

Contraceptive Technologies

Experience of Rural Indian Women

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There are two ways of looking at any contraceptive technology. One is from the professional or expert's viewpoint, the other is from the user's point of view. I work with rural women who are the ultimate users of these technologies. I shall try to describe how they view different contraceptive methods.

In an epidemiologic study of two villages in Gadchiroli, India, 92 percent of the women were found to be suffering from gynaecological diseases; each woman had an average of 3.6 gynaecological diseases. Most of the diseases were chronic. Infections of the genital tract accounted for more than 50 percent of these illnesses. This has a bearing on contraception in two ways. When an IUD is inserted or a tubectomy is performed in these women without treating their gynaecological diseases, it results in the aggravation of disease, pain or menorrhagia. As a result, women discontinue the use of the IUD (CuT in India) and spread the message by word of mouth that contraception leads to suffering. We also found that the women who used female methods of contraception had a significantly higher proportion of gynaecological diseases, suggesting that contraception may have



introduced or predisposed the women to gynaecological diseases. This relationship between contraception and gynaecological diseases is important both from the point of view of women and of the health care providers. The efforts and resources expended by the health care system to promote widespread use of contraceptive methods are futile as long as certain basic requirements of women are not met.

Local Methods

Recently, in a camp of Trained Birth Attendants (TBAs), some TBAs were secretly trying to persuade others (who were about to go in the deeper forest to collect *tendu* leaves) to get them something. On asking

what it was, they confided that they were requesting others to bring *Tenducha Chick*, a gum from a tree called *Tendu*. This is because these women firmly believe that consumption of this *tendu* gum leads to permanent cessation of menses and loss of fertility. The *tendu* gum is a popular method of contraception. We were unable to confirm the efficacy of this method but it brings into focus the fact that, despite the aggressive promotion of the family planning programme, many women have more faith in indigenous methods of contraception. It also reveals

that available medical methods of contraception are not acceptable to many women. They are still seeking alternative solutions rooted in their own culture.

Insensitivite to Side Effects

Why do women seek indigenous contraceptives? A major reason, they say, is the lack of side effects they commonly associate with modern contraceptives, such as backache, abdominal pain, white discharge, weakness, and irregular or excessive menstruation. Scientists who record these side effects during initial trials, or health care professionals to whom women later on complain of these side effects, are insensitive to these complaints. They regard these as

minor, insignificant side effects which should be ignored by the consumers. Or they put some medical label such as dysmenorrhoea on it and ignore it. What these scientists and doctors forget is the changed power relationship in family planning. They are accustomed to providing curative care to acutely ill patients. In such situations, they can legitimately expect patients to put up with some discomfort caused by therapy in exchange for relief from a major sickness. The doctor is in the dominant position with authority concentrated in his hands. The patients have to meekly accept whatever the doctor orders or advises. In public health programmes or family planning the situation is different. Here, health care providers seek compliance from people in preventing something which is not an immediate problem. They cannot expect people to ignore so called minor side effects nor can they dismiss

complaints about side effects. They cannot dictate to consumers in this different power relationship.

Unwanted Pregnancies

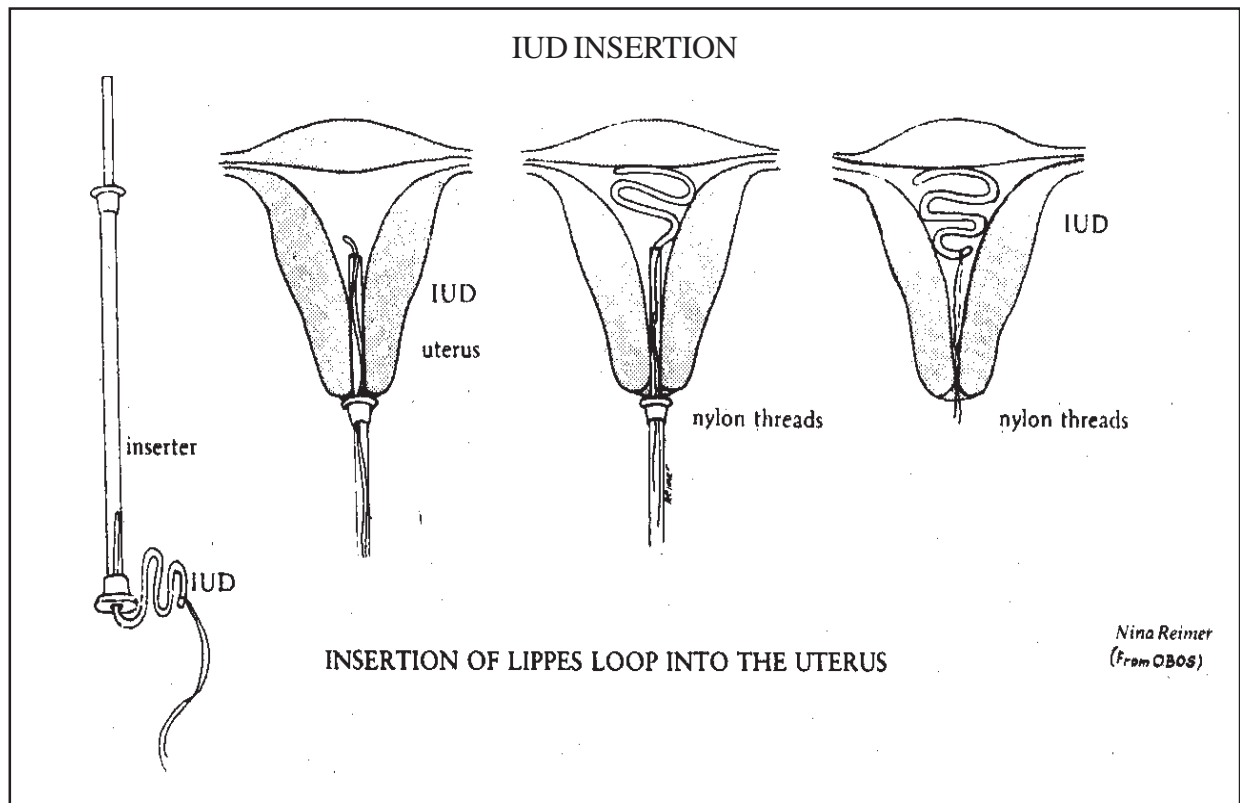
Unwanted pregnancies result from pre-marital sex, from unprotected marital sex, or from failure of contraception. Though most of the Indian health professionals believe that pre-marital or extra-marital sex is severely prohibited by cultural and religious taboos in India, we think that this is a middle class myth. In our community-based study of gynaecological diseases, we concluded during physical examinations that 46.7 percent of unmarried girls in our study have had intercourse. This was also confirmed by group and individual discussions with women, men, TBAs, key-informants and unmarried girls. Thus, sexually active unmarried girls do need protection from unwanted pregnancies.

Why do married couples resort to

unprotected sex even though they don't want a child? The main reason is that many couples are not happy with the available contraceptive methods.

IUD : It leads to menorrhagia, white discharge, backache and abdominal cramps. It sometimes fails. Introduction of IUD generates immense anxiety because women do not know exactly what an IUD is (most of them have never seen it nor are they shown) and where the IUD is actually inserted. They see the whole set of equipment (insertor, and so on) and think that the whole thing has been implanted. They believe that it ascends from the pelvis to the abdomen and later on into the chest (where all the vital organs are) because there is no concept of abdominal diaphragm in these women's view of body structure. Naturally, they believe that they are risking their lives when they accept an IUD.

IUDs are often inserted by nurses



and doctors without ascertaining whether the woman is pregnant or not. Most of the nurses and male doctors are ill trained to diagnose early pregnancy. They are also poorly trained in proper IUD insertion. In their anxiety to reach the IUD insertion target, nurses and doctors go ahead with introducing the IUD even though they may suspect that the woman is pregnant. In these situations, introduction of an IUD leads either to termination of pregnancy, with consequent heavy bleeding, or continuation of pregnancy, leading to an impression that the woman conceived in spite of the IUD.

Many private medical practitioners and gynaecologists fleece exorbitant amounts from women by wrongly leading them to believe that they are introducing a special imported "foreign" IUD while actually they are using the domestic multiload. This is accompanied with a false assurance to the patient that this does not cause any side effects like the usual CuT. This cheating of women must be stopped.

Many health care providers either do not know how to remove CuT (especially when the thread is smaller or turned inwards) or are unwilling to remove the IUD even if the woman wishes to have it removed. For such unfortunate women, CuT becomes a permanent method with its consequent problems, even though they had opted for it only to space their children. In such a situation where is free choice or freedom of reproductive rights? I have seen many old women with postmenopausal bleeding or leucorrhoea with a loop which was inserted 20-30 years ago. Women were scared of pelvic examination because they felt that an IUD might be inserted without their knowledge. In our area, women prefer to go to TBAs for treatment of Reproductive Tract Infections (RTIs)

rather than nurses because they do not trust government nurses and are concerned that an IUD might be inserted.

In my experience, an assurance to the woman that her CuT can be and would be removed easily without any fuss, if she has any side effect or whenever she wants the removal, improves the acceptance rate of the IUD. Thus the current coercive insistence of government health care providers for continuation of IUD is counter productive for contraceptive acceptance.

In the light of the above experience with CuT, one wonders what will happen to these poor women if Norplant is introduced in their bodies and they want it removed either because of side effects or for any other reason?

Laparoscopic Sterilisation: Its introduction was considered the most effective method for use in India. Many women were eager to adopt it. Unfortunately, poor training of the doctors and poor quality of the bands, combined with a mass campaign approach without insistence on quality care, has led to a high failure rate. The magic has worn off.

Vasectomy : It is not acceptable to males because they do not want to

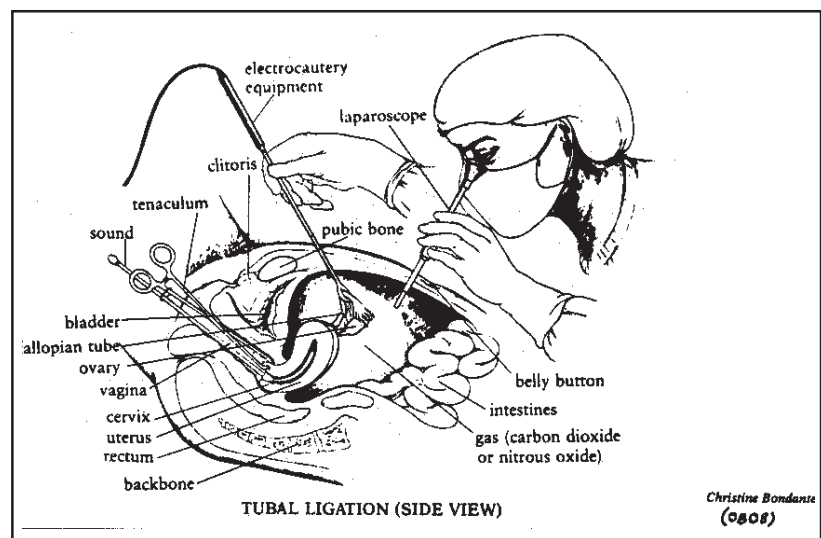
shoulder the burden of contraception. But interestingly, even women show less preference for vasectomy as compared to tubectomy for three reasons.

First, they do not want their husbands to become weaker sexually and physically. This weakness is one of the perceived ill effects of vasectomy.

Second, if the vasectomy fails (and it often does in the low quality mass approach) and a woman conceives, her husband and the community suspect the woman's sexual fidelity to her husband.

Third, some women prefer tubectomy since many of them have extramarital relationships. In nearly 50 percent of the cases where women come to us for an abortion, presumably because of their husband's vasectomy failure, there was in fact, no such failure. The woman had conceived from an extra-marital relationship.

Oral pills : They are very infrequently used by women in rural areas because they are not readily available. Also, many women cannot remember to take the pill regularly. The pill also disturbs the menstrual cycle if taken irregularly (which rural women often do). Moreover, the majority of



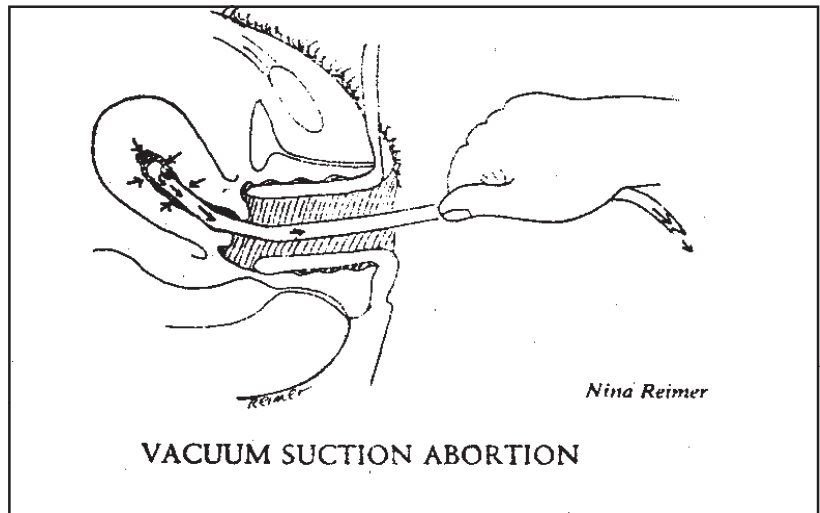
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women do not view pills as a method of contraception. They mistakenly regard them as an aborti-facient and so take them when they have missed a period, or only when there is sexual intercourse. Nausea and oligomenorrhoea in women who take the pill regularly also reduce the likelihood that women will choose this method. Oligomenorrhoea or hypomenorrhoea is supposed to be a serious disease which means the blood (impure) is collecting in the body leading to *Gola Warate*, that is, a lump in the abdomen which presses on the vital organs and leads ultimately to death. This is a very commonly prevalent perception. Also, the pill is a user dependent method and not a provider dependent method. It is not often advocated for by the health workers.

In reality, the choice of contraceptive methods is not made by women. The decision is actually often made by the government health programme officials or workers. Any new method is pushed aggressively without bothering to evaluate and learn from the failures of the previously propagated method. This ultimately brings dis-credit on all the contraceptive methods of the whole family planning programme. The discrediting began with the loop, and continued with abdominal tubectomy, followed by vasectomy, then by oral pills, then by CuT, then by laparoscopic tubectomy. Now the ones waiting in line for large scale introductions are Norplant, RU 486 and a contraceptive vaccine.

Condoms: They are not liked by men for well known reasons. Moreover, the health care providers in rural areas, mostly female nurses, find it difficult and embarrassing to explain their proper use.

Abortion : With all the problems associated with various contraceptives, women frequently



end up having unwanted pregnancies and abortion remains the only solution. Though policy makers and health professionals may not agree, I must say that from the people's point of view abortion is the most widely accepted and commonly used method of family planning. About five million women in India seek abortions every year from so called illegal sources. In spite of legalisation of abortion in India and with quite a liberal abortion law since 1972, only 10 percent of the total induced abortions are performed through licensed safe medical services. For most people, legal and illegal abortions are useless terms. What matters to them is the availability and accessibility of safe abortion services. Legalised abortion services are very scarce in rural areas and wherever they exist, women don't have good experiences. The apathy and ill treatment women experience at the hands of medical professionals, the long waiting periods, heavy charges (though it should be provided free of cost in government hospitals), all lead to fear and a sense of alienation in the minds of women. So most of the rural women seek abortion from quack abortionists at heavy physical, emotional and financial costs. The fee charged by these

quacks is sometimes beyond imagination. An old TBA once took me aside and said that she must tell me a secret, a bit of confidential information before her death. "What is that?" I asked. "It is about the fee extracted by a male quack abortionist from the women who seek his services for termination of unwanted pregnancies. He forces them to sleep with him before and after performing the abortion." I was aghast! The only way to save women from such exploitation is to provide safe, concerned and easily accessible abortion services.

RU 486: Out of the total of 500 abortions we have performed at the Search abortion centre in the last two years, 85 percent of women had resorted to various herbal medicines, high dose oestrogen progesterone preparations (actually banned in India but still available in the market. Even many Ayurvedic companies have flooded the market with these types of drugs!) high dose oral pills, chloroquine tab-lets, ergot tablets, massage, tonics (in the belief that amenorrhoea is due to less blood in the body and weakness) before coming for surgical intervention. Ninety percent of them had suspected pregnancy when they

were overdue by one week. When I asked women and men what method they prefer for abortion, a pill or surgical intervention, the majority opted for a pill because they were scared of an "operation". Other reasons they mentioned include the fear that the doctor might do a sterilisation along with the abortion, and their inability to afford a hospital or to stay away from domestic responsibilities. I talked to them about the prospect of RU 486 coming to India soon. They welcomed the idea, but insisted that it should ensure a complete abortion and should not result in making the patient have to visit the hospital often.

I personally have many doubts about the safe practical use of RU 486 in a country like India where we have a very poor health infrastructure. Women would not be willing to be admitted for long hospitalisation or frequent visits. Corruption and poor quality control of the drugs may ensure that the drug will be obtained over the counter or in the black market. The prohibitive cost would again deprive the rural women of its benefits which would be available only to the urban elite class. In our study, we have seen that in married couples, generally the primary decision maker in terminating a pregnancy is the husband. It's quite likely that some women might be given RU 486 by their husbands without their consent and knowledge. Also, who would be responsible for the continuation of a pregnancy because of improper dosage or schedule of RU 486? With the present callous attitude of health workers, would proper counselling be done? Would there be a regular supply of drugs? Prostaglandins are still not available widely except in big cities and big hospitals. We don't consider it as a user dependent method, it's very much a provider method and that

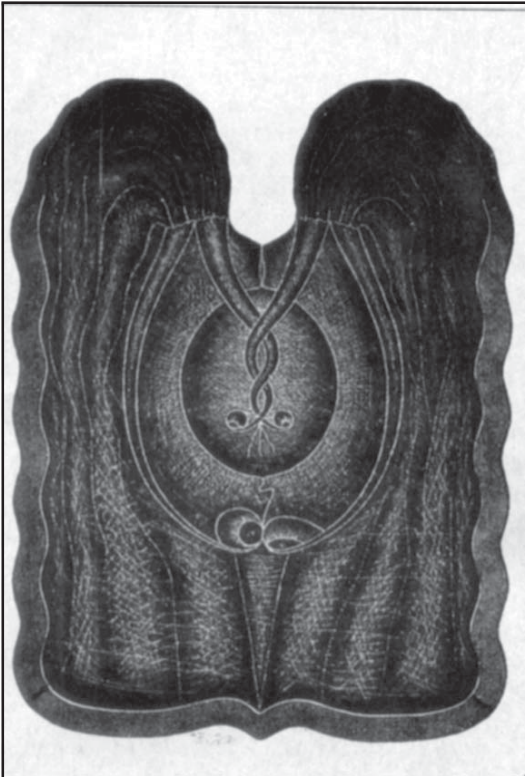
too a provider method that requires quality health care. If at all RU 486 is introduced, then to prevent it from falling into disrepute, as happened with the earlier contraceptives, the users must be clearly informed about the various shortcomings of the method. Overenthusiastic claims about the performance of RU 486 should be avoided from the very beginning. However, if it is propagated in a cautious manner, in phases and backed by evacuation services when needed, RU 486 plus abortion can together fulfil a major felt need of the people.

Norplant: Norplant is most probably going to be introduced soon in India but again we have many doubts, though the guidelines on paper for its use sound all right. There will be a great problem about the proper training of health workers. I have doubts whether really aseptic precautions would be taken while inserting and removing Norplant. Being a provider dependent method, the user may have to pay a lot in terms of money, time, mental stress, and agony at the time of insertion and especially at removal. She won't be able to hide it from other family members and her husband. The trials show discontinuation rates are due mainly to menstrual disorders. For the medical profession, this does not constitute a serious problem, but for women menstrual irregularity is a big problem. There is a difference in efficacy and safety as perceived by women and by medical personnel. Prolonged bleeding would definitely be harmful to women medically as women are already anaemic (in our study of 654 women we found 82 percent had anaemia), socially as it prevents her from religious duties, and sexually because sex is forbidden in this area during menstruation.

Another important thing we found in our area, is that the majority of

women do not use pads, since they cannot afford them. They use instead only the inner end of the sari for soakage of menstrual blood. The whole day these women have to work but because of the fear of staining their clothes they avoid sitting, and remain in a standing position as far as possible. Women are already weak and anaemic, have reproductive tract infections and backache. Imagine their plight in a situation where they have prolonged and/or heavy bleeding and can't even sit or rest. Amenorrhoea is also considered a heavy burden because a pregnancy may be overlooked, thinking the amenorrhoea is due to contraceptive use. Amenorrhoea other than during pregnancy is generally supposed to be caused by witchcraft.

In the reports on Norplant clinical trials, not much is said about its effect in different age groups. In India, it may be accepted by aged women who don't want more children but are afraid of sterilisation. What will be the health effects on them? If not properly counselled, they might misinterpret Norplant as a permanent method. They are in the group that has more chance of abnormal uterine bleeding. How can one differentiate between disease and Norplant induced bleeding, considering the poor health infrastructure and the reluctance of women to undergo an inter-rial examination? The trial reports mention that menstrual disorders become less frequent with the passage of time. It's easy for health workers or policy makers to say this. Will women be willing to wait and continue suffering? Is it justified to expect them to do so? Many women who want it for spacing may be breast feeding. Are we going to refuse to serve them? In an aggressive programme, I am sure, nobody would bother about it. One can imagine the effect on the breast fed baby by the hormones in Norplant,



period of maximum fertility is immediately after menstruation. Secondly, most of the husbands in these villages demand sex from their wives just about every night. Under no circumstances would these men be willing to forego sex for 10 days in a month. Thus, in a practical sense, practising a safe period is difficult in many rural areas. Also, certain cultural practices prohibiting sex during certain time periods, for example, post partum abstinence, are waning very fast.

Today : I am also worried about the

contraceptive sponge called *Today*. It is advertised and promoted by the manufacturing firm in, India. Very false information, including tall claims of 99.6 percent efficacy, are made. Some urban middle class women are falling prey to these unethical advertisements with consequent bad experience and high failure rates. This method needs more study.

Summary

We have tried to emphasise three points.

Acceptance of contraceptives is low, in part because of the many side effects which affect women.

Contraceptive care must be preceded by care for RTIs and gynaecological diseases.

Abortion services must be an essential component of contraceptive choice, both because of their intrinsic importance and as a supplement to most of the other contraceptive methods when they fail.

or by failure of lactation. At present, legalised abortion services in most of the government hospitals are provided on the condition the woman accept an IUD or sterilisation. I am afraid the same may happen with Norplant.

Hence Norplant also needs very careful, close follow up and unconditional removal whenever a woman wants it removed.

Natural Methods : I also want to share my experiences and apprehensions about some other methods. Nowadays, there is a lot of talk about natural methods of fertility awareness and safe period coitus as reliable and safe methods of family planning. I see two immediate problems. One, most of the women have no information about the physiology of ovulation and of a safe period. (This is from our study of 654 rural women.) They believe that the

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