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Non-Permanent Contraceptive Methods in India:
Exploring the Inter-play of Ethics, Policy, and Cultural Influences

By

Courtney Elizabeth Henderson

A dissertation submitted in partial satisfaction of the
requirements for the degree of
Doctor of Public Health
in the
Graduate Division
of the
University of California, Berkeley

Committee in Charge:
Professor Malcolm Potts, Chair
Professor Jodi Halpern
Professor Cheri Pies
Professor Jenna Johnson-Hanks

Spring 2014

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Abstract

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Doctor of Public Health

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Professor Malcolm Potts, Chair

Universal access to reproductive health and the promotion of reproductive rights were key goals articulated at the International Conference on Population and Development in 1994. The role of contraception in meeting these goals is critical. Access to contraception helps women avoid unintended pregnancies, improves maternal and infant health by spacing births, and reduces the need for abortions. The benefits of modern contraception also extend beyond the realm of health to economic and social gains for women. Women who delay pregnancy are more likely to remain in school and participate in the labor force. While the past decades have witnessed significant increases in the provision of modern contraceptive methods, there are still more than 200 million women around the globe who want to delay or stop pregnancy, but do not have access to contraception. Women in South Asia and Sub-Saharan Africa suffer disproportionately from poor health related to pregnancy and childbirth, and thus, stand to gain the greatest benefit from investments in contraception policies and programs.

In India, state-sponsored family planning programs have been promoted since 1951. The predominant focus has been on permanent methods, and female sterilization currently accounts for nearly 60% of modern contraceptive use. The use of non-permanent contraceptive methods, including oral contraceptive pills, injectable contraceptives, and intra-uterine devices, remains low. This dissertation sought to explore women's experiences with making decisions about, and using, non-permanent contraceptive methods, taking into account individual, family, and community influences. Building upon those women's experiences and their reasons for using non-permanent methods, this research then explores key opinion leaders' attitudes towards, and the policy landscape of, injectable contraceptives within India, a method that has been controversial within that country. Finally, a new theoretical framework of autonomy is proposed for analyzing women's reproductive and contraceptive decision-making, and rights to self-determination.

Dedication

To my parents, who encouraged me to believe that anything was possible, and who taught me to never give up.

To Chris, who made everything possible.

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My sincerest thanks go to my dissertation committee, for their support and guidance throughout my graduate career. I would like to thank Dr. Malcolm Potts, my advisor and committee chair, who always believed in me, and who was unwavering in his encouragement. Dr. Jodi Halpern instilled in me a profound interest in ethical dilemmas in reproductive decision-making, and was a thoughtful contributor throughout this process. Dr. Jenna Johnson-Hanks was particularly instrumental in challenging me to explore areas that reached far beyond the traditional realm of public health. Her guidance enriched this dissertation dramatically. Dr. Cheri Pies lent her support throughout the development of this research, and I always knew that I could look to her for both practical and emotional support.

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CHAPTER 1. INTRODUCTION

Universal access to reproductive health and the promotion of reproductive rights were two key goals articulated at the International Conference on Population and Development (ICPD) in 1994. The role of contraception in meeting these goals is critical. Access to contraception helps women avoid unintended pregnancies, improves maternal and infant health by spacing births, and reduces the need for abortions. The benefits of modern contraception also extend beyond the realm of health to economic and social gains for women. Women who delay pregnancy are more likely to remain in school and participate in the labor force. While the past decades have witnessed significant increases in the provision of modern contraceptive methods, there are still more than 200 million women around the globe who want to delay or stop pregnancy, but do not have access to contraception (Singh & Darroch, 2009).

Women in South Asia and Sub-Saharan Africa suffer disproportionately from poor health related to pregnancy and childbirth, and thus, stand to gain the greatest benefit from investments in contraception policies and programs. In 1951, India became the first country in the developing world to adopt a state-sponsored family planning program (Visaria, Jejeebhoy, & Merrick 1999). Yet despite six decades of family planning promotion, the reproductive health situation in India remains poor, particularly in the North. In Uttar Pradesh, India's most populous state, the maternal mortality ratio is 359 maternal deaths per 100,000 live births (versus 212/100,00 for all of India) (Ministry of Health and Family Welfare, Government of India, 2013). While the Indian National Family Planning Program currently provides five contraceptive methods, including male and female sterilization, intra-uterine devices, oral contraceptive pills, and condoms, the predominant focus of the program has been on terminal methods. Among modern contraceptive method users in Uttar Pradesh, female sterilization accounts for nearly 60% of use. Five, six, and twenty-nine percent of modern method users in Uttar Pradesh use intra-uterine devices, oral contraceptive pills, and condoms, respectively. Injectable contraceptives, while offered through the private sector in India, account for less than 1% of use in every Indian state, and are not offered through the Indian Government's family planning program (International Institute for Population Sciences and Macro International, 2007).

Many of the socio-cultural norms that influence women's perceptions and use of contraception in India assign the burden of family planning to women. Yet women's contraceptive use in India remains primarily limited to female sterilization. Demographic and socioeconomic factors that influence use of contraception in India have been relatively well documented, as have women's perceptions of permanent methods. The historical legacy of family planning in India, governmental policies that determine who can and who can not use particular contraceptive methods, and power and gender dynamics likely play important roles in utilization of contraception in this context. A critical gap in the literature pertains to Indian women's use of non-permanent contraceptive methods, and this is the broad topic for this dissertation.

To explore the intersection of ethics, policy, and cultural influences to non-permanent contraception in India, this dissertation proposes three papers. The first paper, *“Happiness Means Another Son”: Exploring Women’s Decision-Making and Experiences with Non-Permanent Contraceptive Methods in Uttar Pradesh, India*, employs in-depth interviews to explore attitudes on fertility, family size and spacing of births, and prior and current use of non-permanent contraceptive methods among economically marginalized women living in rural Uttar Pradesh, a North Indian state. In addition, the aims of this paper include identifying factors that promote the use of non-permanent contraceptive methods among women, and factors that act as barriers to women’s use of these methods. The overarching goal of this paper is to explore these topics from the perspective of women within their communities, taking into account the larger social and cultural contexts in which they live.

The second paper, *A Qualitative Exploration of Key Opinion Leaders’ Attitudes Toward Injectable Contraceptives in India*, integrates media content analysis and in-depth interviews to explore opinions and attitudes of key opinion leaders within India toward one specific non-permanent contraceptive technology: injectable contraceptives. The aims of this paper include exploring reasons that key opinion leaders have for supporting or opposing the inclusion of injectable contraceptives in the Indian National Family Planning Program, in addition to how those leaders influence national contraceptive policy. Given that contraceptive options for economically marginalized women are firstly determined by contraceptive policy, and which methods get included in the public sector program, the overarching goal of this paper is to describe how key opinion leaders understand and influence non-permanent contraceptive options, particularly injectable contraceptives, for women.

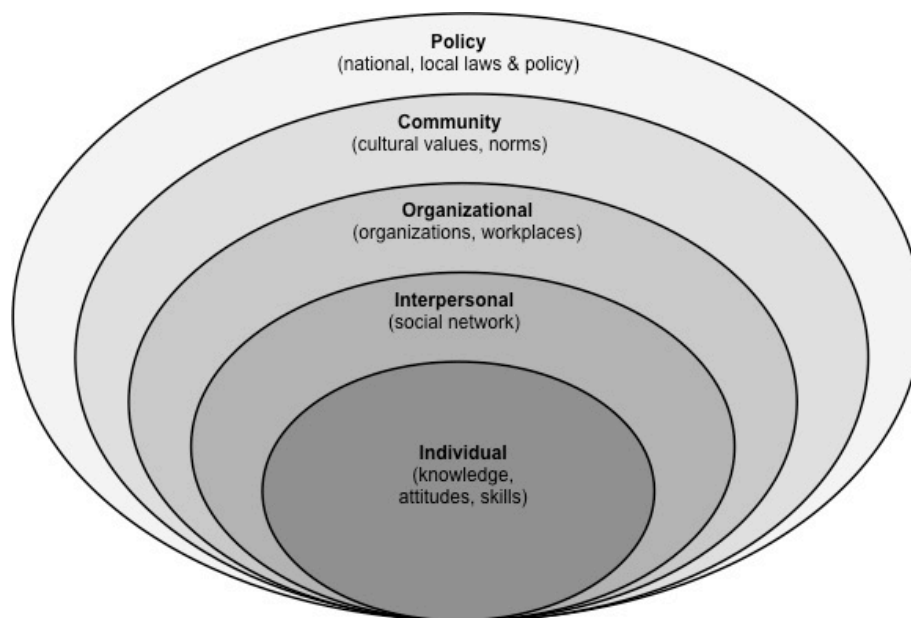
The third paper, *Reproduction And Contraception Among North Indian Women In Uttar Pradesh: Moving Towards A Reactive Framework Of Autonomy*, draws upon the human rights literature and ethical principles to describe the constraints on Indian women’s autonomy as it relates to their reproductive lives. To demonstrate these constraints, the qualitative data collected for the first paper is also used here. Western frameworks of autonomy may not be the most appropriate in the particular context in which Indian women describe their reproductive decisions and actions. Thus, a new theoretical framework for promoting women’s autonomy, particularly in regards to self-determination, is described.

The theoretical approach to this dissertation draws from both the Social Ecological Theory and Political Economy Theory. Briefly, Social Ecological Theory postulates that there are multiple effects and inter-relatedness of environmental conditions, human behavior, and well being. The social ecological paradigm characterizes environmental settings as having both physical (i.e., geography, technology) and social (i.e., politics, economics, culture) dimensions that can influence a variety of health outcomes (Stokols, 1992). In addition, human health is influenced by personal attributes and behaviors. Social ecological approaches incorporate multiple levels of analysis and emphasize the dynamic interplay between people and their environments, as opposed to focusing solely on environmental, biological, or behavioral determinants of health

(Stokols, 1996). With Social Ecological Theory, one attempts to analyze how all of these factors inter-relate, as opposed to viewing each factor in isolation. This is particularly important in the Indian context, since women do not make the decision to use, or seek, contraception in isolation. Instead, women work within a web of social interaction, with many different factors that contribute to the actual adoption of contraception. In addition, key opinion leaders navigate their own webs of social interaction, and these influence their attitudes toward, and opinions of, injectable contraceptives. See figure 1, below, for a diagram of the Social Ecological Model. Social Ecological Theory clearly lends many strengths to the analysis of contraceptive use in this context. However, on its' own, it still fails to take into account a critical factor: historical context, and thus, this research also draws from Political Economy Theory. Similar to Social Ecology Theory, Political Economy Theory stresses the importance of viewing health problems in terms of their relationship to other facets of society and environment. This framework adds to Social Ecological Theory by specifically, *“suggesting that such problems must also be viewed in broad historical relief”* (Minkler, Wallace & MacDonald, 1994). This is critical given the long, and sometimes blemished, history of family planning promotion in India.

My dissertation work includes research at multiple levels of the Social Ecological Model, viewed within historical relief. In paper 1, I focus on the individual, family, and community influences that a woman encounters when deciding or actually using non-permanent contraception, and describe enabling factors and barriers within those levels. In paper 2, I analyze social environmental settings, including policies, that impact women's ability to use non-permanent contraceptive methods. Finally, in paper 3, I incorporate human rights and ethics literatures to analyze women's right to self-determination, within the local contexts and constraints in which they live.

Figure 1. Social Ecological Model



CHAPTER 2. “HAPPINESS MEANS ANOTHER SON”: EXPLORING WOMEN’S DECISION-MAKING AND EXPERIENCES WITH NON-PERMANENT CONTRACEPTIVE METHODS IN UTTAR PRADESH, INDIA

Abstract

Introduction: Female sterilization is the predominant form of modern contraceptive use in India, with limited use of non-permanent contraceptive methods for spacing births. This research uses the Social Ecological Model as its theoretical framework to explore women’s perceptions and experiences with non-permanent contraceptive methods, including oral contraceptive pills, injectable contraceptives, and intra-uterine devices. In addition, enabling factors and barriers to the use of non-permanent contraceptive methods are identified.

Methods: In-depth interviews were conducted with currently married women aged 19-39 from June to August 2012 in the districts of Meerut and Bijnor in Uttar Pradesh, India. Villages for the study were purposively selected based upon areas in which there is current demand for contraceptive services. A semi-structured interview guide was field-tested prior to recruitment of study participants. Interviews were conducted in Hindi and were digitally recorded. Data analysis was based on constant comparison, rooted in grounded theory.

Results: A total of 42 women were interviewed. Women reported a strong desire for limiting family size and for spacing children. Knowledge of contraceptives was primarily obtained from Accredited Social Health Activists and female family members. Counseling on potential side effects, family support, and proximity to contraceptive providers were identified as enabling factors. Barriers to use included fear of side effects, inadequate counseling, and power dynamics within the family in which women had to seek permission from husbands and mothers-in-law to use contraception.

Discussion: This research sought to fill a critical gap in the literature pertaining to Indian women’s perceptions and use of non-permanent contraceptive methods. Understanding women’s perceptions of injectable contraceptives and intra-uterine devices is a first step toward filling this gap. Understanding factors that promote use of these methods, in addition to those factors that limit use, is fundamental to developing innovative approaches to meet non-permanent contraceptive needs among women living in Meerut and Bijnor, Uttar Pradesh, India.

I. INTRODUCTION

In 1951, India became the first country in the developing world to adopt a state-sponsored family planning program (Visaria, Jejeebhoy, & Merrick, 1999). Despite six decades of family planning promotion, reproductive health outcomes in India remain poor, particularly in the Northern regions of the country. Research has demonstrated that high fertility is associated with adverse health outcomes for both women and their infants (Bhargava, 2003). In Uttar Pradesh, a North Indian state, fertility and mortality remain high, with a total fertility rate (TFR) of 3.4 (versus 2.4 for all of India), and a maternal mortality ratio of 359 maternal deaths per 100,000 live births (versus 212/100,00 for all of India) (Ministry of Health and Family Welfare, Government of India, 2013).

Promotion of family planning averts maternal and infant deaths, and has potential to lead to reductions in poverty and improvement in women's educational status (Cleland, Bernstein, Ezeh, Faundes, Glasier, & Innis 2006). Moreover, expanding the number of options of available contraceptive methods leads to increased contraception use (Ross, Hardee, Mumford & Eid, 2001). In 1997, India's National Family Planning Program adopted a broader human rights framework involving a focus on family planning needs, client choice, and service quality (Visaria et al., 1999). Despite this paradigm shift, contraceptive use remains skewed toward female sterilization, accounting for 66% of modern contraceptive use (International Institute for Population Sciences and Macro International, 2007). Users of modern contraceptive methods in India also use condoms (10%), oral contraceptive pills (6%), and intrauterine devices (4%). Injectable contraceptives have been a controversial method within the country, and account for less than 1% of modern contraceptive method use in every state, except Sikkim (International Institute for Population Sciences and Macro International, 2007).

Barriers to fertility regulation in developing countries have been previously described, including the status of women, provider bias, and medical and legal restrictions (Campbell, Sahin-Hodoglugil, & Potts, 2006). Within India, demographic and socioeconomic factors that influence use of contraception have been relatively well documented, as have women's perceptions of sterilization (Char, Saavala, & Kulmala, 2009; Char, Saavala, & Kulmala, 2010; Edmeades, Lee-Rife, & Malhotra, 2010). A critical gap in the literature pertains to Northern Indian women's motivations and use of non-permanent contraceptive methods to space births. Accordingly, the objectives of this research are to explore perceptions, enabling factors, and barriers to the use of oral contraceptive pills, injectable contraceptives, and intra-uterine devices among women living in Uttar Pradesh, India.

The Social Ecological Theory (Stokols, 1996) provides a productive lens for a multifaceted understanding of the use of contraceptive methods. This model focuses on the dynamic interplay between situational and personal levels that determine health outcomes, accounting for the numerous physical, social, and cultural factors that influence a woman's decision to use contraception. This research employs the Social Ecological Theory as a framework for a multilevel investigation of non-permanent

contraceptive use among women who have experience using such methods (see figure 1, Introduction chapter). This chapter is structured to begin with a focus on the individual actor, and then moves into an exploration of the different levels of context in which women are embedded. By elucidating the enabling and constraining factors that influence a woman's motivation, decision-making process, and the practical aspects of using non-permanent methods, this research is anticipated to inform both theory and practice. Understanding these complex and inter-related phenomena is critical to developing culturally relevant programmatic, education, and outreach activities in Uttar Pradesh. Such insight is also essential to inform Indian family planning policies that are founded in notions of choice and reproductive justice as the way to allow all Indian women to choose and have their desired family size.

II. METHODS

In-depth interviews (n=42) were conducted with currently married women aged 19-39 from June to August 2012. A semi-structured interview guide was developed and included open-ended and probing questions to elucidate women's knowledge of, and experiences using, non-permanent contraceptive methods, including oral contraceptive pills, injectable contraceptives, and intra-uterine devices. These areas for inquiry were theoretically constructed based upon questionnaires found in the literature that have been used to assess Indian women's knowledge and awareness regarding contraception (Prachi, Das, Ankur, Shipra, & Binita 2008; Bajwa, Bajwa, Ghai, Singh, & Singh, 2011). Research from other South Asian countries also provided important theoretical constructs for assessing knowledge and perceptions of contraception (Mustafa, Afreen, & Hashmi, 2008; Khan, 1996). The in-depth interview guide also explored factors that promote use of different non-permanent contraceptive methods, factors that limit use of these methods, and reasons for discontinuation of these methods. Questions pertaining to barriers were constructed based upon prior questionnaires that specifically explored barriers to use contraceptive methods (Prachi et al., 2008; Bajwa et al., 2011).

The interview guide was translated into Hindi, the predominant language spoken in Uttar Pradesh. The translated version was then back-translated into English to ensure accuracy. Prior to recruitment of study participants, the interview guide was field-tested. Data gathered during field-testing is not included in the analysis presented in this paper. Consistent with the iterative nature of qualitative research (Denzin, 1978), the field-tested guide was modified over time as preliminary analysis of initial interviews suggested new lines of inquiry and the need for more detailed information on particular topics.

Villages for the study were purposively selected based upon areas in which there was already demand for, and use of, non-permanent contraceptive methods. These villages were identified from a database maintained by World Health Partners, a local non-governmental organization that includes a network of health care providers who provide contraception to women living in rural Uttar Pradesh. Local health care staff identified interview candidates who were married and known to be using a non-permanent

contraceptive method, and who had given their consent to be contacted for research purposes. Although such sampling is non-random, this strategy allowed the research team access into the lives of women by establishing credibility and trust among the research participants (Small, 2009). To understand why women want to use particular contraceptive methods, and to develop appropriate educational and outreach strategies, it was critical to understand how women perceive these methods, what factors contributed to their decision to use these methods, and any barriers they had encountered. Therefore, women who were current users of either injectable contraceptives or intra-uterine devices (IUDs) were interviewed.

Study participants were recruited from June to August 2012. Women were approached and recruited into the study by local in-country research staff. A verbal recruitment script was used that explained the study and eligibility criteria. Written recruitment materials were not utilized, as nearly 40% of the women residing in Uttar Pradesh are illiterate (Indian Ministry of Health and Family Welfare, Government of India, 2013). For those women who agreed to participate in the study, the interview occurred immediately.

Before commencing interviews with research participants, the two Indian female research assistants hired for this study completed three days of training in the ethics of conducting research with vulnerable populations, reproductive health and contraceptive concepts, and interviewing techniques. Research staff conducted mock interviews with the research team before beginning data collection.

All study participants were asked to provide verbal informed consent. Research staff conducted all interviews in Hindi, transcribed and translated interview data, and completed accuracy checks of the transcriptions. Interviews were digitally recorded, and lasted no more than one hour. All interviews were conducted in private rooms at the health care clinics in order to maintain privacy of participants, or in equally private locations preferred by the study participants (i.e., if a participant preferred to have the interview conducted in the privacy of her own home when other household members were not present).¹ The interviewer recorded non-verbal cues and observational data during the interview. Interviews were stopped immediately if there was any intrusion by another person, or risk of being overheard. Interviews were not re-started until privacy had been re-established, and the study participant was specifically asked if she was comfortable continuing the interview.

At the end of each interview, basic demographic data was recorded, including participant age, district of residence, education level, and parity. Interviewers prepared short memos following every interview. In addition, the entire study team debriefed

¹ It should be noted that I sat in on interviews during the beginning of the study, acting as an observer. This allowed me to record field notes, which were used during data analysis, and also helped me to gain insight into the research subjects' lives. At the conclusion of interviews, the research participants would often ask me questions about my own life, particularly in regards to marriage and children, which were translated by the interviewers. However, my presence, along with that of the Master of Public Health student, Anne Villumsen, who accompanied me on this research study, also created disturbances. Villagers were extremely interested in why we had come to their villages, sometimes making it difficult to interview women. After discussing this as a research team, we collectively decided that Anne and I should continue to accompany the interviewers to the villages, but refrain from going to the houses of study participants. In this way, we could still gather qualitative data as observers.

following every interview. This served as an assessment of quality and consistency of interviews and allowed the study team to constantly evaluate research activities in the field as they occurred. Participants did not receive financial incentives for participation in this research.

Interviews were transcribed and translated into English. All coding was done by hand. The methodology for data analysis is rooted in concepts of constant comparison and grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998; Charmaz, 2006). All data was first reviewed to develop a broad understanding of the content as it related to the study's specific aims. Short memos were prepared to identify, name, describe, and categorize phenomena in the text. Next, materials from memos, interviews, and observational data were coded line-by-line. A complete list of codes (codebook) was developed, which included four basic components: the thematic area, the code, a full definition of the code, and examples of the code. Two types of coding were utilized: open coding to identify emergent themes and a priori coding, based on themes from the interview guide. Finally, axial coding was used to connect codes to one another.

This study was approved by the University of California, Berkeley Institutional Review Board, protocol 2012-02-4053.

III. RESULTS

A total of 42 women were interviewed, of which four requested not to be audio-recorded. Data were collected regarding attitudes on fertility, attitudes on family size and spacing of births, and prior and current use of non-permanent contraceptive methods. Study participants were from eight different rural villages in the state of Uttar Pradesh; four villages each were in the districts of Meerut and Bijnor. Selected demographic characteristics of all participants are presented in Table 1. Reproductive characteristics are presented in Table 2.

Of the 42 women interviewed, 25 women were currently using injectable contraceptives, while 17 women were currently using intra-uterine devices. Women who were not currently using a contraceptive method were not interviewed. Of the 25 women currently using injectable contraceptives, 17 women had received their first injection within the three months preceding the interviews. Of the 17 women currently using intra-uterine devices, 13 women had their intra-uterine device inserted recently (from 20 days preceding interview to approximately four months), while the remaining four women had been using an intra-uterine device for greater than three years.

Table 1. Selected Demographic Characteristics of Study Participants (n=42), by Current Contraceptive Method

Characteristic	Injectable User (n=25)	IUD User (n=25)	Total (n=42)
Present Age (years)			
15-19	0	1	1
20-24	8	1	9
25-29	8	7	15
30-34	7	5	12
35-39	2	3	5
Years of Education			
No formal (0 years)	8	4	12
Not completed Standard (≤ 5 years)	3	4	7
Completed Standard (8 years)	3	2	5
Completed High School (10 years)	4	1	5
Completed Secondary (12 years)	4	3	7
More than 13 years of schooling	3	3	6
Occupation			
Housewife	24	16	40
Self-employed	1	1	2
Caste			
No response	2	2	4
Scheduled caste ²	2	2	4
Other backwards caste ³	17	12	29
General ⁴	4	1	5
Religion			
Hindu	17	13	30
Muslim (Sunni)	8	4	12
Household			
Joint	22	13	35
Nuclear	3	4	7
Monthly Income⁵			
Don't Know	8	6	14
< 5,000 Indian rupees	10	5	15
5,001 - 10,000 Indian rupees	3	4	7
> 10,001 Indian rupees	4	2	6

² Scheduled castes are historically disadvantaged groups in India. During British rule in India, these groups were known as the depressed classes. For additional information on scheduled castes, see: Ministry of Social Justice and Empowerment, 2002.

³ Other backwards caste is a term used by the Indian Government to describe educationally or economically marginalized groups. The Indian government has developed various schemes to aid the educational and economic development of these groups.

⁴ General caste includes those castes that are not categorized as socially or economically marginalized; for example, Brahmin, a caste in which individuals are usually holy priests or teachers.

⁵ At the current (April 2014) exchange rate, \$1.00 U.S. dollar is equivalent to 61.33 Indian rupees. Thus, a monthly income of 5,000 Indian rupees is approximately equivalent to \$82.00 U.S. dollars.

Table 2. Selected Reproductive Characteristics of Study Participants (n=42), by Current Contraceptive Method

Characteristic	Injectable User (n=25)	IUD User (n=17)	Total (n=42)
Age at Marriage (years)			
15-17	6	5	11
18-20	10	7	17
21-24	9	5	14
Age at First Birth (years)			
16-18	5	4	9
19-21	12	8	20
22-24	8	4	12
Unreported	0	1	1
Number of Years Between Marriage and First Birth			
1	20	11	31
2-3	5	5	10
Unreported	0	1	1
Number of Living Children			
1	7	2	9
2	9	5	14
3	2	5	7
4	4	4	8
5	1	1	2
6	2	0	2
Child Deaths			
None	19	11	30
Have lost \geq 1 child	6	6	12

III. A. Attitudes on Fertility and Family Size

III. A. 1. Attitudes on Family Size

Study participants had between one and six living children (Table 2). Twenty-seven of 42 interviewees stated that the ideal number of children in a family is two. Concerns about the ability to financially support a family were cited as the primary motivation for wanting to limit family size, or for not wanting additional children. Women repeatedly discussed the “time of inflation”, as evidenced by SHR2, a 21-year old injectable user, who stated that, “*Given the increasing inflation, two children is good.*” Respondents who provided other answers to the ideal number of children in a family generally reported the ideal as the number of children they actually had. SHR9, a 27-year old IUD user who had four children, answered as follows when queried about ideal family size:

Interviewer: In any family how many children should be there ideally?

Respondent: Maximum, four children.

Interviewer: Why four only?

Respondent: As it's the time of inflation, either you feed them or educate them properly. If there are limited children, then one can take care of providing them with both food and education.

Respondents also linked their economic status to a desire to not want to bear additional children, as evidenced by SHR21, a 35-year-old IUD user, who said: *"First of all, I am poor. If you have more children, then you cannot feed them."* Relatedly, women linked small family size to the possibility of increased educational attainment for their children. As described by SAN13, a 33-year-old IUD user:

Having a small family would have many benefits, for upbringing, education can be imparted. Also the girl gets married off easily. Now the girl needs to be trained and educated before they get married...When the girl is educated, then she would be preferred, like my sister-in-law, she has done master's double MA, and she also teaches in a school. She is very intelligent, she recently got married.

Twenty-one respondents stated that they did not want any additional children, while five respondents stated that they did want additional children. The remaining 17 respondents stated that the number of children they would have would be determined by God or nature, or that they would have to wait to see what the future held for them. As described by SHR15, a 30-year-old injectable user: *"For 1-2 years, I will use injection, and then we will see what happens in the future."*

III. A. 2. Attitudes on Spacing Children

Thirty-four of 42 respondents reported that ideally, children should be spaced from three to five years apart. Women discussed the benefits of spacing children for this length of time in terms of their ability to manage and care for small children; promotion of health of the mother; and ability to ensure physical capacity and enough time to complete daily chores required within the home. SAN11, a 23-year-old injectable user, emphasized that longer spacing gaps allow children to manage on their own when another child is born: *"By giving a gap of five years at least, one child would be capable of eating and drinking on his or her own."* When queried about reasons for maintaining a gap between children, SAN14, a 34-year-old IUD user, discussed the benefits to health for both the mother and child:

Interviewer: Why do they want (a gap)?

Respondent: It is because the child upbringing would be good, and this is the first reason.

Interviewer: Any other reason?

Respondent: Ma (Mother) also remains healthy and the child too remains healthy, that's all the reason.

Several respondents discussed the link between spacing and being able to provide proper food and nutrition to their children, as evidenced by SAN20, a 29-year-old injectable user:

If the child is small and the next one comes, then how one can take care of his child and as a result how he will be okay? One has to hold one child and then the second child. If there is an age gap of 2 years, 3 years, 4 years, then the child would be well, our health will also be good. Mother's health will be good. They both will be well and they will get proper food.

III. A. 3. Social Obligations to Family that Impact Fertility

Moving out from individual level attitudes toward fertility to social network influences in a Social Ecological framework, women described having to manage complex social obligations to their families, which impacted their ability to regulate fertility. Of 42 respondents, 31 reported that they had delivered a child within one year of marriage (Table 2). The majority of women stated that they did not plan their first birth, and had not used contraception during the early years of their marriage. In addition, women often reported having more children than they initially planned or wanted. When queried directly about expectations or preferences for a given gender, most women reported that they value both sons and daughters equally, as discussed by SHR1, a 30-year-old injectable user:

Interviewer: How many children an ideal family should have?

Respondent: Who could tell about other's mind? An ideal family should have two children, a girl and a boy.

Interviewer: Ok, tell me who should get preference, whether there should be more of a girl or a boy?

Respondent: For me both girls and boys are equal (laughs). If there is a girl, there is a girl.

Interviewer: How about your family?

Respondent: No, even they don't differentiate.

Interviewer: What if you had two daughters?

Respondent: If there were two daughters, then also we would have been happy.

Despite discussions about the equal value of sons and daughters, most women discussed an ideal family as including at least one son, as evidenced by the following quote from SHR24, a 28-year-old intra-uterine device user who had two sons and one daughter:

Interviewer: According to you, one should have a daughter or a son?

Respondent: Both are equally important.

Interviewer: How so?

Respondent: Boy is a support. Girl is a support too.

Interviewer: What did you want?

Respondent: I wanted both a girl and a boy.

Interviewer: Why a boy?

Respondent: Because he carries the father's name.

Interviewer: Why a girl?

Respondent: Because of kanya daan⁶

Women also discussed how they had continued having additional children until a son was born. SAN8, a 36-year-old injectable user, stated that, “*Well waiting for a boy, we have four daughters.*” Similarly, SAN3, a 27-year-old IUD user, describes her personal desire for sons and how she continued to have children in the hopes of having a son:

Interviewer: Any expectation from your family for their preference of numbers of children?

Respondent: No, it was our wish to have two sons, at least two...I bore three daughters, while waiting and expecting for another son. I got three daughters including this baby (points to lap) as an extra.

Women frequently discussed familial pressure from family elders' to continue childbearing until a son had been born. One interviewee (SHR4, a 31-year-old injectable user) described how her mother-in-law and father-in-law pressured her to continue bearing children in the hopes that a son would be born:

Respondent: Everyone else will have some say that I should have more children, but one has to see for oneself.

Interviewer: Who else?

Respondent: Mother-in-law, father-in-law.

Interviewer: How many more children do they want?

Respondent: Now, I have already stopped.

Interviewer: What did you say to them?

Respondent: I told them no more. For the sake of a son, five daughters were born. Craving for one more son resulted in this....My family said that to give him (husband) one more happiness.

Interviewer: What does happiness mean?

Respondent: It means another son.

Women also described the decision-making power that husbands possessed in terms of decisions regarding childbearing and use of contraception. One interviewee (SHR20), a 25-year-old injectable user who had one son and one daughter, described how her husband had recently made the decision that she must discontinue her current contraceptive method in the hopes of bearing a second son:

⁶ Kanya daan is the most highly valued Hindu marriage ritual, in which parents give their virgin daughter to the husband's family. While there are many interpretations of kanya daan, one is the Hindu theory that giving a virgin daughter to the husband's family increases the parent's prestige and purifies them of sin.

Respondent: I had taken injection initially. Now, my husband has told that now we can have children. I took on injection...but my husband told me not to take injection anymore as we can have children.

Interviewer: So he (husband) wants another child?

Respondent: Yes, he wants another child. Right now there is only one son. He wishes to have one more son. This is a matter of one's fate. That is why I have stopped taking the injection. I had taken only one injection.

Interviewer: When did you get it?

Respondent: Just last month.

Interviewer: What do your family members prefer to have, a girl child or a boy child?

Respondent: They equally want a girl and a boy child.

Interviewer: But now you have had a girl and a boy child and now want the third child as a son?

Respondent: Yes, he (husband) wishes to have the third child to be a son....it is considered good to have two sons.

An obligation to provide more than one son appeared as a theme throughout the interviews. This must be considered in the context of frequent childhood deaths: more than one fourth of the women had experienced losing a child (Table 2). Hence, it becomes important for women to have “enough” sons as exemplified by the following quote by SHR3, a 25-year-old IUD user, who said that, “*Two boys should be there. In case something happens to one, then we still have hope on the second one.*”

Women who described the value of having both a son and a daughter often associated such a view with increased educational status. SHR2, 21-year-old injectable user, who had received nine years of education, discussed this as follows:

Interviewer: Do you have preference for a boy or a girl?

Respondent: They are equally valued by me.

Interviewer: How about your family?

Respondent: My family is well educated so they give equal importance to both girls and boys. Amongst the whole family, my daughter is the only girl child and she is loved by every one.

Some women also reported perceived family obligations pertaining to limiting family size, as opposed to pressures to continue child bearing. A 23-year-old interviewee (SAN11), currently using injectable contraceptives and who had one son, described the influence of her mother-in-law, “*We don't have our (husband and wife) say. Especially my mother-in-law, it's not our wish. Everything happens as per they say...as they are elders to us. My mother-in-law advised me to have just one child.*”

III. B. Knowledge & Use of Contraceptive Methods

III. B. 1. Awareness of Contraceptive Methods

Overall, interviewees were aware of several contraceptive methods that can be used to space or limit children, though awareness of those methods differed dramatically by respondent. SHR17, a 25-year-old injectable user, reported that she only knew of “*injection or birth control pills.*” SHR15, a 30-year-old injectable user, when asked the same question, reported that, “*There are many. There is Copper T, multi-load, injection, pills.*” In the villages where this study was conducted, two types of intra-uterine devices were described, including both the Copper-T intra-uterine device and the multi-load intra-uterine device. The primary difference between the two is that the Copper-T 380 intra-uterine device is effective for 10 years, whereas the multi-load intra-uterine device is effective for five years. Women also described knowing about sterilization, condoms, and natural methods, including abstinence and withdrawal.

The primary source of information about contraception was the Accredited Social Health Activists (ASHAs). ASHAs are community health workers commissioned by the Indian Ministry of Health and Family Welfare. ASHAs work as an interface between the community and public health system, and counsel women on birth preparedness, safe delivery, breast-feeding, and contraception. In the villages sampled for inclusion in this study, ASHAs also partner with World Health Partners to link women to providers for contraceptive services. ASHAs were described as moving around in the neighborhood, going to women’s homes, and informing women about contraception. As SHR17, a 25-year-old injectable user described:

Interviewer: Who told you about the injection?

Respondent: The village ASHA.

Interviewer: Where did you meet her?

Respondent: Here only.

Interviewer: Where?

Respondent: At home. She had come for examining the children.

The majority of women reported that ASHAs fulfill a supportive role. When women experienced problems or had questions about their contraceptive method, they sought advice from the ASHAs. Women also seemed to believe that ASHAs were thinking of the women’s best interests, and would counsel them appropriately regarding contraceptives. This was evidenced by the following quote from SAN9, a 26-year-old injectable user who stated that, “*ASHA is like my sister...she would...not counsel me to go for operation. Methods are many and solutions available.*”

However, several women also reported that ASHAs prompted them to adopt an intra-uterine device instead of injectable contraceptives. SHR2, a 21-year old who opted to use injectable contraceptives, described how the ASHA emphasized intra-uterine devices, “*Auntyji (ASHA) was telling me to use Copper T, but I don’t have any energy and it is not something that I can withstand. I keep on hearing that Copper T can be*

problematic.” SHR11, a 22-year-old intra-uterine device user who reported that she was satisfied with her method choice, described how the ASHA informed her that an intra-uterine device was better than injectables:

Interviewer: What motivated you to use multi-load (intra-uterine device)?

Respondent: To have gap between children.

Interviewer: Why multi-load only? She (ASHA) must have told you about other methods of birth control?

Respondent: She had told me to use multi-load method. I told her about injection, but she said that multi-load is better. She said that injection was not good.

Interviewer: Why is the injection not good?

Respondent: Injection, one has to get every three months, but with multi-load, it gives a gap of five years.

III. B. 2. Perceptions and Prior Use of Oral Contraceptive Pills

Fifteen women reported that they had previously attempted to use oral contraceptive pills. However, all had discontinued use due to side effects, inconvenience, or lack of trust in the method's ability to prevent pregnancy. The majority of previous pill users reported that oral contraceptive pills generated bloating and heat in the body – a statement reiterated by both interviewees with personal oral contraceptive pill experience and interviewees who had been given this information by other women in their communities. SAN14, a 34-year-old IUD user, described the side effects she experienced when previously using oral contraceptive pills:

Respondent: For some time, I used Mala-D (oral contraceptive pill).⁷ Then the health was not good, not used to keep well, headache.

Interviewer: Any other problem?

Respondent: Haanji (yes). It did not suit me. I used to feel dizzy, I felt nauseated. Then again, I took the advice of madam, the doctor, and I was guided to opt for multi-load (intra-uterine device).

SHR4, a 31-year-old injectable user who had previously used oral contraceptive pills, discussed the pills as a “hot medicine”:

Respondent: One time I had consumed Mala-D. Then there were outbreaks, marks over my body...my face had swollen...for 2-3 days. Then I stopped. That is why I don't take pills. If someone gives me a hot medicine, then it happens.

Respondents who did not have prior experience with oral contraceptive pills also discussed hearing about side effects of the method. The knowledge of these side effects often led women to not want to use these pills, as evidenced by SAN11, a 23-year-old injectable user, who said that, “Pills make body grow and bloat with lots of discomfort.”

⁷ Mala-D is a combined estrogen/progestin oral contraceptive pill available over-the-counter in the Indian market.

Furthermore, oral contraceptive pills were perceived as an ineffective method in pregnancy prevention. This may be attributable to the fact that several of the respondents either did not know that oral contraceptive pills had to be taken daily, or forgot to take them on a consistent basis, as evidenced by the following quote from SAN10, a 33-year-old injectable user who had previously used oral contraceptive pills:

Respondent: In the case of pills...I have felt no discomfort. I used to get my period in time. I have never missed a period during pills.

Interviewer: So why did you stop taking pills?

Respondent: I just missed my pills and conceived by mistake. Had to take regularly, daily.

III. B. 3. Current Experiences with Injectable Contraceptives

Of the 25 women currently using injectable contraceptives, all were using Depo-Provera, locally referred to as “DIMPA” or simply “the injection.” The majority of women discussed choosing this method because they had previously found other methods, such as oral contraceptive pills or intra-uterine devices, unsatisfactory. Women also described a fear to use female sterilization, and how it may only be appropriate for a small subset of women, including those who had already achieved a sufficient age and those who do not have small children. The reason for the latter may be grounded in the reported side effect that sterilization disrupts milk formation in the body, and hence, disrupts the ability to breast-feed small children. Two women indicated that their provider had advised them against sterilization, as they were supposedly “too young”, according to the provider. Women like SAN17, a 34-year-old injectable user, also discussed the risks of female sterilization in a context of high childhood mortality:

As he (husband) discourages for operation. In my family, there was this case. Out of two children, one child died and operation had already been done. So it would be not okay having just one child. And also sometime operation also gets open, so it's not fully sure about it's result. I shall never go for operation.

Muslim women frequently described how their religious values prohibited the use of both intra-uterine devices and sterilization. According to SAN8, a 36-year-old Muslim injectable user, “*It is said that multi-load (intra-uterine device) is also not allowed in my religion. It is gunah (forbidden). Many take to DIMPA (Depo-Provera) in my area.*” SAN10 later went on to discuss problems or inconveniences with other methods that led her to use injectable contraceptives, “*Operation (female sterilization) is gunah. Pills have to be taken daily, while Copper-T caused discomfort.*”

Though many of the injectable using respondents were new users, two-thirds of these had experienced some degree of side effects. Half of these were referred to as being problematic, and were often related to menstrual irregularities. Spotting and prolonged menstrual cycle were reported as an especially problematic side effect of injectable contraceptive use because a woman’s ability to engage in certain tasks was

diminished.⁸ SAN8, a 36-year-old injectable user discussed how her menstrual cycle had become irregular since beginning injectable contraception, and how this impacted her ability to participate in religious prayer:

In my case, menses would not happen and then and when it happens, I would continue to have it....as you know, I am a Muslim. When I get menses, I cannot do Namaz⁹. When I skip my Namaz, I do not feel ok.

Women also discussed non-menstrual related side effects of injectable contraceptive use. Most often, these side effects were described as allergy-like symptoms, itchiness, skin irritation or marks on the skin, fever, and pain in the urinary tract. SAN20, a 29-year-old injectable user, described a burning sensation she experienced after receiving a dose of injectable contraceptives, and how she intends to discontinue the method due to this side effect:

I was having burning sensation around the urinary track, the burning sensation used to be like fire, and the menstrual cycle which I had was for 14-15 days... I am finding this difficult and so because of this, me and my husband have decided not to have injection, because I am having burning sensation a lot and I feel, what if I get a disease?....My younger sister-in-law faced the same problem. Even she is having the burning sensation just like me. I had taken injection on 19th and she had it on 16th and since there was a gap between both of us, she shared with me that she was having burning sensation and then I also shared the same with her. Then we thought it was because of the injection.

Several women reported that they were attempting to manage side effects attributed to injectable contraceptives with medication, while others asked the interviewers if they could be told of medication that would help them cope with the side effects they were experiencing. SAN17, a 34-year-old injectable user, describes how the ASHA told her that she could take medicine if she experiences side effects:

Poonam (ASHA), the lady who visits, she told me about copper-T and injection. Then I told her copper-T does not suit me. I don't mind taking injection provided there are no side effects. Then she said even if some side effects happens...she would give me medicine for the problem and side effects.

SAN8, a 36-year-old injectable user, described a prolonged menses, and asked the interviewer for advice about medicine that she might take to resolve those side effects: “After use of DIMPA, menses comes and does not stop consecutively for 15 days...so it would be a little helpful if you could tell me or suggest to me some medicine.”

⁸ In Northern India, a number of taboos and social and cultural restrictions exist concerning menstruation for both Hindu and Muslim women. Women who are menstruating may not be able to enter the kitchen, thus limiting their ability to perform required cooking duties, or may not be able to touch religious books or go to the shrine. (Kumar A & Srivastava K, 2011).

⁹ The salat, the five daily obligatory prayers by Muslims, is also known as namaz in India. (Kumar A & Srivastava K, 2011).

Many women reported that they would continue using injectable contraceptives if they did not experience side effects. However, women also stated that if they did experience side effects, they would discontinue the method. SAN17, a 34-year-old injectable user reported that, *“in case there is no side effect, will continue to take injection. In case I do have side effects, then I would resort to multi-load.”*

III. B. 4. Current Experiences with Intra-Uterine Devices

Among the 17 women who were currently using intra-uterine devices, most women were using the multi-load intra-uterine device, though some were using the Copper-T intra-uterine device. Intra-uterine devices were generally perceived as convenient, particularly because the method is inserted only once and then offers pregnancy prevention for up to five years. SAN2, a 27-year-old intra-uterine device user, noted that, *“it helps remove the fear of any unwanted conception. I am free for five years.”* SAN15, a 19-year-old intra-uterine device user, discussed the convenience of the multi-load intra-uterine device:

Interviewer: Why did you choose multi load only?

Respondent: It is good. One does not experience any problem while applying it, one can easily use it and there are no problems.

Interviewer: What benefit?

Respondent: Not required to apply anything once it's in. It's convenient and a one time affair. I went to the doctor and got it without problem....since newer technology has evolved, it is more dependable.

SHR3, a 25-year-old IUD user, also explained the ease with which she had been able to use a Copper-T intra-uterine device:

Interviewer: How do you feel using Copper T?

Respondent: Initially, I did experience some pain, which is understandable. I have heard that Copper T feels good. In case it doesn't suit, then you can get it removed....I am able to do all the work. I just take some precautions, to abstain from husband and to avoid lifting heavy weight.

However, there were also several women who discussed prior experiences with side effects from intra-uterine devices that led to discontinuation of the method. Most often, these side effects related to pain or pinching that limited a woman's ability to perform required chores and housework. SHR15, a 30-year-old injectable user who had previously used a Copper-T intra-uterine device, discussed why she had it removed, *“I could not use it as I have to carry heavy crops to help my husband. It used to be a little painful and pinched me.”* This should be considered in a context in which the daily activities of rural Indian women include bending, lifting heavy loads, and sitting in a squatting position for cooking activities.

Similar to the case with injectable contraceptives, women who were currently using intra-uterine devices also noted difficulties with side effects. SAN18, a 29-year-old who

had an intra-uterine device inserted two months prior to the interview, discussed how she had experienced consistent bleeding since having the device inserted. She described her discomfort and how that impacted her ability to participate in religious activities as follows, *“I feel a lot of discomfort. I cannot keep roza muslim ritual. And I cannot read holy book. Multi-load is effective, but not without inconveniences.”*

Respondents who had not elected to use an intra-uterine device discussed their fears of the method and the potential for it to undermine their health. The fears most commonly discussed were that the intra-uterine device could shift upwards into the ribs, that the string could break, causing subsequent problems, or that the method could cause a woman’s body to become weak. This must be viewed in a context in which women have little knowledge of how medical technologies might interface with, and impact, their reproductive systems. SHR14, a 28-year-old injectable user, discussed this:

Interviewer: You mentioned about Copper T and sterilization. Why didn’t you opt for Copper T?

Respondent: Everybody said that it is dangerous.

Interviewer: What kind of danger?

Respondent: People say that thread is used in this, and then there is a problem taking this thread out. If people say that this method is dangerous, then one does not feel like getting it.

Interviewer: Have you heard about any woman who experienced problems after using Copper T?

Respondent: People discuss that Copper T is dangerous, and that one finds it difficult to work after using it. The body wears out.

Interviewer: In what way the body wears out?

Respondent: One cannot work properly.

Similar to women who were using injectable contraceptives, women who were using intra-uterine devices discussed that they would continue using their current method if they did not suffer from side effects. However, women stated that if side effects developed, and could not be managed with medication, they would discontinue their current method. SAN15, a 19-year-old intra-uterine device user discussed this in relation to her current method:

As long as the multi-load suits me, I don’t require any other (method). But in case I do, I would speak to the lady (ASHA) who visited and may perhaps see the doctor, but don’t think I would ever have problem, as I am fine. I can do all the work alone.

III. C. Enabling Factors

The next section of this chapter describes enabling factors, or those factors that support or promote a woman’s use of non-permanent contraception. These factors are identified in accord with the theoretical framework, and thus, focus on social, cultural,

and environmental factors that influence non-permanent contraceptive decision-making and use.

III. C. 1. Support of Family Members

At the family level, social support of immediate family members was a crucial factor in enabling women to learn about contraception. It should be noted that thirty-five of the 42 women lived in joint households (Table 1) with the husband's family.¹⁰ Respondents discussed the importance of female family members for obtaining information on contraceptives. SAN13, a 33-year-old intra-uterine device user discussed speaking about contraceptive issues with other women in her household:

Interviewer: Do you talk to other women about their methods and any experiences?

Respondent: Yes, we do talk within the family, like with my sister-in-law (husband's sister). It is important to talk within one's family. My sister-in-law is going to her in-laws, so she asks me questions about multi-load (IUD), so we share with each other.

Similarly, SAN15, a 19-year-old intra-uterine device user, discussed obtaining contraceptive information from other women in her household, *"There are so many women in my family. We are all so frank with each other. In fact, my great-grandmother-in-law and cousin's mother-in-law also give us suggestions for not conceiving."*

This family support appeared particularly important, as many women reported that social supports outside of the family are non-existent. When questioned about with whom she talked regarding contraception, SAN12, a 23-year-old injectable user, stated, *"Since I am a new bahu¹¹, I do not go out or talk to women so frequently."* Respondents also indicated that they typically do not leave the home unaccompanied. Thus, most women reported that obtaining contraception had to be done in the company of, and hence acceptance by, their husbands, a female family member, and/or the ASHA.

III. C. 2. Support of ASHAs

At the community level, the AHSAs provided contraceptive information, motivated women to seek contraceptive services, and accompanied women to health centers to obtain such services. SHR 21, a 35-year-old IUD user, described how the village ASHA had accompanied her in going to the local health center for an intra-uterine device insertion, and how she could go to the ASHA if she had any problems with her chosen method: *"I went with her (ASHA), then it has been okay...If one has any problems (with*

¹⁰ There are many complex systems of kinship and marriage in India. In many rural regions of Northern India, women are married into families that may be located hundreds of miles from their natal family. It is said that Indian women are not just marrying a husband, but his entire family. Culturally, daughters-in-law are expected to be subservient to their husbands, mothers-in-law, all elders in the family, and to daughters of the household. Newly married women have little, if any, decision-making power in the household.

¹¹ Bahu is a Hindi word for a newly married daughter-in-law who lives with her husband's family after marriage. Most recently married women must seek permission to leave their homes.

IUD), then one comes to her (ASHA) at once.” Other respondents also described the ASHA as a social support.

III. C. 3. Distance to Contraceptive Services

At the environmental level, short distance to the health clinic may be an important enabling factor to access and use of contraceptive services. Many women described how they lived within walking distance or a relatively short ride by motorcycle, bus, or tempo¹² from their contraceptive provider. Women discussed the importance and convenience of having a health center that was in close geographic proximity to where they lived, as evidenced by SAN15, “*Right across the road, it’s (health center) near by...it’s neat and clean. The doctors are good. The people attending to patients are nice. We are blessed to have the Center so close to my residence.*”

III. D. Barriers

Barriers include those factors that limit or hinder a woman’s use of contraception. Similar to the section on Enabling Factors, barriers are identified in accord with the theoretical framework. The barriers identified below are concentrated at the family and provider levels. In addition, participants described religious values that impede the use of certain contraceptive methods, including both non-permanent and permanent methods. These religious values are not described here, as they have already been discussed earlier in this results section.

III. D. 1. Fear of Side Effects and Inadequate Counseling

Concern over intolerable side effects that are harmful to either the woman’s health or that of the child’s health emerged as a dominant theme. Women who discussed being counseled about potential inconveniences or side effects were generally more satisfied with their method. However, many women indicated that the counseling they had received upon adopting their contraceptive method was inadequate. Women reported not being told of possible side effects, as evidenced by the following interviewee (SHR13, a 23-year-old injectable user) when asked what the provider had told her during counseling, “*No, he didn’t say nothing. After getting the injection, I just came out. My husband might be knowing.*” SHR13 also discussed a lack of counseling coupled with the need to seek permission from her husband to receive her next injectable dose:

Interviewer: How long ago did you have the injection?

Respondent: I had injection last month in Rohta (a nearby village).

Interviewer: When will you get the next one?

Respondent: When he (husband) says. I cannot go ahead and do it until he says that. This will lead to fights at home.

Interviewer: Nobody at the center informed you when to visit next?

Respondent: No one told me there.

¹² Tempos are small, three-wheeled vehicles commonly used in India for carrying goods or people.

While not reported frequently, it should be noted that two injectable contraceptive users stated that the doctor who had injected them had done so after assuring them that injectable contraception would have no side effects. SAN9, a 26-year-old injectable user, noted that, *“the doctor said that it (injectable) has no side effect”*.

III. D. 2. Power Dynamics within the Family

While many women described the social support of their families, they also described an inability to begin using contraception without approval from their husbands. SAN8, a 36-year-old injectable user discussed how husbands could refuse a wife’s use of contraception: *“I have seen other women who couldn’t use (contraception) because husband didn’t allow. Some straight refuse.”* SHR13, a 23-year-old injectable user stated that, *“if he (husband) wants me to use birth control, then I will use it, and if he (husband) does not want me to use it, then I won’t.”* She also described her experience in adopting a contraceptive method that her husband had chosen:

Interviewer: How did you think of having injection when you had earlier heard about Copper-T?

Respondent: He (husband) told me about injection, to get that.

Interviewer: What did you think?

Respondent: I told him that whatever he thinks, I would do accordingly. Wives are supposed to follow their husbands.

Some respondents described a desire to use alternative contraceptives than what they were currently using, but could not, as their husbands had refused. SHR15, a 30-year-old injectable user, discussed how her husband had told her that she could not use an intra-uterine device:

Interviewer: Have you thought of using multi-load, which is for five years?

Respondent: I was thinking, but my husband is refusing.

Interviewer: Why so?

Respondent: He said to get injection for a year or two and then we will think.

Frequently, respondents reported the need to seek permission from their mothers-in-law in order to use contraception. SAN5, a 20-year-old injectable user, stated that, *“I need to take permission, first from my husband, then my mother-in-law.”* SHR3, a 25-year-old intra-uterine device user stated that, *“I talk to my mother-in-law first. She is elder to me. I cannot do anything without her permission. If I do things on my own, then it will be harmful to me only.”* Here, the respondent describes potential risks to her safety and well being if she does not gain prior approval from her mother-in-law.

IV. DISCUSSION

This study sought to explore women’s perceptions and experiences with non-permanent methods of contraception, including oral contraceptive pills, injectable contraceptives, and intra-uterine devices, and to identify both enabling factors and barriers to women’s

use of these methods. Women who were not currently using contraception were not included in this study. It is possible that women who are not current contraceptive users may have experienced barriers that prohibited their use of contraception. However, because this research specifically sought to understand those factors that promote and limit a woman's use of contraception, only current users of contraceptives were recruited. While the study initially set out to investigate contraceptive use in relation to spacing of births, it should be noted that 21 of 42 women were using their current method to limit all future births - that is, they did not want to have any future pregnancies.

Women's prior use of oral contraceptive pills, and discontinuation due to side effects and unintended pregnancies suggests that this method may be difficult for women to use. Women reported difficulty in remembering to take their pills daily, and indeed, this method may prove more complex to use regularly and effectively than a one-time intra-uterine device insertion or quarterly injection. That women had discontinued prior use of oral contraceptive pills, yet were currently using either injectable contraceptives or intra-uterine devices demonstrates that women do want to regulate their fertility. Indeed, the sample of women included in this study expressed a strong desire to prevent pregnancy for a variety of reasons, including to promote their own health, the health of their children, and for economic reasons. However, women continue to face many barriers that impinge upon their ability to use contraception.

At the social network level of the Social Ecological Model, women discussed the influence of husbands and family elders in decision-making related to reproductive choices and contraception. That women possess little power or autonomy to make such decisions is evident from the qualitative data. Moreover, many women in this study described a lack of social networks outside of their families and households. Women most frequently relied upon immediate family members or ASHAs for contraceptive information. Because husbands and family members strongly influence reproductive behavior and decisions, programs must also be developed to include these stakeholders.

While ASHAs are an important source of information, the continued use of incentives for identifying a contraceptive adopter is problematic. The promotion of longer-term methods, such as intra-uterine devices, by the ASHAs may result from the fact that ASHAs receive different levels of compensation for different contraceptive methods. In the study area, ASHAs are paid 50 Indian rupees (approximately \$1 USD) for recruiting an injectable contraceptive user; 100 Indian rupees for an intra-uterine device insertion; and 200 Indian rupees if a woman undergoes sterilization. Providing higher incentive levels for permanent contraceptive methods may induce provider bias to more strongly recommend those methods for which they will receive greater compensation. Moreover, the continued use of incentive schemes for adoption of contraception is in direct conflict with human rights documents.

This research also demonstrates that there is a need for education, both for potential end-users of contraception and their social networks. Many women interviewed in this

study reported not being aware of potential side effects of their contraceptive methods. Education for providers is also indicated. That two providers actually told women that they would not experience any side effects is particularly problematic. Providers must be empowered to counsel women before method initiation, so that women are able to make informed decisions about their method choice. In addition, evidence from other countries has demonstrated that counseling is associated with greater contraceptive method satisfaction and longer continuation rates (Hubacher, Goco, Gonzalez, & Taylor, 1999).

Women frequently described reasons for non-use of sterilization. These were related both to religious values that prohibit the use of this method, but also to the risks of sterilization in a context where childhood mortality remains high. Women described the uncertainty surrounding their children's survival, coupled with their hesitancy to undergo sterilization. This demonstrates that women have a need for non-permanent, but long-term methods of contraception, and thus, the methods described in this research may have a particularly important role to play. Injectable contraceptives have been controversial in India, and thus, it is worth addressing their use here. While the method can have a variety of side effects, it is important to note that a subset of women in this study described injectable contraceptives as the only method suitable for their use. For women who found oral contraceptive pills to be unsuitable, and who also stated that their religious beliefs prohibited the use of intra-uterine devices or sterilization, injectable contraceptives may be appropriate. Any method must be delivered with appropriate counseling and information, so that women can make informed decisions about the use of that method.

Finally, while not the focus of this research, several women discussed a link between small family size and the possibility of educational attainment, particularly for their children. While prior research has demonstrated links between increased educational attainment and positive health outcomes for Indian women and their children (Govindasamy & Ramesh, 1997; Rajna, Mishra, & Krishnamoorthy, 1998), the women in this study also clearly valued such opportunities. Moreover, nearly one-third of the participants in this study had been married before the legal age of marriage of 18 in India. Prior studies have demonstrated that increased educational attainment and workforce participation are associated with later age at marriage (Nas & Dey, 1998). Given that many women discussed concerns over their health and the desire to space births or stop childbearing to improve their health, education may be an important pathway by which women could achieve these goals.

V. STRENGTHS AND LIMITATIONS

There are limitations to this research. First, because providers from World Health Partners aided in recruitment activities for this study, study participants may have felt compelled to provide socially desirable responses, since they knew that the research team was in some way affiliated with local health care providers. In addition, providers may have identified potential participants for recruitment that they knew would report positive experiences with their current contraceptive method. However, upon review of

the transcripts, participants described a wide range of experiences with their methods; for example, a lack of counseling upon receipt of their method. This would seem to indicate that providers did not select participants who only had positive experiences. In addition, this recruitment strategy allowed the research team access into the lives of women by establishing credibility and trust. Such access may not have been granted had the research team not established trust among local providers, and subsequently, the women who were interviewed.

Second, because all interviews were conducted in Hindi, it is possible that problems may have arisen with comprehension and interpretation in English. In the transcripts, research assistants noted when they were not familiar with a word spoken in the local dialect by participants who were interviewed. This may mean that important pieces of data from the interviews were lost. The research assistants who interviewed study participants had not previously worked for World Health Partners, and thus, it is unlikely that they would have felt compelled to censor the translation of transcripts. However, there is no way of knowing if either of these limitations may have occurred, since study authors did not complete the transcription or translation activities.

Third, while the focus of this research was in exploring women's perceptions and experiences with non-permanent contraceptive method, only current users of injectable contraceptives or intra-uterine devices were interviewed. Upon arrival in India, it was determined that sampling users of oral contraceptive pills would not be feasible. This is because oral contraceptive pills are provided over-the-counter at pharmacies and thus, individuals using this method would have been difficult to identify and locate. However, 15 respondents had previously used oral contraceptive pills, and as such, results on women's perspectives and experiences with this method are included in this paper.

Fourth, all data was self-reported. No complementary information was collected to verify women's current contraceptive use or prior use of contraceptives. However, given that this study sought to understand non-permanent contraceptive use from the perspective of rural women in Uttar Pradesh, self-report was most appropriate. In addition, qualitative methodologies may give discourse power to women. This may be particularly important in this context, where women have little power, autonomy, or decision-making authority. Having the opportunity to discuss their experiences with contraceptives may have been an empowering event, as evidenced by the fact that many women thanked the research team for asking their opinions, and inquired if the team would be coming back to the villages.

Lastly, the results of this study are not generalizable to all women in Uttar Pradesh, or even women residing in different villages in Uttar Pradesh. Yet, this was not the purpose of this research study, which sought to explore women's experiences with non-permanent contraception, while taking into account social, cultural, and environmental factors. Generalization to a broader or larger group of women would be antithetical to the nature of this work.

VI. CONCLUSIONS

This research sought to fill a critical gap in the literature pertaining to Indian women's perceptions and use of non-permanent contraceptive methods. Understanding women's perceptions of oral contraceptive pills, injectable contraceptives, and intra-uterine devices is a first step toward filling this gap. Understanding factors that promote use of these methods, in addition to those factors that limit use, is fundamental to developing innovative approaches to meet non-permanent contraceptive needs among women living in Meerut and Bijnor, Uttar Pradesh, India. Given the gaps in the literature, future research efforts should focus on approaches to overcome barriers that women encounter in seeking contraceptive services. The potential for non-permanent contraceptive methods to meet the reproductive needs of women in rural Uttar Pradesh is undoubtedly great. However, more research is needed to elucidate the pathways by which women can be empowered to overcome the barriers that they face in seeking and using contraceptive services.

CHAPTER 3: A QUALITATIVE EXPLORATION OF KEY OPINION LEADERS' ATTITUDES TOWARD INJECTABLE CONTRACEPTIVES IN INDIA

Abstract

Introduction: India's National Population Policy highlights expanding voluntary family planning options. However, injectable contraceptives are excluded from the Indian National Family Planning Program. The lack of injectable contraceptives through this program results in fewer contraceptive options for economically marginalized women who do not have access to private sector options.

Methods: This research uses Social Ecological Theory and Political Economy Theory as its theoretical frameworks, and employs qualitative methods, including media content analysis and in-depth interviews, to investigate key opinion leaders' attitudes toward injectable contraceptives' and the method's role in the Indian National Family Planning Program. Interviews were conducted in English and were digitally recorded. Data analysis was based on constant comparison, rooted in grounded theory, and was conducted using the qualitative software package, Dedoose®.

Results: The media content analysis identified supportive and oppositional frames to the inclusion of injectable contraceptives in the Indian National Family Planning Program. Those frames were explored in detail among 31 key opinion leaders, who were interviewed. Stakeholder groups included international non-governmental organizations, Indian non-governmental organizations, including service delivery, research, and advocacy organizations, Indian women's organizations, and Indian government representatives. Key opinion leaders who were opposed to the method's introduction in the government program cited quality of care and safety issues, lack of information and informed consent, and a lack of data from clinical trials. Key opinion leaders who were supportive of the method cited the importance of choice for women, specific benefits of injectable contraceptives, and adequate data on the method. Stakeholder groups who were in favor or opposed to the method's inclusion in the government program agreed on several fundamental issues, including issues of side effects with injectable contraceptives, and a lack of contraceptive options for women within the country.

Discussion: Understanding key opinion leaders' attitudes toward injectable contraceptives, and how those leaders influence contraceptive policy, is critical to the development of family planning programs and policies. Such information may be useful beyond the scope of family planning, extending to other reproductive health services and policies in India.

I. INTRODUCTION

India's current National Population Policy highlights the importance of expanding choices for voluntary family planning within a broader rights framework (India Ministry of Health and Family Welfare, National Commission on Population, 2000). However, contraceptive options within the Indian National Family Planning Program are limited, and injectable contraceptives remain excluded from the program.¹³ After many years of public controversy, the United States Food and Drug Administration (US FDA) approved the injectable contraceptive, depot medroxyprogesterone acetate (DMPA),¹⁴ in 1992.¹⁵ Shortly thereafter, the product was introduced into the Indian market, when the Drug Controller of India approved it for marketing by private providers and for social marketing purposes. At that time, the Indian Council of Medical Research recommended post-marketing surveillance of the product, instead of Phase III clinical trials, citing the US FDA approval and studies from the World Health Organization (Sudhir & Malarcher, 2010).

In response to DMPA's introduction, protests were launched from several Indian women's organizations, which filed a petition to the Indian Supreme Court asking for a ban on the product.¹⁶ In 1995, the Indian Drug Technical Advisory Board (DTAB), on the order of the Indian Supreme Court, made an interim recommendation that DMPA should not be allowed for use in the National Family Planning Program, and that its use should be restricted to women who are aware of all implications of use of the method. The court case involving DMPA ended in 2001, without a ban on the product. The court ordered that DTAB must continue with regular meetings to review any drug for which there are safety concerns (Sudhir et al., 2010; SAMA, 2003).

From the time of the interim recommendation through the present, there has been significant growth in the provision of injectable contraceptives in the private sector. To address this growth, and to advocate for an expansion of contraceptive choices within the Government's National Family Planning Program, in 2004, Parivar Seva Sanstha, an Indian non-governmental service delivery organization, arranged a workshop in collaboration with the United Nations Population Fund (UNFPA), the Packard Foundation, and the Indian Government. The goal of the workshop was expand contraceptive choices with the inclusion of injectable contraceptives in the Government program. More than 40 Indian health and women's organizations responded to that workshop by signing a memorandum against injectable contraceptives that was submitted to the Indian Union Health Minister (Sudhir et al., 2010; Sarojini & Murthy,

¹³ The Indian National Family Planning Program, administered by the Ministry of Health and Family Welfare, currently provides the following contraceptive services: male and female sterilization, Copper-T intra-uterine devices, oral contraceptive pills, emergency contraceptive pills, and condoms.

¹⁴ DMPA is a progestogen-only contraceptive that is injected intra-muscularly once every three months.

¹⁵ There was controversy over the introduction of DMPA into the United States market because laboratory studies had demonstrated that the drug caused malignant mammary tumors in beagle dogs. See Skegg (1995).

¹⁶ The women's organizations noted that DMPA had not undergone the requisite phase III clinical trials. In addition, a case against another injectable contraceptive, norethisterone enanthate (NET-EN), was still pending in the Indian Supreme Court. The NET-EN case was filed by Saheli, Chingari, and others, and petitioned for a stay on phase IV clinical trials of NET-EN and the product's entry into the National Family Welfare Programme. The petition cited the potential hazards of NET-EN, violation of informed consent, and unsuitability of the method for an ill-equipped healthcare system. See SAMA (2003) and Saheli (2004).

2005). Concerns over injectable contraceptives included severe side effects, the inability of the public sector to provide adequate screening, counseling, and follow-up, and inadequate post-marketing studies (SAMA, 2003; Saheli 2004). In response to this memorandum, the Ministry of Health and Family Welfare responded that they were not planning to introduce injectable contraceptives into the National Family Planning Program until the Indian Council of Medical Research had conducted additional trials, and found positive results (Sudhir et al., 2010).

The issue of injectable contraceptives is not just one of policy, but also one of economics. Women who have sufficient economic resources can decide to select this method in the private sector, while economically marginalized women, even if they decide they want to use this method, cannot. In short, poor women in India have a reduced menu of choice when it comes to contraceptive technologies, compared to their wealthier counterparts.

Understanding the reasons why key opinion leaders support or oppose injectable contraceptives, in addition to how those leaders influence national contraceptive policy, is critical to the development of effective family planning programs and policies. Media framing is one technique through which social problems are constructed. Frames define problems, identify causes, and suggest solutions (Entman, 1995). The literature has demonstrated that media framing has an impact on public health in the domain of health policy formation (Dorfman, 2005). Thus, this research included both a media content analysis and in-depth interviews with key opinion leaders to explore current discourses surrounding injectable contraceptives in India, the role that key opinion leaders play in shaping these discourses, and how key opinion leaders influence national policy that determines access to injectable contraceptives. It is expected that this research will inform efforts for contraceptive policy development. Such information will likely be useful beyond the scope of family planning, extending to other reproductive health services and policies in India.

The Social Ecological Theory (Stokols, 1996) provides a productive lens through which to understand the complex and multifaceted viewpoints of key opinion leaders in regards to injectable contraceptives. The Social Ecological Theory depicts multiple layers within which an individual is embedded, and thus, the multiple influences that they experience and must negotiate. For example, individuals possess knowledge and skills related to injectable contraceptives, yet these are influenced by interpersonal social networks. In addition, organizations, cultural values and norms, and local and national policies all form a web within which an individual is located (see figure 1, chapter 2 for a depiction of the Social Ecological Model). Similar to Social Ecology Theory, Political Economy Theory stresses the importance of viewing health problems in terms of their relationship to other facets of society and environment. This theory adds to Social Ecological Theory by specifically, “suggesting that such problems must also be viewed in broad historical relief” (Minkler, Wallace, & MacDonald, 1994). This is critical given the long history of family planning promotion in India. The attention to the dynamics of class and gender, and how these interact to effect the lives of individuals

and broader social groups, also makes Political Economy a useful framework for this research.

II. METHODS

The research approach integrated media content analysis and in-depth interviews with study participants. The content analysis was completed during July through October 2012. Semi-structured in-depth interviews were conducted with key opinion leaders from both Indian and international organizations. Interviews were conducted in India during June through August 2012 and May through July 2013. This research was approved by the University of California, Berkeley Institutional Review Board (protocol # 2012-02-4053).

II. A. Media Content Analysis Design

Indian newspapers were sampled for relevant content, both because they are easily accessible and because newspapers typically set the agenda for other media, including television and blogs (Pew Research Center, 2013). A defined set of keywords (including injectable contraceptive, family planning, Depo-Provera, DMPA, and injectable controversy) was used to sample newspaper articles that appeared between 2004-2006 and 2011-2012 in the database *Access World News*. The earlier time frame was chosen because the debate over injectable contraceptives was at its peak in 2004, following the injectable contraceptive workshop organized by Parivar Seva Sanstha. The latter time frame was chosen to collect current data relevant to the issue of injectable contraceptives in India. Individual paragraphs, instead of entire news stories, were coded. In addition to identifying supportive and oppositional frames, paragraphs were also coded to identify individuals or groups receiving news coverage.

II. B. In-Depth Interviews Design

II. B. 1. Development of Interview Guide

A semi-structured interview guide was developed and included open-ended and probing questions to explore key opinion leaders' attitudes on non-permanent contraceptive methods. Questions were included to specifically explore key opinion leaders' attitudes toward injectable contraceptives, and their reasons for supporting or opposing this methods' inclusion in the Indian National Family Planning Program. The interview guide was written in English, the predominant language spoken by individuals identified as key opinion leaders. Consistent with the iterative nature of qualitative research (Denzin, 1978), the original interview guide was modified over time as preliminary analysis of initial interviews suggested new lines of inquiry and the need for more detailed information on particular topics.

II. B. 2. Sampling and Recruitment

Potential study participants were first identified from the media content analysis, using intensity driven purposive sampling (Patton, 1990). Additional study participants were identified and recruited through snowball sampling techniques. To help ensure that individuals being identified through snowball sampling were key opinion leaders on the issue of injectable contraceptives in India, snowball mapping was used to identify the number of individuals that had identified a key opinion leader. The majority of respondents who participated in this study were identified by at least two other key opinion leaders. This sampling strategy was purposefully non-random, as the research team was attempting to gain access to public figures that were key opinion leaders who had publicly expressed opinions on injectable contraceptives.

II. B. 3. Interview Procedures

All study participants were asked to provide written informed consent for interviews conducted in-person and verbal informed consent for interviews conducted via phone. Interviews were conducted in English, were digitally recorded, and lasted between one and two hours. All interviews were conducted by one interviewer, in the private offices of study participants in order to maintain privacy of participants or via phone. The interviewer wrote down non-verbal cues and observational data during interviews. Interviews were stopped immediately if there was any intrusion by another person, or risk of being overheard. Interviews were not re-started until privacy had been re-established, and the study participant was specifically asked if he or she was comfortable continuing the interview. The interviewer prepared short memos following every interview. In addition, the study team debriefed following every interview. This served as an assessment of quality and consistency of interviews and allowed the study team to constantly evaluate research activities in the field as they occurred. Participants did not receive financial incentives for participation in this research.

II. B. 4. Coding and Analysis of Interview Data

Interviews were transcribed in English. Preliminary coding was done in the field in order to develop a broad understanding of the data, and to identify additional areas of inquiry. Text files of all interviews, observational data, and memos were imported into Dedoose® for coding and analysis. Multiple forms of coding were used to examine the data. The methodology for data analysis is rooted in concepts of grounded theory and constant comparison (Glaser & Strauss, 1967; Strauss & Corbin, 1998; Charmaz, 2006). All data are first reviewed to develop a broad understanding of the content as it relates to the study's specific aims. Short memos were prepared to identify, name, describe, and categorize phenomena in the text. During this step, the boundaries of specific codes were defined. Next, materials from memos, interviews, and observational data were coded to produce data into analyzable units. Segments of text from a few words to several paragraphs were coded. Two types of coding were utilized: open coding to identify emergent themes and a priori coding, based on themes from the interview guide. Finally, axial coding was used to connect codes to one another. A complete list

of codes (codebook) was developed, which included four basic components: the code, a brief definition, a full definition, and examples.

III. RESULTS

III. A. Content Analysis

A total of 67 articles were identified. Of these, 22 were relevant to the research question. Those articles that were not relevant were most frequently related to other contraceptive methods, or were out of the geographic scope of this research. In an attempt to identify additional news articles, search criteria were expanded to include the entire region of Asia. Of 94 articles, only three additional articles were relevant to this analysis. One of these three articles was only tangentially related, but was included, since one of its paragraphs specifically mentioned deterrents to use of injectable contraceptives in India. Of 157 total paragraphs analyzed, 75 were directly oppositional or critical to the inclusion of injectable contraceptives in the Indian Government's National Family Planning Program, while 80 were directly supportive, or supportive of family planning efforts more generally. Two paragraphs were coded as neither oppositional nor supportive.

III. A. 1. Oppositional and Supportive Frames

Within the paragraphs analyzed, 33 different oppositional frames were identified. These frames were collapsed into five themes, seen in Table 1. The risk of hazardous side effects was the oppositional frame used most frequently. General side effects, damaging effects to women's health, increased risk of bone loss, increased risk of HIV infection, and interruptions to the menstrual cycle were all cited frequently within the side effects and risk theme. The oppositional frames intersected to form an overall message that injectable contraceptives are dangerous, cannot be implemented safely given the Indian Government's ill-equipped healthcare personnel and infrastructure, and are being used by Western powers (including the World Bank and large pharmaceutical companies) and the Indian Government to control populations coercively.

Forty-one different frames were identified in support of including injectable contraceptives in the Indian Government's National Family Planning Program. Similarly, these frames were collapsed into five themes, seen in Table 1. Within the effective method theme, frames focused on effectiveness, convenience, and safety of injectable contraceptives. These frames were used most often. Frames that focus on overarching values – namely, choice and access for all women - were invoked in frames supporting improved choice. However, these frames were only the fourth most common type of frame used.

Table 1. Media Content Analysis: Oppositional and Supportive Frames			
Oppositional Frames	Count	Supportive Frames	Count
Side Effects and Risks	58	Effective Method	24
Inadequate Health System	9	Pregnancy Prevention	11
Coercive Governmental Policies	8	World-Wide Acceptance	9
Ethics, Western Power	8	Improved Choice	9
Provider-Controlled Method	4	Adequate Health System	4

III. A. 2. Who is Included in Coverage

The fact that 75 paragraphs were oppositional, while 80 were supportive, would suggest that the news coverage of this issue is relatively balanced; that is, that equal amounts of newsprint were given to those who support and those who oppose injectable contraceptives. However, an analysis of whose voice is actually included in the news articles provided additional detail. Opponents to the inclusion of injectable contraceptives in the Government's National Family Planning Program were quoted 59 different times. By comparison, supporters to the inclusion of injectable contraceptives were quoted approximately half as often (31 times). Among the opposition, those quoted most frequently were women's groups (though names of specific women's groups were often omitted), followed by Brinda Karat, a member of Parliament, the Marxist Party of India, and the All-India Democratic Women's Association. Public health experts and groups were also cited, but specific names of individuals or groups were largely omitted. Among supporters, the Federation of Obstetric and Gynecological Societies of India (FOGSI) was quoted most frequently, followed by Douglas Huber, a consultant at Management Sciences for Health in Boston, Massachusetts. Other supportive voices that were quoted include the Health Ministry, various non-governmental organizations, including the Packard Foundation, and local organizations. However, the frequency of quoted material from these other supportive voices was minimal. Interestingly, the one voice that might be most important in this controversy includes the women who are the end-users of injectable contraceptives. Not a single quote from end-users was identified.

III. B. In-Depth Interviews

A total of 31 in-depth interviews were conducted with key opinion leaders from international non-governmental organizations, Indian non-governmental organizations, Indian women's organizations, and Indian government officials. International non-governmental organizations and Indian non-governmental organizations included those organizations conducting research, providing direct contraceptive services, or advocating on contraceptive policies. Table 2 lists stakeholder groups and the gender

of participants by stakeholder group. Table 3 lists stakeholder group positions on the inclusion of whether injectable contraceptives within the Indian National Family Planning Program.

Table 2. Gender of Key Opinion Leaders, by Stakeholder Group (n=31)		
Stakeholder Group	Male (n)	Female (n)
International Non-Governmental Organizations ¹⁷	6	8
Indian Non-Governmental Organizations ¹⁸	7	5
Indian Women's Organizations ¹⁹	0	3
Indian Government ²⁰	2	0

Table 3. Stakeholder Group Positions on Inclusion of Injectable Contraceptives in Government Program (n=31)		
Stakeholder Group	Opposed	Supportive
International Non-Governmental Organizations	1	13 ²¹
Indian Non-Governmental Organizations	1	11 ²²
Indian Women's Organizations	3	0
Indian Government	0	2

III. B. 1. Cluster of Issues Among Those Who Are Opposed to Injectable Contraceptives

The next section of this chapter discusses a cluster issues described by those key opinion leaders who expressed a position of opposition to the inclusion of injectable contraceptives in the Indian National Family Planning Program. Five different key opinion leaders held such a position. Respondents who supported this viewpoint included one key opinion leader from an international non-governmental organization, one respondent from an Indian non-governmental organization, and three respondents from Indian women's organizations. An additional respondent expressed positions that both advocated for and against the inclusion of injectable contraceptives in the government program.

¹⁷ Respondents were interviewed from the following international non-governmental organizations: (1) Population Council; (2) UNFPA; (3) Gates Foundation; (4) International Center for Research on Women; (5) IPAS; (6) Abt Associates; (7) Ford Foundation; (8) PATH; (9): FHI 360; (10) David & Lucille Packard Foundation; (11) Jhpiego.

¹⁸ Respondents were interviewed from the following Indian non-governmental organizations: (1) Center for Health and Social Justice; (2) Parivar Seva Sanstha; (3) Federation of Obstetric and Gynaecological Societies of India; (4) World Health Partners; (5) Population Health Services India; (6) Family Planning Association of India; (7) Advocating Reproductive Choices; (8) Center for Women's Development Studies; (9) Human Rights Law Network.

¹⁹ Respondents were interviewed from the following Indian women's organizations: (1) Saheli; (2) SAMA; (3) All-India Democratic Women's Association.

²⁰ Respondents included one individual currently working at the Indian Council of Medical Research, and one individual who worked as a former government representative within the Indian Ministry of Health and Family Welfare.

²¹ One respondent supported the inclusion of injectable contraceptives in the government program only under certain conditions. This respondent noted that injectable contraceptives should be provided through the government program in geographic areas where healthcare infrastructure is of higher quality, and where quality of care, and particularly, follow-up care, can be assured.

²² One respondent expressed both supportive and oppositional viewpoints to the inclusion of injectable contraceptives in the government program.

III. B. 1. a. Quality of Care and Safety Issues

Respondents who expressed an opinion that injectable contraceptives should not be included in the Indian National Family Planning Program most frequently discussed a cluster of issues pertaining to quality of care and safety of injectable contraceptives. Quality of care issues included a fractured public health system that isn't properly equipped to provide adequate contraceptive counseling; lack of follow-up care for women who experience side effects or problems after receiving injectable contraceptives; and an inability to appropriately monitor women for side effects, particularly in the context of a highly rural and migratory population. C13, a key opinion leader from an Indian women's organization, noted that *"It's (injectable contraceptive) available in the private, it's not that it's not available at all in India. It is available in private, but it is not available in the (public) health systems. And that's because of the health system, the way it is."* Here, the respondent describes the health system as "the way it is", or without the necessary infrastructure, personnel, and resources to deliver injectable contraceptives. Similarly, C9, a key opinion leader from an Indian research and advocacy non-governmental organization, discussed quality of care and monitoring issues:

But the only thing is the quality issues are a concern: access and quality. And how they (injectable contraceptives) will be administered. Because right now we are seeing that government is dealing with these issues. Grappling with basic issues: lack of water, sanitation, women lying on the floor after operations...The monitoring or the audit authorities in each district, they're supposed to keep monitoring. That's not working.

C9 later discussed how the quality of care of services that are currently provided through the public system is inadequate, and thus, it would be difficult to include yet another contraceptive service:

If you roll out injectables, quality of care is already poor in the services, which are, as of now, provided. Those kinds of issues will remain the concern for us.

Respondents discussed a variety of safety and side effect issues pertaining to the use of injectable contraceptives. Most often, these concerns related to bone loss, heavy or irregular menstrual bleeding among a population of women where anemia prevalence is high,²³ and general concerns over long-acting hormonal contraceptives. Concerns over side effects were frequently linked to a lack of appropriate follow-up care within the public sector health system. C11, a key opinion leader from an Indian women's organization, noted that, *"unless there is enough service provision, and proper provision, and treatment if there are side effects. If these are not done, then it (injectable contraceptives) should not be introduced."* C16, a key opinion leader from an Indian women's organization, discussed concerns of injectable contraceptives in the

²³ India has the highest occurrence of anemia in the world. According to data from the 2005-2006 National Family Health Survey, more than 50% of reproductive aged women in Uttar Pradesh are anemic (Bharati S, et al, 2012).

context of a highly malnourished and anemic population, and linked those safety concerns to a healthcare system that doesn't provide appropriate follow-up care:

Interviewer: And you've already touched on injectable contraceptive a little bit and we've heard a lot of different viewpoints on that contraceptive method.

Respondent: Ya, there's a mixed opinion on it.

Interviewer: Can you just give us a little more of your viewpoint on injectables?

Respondent: A, injectable contraceptives have not been found to be completely safe. B, in a population where almost 55% are anemic, you just do not know what impact it will have on those body systems. Malnourishment is so high. So in such cases to go in for injectable contraceptives seems to be not the best of choices at all. C, the kind of after care, the follow-up, monitoring, help, support systems that are required are simply absent in our country.

Similarly, C22, a key opinion leader from an Indian non-governmental organization, discussed a reluctance to introduce any contraceptive method that has long-acting impacts on women's health in the context of a healthcare system that doesn't have systems for monitoring in place:

Anything that requires regular, continuous monitoring over a period of time. I'm saying our assessment is that, on the ground, we do not have any effective method of monitoring. So it will not work, it has never worked and I think whether its government or medical establishment introducing it (injectable contraceptives), they need to think. Because the fact is, we do not have any methods of monitoring people's health...And anything which has long term (effects) on women's health should be thought about.

Respondents also discussed the issue of safety and side effects of injectable contraceptives within the context of the Black Box warning that was added to Depo-Provera in 2004 by the US FDA and Pfizer. The warning noted that one of the side effects of Depo-Provera is bone loss, which grows worse the longer the drug is administered, and which may be irreversible. C13, a key opinion leader from an Indian women's organization, discussed this:

One (concern) is of safety and the side effects. I mean, you must know that was Pfizer gave a black box warning some years ago for bone mineral density. They said that there is a chance of something like that happening. And in the context of the women who are going to health systems today, they are already very malnourished.

III. B. 1. b. Lack of Information and Lack of Choice in the Context of a Coercive State

Respondents who believed that injectable contraceptives should not be included in the public sector program described three inter-linked concepts related to a lack of choice

and lack of information, including: (1) a lack of contraceptive options that are currently provided to women through the public sector; (2) contraceptive information that is not transacted to women, and thus, an inability of women to make informed contraceptive decisions; (3) the potential for abuse of women with the introduction of injectable contraceptives in the public sector, particularly in the context of a strong and controlling government machinery. In regards to the first point, respondents described limited contraceptive options, in addition to a continued focus by the government on targeting women for contraceptive services. C16, a key opinion leader from an Indian women's organization, noted:

The point is that women's choices, as far as contraception goes, it is very limited. Effective contraception is hardly available to them. And the government also takes advantage and takes wrong decisions with regard to women and their reproductive health matters. In looking at this whole paradigm of reducing the number of children, they (the government) target the women.

C11, a key opinion leader from a women's organization, also described a lack of contraceptive options, and further noted that the government currently struggles to provide the methods that its policies include. This respondent viewed the inclusion of injectable contraceptives in the public sector as unreasonable, noting that methods that are currently included in policies should be rolled out adequately and appropriately, with all provisions of high quality service, before the inclusion of additional contraceptive methods in the government program:

What we have right now in the basket is just a condom and sterilization. So there are two methods, which the government basket of choice provides. Two and a half. And the pills, which are very bad quality. So if you have injectables, you know, how is that going to be rolled out? Because right now we have rolling out issues.

Despite a lack of contraceptive options, these respondents did not believe the inclusion of injectable contraceptives in the government program was justified, particularly because women are not provided with full information upon which to make an informed decision. Frequently, a lack of information was linked to the concept of a strong government system that wanted to control births. C13, a key opinion leader from an Indian women's organization, described how information, particularly in relation to injectable contraceptive side effects, is not transacted to women:

In India whether it is contraception, such as injectables, the whole information transaction is very, very limited, or low, or not at all. It does not exist... Injectables have been known to have side effects, which are not ever transacted, the information is never transacted to women.

C13 also described how the argument to increase women's choice through the provision of injectable contraceptives, often made by supporters of the method, is flawed since women do not have enough information to make an informed choice:

There is this whole mindset of, “population is going to increase”. So that mindset is still very far from what looks at women and their rights in a different way. And the same argument has been used by groups to say that it is the woman’s right to choose and there is a whole choice argument of, “No, but women have the choice.” But if you actually see in today’s health system, the choice is not a free and an informed choice. There is no choice at all in that sense because she is not told about many of these things.

Lastly, respondents described reservations about injectable contraceptives, due to the potential for governmental control and abuse of women. C29, a key opinion leader from an international non-governmental organization, described how, “*on the whole, I’m open to it (injectable contraceptives)*”, but still would not want the method included in the public sector program due to the potential abuse of poor women:

Interviewer: How do you see that method (injectable contraceptives) fitting into the government program, if at all?

Respondent: I wouldn’t want it to be there in the government system...because the government is full of resources, has a very strong machinery. Poor women go to the government and they are the first to be abused...I wouldn’t recommend that. At least in the private realm, a woman is treated a little more kindly, their opinions are heard, their concerns are heard.

III. B. 1. c. Inadequate Data and Clinical Trials

Respondents frequently discussed a lack of adequate clinical trials that had been conducted on injectable contraceptives, particularly among Indian women, a lack of transparency of Indian governmental bodies that had conducted such clinical trials, and the absence of ethical practice and protocols in prior clinical trials. C22, a key opinion leader from an Indian non-governmental organization, discussed the lack of clinical trials conducted within the Indian context:

Any injectable contraceptive, or any contraceptive, which has not been tried within the context of India and its diversities and its social conditions, health conditions...I think we need to think seriously about introducing it.

C22 also discussed the lack of transparency in relation to contraceptive clinical trials that have been conducted by the Indian Council of Medical Research, and the absence of ethical practice in prior trials:

They (Indian Council of Medical Research) have never shared it (clinical trial results) with us. It was their job to call meetings or say, “these are the trials conducted, these were the results. Let’s have a public debate.” Because we’re not just insanely opposed to all contraceptives, we’re not. I mean we are rational people. We believe women should have better health and they should enjoy

their lives as much as possible, and if better technologies are available, they should be in use. But it cannot be with no concern to women's health and hazardous consequences, and no monitoring with no reprieve and no redresses. That we don't want, because what we feel is that poor women in India are constantly being made guinea pigs for these trials, and with no adherence to ethical norms and no transparency.

This respondent also invoked the history of unethical clinical trials within India. This relates back to the Political Economy theoretical framework that guides this research, which highlights the importance of viewing the issue of injectable contraceptives with broad historical relief. While respondents described the need for additional clinical trials and data on injectable contraceptives within the Indian context, they also viewed that need through a historical lens in which coercive practices have hindered clinical trials. Moreover, it should be noted that respondents described a lack of counseling for poor women and abuses of those same women by those individuals administering clinical trials. In essence, the marginalization of poor Indian women seems to exist at multiple sites within the health system.

C16, a key opinion leader from an Indian women's organization, discussed how clinical trials on injectable contraceptives had been conducted in other countries, where key health indicators may be very different from those among Indian women. Thus, the results of those trials may not be applicable to Indian women.

Many of these trials have been done in countries where your average BMI, your average health indices are high. Over here (in India) you have almost 50% anemia. Over here, you a very high degree of malnutrition. So in such a situation, you do not have any idea of what could be the further impact on an already weak body.

III. B. 2. Cluster of Issues Among Those Who Are Supportive of Injectable Contraceptives

Twenty-six different key opinion leaders discussed reasons for including injectable contraceptives within the Indian National Family Planning Program. Respondents who supported this viewpoint included 13 key opinion leaders from international non-governmental organizations, 11 key opinion leaders from Indian non-governmental organizations, one key opinion leader currently working within the Indian government, and one key opinion leader who previously worked within the Indian Ministry of Health and Family Welfare.

III. B. 2. a. Injectable Contraceptives Should be a Woman's Choice

Respondents who supported the inclusion of injectable contraceptives in the Indian National Family Planning Program frequently discussed a lack of contraceptive options within the public sector and the need to increase options. C8, a key opinion leader from an international non-governmental organization, noted: "As far as the method mix is

concerned, India is so focused on sterilization that even now other methods that are supposed to be in the basket are not, in practice, offered to women.” C25, a key opinion leader from an international research firm, described the lack of injectable contraceptives options within the public sector:

I think the choice of contraceptive options available to women is limited. And that comes both from a normative belief that has been created over the last five decades of communication driven by the government: that family planning equals sterilization. There's also a lack of real choices as well. If someone wants to space, DMPA or any of the injectable contraceptives, whether its monthly, two monthly or three monthly, none of them are part of the basket. The Cyclophem and Net-En are not available in the country at all or not approved for marketing.

Respondents also described the need to increase contraceptive options through the public sector, and the role that injectable contraceptives could fill in expanding those options. C5, a key opinion leader from the Indian Council of Medical Research, discussed how injectable contraceptives should be available to all women:

As a scientist, I am for the injectable. It is a very good option. In my view, where the option should be available to everybody who would like to use them, and depending on the requirement, they should use the contraceptive. Therefore, we should always increase the options available...So whatever the way you would like to use, if you feel this is more acceptable to you, you use that. If you want to use injectable, if it's more acceptable, you use that.

While these respondents believed that injectable contraceptives should be provided through the public sector, they also described caveats to inclusion, including the need to provide adequate information and counseling, so that women would know about potential side effects of injectable contraceptives, and then be able to make informed decisions regarding use of the method. C10, a key opinion leader from an Indian non-governmental service delivery organization, described the following:

Interviewer: Do you think the method (injectable contraceptives) should be included in the government program?

Respondent: Of course. Included, but with the full information about what you will go through if you adopt this method. If you want to use injectables as a method of contraception, you will probably have extremely scant period by the time you get your third or fourth dose, but nothing is wrong with it. And whenever you decide to stop using injectables, your period will return, but it may take nearly up to a year...People ask questions which are justified, because at the end of the day, they do not want to suffer.

Respondents also described the potential of the healthcare infrastructure to provide counseling to address women's concerns about injectable contraceptives. C31, a key opinion leader from an international non-governmental organization, described how auxiliary nurse midwives could administer injectable contraceptives, since they already

administer other injections such as tetanus toxoid. However, this respondent also noted that auxiliary nurse midwives must be trained to provide counseling on injectable contraceptives:

At the primary health centers just like you are giving two TT (tetanus toxoid) injections for the pregnant woman, same way. I mean it's an injection being given. So that's another issue of task shifting; can an ANM (auxiliary nurse midwife) be trained to give an injectable (contraceptive) because she can give an injection? She's giving it. Immunizations are done by ANMS, but can she also do the counseling? You know so those are some of the things.

In addition to describing the inclusion of injectable contraceptives as a way by which to increase contraceptive options in the public sector program, these respondents also discussed whose decision it should be to use injectable contraceptives. Respondents frequently discussed how the decision to use injectable contraceptives should be made by the woman who is the end-user of contraception. C28, a key opinion leader from an Indian professional organization of providers, noted:

I think in an ideal situation, we've got to have all of the options on the table. Some of them we may agree with, some of them we may not, but at the end of it, it's the woman who is going to use it. So we have to give her the option, give her adequate information, and usually women make the right choice, and well, if they don't, it's still a choice.

Respondents also equated increasing contraceptive options with informed choice. C30, a key opinion leader from an international non-governmental organization, described the following:

You only have Depo, which is once in three months, and you have Net-En in India at least, which is once in two months, and Cyclofem was supposed to be the monthly one, its still got its regulatory issues around it. So the point is simple, that it's a choice. So it's like, you get five kinds of milk, you get five kinds of cheese, you get 10 kinds of something, so it's an informed choice. The woman needs to understand it, and if that works for her, then there's no reason why she shouldn't be given the choice to try it. That's how I look at it in terms of all contraception.

While many respondents framed the notion of contraceptive "choice" in rights-based discourses, some key opinion leaders also described the need to provide the method in order to recruit additional clients for contraception or to increase the contraceptive prevalence rate. C12, a key opinion leader who previously worked for an international development agency, noted: "My gut feeling is that if you introduce the injectables in the government of India program, your CPR would easily go up by 2-3% immediately."

III. B. 2. b. Available Contraceptive Methods Do Not Work for Some Women, Coupled with Specific Benefits of Injectable Contraceptives

Respondents discussed the inadequacy of the contraceptive methods currently provided through the public sector in meeting the needs of all women. Frequently, respondents discussed how a large subset of women do not want, or cannot take, a daily medication (such as oral contraceptive pills), an intra-uterine device insertion, or female sterilization. C8, a key opinion leader from an international non-governmental organization, described why women may not want to use intra-uterine devices or oral contraceptive pills:

A lot of women don't want an IUD. They want something long acting which is not stuck inside them. From that perspective, the injectable is a very attractive option. They don't want something they have to take every day. These things are very personal, it (injectable contraceptive) fits a niche for women, probably a smaller niche of women than let's say the IUD or the oral pill, but it certainly fits a kind of woman who wants that.

C25, a key opinion leader from an international research firm, described the advantages of injectable contraceptives over oral contraceptive pills:

To the extent that it (injectable contraceptive) can be provided with adequate quality of care, it is a great method. I think a number of women particularly like injectable contraceptives because it's not something that you need to remember to take everyday. Some other women I've heard stating that they like it because of its high efficacy rates. It comes with its disadvantages, like all the methods. You trade off between efficacy and side effects. And I think the tradeoff here is that the side effects can be a little bit more frightening to the uninformed, than with other methods.

C19, a key opinion leader from an Indian non-governmental advocacy organization, described the positive aspects of injectable contraceptives:

The injectable is long term and it is also cost effective. That means once you are taking one injection, it is at least for three months. For three months, a woman can be free from any tension of getting pregnant. And it also maintains privacy and confidentiality, because in India there are some religious groups, they don't allow to insert something in your body, or physical oppression of any organ. So for those communities, injectables are very beneficial.

Respondents often cited the ability of women to use injectable contraceptives without their families knowing as an explicit advantage of the method over other contraceptive methods. C26, a key opinion leader from an Indian professional organization of providers, described how injectable contraceptives offer privacy for women, and allow women to use the method without relying upon their male partner:

Interviewer: What are some of the main reasons that women give for why they want that method (injectable contraceptives) over others?

Respondent: The compatibility is more because you don't have to take a tablet everyday. And secondly, it certainly maintains privacy. They just go to the healthcare provider and can easily get an injection, so they are happy with that. And of course they don't rely on their male partner, because he might not like to use anything and repeatedly getting pregnant is a problem for her. So she goes to the private sector for privacy and takes it.

C3, a key opinion leader from an international non-governmental organization, described how women can adopt injectable contraceptives without a family's knowledge:

It's (injectable contraceptive) a choice... Often, for many women the ability to negotiate contraception is limited and in this case...they can decide they can access it independent of their partner, and also independent of the act of sex. So personally, I think it's great that women can adopt this even without the family knowing. It provides a great...it's empowering. And I think we should let them decide. If the drug controller of India has decided and approved injectables as a method for use in the country, then let women decide whether they like it or not, whether they use or not...We need to ensure that systems are in place to provide them the support they require.

This respondent describes the importance of women's autonomy in making reproductive decisions related to the use of contraception, and highlights the ability of a woman to use injectable contraceptives without her family's knowledge. Covert use of contraception has been documented in other settings, and this line of reasoning has been used to support the use of injectable contraceptives (Biddlecom & Fapohunda, 1998; Lande & Richey, 2006). However, as described in chapter 2, in the particular context in which this research occurred, women are not the sole decision-makers of their contraceptive methods.

III. B. 2. c. Adequate Data and Evidence

While respondents who did not believe injectable contraceptives should be provided in the Indian National Family Planning Program stated that there was a paucity of appropriate clinical trials and data related to injectable contraceptives, respondents who stated that injectable contraceptives should be included in the public sector program described the opposite. Respondents discussed the advances in data collection on injectable contraceptives during the past 20 years, evidence available from other countries and from the World Health Organization, and evaluations of injectable contraceptive programs that have been conducted within India. C12, a key opinion leader who previously worked at an international development agency, described a personal experience with evaluating an injectable contraceptive program in India:

I am totally for this method (injectable contraceptives) because we did an evaluation of a USAID program in India. I was on the evaluation team. And we met the providers, we met the users, everybody was so happy. Here is a method which has much less dose of the hormone as compared to oral pills, it's given once in three months, women don't have to tell anybody. Many women are quite happy with their amenorrhea; their haemoglobin status is very low so if they don't bleed every month, it is fine with them. There could be some bleeding here and there, but we need to counsel the women in that, no? So I don't see any reason for an opposition or resistance to injectables.

C23, a key opinion leader from an Indian non-governmental service provision organization, described the evidence from neighboring countries and the World Health Organization on Depo-Provera :

We have enough scientific evidence. We have know-how from Iran, from Nepal, we have from Indonesia which has very high DMPA use, from Sri Lanka, from Bangladesh all our neighbors. They have very good experience with DMPA and we have World Health Organization reports. We have all the studies.

III. B. 3. Importance of Larger Political, Social, and Cultural Contexts

Respondents from all stakeholder groups linked issues of contraception and fertility to larger policy, social, and cultural contexts at multiple levels of the Social Ecological Model. One respondent, C29, whose attitude toward injectable contraceptives had changed over the past two decades, described how any contraceptive technology must be viewed within the broader context of policy, culture, and economics:

Interviewer: You said 20 years ago, you were really against it (injectable contraceptives), but now you don't have very strong feelings on it. What made you move on that?

Respondent: Because I think there are more studies on it. For me, a contraceptive is just not a technical device. I think one has to locate it within any political, policy, socio-cultural, and economic context of people's lives. So at that point when I looked at it, it was very problematic to have injectables. Each and every piece of this context was mitigating against women's rights. But today, 20 years down the line, there's been a whole lot of work on it...and there are many studies to show that it's not as harmful as it was thought of before. People who were against it are now sort of toning down their reservations. So on the whole, I'm open to it.

Similarly, C13, a key opinion leader from an Indian women's organization described the larger structural context in which family planning promotion occurs, and how a focus on family planning promotion, as opposed to a focus on broader issues, obfuscates larger contextual issues:

Unless you tackle the structural issues, there is no health. I don't know if you have seen this poster...there is one outside that talks about a woman who has no roof over her head and there is somebody asking her and giving her a choice of contraception. So it's basically talking about the paradox of it, of structural issues and if you are talking about women's rights and their health, where do you locate it? You have to locate it in the larger context.

Respondents also described the powerlessness of women in making fertility and contraceptive decisions, and linked this to women's position in society, patriarchy, gender norms, and son preference. C18, a key opinion leader from an Indian non-governmental service delivery organization, described how women are not able to make their own sexual and contraceptive decisions:

Being a patriarchal society, even choosing their own methods is not given to women. It is taken care of by men. I'm talking about the larger portion of Indian women. Say about 70-80% of Indian women still do not have freedom to choose their own sexual objectives.

C29, a key opinion leader from an international non-governmental organization, who did not believe injectable contraceptives should be included in the public sector, described the differential treatment that women receive depending on if they have a girl or boy child, and how women must seek permission from their husbands and in-laws in order to use contraception, or even leave the home:

Imagine she has a child, again I think if it's a girl or a boy, it makes a difference. If it's a boy, then the kind of food she's given, the way the family celebrates and everything is very different from if she has a girl. Now she has a boy...what if she wants spacing? I don't think that she would have the right to say, "you know, now I'm tired, I think I need to have three years", because that's the government propaganda also. Three years spacing is good for the mother and child.. it's mother and child; it's not a woman's right. So she doesn't have the rights...and let us say that she has the right. If she has a husband or she has understanding in-laws and husband is open to postponing. Does she have the right to decide the contraception? She has to ask permission even for going to the clinic. She has to not only ask permission, he (husband) will decide what kind of contraceptive she should be using.

Frequently, key opinion leaders discussed increased education and literacy rates, and increased participation by women in the workforce as determinants of couples wanting fewer children, of contraceptive use, and as a way to improve the status of women within the country. C28, a key opinion leader from an Indian professional organization of providers, described women's education and the use of contraception:

There is no doubt that at the village level, the multipurpose health workers are involved to some extent with promoting contraceptives. Even at that level (the village) we are seeing the use of some spacing methods. I think a lot of it has to do with more women getting educated and coming into the workforce.

III. B. 4. Need for Open Dialogue

Key opinion leaders from all stakeholder groups also described how there hasn't been room for open debate on the issue of injectable contraceptives, and how open dialogue on the method is now needed. C22, a key opinion leader from an Indian woman's organization, described how there is little transparency in injectable contraceptive data, and how information needs to be shared to inform a public debate:

There is no transparency and no accountability built into the system. And in this day and age, when all the means are available, those should be in place. Then at least we would be in for a more informed debate. At the moment, there's apprehension on all sides, there's lack of trust because there's no sharing of information. So if there are health data results, if there is a database, share it. Share it with us on a healthy ground of sharing and conducting a debate. Maybe we'll change if you have good data to convince us. We'd be happy to be convinced if you've told us that this (injectable contraceptives) is working well.

Similarly, C31, a key opinion leader from an international non-governmental organization, described the need to bring all stakeholders interested in injectable contraceptives together:

We want to bring all these stakeholders together, including the women's groups, parliamentarians, government...we want to like, you know, have one to one dialogue with them and bring all these advocacy efforts together.

C28, a key opinion leader from an Indian service delivery organization, described how an open discussion about injectable contraceptives has never taken place amongst the different stakeholders:

Whenever we have tried to discuss, we say, "ok, let's discuss. This is your view, this is our view. Let's thrash it out technically." But they never come for a meeting. They just oppose, oppose, oppose, say its not good, women are being used as guinea pigs. You know they keep on saying so many things, but when it comes to discussion then you come discuss technically, you discuss that this method has these negatives, this could happen to the woman. Show us the data. We are willing to take it because after all, we are not here to advocate any method. We don't manufacture these products. So I think that discussion has never taken place.

IV. DISCUSSION

This study sought to explore the attitudes of key opinion leaders toward injectable contraceptives within India. Taken together, the results of the media content analysis and in-depth interviews with key opinion leaders highlight important clusters of issues among those who expressed a position of either opposition or support to the inclusion of injectable contraceptives within the Indian Government's National Family Planning Program. Issues identified in the content analysis were explored in greater depth in the interviews, and allowed for a contextualized understanding of the issue of injectable contraceptives within broader social, cultural, and political contexts. This contextualized understanding accorded well with the theoretical framework that was used to guide this research.

The discussion section of this chapter begins by describing areas in which stakeholder groups held like-minded views of basic facts related to the Indian public health system and injectable contraceptives, yet arrived at different conclusions in regards to the inclusion of injectable contraceptives in that system. The discussion then examines areas of discordance within stakeholder groups and areas of concordance among stakeholder groups. Finally, this section concludes with a discussion of the results in relation to the theoretical framework, and strengths and limitations of the study.

IV. A. Agreement on Facts, Disagreement on Conclusions

Though it may appear that there are two diametrically opposed parties involved in injectable contraceptive policy, there was considerable overlap, and even agreement, in the issues and problems discussed by the different stakeholder groups. For example, key opinion leaders fundamentally agreed that the public health infrastructure must be improved to provide better quality of care for contraceptive services, particularly in relation to counseling. Respondents also described the real and valid concerns over side effects that women may experience while using injectable contraceptives, and the need to provide counseling so that women know what side effects they might experience. Despite agreement on these basic facts, stakeholder groups arrived at very different conclusions regarding the inclusion of injectable contraceptives in the public sector.

Among those key opinion leaders who believed injectable contraceptives should not be included in the public sector, poor health care infrastructure related to the roll-out of contraceptive methods and lack of counseling were described as reasons to exclude the method from the program. In contrast, key opinion leaders who believed that injectable contraceptives should be included in the public sector similarly described problems within the public health sector, yet viewed these as barriers to injectable provision that could be overcome. These respondents argued that counseling and quality of care issues should not be specific to injectable contraceptives, but should be applied to all contraceptive methods. These key opinion leaders also discussed ways to deliver injectable contraceptives through the public sector, including through the use of auxiliary nurse midwives who could be trained to provide injectable contraceptives and

counseling on the method, particularly since they already administer other injections. Indeed, community-based models of injectable contraceptive distribution have been developed in other countries (Prata, Gessesew, Cartwright, & Fraser, 2011).

There was also agreement across stakeholder groups that current contraceptive options provided through the public sector are limited. Key opinion leaders frequently described the importance of viewing contraceptive options, and particularly injectable contraceptives, from the viewpoint of the end-user of the method. However, the voice of end-users of injectable contraceptives was completely excluded from media coverage of this issue in the content analysis. In addition, key opinion leaders differed in terms of what they described as the best scenario of contraceptive options for women. The need to increase contraceptive options with the inclusion of injectable contraceptives was a reason cited by those who supported including the method in the government program. More contraceptive options were often equated with making an informed choice. Indeed, the respondents who supported the inclusion of injectable contraceptives in the public sector appeared to share a common belief that adding more contraceptive options would result in greater informed choice by the woman who is the end-user of the method. However, while the government program has several contraceptive options, female sterilization continues to be the predominant method used (International Institute for Population Sciences and Macro International, 2007). Adding additional contraceptive methods to the public sector has not resulted in more autonomous or informed contraceptive decisions for women throughout much of India's history. To the contrary, coercive practices of family planning in India have been described (Gwatkin, 1979). In addition, as seen in chapter 2, women possess little power to make their own contraceptive decisions. Thus, simply adding additional contraceptive options to a policy may not, in practice, result in more contraceptive choices for women.

Those respondents who supported the inclusion of injectable contraceptives in the public sector program also described the notion of choice as a good in and of itself, describing how contraceptive decisions should be left to the woman is the end-user of contraception. These respondents argued that even if a woman makes a poor decision, it is at least her decision to make. This concept invokes notions of woman's autonomy in reproductive health and freedom from constraint, particularly in relation to contraceptives, by those who may not agree with injectable contraceptives as an option.

By contrast, among those who were opposed to the inclusion of injectable contraceptives in the public sector program, two themes that continuously emerged included the historical context of coercive practices against women, and a lack of information upon which women might make informed contraceptive decisions. These respondents argued that adding injectable contraceptives to the public sector would not result in any additional choice, since women do not possess appropriate understanding about possible side effects, and do not have access to information necessary to make informed decisions. These respondents also highlighted the importance of choice in context - that is, women experience the ability to make choices about their contraception very differently, depending on the circumstances in which they receive such services. When the health system is one in which the ability to appropriately

counsel women about contraceptive methods is limited, and when women do not have adequate information about potential side effects or risks of their method, women are not able to make informed decision about the potential use of injectable contraceptives. Similarly, these respondents described issues of equity and justice, which point to the notion that the same contraceptive method in two different contexts, namely when used among wealthy women as opposed to poorer women, may not truly be the same. Instead, injectable contraceptives may have different meanings in different settings, and could also be used differently, depending on the population and context of service provision. Where women lack information, and possess little decision-making power, they may be more subject to coercive or manipulative forces from family members or healthcare providers, as opposed to better-educated, wealthier women who use private sector services for reproductive health needs.

The in-depth interviews also demonstrate that the implications of adding injectable contraceptives to government programs may be very different within the various regions of India, given the diversity of social and cultural norms in the country. In areas where women have little reproductive autonomy, adding an additional contraceptive method to the National Family Planning Program may not result in improved options for women in their communities, particularly if they are constrained at multiple levels of the Social Ecological Model. Relatedly, the argument by respondents who were supportive of injectable contraceptives that injectables can be used without a family's permission, and hence, may promote women's autonomy, may not be germane to all contexts and communities within India.

IV. B. Areas of Discordance within Stakeholder Groups

There were areas in which ideas within stakeholder groups did not appear to align. Key opinion leaders who supported the inclusion of injectable contraceptives within the government program often discussed the method within a human rights and women's rights discourse. However, these same stakeholders sometimes slipped into a discourse of population numbers, the need to stabilize the population, and the provision of contraceptive methods for the purpose of increasing contraceptive prevalence rates. This type of language confirms some of the fears of those key opinion leaders who are opposed to the inclusion of injectable contraceptives, in that a motivation to provide injectable contraceptives may not actually be in promoting individual choice and rights, but in increasing contraceptive prevalence rate and lowering fertility rates.

Among those key opinion leaders who were opposed to injectable contraceptives, it was noted that the method is unsafe for use within the public sector. These stakeholders described a lack of quality of care as an important reason for excluding injectable contraceptives from the public sector, yet did not view quality of care issues as reasons to exclude other, more invasive contraceptive methods, such as intra-uterine devices. It is important to note that one difference between injectable contraceptives and intra-uterine devices is that the latter can be physically removed from the body if side effects occur. In addition, these respondents also stated that they believed injectable contraceptives were unsafe, and thus should not be available in the public system, yet

also discussed the availability of the method via the private sector. This seems to indicate that respondents believe that the private sector is more equipped to handle provision of this method. Indeed, women who receive injectable contraceptives through the private sector system may receive higher quality counseling about potential side effects, and thus, may be in better positions to make informed decisions about the use of the method. However, this still does not account for the issue of safety or the lack of clinical trials data related to injectable contraceptives, also described as reasons for opposition to the method by these same respondents.

Respondents who were supportive of providing injectable contraceptives through the public sector also discussed the availability of the method via the private, and not public sector, yet framed that as a reproductive health inequity. C8, a key opinion leader from an international organization, noted, “*Why is it that only rich women are allowed to have it?*” Key opinion leaders who were supportive of including the method in the government program described the contradictory nature of providing injectable contraceptives through the private sector, while making claims that the method is not safe to provide through the public sector.

IV. C. Areas of Agreement

While there were areas of discordance among and within stakeholder groups, there were also areas of concordance among stakeholder groups. Respondents from all stakeholder groups described the need for open dialogue on injectable contraceptives. The quotes presented in the results section, regarding the need for open dialogue demonstrate the importance of open debate and transparency, two separate, though inter-linked concepts. That key opinion leaders described a need for open dialogue may indicate a shift in viewpoints on injectable contraceptives, or at least a shift to re-engage with other individuals who hold differing views. While some of the stakeholder groups included in this research have historically held oppositional views in relation to injectable contraceptives, there has been little open dialogue on the subject amongst stakeholder groups, particularly since the Supreme Court case ruling that stated that injectable contraceptives could not be provided through the public sector. Thus, there is an opportunity for stakeholder groups to begin an open discussion on the issue of injectable contraceptives. Key opinion leaders also described the need for transparency of data. Indeed, transparency and information sharing are likely prerequisites to building trust, and engaging in open and informed dialogue.

In addition, stakeholder groups fundamentally agreed about issues related to provider bias, the dismissal by providers of side effects that women experience as myths or misconceptions, and the need to improve the public health infrastructure. There was also agreement in regards to the lack of contraceptive options for women that currently exist through the public sector program. These are areas in which stakeholder groups might engage one another in active and open debate to inform and shape contraceptive and population policies.

IV. D. Results and Theory

Key opinion leaders enforced the use of the Social Ecological Model and Political Economy Theory by linking contraceptive use, issues of fertility, and their opinions toward injectable contraceptives, to larger political, economic, and social issues. At the inter-personal, or social network level, of the Social Ecological Model, respondents described family influences upon women's decisions to use contraception, including the need for women to seek permission to use contraception, or even to leave the home to go to a clinic. Moving outwards in the Social Ecological Model to community and cultural values, respondents linked familial level influences to the powerlessness of women in Indian society, patriarchy, gender norms, and son preference. Respondents described how these contexts combined to obstruct women's freedom and reproductive rights.

Respondents also described the organizational context of the Indian National Family Planning Program. Those respondents who were opposed to the introduction of injectable contraceptives in the National Family Planning Program described a lack of quality of care and counseling, and the potential for coercive practices against women if injectable contraceptives were to be introduced. Those respondents who were supportive to the inclusion of injectable contraceptives in the public sector also described the need to improve the public health infrastructure, particularly in relation to counseling services for women.

In relation to policy level influences within the Social Ecological Model, respondents most frequently described past policies of the Indian government in relation to population control. Key opinion leaders drew upon their experiences and their knowledge of the history of family planning promotion and programs in India to inform their current opinions of, and attitudes toward, injectable contraceptives. This accords well with the integration of Political Economy Theory with Social Ecological Theory, as described in the background section of this chapter.

Lastly, key opinion leaders discussed the need for interventions beyond the realm of those aimed at fertility. This has important implications for future programs. It is clear that there is a great need for contraception, yet respondents reiterated that contraception, alone, is not enough. Programs must promote women's educational attainment and participation in the workforce, as potential pathways by which women might gain autonomy to make informed reproductive and contraceptive decisions.

V. STRENGTHS AND LIMITATIONS

There are limitations to this research. First, the media content analysis was only conducted among English-language newspapers. Newspapers written in Hindi or any of the other official languages of India were not included. Given that the issue of injectable contraceptives has been covered at the national level, as a potential national policy, the use of English-language newspapers seemed appropriate. In addition, only print news media coverage was included in this analysis. Other sources of media, for

example, blogs and television, were not included. Because newspapers typically set the agenda for other sources of media, this was appropriate.

Second, there is an entire body of literature on interviews as social interactions, and how those social interactions may create structured effects on the type of data that is produced in those interviews. It is important to acknowledge that the study author is not native to India, and thus, in-depth interview participants may have structured their responses as a reaction to the interviewer. It is impossible to know to what extent participants provided descriptions of what they believed the interviewer wanted to hear. For example, many participants described women's individual rights related to contraception and fertility. It is possible that those descriptions were structured to respond to an interviewer who comes from a Western society, in which individual rights and personal autonomy are highly valued. Similarly, the study author may interpret data based upon her own lived experiences, or may attribute meanings to given phenomenon differently than other individuals who analyze the same data.

VI. CONCLUSIONS

This research sought to fill a critical gap in the literature pertaining to key opinion leaders' attitudes toward injectable contraceptives. Understanding these attitudes is fundamental to the development of population and reproductive health policies that determine the types of contraceptive methods that economically marginalized women may access. Perhaps most interestingly, respondents agreed that there is a need for open dialogue on the issue of injectable contraceptives. This research could serve as a platform upon which key opinion leaders might begin to engage with one another on this topic, to shape population and contraception policies.

CHAPTER 4: REPRODUCTION AND CONTRACEPTION AMONG NORTH INDIAN WOMEN IN UTTAR PRADESH: MOVING TOWARDS A FRAMEWORK OF REACTIVE AUTONOMY

Abstract

Human rights to reproductive decision-making, and the means by which to assert those rights, have long been articulated for men and women. Barriers that specifically impact women's voluntary control in reproduction were recognized at the International Conference on Population and Development Conference (ICPD) of 1994, and renewed attention was devoted to empowering women. In India, population policies shifted subsequent to the ICPD to reflect one of the two critical conditions to fulfilling autonomy: understanding. Despite new policy language, many Indian women continue to lack the information necessary to make informed decisions about contraception. More importantly, India's policies did not shift to address the other critical condition to fulfilling autonomy: voluntariness. Qualitative research from Uttar Pradesh demonstrates that women continue to lack the autonomy to make decisions about reproduction and contraceptive use. Moreover, women often view childbearing in terms of fate or religious beliefs. As such, Western notions of autonomy, frequently grounded in models of rationality and intentionality, may not be appropriate in this setting. What may be more relevant is that women possess reactive autonomy, a new framework for autonomy proposed in this chapter. Reactive autonomy includes the ability of women to respond to ongoing demands placed upon them by multiple different actors, and the capacity to overcome social or cultural barriers that they face on a daily basis. This is something that must be strived for, both in Indian population policies and in the very real world in which women experience a wide range of constraints upon their autonomy.

I. INTRODUCTION

Rights of reproduction were first articulated at the International Human Rights Conference, held in Teheran in 1968. Since that time, the rights to reproductive decision-making have been affirmed, and expanded to include not only the right itself, but also the rights to information, education, and the means to assert those rights. Moreover, because a right necessarily implies a duty, these rights obligate governments to fulfill such rights. The 1979 Convention on the Elimination of the Discrimination Against Women (CEDAW), stated that, “State parties shall take appropriate measures to...ensure on a basis of equality of men and women...the same rights to decide freely and responsibly on the number and spacing of their children, and to have access to the information, education and means to enable them to exercise these rights.” (United Nations, 1979).

Despite the articulation of these rights, there have been instances of policy and program formulation and implementation within overarching frameworks of population growth and economic development. In this paper, I will argue that while India’s population policies shifted dramatically to promote the rights described above, particularly for women in relation to family planning programs, those policies do not adequately address understanding or voluntariness, two conditions critical to the promotion of women’s autonomy, particularly for economically marginalized women living in rural Uttar Pradesh, India. The data in this article is based on four months of field work that I conducted in India in 2012 and 2013, including observation and informal interviews with healthcare providers in Meerut and Bijnor, two districts in Uttar Pradesh, in-depth interviews with women in those villages, and in-depth interviews with key opinion leaders of contraceptive policy in New Delhi. The methodology for development of research tools, sampling, recruitment, conduct of interviews, and analysis is described in chapters 2 and 3 of this dissertation, and hence, is not repeated here.

In the first section of this paper, I will describe the historical context of India’s National Family Planning Program, and the recognition by the Indian Government and international bodies for the need to empower women in their reproductive lives. In the second section of this paper, I will explain changes made to Indian population policies to prioritize women’s autonomy. Next, I will depict India’s current policies within an autonomy framework. Here, I will focus on the two conditions of autonomy, including understanding and voluntariness. I will use qualitative data to demonstrate how Indian women living in rural Uttar Pradesh lack the necessary information for understanding related to contraceptive method decisions. I will also illustrate how women face multiple constraints on voluntariness, both related to reproduction and contraception. Finally, I will examine western notions of autonomy within the Northern Indian context, and will explicate an alternative view of women’s autonomy in this setting, which I call reactive autonomy.

II. HISTORICAL CONTEXT OF FAMILY PLANNING IN INDIA

II. A. India's Population Schemes

After gaining independence from British rule in 1947, India developed the first national family planning program. As originally envisioned in 1951²⁴, the program was defined by a series of goals designed to limit the population's growth rate to ensure sufficient resources for its population and to improve the health of the nation. This was accomplished through the introduction, in the mid-1960's, of method-specific targets set by the central government which were pursued at the local level (Visaria, Jejeebhoy, & Merrick, 1999).

In 1975, concerns over population escalated when Prime Minister Indira Gandhi declared a "State of Emergency"²⁵, citing threats to national security, and challenges caused by recent flooding and famines, as reasons for her authority to rule by decree. During this time, all elections were suspended, and many civil liberties were severely curbed (Kohli & Basu, 2013). Population policy was one of the areas most affected, with the implementation of a variety of schemes that provided either incentives or disincentives for adopting a small family norm, or for adopting a terminal method of contraception. For example, Uttar Pradesh gave an order to teachers to be sterilized or forfeit one-month's salary. In Bihar, public food rations were denied to families with three children or more (Chadney, 1988).

Population-related schemes also affected local health care workers, who were compelled to meet targets for sterilization goals and received financial incentives for meeting such goals. When goals were not met, health care workers faced reductions in salary, severe reprimands from supervisors, and job transfers to less desirable regions (Visaria L et al., 1999). In Uttar Pradesh, family planning and health department workers were not paid until they produced the required number of sterilization acceptors (Chadney, 1988). As such, local health care workers were faced with the difficult decision of either losing their source of livelihood or pressuring individuals into accepting sterilization. As a result, nearly 8.5 million men and women underwent sterilization during 1976-1977²⁶, often in sterilization camps, with limited information about the procedure, possible complications, or follow-up care (Gwatkin, 1979). Moreover, those individuals from marginalized groups were targeted most frequently (Connelly, 2006).

Indira Gandhi was removed from office in 1977, when the Janata Party won elections and assumed control. Interestingly, although the new government offered compensation to those who had been forcibly sterilized, relatively few claimed that

²⁴ During the early years of the Indian Family Planning Program, the rhythm method was the only birth control method recommended by the Indian Government. In 1956, the government began to offer condoms, diaphragms, and spermicidal jellies, free of charge. Intra-uterine devices were introduced in the 1960s, along with an information and education component to increase couples' knowledge, and change contraceptive behaviors (Indian Planning Commission, 1951; Gwatkin, 1979).

²⁵ In India, the "Emergency" refers to a 21-month period from 25 June 1975 until 21 March 1977, when Prime Minister Indira Gandhi declared a state of emergency throughout the country.

²⁶ The Indian National Family Planning Program delivered approximately 8.3 million sterilizations to men and women during 1976-1977, up from 2.3 million sterilizations in previous year (Gwatkin, 1979).

compensation. While there were many unacceptable, coercive sterilizations, part of the public backlash against Gandhi may have also been the result of a more involved bureaucracy (Soonawala, 1993). Shortly after the Emergency Period, the Department of Family Planning changed its name to the Department of Family Welfare, to highlight a shift away from Gandhi's policies, and a shift from compulsion to voluntarism in family planning (Chadney, 1988). Gandhi was re-elected in 1980, but pressures to drastically change the family planning program had mounted. According to Rao (2006: 248):

Partly as a result of pressures generated by women's groups and health groups calling for a radical reconsideration of the program's goals and objectives, and partly in preparation for the third decennial International Conference on Population and Development (ICPD) at Cairo in 1994, the Government of India initiated a search for a new direction to population policy.

However, from the 1980's through the present day, there continued to be documented cases of aggressive promotion of terminal contraceptive methods, monetary incentives for adopting terminal or long-term methods, such as intra-uterine devices, incentives for adopting a small family norm, and poor quality of sterilization camps. As an example, in 1994, the state of Haryana introduced a measure prohibiting individuals with more than two children from serving as Sarpanch or Panch, the elected leaders of the Gram Panchayat, or village government.²⁷ The Court upheld this measure under sections 175(1)(q) and 177(1) of the Haryana Panchayati Raj Act of 1994, citing the importance of village leaders serving as examples to the community in promoting the two-child norm. One of the stated objectives in passing this law was to promote the Welfare Family Planning Program, and the adoption of family planning to limit family size to the two-child norm (Human Rights Law Network, 2013:85).

As another example, in 2003, petitioners brought a case to the Supreme Court, demanding that governments take immediate steps to regulate providers of sterilization procedures. The petitioners argued that government health workers had failed to respect the basic dignity of their patients, had failed to counsel women prior to the surgery, and had not discussed alternative forms of contraception. In addition, the petitioners described the use of monetary incentives for women who adopted sterilization. As a result, the Supreme Court, in Ramakant Rai v. Union of India, ordered that State governments take immediate steps to regulate providers of sterilization procedures, and to compensate women and families of women who suffer complications or death as a result of unsafe sterilization surgeries²⁸ (Human Rights Law Network, 2013:221). Despite the Supreme Court's orders in the Ramakant Rai ruling, there continue to be documentations of forced and unsanitary sterilization camps. In January 2012, a sterilization camp was held at a government middle school in the state of Bihar. One doctor, along with non-governmental organization volunteers, sterilized 53 women in two hours. Women were sterilized without consent, and without basic medical standards²⁹ (Human Rights Law Network, 2013:225).

²⁷ For the full court case, see: Javed & Ors v. State of Haryana, Supreme Court AIR 2003 SC 3057.

²⁸ For the full court case, see: Ramakant Rai v. Union of India, Supreme Court W.P. (C) 209/2003.

²⁹ For the full court case, see: Devika Biswas v. Union of India & Ors, Supreme Court W.P. (C) 95/2012.

II. B. Recognition Of Barriers To Women's Voluntary Control, And A Need For Rights To Empower Women

India's population and family planning policies were contested at an international level in 1994, at the International Conference on Population and Development (ICPD), held in Cairo, Egypt. The ICPD ushered in a new level of attention to women's reproductive health and rights. While previously, parts of the discourse had focused on counting numbers of people for the purposes of population control and development, the language at ICPD shifted to focus on individual needs and the empowerment of women (Shalev, 1998). It is worth noting that language that focused on the freedom of women in relation to reproduction and contraception existed much earlier than that described at ICPD (Potts, 1971).

The Programme of Action, agreed to at the ICPD, described the empowerment and autonomy of women as important ends unto themselves.³⁰ In article 4.1, the Programme of Action acknowledged that women face specific constraints, different than those faced by men, in attaining autonomy over their reproductive lives, and in other spheres of their lives: *"In all parts of the world, women are facing threats to their lives, health and well being as a result of being overburdened with work and of their lack of power and influence"* (United Nations Population Division, 1994: Article 4.1).

The Programme of Action sought to specifically address the barriers to woman's voluntary control and decision-making capacity, particularly in relation to reproduction:

Achieving change requires policy and programme actions that will improve women's access to secure livelihoods and economic resources, alleviate their extreme responsibilities with regard to housework, remove legal impediments to their participation in public life, and raise social awareness through effective programmes of education and mass communication. In addition, improving the status of women also enhances their decision-making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction (United Nations Population Division, 1994: Article 4.1).

The Programme of Action stated several actions that countries should take to empower women, including the establishment of mechanisms for women's equal participation in political processes, providing education to women, eliminating violence against women, and adopting measures to insure that women can achieve economic self-reliance (United Nations Population Division, 1994: Article 4.4). A total of 179 governments signed the ICPD Programme of Action. In addition to its' descriptions of the importance of women's empowerment, the Programme of Action specifically addressed reproductive health and reproductive rights. In defining reproductive health, the Programme of Action took the World Health Organization definition of health as a state of complete physical, mental, and social wellbeing (and not merely the absence of disease) and extended this specifically to all matters related to the reproductive system.

³⁰ It should also be noted that Article 4.1 also specifically noted that the empowerment and autonomy of women is "essential for the achievement of sustainable development" (ICPD Programme of Action, Article 4.1, 1995).

Moreover, the document articulated that, “*Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so*” (United Nations Population Division, 1994: Article 7.2). Drawing upon the field of human rights, the Programme of Action further articulated the right of all couples and individuals to exercise decisional autonomy³¹ and self-determination³² in their reproductive lives:

Reproductive rights...rest on the recognition of the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (United Nations Population Division, 1994: Article 7.3).

III. CHANGES IN INDIAN POPULATION POLICY FOLLOWING THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT

In 1995, following the ICPD, the World Bank published a report, entitled “India’s Family Welfare Program: toward a reproductive and child health approach.” The objective was to identify, in collaboration with the Indian Ministry of Health and Family Welfare, actions that could be taken to reposition the Indian Family Welfare Program toward a reproductive health approach. The report described issues surrounding the use of contraceptive targets and incentives, and the contraceptive method mix. Specifically, the report highlighted the need to move away from a demographically driven target and incentive system of family planning to a voluntary, target-free approach in which client needs are emphasized (Rao, 2006; World Bank, 1995). The report further stated that the earlier approach by the Indian Family Welfare Program was adversative to the goals of women’s empowerment articulated at the ICPD:

The current contraceptive target and incentive system gives a demographic planning emphasis to the FWP, which is antithetical to the reproductive and child health, client-centered approach advocated in the India country report for the Cairo Conference (World Bank, 1995:iii).

In addition, the report stressed the need for “*broadening the choice of contraceptives,*” particularly in relation to contraceptive methods to space births (as opposed to permanent methods to limit births). The report specifically described the potential of oral contraceptive pills and injectable contraceptives in meeting the family planning needs of those individuals and couples for whom sterilization is inappropriate or unwanted.

³¹ In this chapter, I refer to decisional autonomy as the ability to make decisions, sometimes described by other authors as decision-making capacity. I refer to executional autonomy as the ability to carry out autonomous decisions.

³² In this chapter, I refer to self-determination as the ability to determine, throughout the life course, one’s own destiny.

In 1996, India shifted its National Population Policy (NPP) to incorporate some of those goals articulated at the ICPD and from the World Bank report.³³ This included increasing funding to the country's National Family Welfare Program, and a focus on improving women's reproductive health within a broader human rights framework. Shortly thereafter, the government launched the Reproductive and Child Health (RCH) program. The RCH program stated that all centrally determined demographic target goals, as established under the original National Family Planning Program, would be eliminated. Instead, individual community service needs would determine program priorities (World Bank, 1997).

The official policy of the Indian government is that all women and couples can choose a contraceptive from the full range of methods available and that they are provided with complete information about those methods. Indeed, India's current National Population Policy states one of its goals as, "*achieve universal access to information and counseling, and services for fertility regulation and contraception within a basket of choices.*" The same policy also highlights the importance of expanding the menu of choices for voluntary contraceptive services, by stating the following: "*a wider, affordable choice of contraceptives will be made accessible at diverse delivery points, with counseling services to enable acceptors to exercise voluntary and informed consent*" (Indian Ministry of Health and Family Welfare, 2000). Such language within India's National Population Policy supports the notion that the Indian Government had prioritized providing information and access (or the means, in terms of contraceptive services) to women and couples.

IV. INDIA'S POLICIES WITHIN AN AUTONOMY FRAMEWORK

IV. A. Autonomy and Understanding

Within an ethics framework, the transformation of Indian population policies indicates that a renewed attention was given to promoting women's autonomy. As Beauchamp and Childress discuss, personal autonomy, in this case applied to the Indian woman, occurs when a person rules herself, free from personal limitations that prevent meaningful choice (Beauchamp & Childress, 1989). Clearly, the Indian Government had set out to free women from such personal limitations, by providing adequate information and counseling so that women could make autonomous decisions about contraceptive use.

As Beauchamp and Childress note, there is no consensus in how to analyze the concept of understanding. Thus, a useful framework for such analysis is that, "*one understands if one has justified beliefs about the nature and consequences of one's actions. This understanding need not be full or complete, because a substantial grasp of central facts and other descriptions will often be sufficient*" (Beauchamp & Childress, 1989:100). I contend that the women who were interviewed for the research described

³³ Goals from the ICPD that were incorporated into India's National Population Plan included making sex-selective abortion illegal, eliminating method-specific targets for family planning services, and reserving one third of Parliament and state legislature seats for women (UNFPA, 1995).

in chapter 2 of this dissertation, did have sufficient understanding of their situations and experiences with pregnancy to make autonomous decisions about the actual use of contraception to control their reproduction. That is, women knew that they wanted to stop or postpone childbearing, and gave a variety of reasons for this - ranging from the health needs of the mother and children, to financial concerns, and concerns over the ability to continue required work within the home.

In contrast, and as the qualitative research presented in chapter 2 demonstrates, women do not, in practice, have universal access to information and counseling to make informed contraceptive method-specific decisions (that is, to choose which contraceptive method to use). For example, women described how they were often informed of only one, or limited, contraceptive methods. In addition, women described their receipt of only limited counseling, or no counseling with regards to their current contraceptive method. For example, SHR13, a 23-year-old injectable user, when asked what the provider had told her during counseling, responded: *“No, he (provider) didn’t say anything. After getting the injection, I just came out. My husband might know.”*

That women lacked adequate understanding to make contraceptive method-specific decisions is further supported by the fact that women infrequently knew of possible side effects of contraceptive methods before they experienced the side effect(s) personally. This became clear as women discussed prior use of oral contraceptive pills. Many of the women described experiencing some degree of side effects, such as dizziness, bloating, and nausea, which had led to their discontinuation of the method. SHR4, a 31-year-old injectable user who had previously used oral contraceptive pills, discussed her discontinuation of the method after experiencing side effects: *“One time I had consumed Mala-D (oral contraceptive pill). Then there were outbreaks, marks over my body. My face had swollen for two to three days. Then I stopped. That is why I don’t take pills. If someone gives me a hot medicine, then it happens.”*

In addition, many of the women who reported side effects with their current contraceptive method discussed how they intended to continue their current method, so long as their side effects resolved. If side effects did not resolve, some women discussed discontinuing their current method, and also asked the interviewers if there were any other methods that they could use that wouldn’t have side effects. As articulated by SAN8, a 36-year-old injectable contraceptive user:

After use of DIMPA (injectable contraceptive), my menses comes and does not stop consecutively for 15 days. It would be a little helpful if you could tell me or suggest me some medicine.

However, it should also be noted that women discussed continuing their current method, despite problematic side effects, for the sake of preventing pregnancy. This indicates that women weighed the consequences of two different actions - discontinuing their contraceptive method, and thus their suffering of side effects, versus the possibility of getting pregnant, and the consequences of each in regards to their larger goal of pregnancy prevention. Yet I still argue that if women do not have a grasp of central

facts relevant to their contraceptive method, such as possible effects, they could not have made an autonomous decision to actually use that method.

IV. B. Autonomy and Voluntariness

In addition to the importance of understanding in autonomy, persons must also be free from controlling influences by others. In other words, they must be able to exercise voluntariness in their actions. Beauchamp and Childress describe voluntariness as *“the condition of a person’s being independent of manipulative and coercive influences exerted by others in order to control the person”* (Beauchamp and Childress, 1989:106).

Constraints on women’s voluntariness were not addressed with the revised Indian Ministry of Health and Family Welfare policies. Indeed, the policies may actually contradict the conditions of voluntariness for autonomy. The National Population Policy contains a section entitled, *“Promotional and Motivational Measures for Adoption of the Small Family Norm.”* This section describes the provision of incentives and disincentives that still exist for adopting a small family norm of two children or less. For example, the National Population Policy describes several points related to the provision of incentives and rewards for Indian couples living below the poverty line (BPL) that adopt a terminal method of contraception:

Couples below the poverty line, who undergo sterilisation with not more than two living children, would become eligible (along with children) for health insurance (for hospitalisation) not exceeding Rs. 5000, and a personal accident insurance cover for the spouse undergoing sterilization

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, will be rewarded (Indian Ministry of Health and Family Welfare, 2000).

Other schemes also exist that provide either incentives, or disincentives, for couples who adopt the small family norm (two children or less). For example, the National Population Policy states that, *“Panchayats and Zila Parishads will be rewarded and honoured for exemplary performance in universalising the small family norm”*. In addition:

The 42nd Constitutional Amendment has frozen the number of representatives in the Lok Sabha (on the basis of population) at 1971 Census levels. The freeze is currently valid until 2001, and has served as an incentive for State Governments to fearlessly pursue the agenda for population stabilisation. This freeze needs to be extended until 2026 (Indian Ministry of Health and Family Welfare, 2000).

That the policies of the Indian Government did not shift to reflect voluntariness may not be surprising, given the powerful role the World Bank and United Nations played at the ICPD, and their influence in persuading governments to adopt certain measures. As

Rao points out, even in the 1995 report from the World Bank, demographic goals, and the use of incentives and disincentives, continued to be advocated. The Family Welfare Programme could, *“offer panchayats³⁴ financial incentives to take reproductive and child health initiatives and to build ownership of and responsibility for the program”* (World Bank, 1995:23). Moreover, the use of targets continued to be promoted by the World Bank in the mid-1990s: *“It has increasingly been recognized that we should get rid of “tyranny of targets” altogether. Targets based on micro-level planning suiting the local specific needs may, however, continue to be fixed for monitoring of the program”* (World Bank, 1995:42).

In practice, it is clear that women’s voluntariness continues to be severely constrained. Prior research demonstrates that there are several social and cultural reasons, in addition to gender and power structures, which limit women’s voluntariness, both in reproduction and contraceptive decision-making. First, power structures within the family are important considerations in India, especially given the relative lack of women’s decision-making autonomy within the household (Jejeebhoy, 1998). In part, this may be attributed to the young age of marriage for many Indian women. In Uttar Pradesh, the average age at marriage for females is 17.5 compared to 20.1 for their male counterparts (UNICEF, 2012). Prior research demonstrates a correlative relationship between young age at marriage and lack of autonomy in reproductive and household decisions. For example, Santhya, et al found that Indian women who married after the age of 18 had a 1.4 increased odds of using contraception to delay the first pregnancy, compared to women married before the age of 18 (Santha, Ram, Acharya, et al, 2010). Second, there are external actors who may play a powerful role in fertility decision-making. Both husbands and mothers-in-law have been identified by prior research as key decision-makers in fertility decision-making in India (Char, Saavala, & Kulmala, 2009; Kulkarni, Chauhan, 2009; Char, Saavala, Kulmala, 2010). Thus, it is likely that their perceptions of contraception will influence the perceptions of women who might actually become contraceptive adopters. Third, son preference remains highly correlated with contraceptive use in Northern India. Increased parity, particularly when a son is born, results in an increased odds that a woman will use contraception (Jayaraman, Mishra, Arnold, 2009; Arokiasamy, 2002; Singh et al, 2009). That sons are so highly valued is not surprising, given that it is sons, and not daughters, who provide for their parents as they progress into old age. Daughters, when married, are sent to live with their husbands’ families and thus, are not able to provide such care.

Women who were interviewed for this research often described the decision to use contraception as a personal and individualized choice, and frequently discussed how no two people are alike, and thus, must make their own decisions. SAN3, a 27-year-old intra-uterine device user, described how the decision to use a given contraceptive is an individual decision:

³⁴ The Panchayati Raj is an institution of self-government. In every state, Panchayats are constituted at the village, intermediate, and district levels, and are chosen by direct elections from territorial constituencies in the Panchayat area. The Panchayat Act of 1992 proposed the addition of new features to the Constitution to “impart certainty, continuity, and strength” to the Panchayati Raj (Indian Constitution, Seventy-third Amendment, 1992).

Interviewer: What (contraceptive method) do women prefer most?

Respondent: Well, no one is alike. People opt (for contraception) as per their choice. It varies, as per their whims and fancies.

Despite this depiction of contraceptive decisions as an individual and woman's decision, the research from chapter 2 reflects the multiple constraints on voluntariness that women face. Women frequently discussed the controlling influence of their families, particularly of husbands and mothers-in-law, in decisions on when to begin childbearing, when to stop childbearing, and when to use or not use contraception. SAN11, a 23-year-old injectable contraceptive user, who had only one child described how she wanted to have one more additional child, but that the decision was not hers to make:

My family alone, we don't have our say, especially my mother-in-law, it's not our wish, everything happens as per the say as they are elders to us. My mother-in-law advised me to have just one child.

In addition to the controlling influence of mothers-in-law on reproductive decisions, women frequently described their opinions either as their husband's opinions, or in conjunction with their husband's opinion. SAN12, a 23-year-old injectable contraceptive user, who had a 10-month-old baby, linked her desires to not have additional children to those of her husband:

Well she (daughter) is so small...she is yet to grow (laughs and chuckles). In case I get another baby in two years, my child would be disturbed. Neither my husband wants, nor I want, any baby as on now.

While one might infer that the above quote indicates husband-wife communication and discussion of reproductive intentions, many women described how husbands determined decisions related to fertility and contraceptive use. SHR13, a 23-year-old injectable user who had one child, described how the decision to use birth control was made by her husband: "...If he (husband) wants me to use birth control, then I will use it, and if he does not want me to use it, then I won't." Similarly, women described other areas of their lives in which their husbands were the primary decision-makers. SHR13 described how her husband wanted her to complete her secondary schooling in order to increase the family's earnings:

My husband wants me to study. It is very difficult to raise two children with one earning these days. Everything is so expensive. We do not have our own farming and just rely on daily wage earned through labor works.

While rare, it should be noted that there were a few women who reported that they were able to have any number of children that they would like, and that the decision for how many children to have was their decision. SAN10, a 33-year-old injectable user, who had four living children, talked about the number of children she will have, and how that is her choice:

Interviewer: According to you, how many children are ideal in a family?

Respondent: In a family, any number that one wants. Any, as per one likes.

Interviewer: How many?

Respondent: Self choice. It is up to us. This is my choice, and my husband's wish, too.

Similar to findings from other studies that have demonstrated that healthcare providers continue to promote the adoption of a specific contraceptive method (Koenig, Foo, & Joshi, 2000), provider influence and bias of longer-term methods was identified in this research. Women described how Accredited Social Health Activists (ASHAs), who identify women for contraceptive services at the village level, emphasized long-term contraceptive methods. According to SHR2, a 21-year old who opted to use injectable contraceptives, *"Auntyji (ASHA) was telling me to use Copper T, but I don't have any energy and it is not something that I can withstand. I keep on hearing that Copper T can be problematic."* It should be noted that in the study area of this research, ASHAs are paid according to the type of contraceptive method that a woman adopts. ASHAs receive 50 Indian rupees (approximately \$1 USD) for recruiting an injectable contraceptive user; 100 Indian rupees for an intra-uterine device insertion; and 200 Indian rupees if a woman undergoes sterilization.

V. WHEN WESTERN NOTIONS OF AUTONOMY DO NOT WORK

There are circumstances in which western notions of autonomy within a reproduction framework are irrelevant, or simply do not work, within other contexts. In the Northern Indian context, women may not consciously make decisions about childbearing and reproduction within Westernized frameworks of autonomy. Similarly, notions of self-determination may be more valued within western settings, compared to non-western settings where family-determination may be more important (Fan, 1997). Many of the women who were interviewed described how their reproductive outcomes are the result of fate, Nature, or God. In a context where women experience uncertainty regarding whether their children will even survive, it is not surprising that women defer to values of fate and religion. SHR9, a 27-year-old Muslim intra-uterine device user, described how maintaining a period of spacing between children depends on each woman's individual choice, and also related the number of children she has to her religious values (Allah):

Interviewer: You must be aware that some women want to keep a gap of sometimes 3 years, 4 years. Why do you think they like to keep a gap?

Respondent: I have not done like that.

Interviewer: How about others?

Respondent: (laughs) It depends on their choice, what can I say about that?

Interviewer: So you have not kept any gap year?

Respondent: No, I have small children

Interviewer: Why not?

Respondent: Just like that, as Allah has given, and so I have taken them (my children), but I stay sick.

SAN1, a 31-year-old Hindu, who was currently using injectable contraceptives, described a failed abortion. She discussed how, despite an abortion attempt, her baby had survived, and how she took this as a sign from Nature that she should continue the pregnancy:

I tried to abort when I conceived. I got medicine from the store after asking the doctor. After four to five days of conception, something went wrong. I had bleeding, I became weak. Then I went to the hospital, I underwent ultrasound, as told by the doctor. The doctor said the baby is okay. The doctor confirmed that the baby is all right. Then I said let the baby live, if the Nature so wants, let the baby come.

Related to the issues of fate and religion, women frequently described an inability to determine what circumstances might occur in the future, and thus, an inability to plan their reproduction. As articulated by SHR21, a 35-year-old intra-uterine device user, when asked what method she would continue after five years, *“If there is no problem, then I will see in the future.”* SHR14, a 28-year-old injectable user, further describes uncertainty, both related to the survival of her son, and how many children she will have in the future:

Respondent: I asked his father if he wanted more children. He said no. In fact, the third child is extra. Then I shared (with my husband) that I should get the operation. He said not to get the operation now. Who knows what will happen in time, and our son is young now.

Interviewer. Okay, so for this reason, you did not get the operation?

Respondent: Yes.

Interviewer: So you may have a child in the future.

Respondent: Who knows? No one knows what will happen the next minute. No one knows what will happen in time.

In the above quote, the respondent implies that she must wait to undergo female sterilization, as her son is still young, and she does not know if he will survive. Undergoing a sterilization procedure and losing an only son would leave a family without any possibility of having future sons. In essence, the respondent is not comfortable embarking on a permanent method of contraception, until her son is old enough, and she has more confidence that he will actually survive into adulthood.

Indeed, women often did not view planning related to when to have children, or how many children to have, as their responsibility. A limitation then, of western frameworks of autonomy, at least as applied to the Northern Indian context, is that they often describe autonomous action in terms of planned action. This emphasis on planned action would seem to be inappropriate in a setting where women themselves do not view reproductive planning as part of their purview. Indeed, the notion of planning within rational choice theory has been criticized before.³⁵ Such models focus on actors who face a choice situation, and then identify their goals, evaluate the benefits and

³⁵ A full description of the criticisms of rational choice theory is beyond the scope of this paper. See: Garfinkel, 1967; Schutz, 1943.

disadvantages of their options in reaching pre-existing goals, and assess the desirable and undesirable consequences of each option (Denzin, 1990). A second, though related problem of rational choice models is that they assume that consequences are predictable. Johnson-Hanks' work demonstrates how women's reproductive behavior can deviate from models of rationality and planned behavior, in her description of the rejection of a model of prior intentions among Cameroonian women. As Johnson-Hanks notes, "*their refusal of rational choice does not mean that they do not act with intention of any kind*" (Johnson-Hanks, 2005). Rather, women employ a "*judicious opportunism*", grasping at any opportunity that is available in the present, in managing their reproductive lives. Lastly, there are other critical limitations to these models, in that they do not situate women's experiences within wider social and cultural contexts (Esacove, 2008).

Even when the concept of planning did fit in with how women made initial reproductive or contraceptive decisions, such a framework fails to grasp the ubiquitous barriers that women face in exercising their autonomy. I will illustrate why this might be so with an example from my fieldwork in India. Suppose a woman, who is living in a small rural village in Uttar Pradesh, India, has already delivered four children, including three daughters and one son. Her health has suffered during the past year, since the birth of her last child, and because she is worried about the state of her health, she does not want to have any more children. In other words, she has articulated a plan. One day, she receives a visit from an Accredited Social Health Activist (ASHA) at her home. The ASHA tells her about two different contraceptive methods, including injectable contraceptives and female sterilization. Applying a model of rationality, the woman now faces a choice situation - to begin some form of contraception, or not. She has already articulated her goal (even if that has only been to herself) to not have any additional children. The woman is then provided with adequate information and appropriate counseling about the benefits and risks of each contraceptive method, including potential side effects that may be experienced. She is thus able to consider the benefits and disadvantages of each contraceptive option, and weigh the consequences of those options. The woman is Muslim, and thus, tells the ASHA that female sterilization conflicts with her religious values. She then decides that she would like to begin injectable contraceptives. In such a case, and within a framework of rationality and intentionality, this woman is able to exercise autonomy over the decision to use or not use contraception at a given point in time, namely when the ASHA arrives at the woman's doorstep.

However, rationality models that readily support decisional autonomy - that is, autonomy over a particular decision at a single point in time - are lacking in their ability to support a woman's capacity to actually carry out those decisions (often described as executional autonomy). Let us use the same example from above. The woman has just decided that she would like to use injectable contraceptives. Within more westernized contexts, she might then be able to actually begin using injectable contraceptives. In other words, she might be able to actually carry out her decision. However, our models have not yet accounted for the strong social and cultural contexts that surround fertility in Northern India, where mothers-in-law and husbands often determine when a woman should stop

bearing children, and where permission must be sought to use a contraceptive technology. We can take the example still further, by imagining that a woman's husband agrees that she can use injectable contraceptives at this point in time. Yet, she may still face constraints that limit her ability to exercise her decision. She may lack the economic means by which to purchase injectable contraceptives. She may spend what are already limited economic resources to take a bus for thirty minutes to go to a clinic for her first injection, only to find that the healthcare provider is not there that day, or that the clinic stock of injectable contraceptives has been depleted.

Perhaps most importantly, this framework does not support a longer view of reproductive autonomy throughout a woman's life course, or a woman's self-determination. Suppose the woman was able to make the decision to use injectable contraceptives, was able to obtain permission from her husband or family to use the method, and was able to actually acquire an injection at the healthcare clinic. It is now nine months later, and she has received three injections. Given a context where there is high infant and child mortality, her family now insists that she become pregnant again, in case something happens to her one living son, in the hopes of delivering a second son. Given her low power status within the family, it becomes apparent that she will not have the autonomy to control her fertility throughout her reproductive life course.

Johnson-Hanks adeptly critiques the use of rationality models of action (or inaction) as the dominant paradigm for explaining women's reproductive behaviors in the development of international reproductive health programs and policies (Johnson-Hanks, 2005). That those models also appear inappropriate in the Indian context given women's own views of their reproductive lives, begs the question: What then, is a more appropriate model in this context? If western notions of autonomy fail us, what does work?

VI. AN ALTERNATIVE VIEW: REACTIVE AUTONOMY

What I hope I have demonstrated up to this point is that Indian women living in rural Uttar Pradesh lack adequate understanding to make method-specific decisions related to contraception. More importantly, that these women face multiple constraints upon their voluntariness, inhibiting their ability to act autonomously. These constraints become important both in terms of reproduction (for example, when to have children, and how many children to have), and in terms of contraceptive use (for example, who makes or influences contraceptive decisions). Given that women do not have a view of their own autonomy that aligns with that of western values of autonomy, what one might regard as a proactive autonomy, particularly in regards to models of rationality and planning, it is now important to articulate an alternative view to the promotion of women's autonomy and empowerment in this context - what I refer to as reactive autonomy.

While it is clear that western ideals of autonomy may not be the most relevant or applicable to the lives of rural Indian women, it does not mean that one should abandon all principles of autonomy. Instead, one must be flexible in defining what autonomy

means in vastly different contexts. Moreover, I argue that attention must continue to be devoted to the empowerment of women in their reproductive lives and in other spheres of their lives, as articulated at the ICPD. Indeed, when key opinion leaders were interviewed (see chapter 3 of this dissertation), the majority of those individuals linked women's reproduction and contraceptive use to larger structural issues of education, literacy, and women's participation in the workforce. In essence, they were expounding concepts of women's empowerment articulated at ICPD.

The quotes from women, described both in this chapter and in chapter 2, demonstrate that it is not that women do not plan at all when it comes to their reproduction. However, women do need to be empowered to be able to act on their plans. Women should be provided with appropriate information to make informed contraceptive method-specific decisions. In practice, this means that a greater transference of information must occur, so that women have the understanding required to make these as autonomous decisions.

With regards to voluntariness, women must be free from undue constraints, be empowered to make decisions, and have the capacity to act upon those decisions, regarding how many children to have, when to bear children, and when to stop bearing children. Women clearly face many different barriers throughout their reproductive lives, and indeed, there are many different stakeholders who influence a woman's reproduction in this context. Women may not be deliberative within rationality frameworks, but that is because they constantly have to negotiate and act in the context of ongoing demands and incursions from other people in their lives. What then is most important in this context of demands and barriers, is that women are empowered to react to barriers that they may face, such as those described in chapter 2 of this dissertation. Currently, the Government of India's policies are missing this attention to empowering women. Indeed, those policies place certain constraints upon women's voluntariness with regards to reproduction and contraceptive use; for example, the use of incentive and disincentive schemes to promote the adoption of a small family norm and terminal contraceptive methods. While Childress directs us to distinguish the ideal of autonomy from the conditions for autonomous choice (Childress, 1990), it is apparent that those conditions have not yet been developed for Indian women

VII. CONCLUSIONS

Human rights to reproductive decision-making, and the means by which to assert those rights, were articulated long before the ICPD. At ICPD, women's empowerment was prioritized. Despite this new emphasis, and subsequent changes to Indian population policies, many Indian women continue to lack the two conditions to fulfilling autonomy: understanding and voluntariness. This results from constraints upon women from families and within their communities, but also from national level policies that provide incentives and disincentives related to reproduction. Qualitative research from Uttar Pradesh demonstrates that, in addition to lacking the autonomy to make decisions about reproduction and contraception, women also viewed childbearing in terms of fate or religious values. As such, Western notions of autonomy, frequently grounded in

models of rationality and intentionality, may not be appropriate in this setting. Instead of using western frameworks of autonomy in this context, I have proposed a new theoretical framework for autonomy, called reactive autonomy. If women are to possess a sense of reactive autonomy, to be able to respond to ongoing demands for additional children, or social or cultural barriers, this is something that must be strived for, both in Indian population policy and in the very real world in which women experience a wide range of constraints upon their autonomy.

CHAPTER 5: CONCLUSION

The goal of this dissertation was to critically examine the intersection of ethics, policy, and cultural influences of non-permanent contraceptive use among women living in India. Findings from interviews with women living in rural Uttar Pradesh, India demonstrate that there is a need for non-permanent contraception among this population. Interviews with key opinion leaders demonstrate the different positions on injectable contraceptives within India, and how family planning policies structure the reproductive and contraceptive environments that women must negotiate. The ethical exploration of autonomy is intended as a catalyst for the development of alternative frameworks of autonomy; specifically those that promote women's self-determination, while taking into account local cultural and social values.

The first dissertation paper explored Northern Indian women's attitudes toward, and use of, non-permanent contraceptive methods, with a focus on oral contraceptive pills, injectable contraceptives, and intra-uterine devices. In-depth interviews were conducted to explore these constructs from the perspectives of the women during two months of in-country fieldwork in 2012. The women described many reasons for wanting to prevent pregnancies, including to protect the health of their children and themselves, and to be able to financially provide for all of their children. However, women often were not able to space births due to family pressures to have additional children and sons. Findings also suggest that women continue to face a variety of barriers at multiple levels of the Social Ecological Model, in making decisions to use contraception, and in actually using it. Within the family, women discussed the influence of husbands and family elders in decision-making related to reproduction and contraception, and how they were not allowed to make these decisions alone. At the community level, women described the influence of providers, including Accredited Social Health Activists and medical professionals from whom they sought contraceptive services. Women also discussed side effects as problematic and as reasons for discontinuation of contraceptive methods.

The second dissertation paper explored the attitudes of key opinion leaders toward injectable contraceptives through the integration of a media content analysis and in-depth interviews with key opinion leaders living in India. While the majority of key opinion leaders expressed a position of support for the inclusion of injectable contraceptives in the Indian National Family Planning Program, there were also key opinion leaders who expressed a position of opposition. While different key opinion leaders fundamentally disagreed about the inclusion of injectable contraceptives in the public sector, there was considerable overlap in the issues and problems discussed by the different stakeholder groups, including the side effects that injectable contraceptives may have, coupled with a need to improve contraceptive counseling, and the lack of contraceptive options within the public sector program. Key opinion leaders frequently described issues of reproduction and contraception within larger political, social and cultural issues, and discussed the need for education and participation by women in the workforce as a means by which to improve the status of women in India.

The third dissertation paper used the qualitative interview data from the first paper to explore Indian women's autonomy in a context where they face multiple constraints upon their voluntariness. These constraints include national population policies that promote incentive and disincentive schemes related to reproduction, and the controlling influence of members within the family and community. Many women did not view reproductive planning within their purview, and even among those who did, they lacked the ability to act on their planned decisions. Western frameworks of autonomy are lacking in their relevance to this context, and thus, a model of reactive autonomy is proposed.

Taken together, this dissertation highlights several directions for future research. Evidence suggests that women do, indeed, have a desire to use non-permanent contraceptive methods. Injectable contraceptives may have an important role to play within the basket of contraceptive options in India, particularly for those women who have tried other contraceptive methods and found them to be unacceptable, or who do not want, or can not, undergo a sterilization procedure. Future research on injectable contraceptives in India should focus on incorporating the perspectives of end users of this method, particularly given that their voice is currently excluded at the policy level and in media portrayals of the issue. Furthermore, additional research is needed to explore the extent to which provider level biases, like those described in chapter 3, are present in the provision of contraceptive services. Lastly, there is a great need for research that explores how women with little personal autonomy can be empowered to make reproductive and contraceptive decisions.

This dissertation also underlines important implications for public health practice. Educational programs to empower women with contraceptive knowledge are needed. Because husbands and family members strongly influence women's reproduction and use of contraception, programs should also be developed to include these stakeholders. Similarly, providers must be empowered to appropriately and adequately counsel women about their contraceptive decisions. Specific to injectable contraceptives, pilot testing the method in select areas or regions would help determine if the method is acceptable in areas other than those villages described in chapter 2. However, this must be done with all the attention to counseling and quality of care that was described by key opinion leaders in chapter 3. Lastly, there is a clear need for programs that empower women to react to the barriers that they face and to make reproductive decisions. Ultimately, this will promote women's self-determination in what is currently a highly patriarchal society. In conclusion, this dissertation provides data that can be used to improve programmatic delivery of contraceptive health services, and to develop population and contraceptive policies that are more sensitive to the needs of marginalized women, both within India and beyond.

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