in overall indicators such as contraceptive prevalence rate and the magnitude of unmet need for contraception. However, underlying issues including limited contraceptive choice, poor quality of services, restricted access, gender inequalities and lack of male involvement continue to plague the programme. Mechanisms to address these issues remain elusive and the strategies outlined in policies remain poorly implemented. A review of the Reproductive and Child Health Programme-1 highlights inter-district and inter-state variations in its implementation. Several lacunae, including low level of ownership of and commitment to reproductive and child health at the state level, weak programme management at the district level, particularly in the Empowered Action Group states, and inadequate decentralisation of processes, remain (MOHFW 2003b).

A beginning has been made to promote expanded and informed contraceptive choice, but considerable efforts have to be made by various stakeholders before contraceptive choice can become a reality in India. There is clearly a need for improving programme implementation and directing programme focus to hitherto under-served population groups and poorly served areas. Some recommendations towards realising these goals are highlighted below.



Programme recommendations

- An expanded reproductive health programme must address men both in terms of their own health needs and in terms of their shared responsibility as partners, husbands and fathers, and should not be limited to promoting the use of male contraceptive methods. The role of male health workers who could play an active role in promoting male involvement also needs to be clearly defined.
- The contraceptive needs of sexually active young people remain largely unmet. Young people, married as well as unmarried, need accurate, user-friendly information and services, and multiple entry points (education, work, sports or other social activities) and settings (home, community, workplace, school or clinic) must be used to enhance access to information and services.
- The review indicates that the vast majority of unmarried, sexually active adolescents are engaging in unprotected sex, and whenever they use a method, pregnancy prevention seems to be the overriding concern rather than preventing both pregnancy and sexually transmitted infections. This indicates the need for educational and counselling efforts emphasising the dual protection properties of condoms.
- Provider bias continues to restrict the rights of women and men in exercising contraceptive choice. Providers need to be oriented about the client's right to exercise choice. Additionally, a variety of providers, including traditional medical practitioners, should be trained and engaged to promote detailed information on various contraceptive methods. There is evidence that trained traditional medical practitioners could be effectively engaged to increase contraceptive knowledge about reversible and non-reversible methods among rural women (Kambo et al. 1994).
- Given that women, especially young women, are powerless and voiceless in sexual and reproductive matters, multi-sectoral activities to enhance women's status are urgently needed. Since reproductive decision-making is often beyond the control of young women and their husbands, engaging other gate-keepers, including senior men and women in the family and influential people in the community, is crucial.
- IEC efforts to enable clients to exercise informed contraceptive choice have been increased, but inadequate collaboration between the health sector, IEC units and other stakeholders is reportedly rendering these efforts ineffective. Hence, inter-sectoral coordination needs to be vigorously promoted.
- The involvement of the community in planning and monitoring remains minimal, and concerted efforts to promote community participation are needed.
- As reflected throughout in this review, there are substantial state-level variations in contraceptive prevalence, the method-mix used, the extent of unmet need, the level of awareness



of reversible methods and the quality of services. This clearly highlights the importance of state-specific interventions to improve family planning services.

Research recommendations

The review reveals significant gaps in our understanding of contraceptive use dynamics and there are several issues that need urgent research attention. Some of these are highlighted below:

- Research on the attitude and practice of men regarding fertility regulation and the factors inhibiting their role and participation in reproductive health could help improve and modify the delivery system. Research is also required to determine men's needs for services and information in specific communities. Operations research is required to assess how educational campaigns could effectively promote shared responsibilities. As methods of fertility regulation available to men are limited, priority should be given to developing male methods of family planning.
- Available evidence suggests that an increasing proportion of unmarried adolescents are sexually active. However, data on their contraceptive behaviours are grossly inadequate. Gaining insights into adolescent sexuality, including the circumstances surrounding sexual initiation and the decision to practise contraception, is important for facilitating user-friendly reproductive health programmes for adolescents.
- Gaining a better understanding of how women and men make choices and negotiate trade-offs among methods could provide useful insights for policy makers, programme managers as well as the clients themselves. Future research should explore the context in which women and men exercise choice, including the power dynamics within relationships, and the interface between clients and the service system.
- Additional research is required to understand why women discontinue use, and whether efforts to provide detailed information under the new programmes have improved contraceptive continuation rates. Similarly, explorations into whether the new rhetoric on quality of care has been translated into reality and impacted contraceptive use dynamics are critically needed.
- Apart from data from the Reproductive and Child Health Survey–2 currently under way and a few small-scale studies, in-depth insights into the impact of new initiatives are scarce. Qualitative studies are needed to assess the perspectives of primary and secondary stakeholders regarding the changes in the programme.



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