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Empowering Women, Securing Futures: Contraception's Role in Socioeconomic Progress in India

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Abstract

Introduction: It is necessary to empower women to enable them to make their own reproductive choices, including contraception as well as use of modern contraception. Our article aims to highlight the importance of women's empowerment regarding contraceptive use in family planning and poverty eradication.

Methods: Our literature search included data on family planning programs, contraceptive use, awareness of and access to contraception, and women empowerment regarding contraceptive use in India; approaches to policymaking regarding family planning; and international data on early legal access, women's reproductive rights, and barriers to contraceptive use.

Results: Despite the introduction of oral contraceptives, 38% of currently married women in the 15–49 age group use sterilization as a method of contraception. Only 28% of married Indian adolescents use contraception. The highest reliance on sterilization is found in women married off early, conceiving early, and with little access to education and information. There are barriers to both use of contraceptives and reversible contraceptives.

Discussion: Family planning programs in India can focus on women's reproductive rights, rather than population control, to bridge the gap in the unmet need for family planning, apart from making information and resources on contraception available to women from all socioeconomic strata.

Keywords: Contraception; Family Planning; Oral Contraceptives; Poverty; Contraceptive Use

Introduction

The late Babtunde Osotimehin, the former executive director of the UN Development Fund, declared family planning one of the most significant investments towards combating poverty [1]. Philanthropist Melinda Gates declared contraceptives as being among the greatest innovations against poverty [2]. Former US President Richard Nixon, during a family planning program campaign, declared that pregnancies that were unwanted or mistimed were initiating or perpetuating poverty in families [3]. India's National Program For Family Planning in 1952 was the first ever in the world [4], even before the USFDA approved the first contraceptive pill, which was in 1960 [5]. Moreover, the use of contraceptives by married Indian women has increased from 48% in 2015–16 to 56% in 2019–21. Despite this, 9% of married women have not had their family planning needs met [6]. The unmet need for family planning is greatest in married 15–19-year-olds, in the less educated, and in the poorest households [7]. Also, the goal of family planning

in India as of yet has been population control rather than the advancement of women's rights and choices regarding reproduction [8]. In this article, we aim to illustrate the connection between women's empowerment, health policies that support women's reproductive choices, contraceptive use, and poverty alleviation.

Methods

We noticed a dual knowledge gap regarding the use of contraceptives. One is the knowledge of researchers regarding contraceptive use in India, including empowerment levels to make reproductive choices, awareness about newer methods of contraception, and which sections haven't had their family planning needs met as of yet; the other is the knowledge of Indian women regarding methods of contraception available, accessibility, and their reproductive rights to utilize contraception. This subsequently affects the policymaking regarding family planning programs, including approach and outcomes.

Therefore, in our literature search, the search terms included 'family planning programs in India', 'contraceptive use and poverty alleviation', 'contraception access in India', 'awareness regarding contraception in India', 'contraceptive use in India', 'barriers to contraceptive use', and 'women empowerment regarding contraceptive use in India'. We have also included data from the fifth National Family Healthy Survey to present the Indian scenario regarding contraceptive use.

Results

Access to contraception empowers women by providing them the agency and requisite knowhow to make choices regarding their body and reproduction; lowers the cost of healthcare; helps with the limiting, delaying, and spacing of pregnancies; and ensures that more girls get a complete education and long-term career opportunities, creating gender equality [9]. Browne and LaLumia [5] have enlisted the following benefits of legal access to oral contraceptives early on:

- Reduces poverty in women by 0.5%.
- Results in immediate reduction of birth among women aged 14–20 years without affecting lifetime fertility. If women gain access to the pill in their late teens, they can make long-term decisions by delaying pregnancies.
- Delayed entry into motherhood will allow women to make economic gains and time their pregnancies in a way that allows for advancement in their careers; it is also associated with significant increase in salaries, number of hours worked, and career earnings obtained by women.
- When women are provided access to contraceptives through family planning programs that are federally funded, childbearing among women living in poverty reduces by 19–30% within the first decade of implementation.
- Young women being able to control their fertility owing to early access promotes financial investment.
- In the US, early legal access was associated with a 2.3% increase in women aged 30–49 who graduated college and a 4.5% increase in graduate mothers.
- Access to the pill before the age of 21 led to participation in the labor force among women aged 20–30 increasing by 8%.

Even women of lower socioeconomic strata in charge of their fertility can seek job opportunities, thereby contributing to the household income and pulling their family out of poverty. This is because having fewer children provides scope for women to focus on existing children; if the woman has a chance to pursue education and a job that pays well, it may also lead to increased financial resources [10].

The first question arising is whether women in India are using modern methods of contraception. Hubacher and Trussed have defined modern contraception as the utilization of medical procedures or technology that influences the natural reproductive process [8]. Government family planning programs in India claim to utilize the 'cafeteria approach' that purportedly provides women with the proverbial basket of choices, comprising female and male sterilization, oral contraceptives, condoms, and intrauterine contraceptive device (IUCD) [7]. However, as per the National Family Health Survey 5 (NFHS-5), 38% of married women aged 15–49 use female sterilization, followed by male condoms (10%), contraceptive pills (5%), and traditional methods, including the rhythm method (10%); only 28% of 15–19-year-old married women use contraception, and only 19% in this age group use a modern method [6].

A study by Ewerling, et al. [8] on modern contraceptive use in India had the following findings:

- In the Family Planning 2020 Action Plan, drafted in 2014, the three new methods of modern contraception included non-hormonal weekly pills, injectable contraceptives, and progesterone-only pills for lactating mothers.
- There are three types of contraceptives: short-acting reversible, including oral contraceptives, diaphragms, injectables, condoms, emergency pills, and spermicides; long acting reversible, including the IUCD; and permanent methods, including female and male sterilization.
- India relies primarily on female sterilization because women seeking birth control primarily understand female sterilization as the means to achieve this goal.
- Use of reversible contraception, both short and long-

acting, were found among women who belonged to a higher socioeconomic strata, were educated, and had higher empowerment levels. However, even this group had a lower demand for family planning satisfied (DFPS).

In 2005–2006, 66% of contraceptive use comprised of female sterilization, 77% of women who underwent sterilization were not contraceptive users, more than half were not even 26 when sterilized, and adolescent women who were married also preferred female sterilization as a contraceptive method [7]. Moreover, the highest reliance on sterilization is among women who are least socially independent, i.e., lowest levels of access to information and education, being married and conceiving at an early age, and a disparity in education level and age between spouses [8].

Regarding the awareness about modern methods of contraception among Indians, more than 99% of 15–49-year-old married women and men know about at least one method of contraception, and 52% of married women and men are aware of emergency contraception [6].

Despite almost universal awareness levels, use of reversible methods of contraception still remains low, as does the DFPS, especially among women who got married in their adolescence, are less educated, and live below the poverty line. Awareness of family planning methods does not necessarily translate to use [11].

One reason is the lack of women's bodily autonomy, including the use of contraception. Women's empowerment is their ability to make choices and having control over resources that affect major life outcomes [12]. The reasons the women gave for not using contraception included the need to demonstrate their fertility; familial pressure, such as that from husband and in-laws, to bear children; gender and social norms; and pressure from the community [8].

There is also the pressure to produce male offspring; families preferring male children leads to several unwanted births till the woman gives birth to at least one or two male children [7]. The percentage of women using any contraceptive method, or the contraception prevalence rate, depends on how many decisions the woman participates in; women's participation in decision-making and their use of maternal health services have been shown to be related [12].

Indian women, fearing side effects and having health concerns, do not rely on modern methods of contraception, both short and long-acting; these concerns include fear of menstrual irregularities, a delay in return to fertility, putting on weight, giving birth to babies that are congenitally malformed, and inability to breastfeed the infant [8,11].

Another possible barrier to the use of contraception is the reluctance of men to get involved in family planning. While more than two thirds of men believe contraception to be the sole domain of women, 20% believe that a woman on contraceptives may become promiscuous [13]. More than 75% of the overall use of modern contraception in India is accounted for by female sterilization [9]. Male methods or couple-dependent methods of contraception were used by only 9.1% of married couples in 2005-2006; and only 1.1% of men used and 5.5% used condoms in the same time period [7]. In fact, the patriarchal outlook that characterizes Indian societal norms views vasectomy as a threat to male sexuality and masculinity [8].

Globally, several other barriers have been identified to both use of contraceptives and use of reversible methods, including misconceptions about contraception; lack of comfort among women, especially teens and unmarried women, to discuss their concerns; women desiring more children; social class, education, and religion; ignorance and superstition; culture; financial constraints; regional barriers; and poor health services, knowledge of methods, and support from health providers [11]. All these barriers are relevant in the Indian context as well, especially in underdeveloped, populous states like Bihar and Uttar Pradesh, where girls have lower levels of education and women have lower socioeconomic status, mortality rates of mother and infant as well as poverty levels are higher, people want more children, and contraceptive prevalence rates are lower [7].

Discussion

Indian family-planning programs have shown positive results in the increased awareness, use of modern contraception, and the decrease in unmet need for family planning. However, the prevalent method of family planning continues to be female sterilization, despite the introduction of newer, reversible methods, including long and short-acting contraception. Moreover, one in five women did not know the outcome of sterilization, 62% received financial incentives to undergo sterilization, and 6.5 million of the 92 million women of reproductive age sterilized in India regret having undergone the procedure [8]. Therefore, apart from the unmet need for family planning due to the usage gap, there is also a knowledge gap in contraceptive use.

Moreover, certain barriers exist to contraceptive use, the biggest one of which is lack of empowerment for a woman to make sexual and reproductive choices. Lack of education and economic independence worsens this problem, especially when the woman faces opposition from her spouse to contraception use. Women also find it difficult to discuss because of societal taboos and lack of support from health

providers. Many women, due to poverty or lack of mobility, cannot access reproductive health services.

There are several steps that can be taken to overcome these barriers.

For one, family planning programs, rather than focusing on population control, can emphasize women's reproductive rights and bodily autonomy. Instead of being offered financial incentives for sterilization, women targeted by family planning programs can be provided information on modern, reversible methods of contraception, how to space these methods, the judicious use of contraceptives, and addressing any and every health concern of contraceptive use voiced by women. The goal of family planning, rather than to reach a target, can be to help women emerge as the primary decision-makers regarding fertility.

Moreover, awareness is best if it always translate to use. Towards this, family planning programs can incorporate the following:

- Targeting superstitions and personal beliefs against contraception, especially in rural populations.
- These programs can be contextualized to the socioeconomic, cultural, religious, regional, and linguistic background of the target audience, especially in a diverse nation like India, for greater outreach. This is specifically needed for remote rural areas.
- Involving men in family planning: Educating them against prejudices regarding contraception, encouraging them to acknowledge and accept female autonomy and choice, and counseling them to be active supporters in their spouse's decisions regarding contraception and parity.

To address the barrier of access to health services and their quality, Muttreja and Singh [9] have suggested the following: reproductive, maternal, newborn, child, and adolescent health (RMNCH) counselors, auxiliary nurse midwife (ANM), and accredited social health activists (ASHAs) can be trained to counsel for and address myths and misconceptions regarding reversible contraception methods. This can be done especially in rural areas to bridge the gap in specialized health services. The training can involve teaching these providers to be non-judgmental towards the problems and choices of the women they reach out to, in addition to providing practical, applicable solutions.

Early marriages are still prevalent, and the DFPS is lowest in the 15–19 group of married adolescents. This can be addressed if health policymakers incorporate early access to reversible contraception in both state and central healthcare laws. Family planning programs can work in tandem with these laws to spread awareness and assist adolescent married women in using contraception to delay, space, and limit pregnancies. Such women can pursue higher education and careers, leading to economic empowerment and poverty reduction.

To operationalize the principle that couples and individuals should be able to decide the gap between offspring and how many children to have while being armed with the information and means to do so, the government can provide couples options for contraception [7]. Over half of the Indian population is of reproductive age, and 68.84% live in rural areas; therefore, India's family planning programs have both opportunities and challenges [9]. If all Indian women unwilling to get pregnant use modern, reversible contraceptives, unintended pregnancies would go down by 77% annually, reducing the number of unwanted pregnancies by 16 million fewer [14], lessening financial burden on families, and alleviating poverty.

Conclusion

In conclusion, family planning programs in India can focus on women's reproductive rights and choices, making them the primary decision-makers. Apart from increasing contraception prevalence rate, reliance on reversible methods of contraception can also increase to broaden the scope of reproductive choices. Early access to and awareness of contraception in adolescent and young married women in India has the potential to increase education levels, job opportunities, and lifetime earnings towards poverty alleviation.

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Conflict of Interest

The authors declare no conflict of interest.

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