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Women and Contraceptive Decision-Making in Kerala

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Kerala's below-replacement fertility figures obscure the poor awareness of contraceptive methods amongst women, pointing to the unfinished task of promoting independent and informed reproductive choices.

Kerala reached replacement-level fertility — the rate at which the population remains stable over generations — in the late 1980s, at a time when most Indian states had high- or mid-level fertility levels. Over time, the accepted narrative for Kerala's low fertility has been that women's education led to increased awareness about the advantages of a smaller family. Women's exposure to the family planning programme and their ability to make decisions led to the widespread use of contraception. Kerala's declining infant and maternal mortality were acknowledged as enabling contextual factors.

A qualitative study (nested in a larger longitudinal study) that I carried out in Thiruvananthapuram district during 2014-15 with 30 postpartum women and 10 healthcare providers came up with findings that suggested a very different reality about contraceptive choice. [1] All of the women were literate. More than three-quarters of the respondents had post-secondary education and were from households above the poverty line. But their stories were not that of well-informed, healthy and empowered women who confidently exercised their reproductive choices.

> Although women knew the *names* of these modern methods of contraception, *what* they knew about these methods was limited, and in some instances, inaccurate.

First, most of the women had very limited knowledge and distrust of reversible methods of contraception and relied on less effective 'natural methods' to delay or space pregnancies. Second, women did not often have the freedom to make contraceptive decisions. Third, after achieving the desired family size, birth control was solely the woman's responsibility. And fourth, pregnancy, childbirth and the postpartum periods were fraught with health problems for many women and their newborn infants, which interfered with the use of postpartum contraception.

These key findings diverge from the standard narrative about contraceptive use in Kerala and have significant implications for women's wellbeing.

Distrust in the 'artificial'

According to the National Family Health Survey of 2015-16 (NFHS-4), almost all women in Kerala knew about a modern method of contraception. While female sterilisation was the most widely known method (95.7%), more than 90% of the women knew about condoms, and more than 75% knew about oral contraceptive pills, intrauterine devices (IUD), and vasectomy.

> A vast majority of women had only 'heard' of a pill that prevented pregnancy. Most did not know how oral contraceptive pills were to be used or how they worked.

In-depth interviews in our study revealed a vastly different story. Although women knew the *names* of these modern methods of contraception, *what* they knew about these methods was limited, and in some instances, inaccurate.

For example, a vast majority of women had only 'heard' of a pill that prevented pregnancy. Most did not know how oral contraceptive pills were to be used or how they worked. Some women who said they knew about the pills thought these were taken to induce abortions. A few others believed the pills were to be taken within 24 hours following sexual intercourse— clearly confusing them with emergency contraceptive pills. A few women had learned how the oral pill and the injectable worked from *Arogyamasika*, a popular health magazine. But they believed that hormonal methods were harmful to the body and were best avoided.

Vasectomy was not widely known, except when the doctor or the accredited social health activist (ASHA, or community health worker) had specifically recommended the procedure because the woman could not undergo sterilisation owing to health issues. Most women

said they knew of vasectomy as a method practised in the past, and not as an option in the present. One woman said that vasectomy was a complicated surgery and that she did not think it was appropriate wifely behaviour to expect her husband to make such a major sacrifice for her.

> The general opinion was that the women had not found the use of condoms convenient or that their husbands did not like the method.

Copper T, an intra-uterine device, was a much-disapproved method. Three women had used it and had removed it before too long because of infection, spotting, and severe pain during menstruation, respectively. Almost every woman had heard one or more negative stories about IUDs. They talked about women who had become pregnant despite an IUD was still in; of others whose IUDs had disappeared from their uterus; of women who had become “too fat” or “too thin,” or developed reproductive tract infections, heavy bleeding, and backaches following the use of IUDs.

A third of the women reported that their husbands had occasionally used condoms, although only three reported consistent use to prevent pregnancy. The general opinion was that the women had not found the use of condoms convenient or that their husbands did not like the method and used it intermittently or had stopped using it.

> The general attitude amongst the respondents towards fertility control was to not use artificial methods till the desired family size was achieved.

A method that almost all women mentioned as 'safe' was withdrawal, where the man withdraws before semen is discharged into the vagina. Women described this as *sooshikkum*, ‘being careful’. Nearly every woman reported that she and her husband had used withdrawal to postpone a first pregnancy or space a second pregnancy. A majority of the women who had just delivered their first baby were currently 'being careful'.

The rhythm method (the women referred to it as the “calendar method”) was also mentioned by many as a 'safe' method. When probed for details, though, there was no clarity on which days of the menstrual cycle were to be avoided to prevent pregnancy. Oftentimes, mid-cycle, which is the fertile period, was (wrongly) mentioned as the 'safe' period.

The general attitude amongst the respondents towards fertility control was to not use artificial methods till the desired family size was achieved. Couples would use natural methods till they had the desired number of children and then undergo female sterilisation. It appears that this was the general message that women got from magazines and health workers. According to one woman, the nursing students who came to the community and conducted health education classes had said, "controlling it [fertility] by ourselves is the best way to go about it rather than taking tablets and all that.”

The nurses, Junior Public Health Nurses (JPHNs, or nurse-midwives), and ASHAs whom we spoke to also believed that natural methods were good to adopt. One of them said: “Natural method is good; after marriage, people take care of it [spacing] by themselves. Many people keep spacing intact without using any methods.”

Limited freedom for contraceptive decision-making

The use of the withdrawal method for spacing gives some indication of women's limited choices and freedom to control their fertility as per their desire. Withdrawal is not an easy method to use for either partner and calls for self-control on the part of the man and trust on the part of the woman. Studies have shown that about one woman in five who practice withdrawal get pregnant every year.

> Women for whom the withdrawal method failed often had no option but to continue with the unplanned pregnancy.

Such failures were common among the respondent women, leading to shorter birth intervals or a first pregnancy before they were ready for it. As one of the women described it, such pregnancies interfered with life goals:

“We were supposed to follow self-control [withdrawal] but anyway, it flopped […] he does not have any control […] I was very angry; I had to discontinue my studies […] I have one child now; I don't want any more children. He [my husband] also agrees.”

After childbirth, she found that it was a widespread practice that hospitals "do not do [female] sterilisation after one child. Again, he said, 'we will be careful,' but I went and had Copper-T inserted. They said I could keep it for ten years."

Women for whom the withdrawal method failed often had no option but to continue with the unplanned pregnancy. A woman who became pregnant when her first-born daughter was only eight months old recounted how she was denied an abortion at the government hospital: "The doctor scolded me for getting pregnant very soon [after my first delivery… But] when I asked for an abortion, they told me that they would never do that because there are so many people who wished to have a child but could not, so they advised me to give birth to my child."

Unwilling men

Many of the providers, especially ASHAs and JPHNs, talked about women's lack of freedom to decide on whether or not to use contraception and which method to use: A JPHN said that "[Mothers-in-law's] consent has to be asked [when we advise family planning]. Recently a young woman's mother-in-law said that she had only one son, they can afford more children [...] the woman had delivered two children within 15 months, but the mother-in-law said they wanted more children. The woman is not using any method."

> Husbands either flatly refused vasectomies or pulled back after initially agreeing […] "he has to go for work and if after surgery he has to take rest, who would take care of us?"

In another instance, a mother-in-law objected to an IUD being implanted. "If you put Copper T, my son can get some problems," a respondent health worker quoted her as saying, adding that several parents-in-law made similar objections to contraception being used.

Even when ASHAs and JPHNs encouraged women with health problems to request their husbands to go through vasectomy, there were rarely any takers. Husbands either flatly refused vasectomies or pulled back after initially agreeing. In the case of a woman who had two children in quick succession and was in poor health, her husband "said that he has to go for work and if after surgery he has to take rest, who would take care of us? He also told me to use Copper T for some time and I could go for surgery afterwards."

Poor health of the postpartum women and infants compromising contraceptive intentions

Although the sample of respondents for in-depth interviews was not random but purposively chosen to represent a cross-section of postpartum experiences, the fact that only five of 30 women reported an event-free pregnancy and delivery appears unusual.

> Some were too insecure about their health to adopt a modern reversible contraceptive method, while others were not sure about the survival of the newborn child.

The consequence was that barring those who had postpartum sterilisation, the others were too preoccupied to make contraceptive decisions. Some were too insecure about their health to adopt a modern reversible contraceptive method, while others were not sure about the survival of the newborn child and hence were not in a frame of mind to consider contraception.

A large number of women had begun their pregnancies with an underlying health problem for which they were under treatment. "Thyroid problem" (hyperthyroidism) was commonly reported by many, and five women of 30 were detected with gestational diabetes mellitus during the index pregnancy. Many women had experienced spotting during pregnancy. They had been prescribed bed rest and were being medicated to prevent miscarriages.

Deliveries that were otherwise uneventful were associated with wound infection following episiotomy or caesarean section. There was also one instance of postpartum depression and postpartum psychosis. Seven of 30 women had to cope with significant or serious health problems in their newborn children, requiring constant medical attention as well as care at home. In almost all instances, the women themselves had experienced delivery complications.

Conclusions

Studies from as early as the 1970s on Kerala's rapid fertility decline identified the state's relatively high female literacy rates and the consequent rise in the effective age at marriage for women as major drivers of the fertility decline. Yet, and despite their high levels of education, the reality is that women do not seem to be able to make informed and independent decisions related to reproduction and

contraception.

> We need studies to examine how Kerala's unequal gender power relations play out in contraceptive decision-making.

Mukhopadhyay et al. (2007) drew attention to the unequal gender power relations in Kerala and a strong patriarchal culture perpetuated by women as well as men, despite the state's good performance in terms of standard indicators of women's status: longevity, proportion literate, and higher age at marriage, among others. They discussed the high prevalence of violence against women, including domestic violence, the widespread practice of dowry, and the high levels of stress and poor perceived well-being among women. Several studies have subsequently confirmed the high prevalence of self-reported emotional and physical violence by husbands. We need studies to examine how Kerala's unequal gender power relations play out in contraceptive decision-making.

The veneer of universal institutional deliveries, relatively low maternal mortality ratios, and very low infant mortality rates in Kerala masks the huge burden of pregnancy and delivery-related morbidity and neonatal morbidity resulting in poor quality of lives and interfering with women's ability to prevent an unwanted pregnancy. There are almost no published studies on the extent of morbidity related to pregnancy and delivery from the perspective of the women experiencing these.

> A listing of contraception methods by respondents is assumed to reflect knowledge about contraceptives, rather than mere awareness of existence.

Dissemination of contraceptive information does not seem to be a high priority for Kerala's family planning programme, lulled into complacency by the state's below-replacement -level fertility. According to NFHS-4 data, of the women in Kerala not using contraception, only 17% had received contraceptive information from health workers. A listing of contraception methods by respondents is assumed to reflect knowledge about contraceptives, rather than mere awareness of existence. This is corroborated by Thulaseedharan (2018), who found that amongst young women and men in Thiruvananthapuram district, there was a significant gap between awareness and actual knowledge of contraceptive methods such as oral contraceptive pills, IUDs, injectables and vasectomy.

Limited knowledge on contraceptive methods might also be attributed to the absence of education on sexual and reproductive health issues in schools or even in universities. In my years as a teacher in a masters-level course in public health, a majority of the students — most of them with undergraduate training as health professionals — barely knew beyond the names of all contraceptive methods of contraception.

> The achievement of below-replacement fertility is not the end of the story for women's reproductive health and rights, but only its beginning.

Contraception needs to be viewed as a means to advance women's reproductive health and rights. The achievement of below-replacement fertility is not the end of the story for women's reproductive health and rights, but only its beginning. There is a huge unfinished agenda on women's and men's sexual and reproductive health that demands urgent attention on the part of the state's health policymakers and programme managers.

There is much that Kerala's family planning programme needs to do to inform women and men and to enable timely use of contraceptive methods and encourage the use of vasectomy so that sterilisation does not remain the only method to stop childbearing. More in-depth studies of women's and men's realities would be a good place to begin.

Footnotes:

1 The study was part of a project entitled "Research initiative on factors influencing women's reproductive choices" funded by the Ford Foundation, India.

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