ISSUES OF CONTRACEPTION: ITS DYNAMICS, ACCESS AND STATUS OF PRIVATE SECTOR

This chapter dwells upon issues of contraception, its dynamics, Access and status of private sector. Demographic trends of contraceptive use in Maharashtra, RCH indicators for Maharashtra and Nanded are also included in this chapter.

Demographic Trends and the Dynamics of Contraceptive use in Maharashtra:

It shocked even urban sensibilities when R. D. Karve, teaching in Mumbai College, set up the country’s first birth control clinic in 1921. In Mumbai, easily the most liberal city of even those times, he strove to educate people on birth control by use of contraceptives as a means to ensure the welfare of women and children.

He campaigned diligently, having spent his life educating women on issue of birth control, which to him was a sure path to their emancipation. He did not waver despite stiff opposition and until recently his work went unrecognized. Though non-official legislation supporting a state policy for birth control found support from B.R. Ambedkar, even that was defeated by the view that birth control was to be achieved by abstinence and self-control. This issue was to affect Maharashtra for a number of years even after independence.

Awakened to the emerging realities, the municipal corporation of Mumbai too, took a pioneering step following family planning clinics to be set up in two of the maternity centres. By then the realization had begun to strengthen that mother having too many children; far too frequently especially during the start and the middle of their reproductive age was detrimental to them and their families health. Many a women did not even believe planning a family was possible at all.
The Govt. of Maharashtra's family planning programmer was launched ten years after the municipal corporation of Bombay's path breaking effort, to bring the issue of birth control into the larger public domain. Another decade later, it was handed over to Zilla Parishads (District Councils), guided by the premise that decentralization would accelerate the pace of implementation. Maternal and child health services were integrated into the family planning programme, christening the entire approach 'Family Welfare'. It was characterized, as developments later showed, by massive participation of women who were relatively more willing to accept the methods on offer. The participation of men was restricted to the fringes, a feature not unique to Maharashtra. (Kulkami, 2002)

Cash awards of Rs.25 million each for family planning achievement were given to the Govt. of Maharashtra for two successive years, 1982-83 and 1983-84. It touched a new high in 1990-91: 5.25.000 sterilization against the largest of 5,75,000 set by the Govt. of India. This 91 per cent realization has the highest among the 15 major states. In the 25 years since 1967, more than half the couples came to be protected by family planning methods; 10 million sterilizations and 5 million insertions of Intra Uterine Devices were recorded. The subsequent 10 years efforts culminated in another 5.1 million sterilisations .(Kulkarni, 2002)

KNOWLEDGE AND USE OF FAMILY PLANNING METHODS

(As reflected in National Family Health Survey 1998-99, Maharashtra)

Knowledge of contraceptive methods is nearly universal in Maharashtra with 99 per cent of currently married women recognizing at least one method of contraception. Female sterilization (Tubectomy) is the most widely known method of contraception in Maharashtra, followed by male sterilization (Vasectomy). Knowledge of the officially sponsored spacing methods (Pill, IUD, Condom) is less wide spread. The best-
known spacing methods are the Pill (84 per cent) and the IUD (80 per cent). The condom is known by only 72 per cent of women. Although knowledge of spacing methods remains lower than knowledge of sterilization, knowledge of spacing methods has increased substantially since National Family Health Survey NFHS-1.

The most commonly used method is female sterilization (49 per cent) followed by the condom (11 per cent) pill (9 per cent) and IUD (7 per cent). Four per cent each have ever used male sterilization and traditional methods (Safe period and withdrawal technique). Use of female and male sterilization is higher in rural areas than in urban areas but use of the contraceptive methods (OC pills, Condoms, CuT) is much higher in urban areas than in rural areas.

By 1992, 54 per cent of then married were current users of birth control methods. It was an option exercised by 54 per cent of rural women and 53 per cent in town and cities. Actually, there had been growth in use of contraception by couples from 35 to 56 per cent from 1980 to 1992 and by 1999, it peaked to 61 per cent. However, even non-southern states are ahead in this. Protection is higher at 68 per cent in Himachal Pradesh, 67 percent in Punjab and West Bengal, 62 percent in Haryana, 64 percent in Delhi. Though Maharashtra was a pioneer in the acceptance of Vasectomies in the 50s and 60s nearly 80 per cent of contraception is currently by female sterilization. Use of intrauterine devices (IUD), condom, and pills was confined to a miniscule 8 per cent of the currently married women. There has been an improvement in the use of IUCDs, Condoms, and Pills over the years but that has not been significant enough. On the other hand use of Vasectomies declined from 6.2 per cent to 3.7 per cent between 1992 and 1999.(Human Development Report, Maharashtra, 2002)
SOCIOECONOMIC DIFFERENTIALS IN CURRENT USE OF FAMILY PLANNING METHODS

Contraception prevalence rates increase with the female education leading to an important in all parameters of reproductive health.

Proportion of female sterilization decreases steadily with education from 55 per cent among illiterate women to 31 per cent among women who have completed at least high school. Use of the three modern spacing methods (Condom, CuT, OC pills) increases with education. Contraceptive prevalence is higher among Hindus (62 per cent) than Muslims (49 per cent); however it is the Buddhist/New Buddhist women who, at 66 per cent have the highest rate of contraceptive use in Maharashtra. Female sterilization is most common among Buddhists/New Buddhists (55 per cent) and least common among Muslims (37 per cent) Condom use, by contrast, is highest among Jains (10 per cent) followed Christians (5 per cent) and Hindus (4 per cent).

Contraceptive prevalence increases from 55 per cent among women who have a low standard of living to 66 per cent among women with a high standard of living.

Contraceptive use increases sharply from 4 percent among women with no living children to 82 per cent for women with three living children and 81 per cent for women with four or more living children. Use of both male and female sterilization also increases with the number of living children. Use of each of the three (Condom, CuT, and OC pills) modern spacing methods is highest for women with one living child, and declines steadily for higher parity women. The demographic impact of contraception depends on both the percentage of couples that use contraception and the parity at which they start using. An emphasis on sterilization in the contraceptive method mix however increases the likelihood that women will begin contraceptive use only after achieving their desired family size.
Clearly, spacing methods need to be promoted more deliberately if a reduction is sought in the parity at which women first accept contraception.

The factors that can lead to fertility decline in Maharashtra are not very strong. Percentage of couples exposed to family planning message is lower than all the selected states except West Bengal and Andhra Pradesh. Women generally marry early though there has been a slight improvement. Half the girls in Maharashtra are married by the time they are 16.4 of age. This age at which young girls marry is slight higher in the other three southern states except Andhra Pradesh. Half- that is nearly 50 per cent of the girls married in the age group of 20-24 are those who were married by the time they were 18. In Kerala and Tamil Nadu this percentage is significantly very much lower at 17 and 25 percent respectively. A quarter of the contribution to the total fertility is from the youngest age group, which is much higher than in Kerala and Tamil Nadu throughout, higher than in Andhra Pradesh.

Merely the sterilization numbers do not necessarily have a linear correspondence with a decline in Total Fertility Rate (TFR). It depends at which age sterilizations are performed and the number of children already produced before accepting sterilization. If accepted by most of the couples at a later age and after 3-4 children born, then it has a much lower impact on fertility. The link between achievements of the programme and fertility impact had become so weak in Maharashtra that birth rate was stagnant around 28-29 for 1982-89 despite an increase in recorded couple protection rate from 35 in 1980 to 55 in 1989.

REASONS FOR DISCONTINUATION OF USE OF CONTRACEPTION

The most commonly mentioned reason for discontinuing is that the couples wanted to have a child (42 per cent). Other frequently cited reasons for discontinuing use are that contraceptive use created
a health problem (17 per cent), created a menstrual problem (5 per cent), the husband is away (3 per cent), the woman did not like the method (3 per cent) and the method failed and the woman got pregnant.

Among women who never used contraception, the most commonly mentioned reason for not currently using a method is also the desire for more children (45 per cent), followed by the fact that the woman is post partum or breast feeding (8 per cent). Another 7 per cent of women say they are not using contraception because they are sub fecund or in fecund (less fertile) and 5 per cent are menopausal or had a hysterecmy (removal of uterus). Eight per cent mention different types of opposition, such as that their husband is opposed to family planning (4 per cent), other people are opposed (2 per cent) or it is against their religion (1 per cent). Only 6 per cent mention health-related problems (worry about side effects or health concerns). Another 2 per cent mention not knowing a method or a source to obtain a method as the main reasons for not currently using contraception. Three percent say they are not using contraception because they do not like the existing methods and 3 per cent give not having sex or infrequent sex as their main reasons for non-use.

REASONS FOR NOT INTENDING TO USE CONTRACEPTION

Sixty two percent of women mention a fertility related reason for not-intending to use contraception in the future, 17 per cent mention a method related reason, 11 per cent mention opposition to use and 5 per cent mention a reason related to lack of knowledge.

Fertility Related Reasons are those such as, not having sex, infrequent sex, menopause, woman having undergone hysterectomy (operation for removal of uterus), subfecund or infecund (less fertile) women, those who want as many children as possible. Those Opposed to family planning include, husbands' reluctance and reasons related to religion. Lack of Knowledge, that is, 'knows no method' or 'knows no source' also contribute for non use of
contraceptives. Method Related Reasons, generally, refer to health concerns, worry about side effects, costs too much, afraid of sterilization and does not like existing methods.

CULTURAL VARIATIONS AND CULTURAL CONSTRAINTS

Cultural Variations also influence acceptance of the small family norms and utilization of health services and its impact on the process of decline in fertility ad mortality. Religion and caste can be taken as sources of such cultural practices. After Hindus, Muslims with a 9.7 per cent in the total population and Buddhists with the 6.4 per cent are the two other major religious groups in Maharashtra.

In most of the districts, Muslim Population is much less than 10 per cent but in Marathwada, all the districts except Osmanad have a higher percentage of Muslim population between 11 to 18 per cents. As per the same census, 6.4 per cent of population in Maharashtra is Buddhists.

Marathwada, once part of the erstwhile Nizam’s Hyderabad State, has distinct cultural traits inherited from there. It has relatively higher Muslim population and later Buddhist population. Muslims, for instance, identify family planning with sterilization, to which they are opposed to but might be favorable to spacing methods and have order births compared to any other segment of the population. (.Kulkami, 2002)

Proportion of Muslim population in Nanded city, where the present study is undertaken is relatively high. Because of this it was identified as specific hard core area for implementation of family planning programme by UNFPA along with five other districts in Maharashtra. A special project was implemented in Nanded by UNFPA from 1990-95 considering Nanded as low acceptance area for family planning methods because of relatively high percentage of Muslim population. Therefore the value of present study increases as it deals with the GMPs, in population control programme which in turn
would improve the active participation of people at large, including people from the Muslim community.

Earlier research has shown that Muslim respondents generally do not favor sterilization but they do not have objection to other methods. NFHs-2 data also shows that among Muslim only about 37 per cent respondents have accepted while another 11 per cent use modern spacing methods. 1 per cent use traditional methods. Among Hindus about 54 per cent opted for sterilization and hardly 8 per cent the spacing method. Even among Buddhists, about 61 per cent have accepted sterilization and among scheduled caste 57 per cent have accepted it. Comparisons of Total Fertility Rates show that on an average there are varying fertility rates among social groups of Muslims, Hindus and also among Buddhists, Scheduled castes and Scheduled Tribes. Tribals have their own distinct culture, diet pattern and system of medicine and they hardly resort to the modern system. (Kulkarni, 2002)

Through programs and services are the same across the state, the efficiency of their implementation, the quality and the extent to which these services are accessible, efficient and utilized by the people differ from district to district. It depends on the attitude and the overall level of modernization reached by the people, who are both-beneficiaries of the programs as well as the workers who implement the program. Education, urbanization and exposure to main media act as modernizing forces, which can change attitudes and improve the utilization and quality of various programs. At the same time many cultural practices and behavioral patterns continued over generations can act as constraints. If different regions have inherited different cultural traits, they do not progress at the same pace. So it is essential to see whether there are pockets where the forces not congenial to such changes and then design strategies to overcome constraints
In Maharashtra many women have unmet need for spacing especially before their first birth and between their first and second births. Prevalence of unmet needs for limiting among older women suggests that there is also need to further strengthen sterilization services for couples who want to use sterilization. At the same time family planning programme in Maharashtra needs to give high priority to providing women who want to stop child bearing but who do not wish to adopt sterilization methods and options they find acceptable for long term use. (NFHS Maharastra 1998-99)

The table no.4.1 shows that the acceptance of Vasectomy is reduced to a great extent, the acceptance of Tubectomy is also reduced whereas that of temporary methods like, CuT, OC pills and Condoms has increased over the years. The study of acceptance of various family planning methods also gives idea regarding status of Maharashtra state in relation to population control. The table no.(4.1) shows the trends of acceptance of various Contraceptive methods in last two decades (from the year 1980 up to 1999)

Table 4.1: Percentage of Family Planning Acceptors By Various Methods in Maharashtra.

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Year</th>
<th>Vas</th>
<th>Tube</th>
<th>IUD</th>
<th>Condom</th>
<th>OC Pills</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1980-81</td>
<td>15.67</td>
<td>44.29</td>
<td>7.29</td>
<td>30.84</td>
<td>1.91</td>
</tr>
<tr>
<td>2</td>
<td>1985-86</td>
<td>6.44</td>
<td>25.52</td>
<td>23.98</td>
<td>31.14</td>
<td>9.92</td>
</tr>
<tr>
<td>3</td>
<td>1990-91</td>
<td>0.89</td>
<td>20.64</td>
<td>18.40</td>
<td>43.29</td>
<td>16.78</td>
</tr>
<tr>
<td>4</td>
<td>1996-97</td>
<td>0.23</td>
<td>22.25</td>
<td>19.40</td>
<td>41.82</td>
<td>16.28</td>
</tr>
<tr>
<td>5</td>
<td>1998-99</td>
<td>0.27</td>
<td>28.08</td>
<td>21.38</td>
<td>31.17</td>
<td>19.10</td>
</tr>
</tbody>
</table>


Male participation and Vasectomy

Looking into the reduction in the acceptance of Vasectomy to a great extent participation of males in population control programme and reasons for least acceptance of Vasectomy need special consideration. The following discussion deals with some of the
national and international studies related to male participation and Vasectomy.

For man who wants no more children, Vasectomy—Voluntary Male sterilization offers much: effectiveness a quick and simple procedure, permanent protection, convenience, little risk of complication, no long term effects on his own health or sexual performance and no health risk for his life. Yet, Vasectomy is the least known and least used family planning method. Many family planning programs have neglected Vasectomy but more training for the providers and more publicity for the procedure can stimulate interest.

World made, an estimated 42 million couples rely on Vasectomy. By comparison, nearly 140 million rely on female sterilization. Vasectomy is major family planning method only in six developed countries The US, Newzeland, Australia, Great Britain, Canada and the Netherlands and in three developing countries—China, India and South Korea. In most countries the method hardly used and few people have heard of vasectomy compared with other methods.

Vasectomy is favored in Newzeland (23 per cent), Australia, UK and North America (10-13 per cent of married couples) (Fairly et al 1993). In India, the Vasectomy has sharply declined from 58.4 per cent of total sterilization in 1960 to hardly 4.2 per cent in 1992 (Tripathy et al, 1994).

**WHY IS A GOOD METHOD SO NEGLECTED?**

The blame has often been laid on men. It is said that men do not care about avoiding pregnancy that they prize their fertility, that they think—wrongly—that vasectomy will end their manhood, that they unreasonably fear a major procedure that they put all responsibility for family planning on women.
But blaming men is no excuse for neglecting Vasectomy services. Many men's attitude is changing. They are concerned with the health and well being of their wives and families, and so Vasectomy makes sense for them. More than could change their attitudes if they understood Vasectomy. The main reason for low levels of use may lie not in men's attitudes but rather in policy makers' and providers' lack of attention to Vasectomy and sometimes-even prejudices against it.

Experience makes it clear that high quality Vasectomy services can draw clients, for example, private voluntary organisation in Columbia and Brazil has gradually built up clientage for Vasectomy. So far the government has never tried to promote Vasectomy. All that is required is an intensive programme to educate couples about the procedure and dispel popular misconceptions about the consequence of Vasectomy.

**RCH Indicators in Maharashtra and Nanded**

Health status of Maharashtra State and Nanded district in relation to population control can be judged by studying some of the RCH indicators. The figures in Table No. 4.2 denote that the proportion of girls married below 18 years, birth order of 3+, Total unmet needs for contraception in Nanded district is more as compared to Maharashtra state. In fact these figures are highest among all the districts of Maharashtra.
Table 4.2: Indicators Of RCH In Maharashtra And Nanded

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Indicators</th>
<th>Maharashtra</th>
<th>Nanded</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Girls married below 18 years.</td>
<td>30.9</td>
<td>63.7</td>
</tr>
<tr>
<td>2</td>
<td>Birth order of 3 +</td>
<td>34.6</td>
<td>43.5</td>
</tr>
<tr>
<td>3</td>
<td>Women aged 15-44 knowing all FP methods</td>
<td>62.6</td>
<td>48.7</td>
</tr>
<tr>
<td>4</td>
<td>Couple Protection Rate (CPR) using any modern methods (percentage)</td>
<td>58.3</td>
<td>51.4</td>
</tr>
<tr>
<td>5</td>
<td>Total unmet needs for contraception</td>
<td>19.6</td>
<td>30.5</td>
</tr>
</tbody>
</table>

Source: Rapid household survey under RCH project 1998-99, IIPS Mumbai (The figures in bold show highest in Maharashtra)

As shown in Table No. 4.3 Total Fertility Rate (TFR) of Nanded district is also highest in Maharashtra. The mean age for marriage in girls is lowest in Nanded district. The importance of the present study is of more value in the context of involving GMPs to improve the performance of Nanded District in relation to these indicators.

Table 4.3: Indicators of RCH in Maharashtra and Nanded

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Indicators</th>
<th>Maharashtra</th>
<th>Nanded</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Total Fertility Rate (TFR)</td>
<td>2.5</td>
<td>3.4</td>
</tr>
<tr>
<td>2</td>
<td>Deliveres Conducted by trained staff</td>
<td>59</td>
<td>47.2</td>
</tr>
<tr>
<td>3</td>
<td>Infant Mortality Rate (IMR)</td>
<td>43.7</td>
<td>34.0</td>
</tr>
<tr>
<td>4</td>
<td>Average Age for Sterilisation</td>
<td>27.5</td>
<td>28.6</td>
</tr>
<tr>
<td>5</td>
<td>Mean age of Marriage for girls.</td>
<td>19.3</td>
<td>16.6</td>
</tr>
<tr>
<td></td>
<td>Difference</td>
<td>8.2</td>
<td>Difference 12.0</td>
</tr>
</tbody>
</table>

Source: As per information given by Dr. Bhatlawande (Director, Family Planning, Maharashtra State) in a workshop at Aurangabad on 1st July 2002. (The figures in bold show highest in Maharashtra)

The table no. 4.4 shows the performance of Nanded district in relation to various RCH indicators in last three years (from the year...
Table 4.4: Indicators Of RCH: Status Of Nanded

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Birth Rate</td>
<td>26.2</td>
<td>26.4</td>
<td>24.9</td>
<td>1.8</td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td>Death Rate</td>
<td>5.1</td>
<td>5.3</td>
<td>6.0</td>
<td>6.4</td>
<td>5.0</td>
</tr>
<tr>
<td>3</td>
<td>Neonatal Mortality Rate</td>
<td>48.0</td>
<td>40.38</td>
<td>43.0</td>
<td>20.0</td>
<td>10.0</td>
</tr>
<tr>
<td>4</td>
<td>Infant Mortality Rate</td>
<td>53.0</td>
<td>51.1</td>
<td>43.1</td>
<td>25.0</td>
<td>15.0</td>
</tr>
<tr>
<td>5</td>
<td>Maternal Mortality Rate</td>
<td>3.7</td>
<td>1.3</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Total Fertility Rate(TFR)</td>
<td>4.0</td>
<td>3.7</td>
<td>3.3</td>
<td>2.8</td>
<td>1.8</td>
</tr>
<tr>
<td>7</td>
<td>Couple protection Rate(CPR)</td>
<td>47.3</td>
<td>53.0</td>
<td>56.0</td>
<td>60.0</td>
<td></td>
</tr>
</tbody>
</table>

Source:- Health Department, Zilla Parishad, Nanded.

Family Planning Services: Status of Access

According to Coyagi (1996) ensure couples to have access to a caring family planning services to reduce pregnancy too early, too late, too many, too often backed by a safe and emphatic abortion service. Community based distribution of contraceptive is the most accessible, acceptable, cost effective and successful distribution system. Acceptability depends on whether a contraceptive method suits to the individual or not. And the suitability is related to the choices offered to the person. Being denied choices punishes a person imprisoned; a person denied choices is punished even without being imprisoned. Better services would attract more clients and encourage more clients to continue practicing contraception.
The demand for family planning is growing faster than supply (Robey, b. et al, 1992). Many people discontinue using contraception and some never adopt contraception because they lack proper access to suitable contraceptive methods (Bruce, 1990) The success of Family Planning Program ultimately hinges on their ability to meet the individual needs of a spectrum of potential clients (Ainsworth, 1985).

It is now widely acknowledged that the provision of quality health services to people is the key to the success of the programme. The GMPs, if trained properly can provide quality family planning services. It is not enough to acknowledge that films and television offer the best means of spreading the message of the small family norms. In fact, the GMPs will convert the awareness created by films and television into actual using of contraceptive methods by properly communicating the message. Thus, the access to information regarding contraception would increase. In the developing world there has been a 4 to 5-fold rise in the contraceptive users during the last 3 decades. Due to increase in the female literacy and improved contraceptive acceptance, women now have smaller and healthier families. They work outside their homes, enjoy a better quality of life and live longer. But the benefits from the modern contraceptive revolution have not been made available universally. Millions of women are still denied access to information and means of fertility regulation as a result of which they are forced to face hazards of unplanned pregnancies and unsafe abortion.

Around the world, people increasingly want smaller families. Easy and affordable access to a wide range of contraceptive methods is essential for each couple to find the method that best meets their needs in planning their families. Since no one method can satisfy all couples, a greater choice of methods also helps to increase overall contraceptive use. This in turn contributes to healthier patterns of child bearing, slower population growth and overall development.
Unless we meet contraceptive needs to individuals in the remainder of this century we have no chance of meeting the world's development needs (Sadik N-b 1994).

John C Caldwell et al (2000) expressed that continued increase in levels of contraceptive use is necessary to achieve global replacement level fertility by the middle of the twenty first century. One of the four factors postulated in the United Nations medium population projection was the existence of family planning program that can facilitate the diffusion of Family Planning ideas and access to the means of implementing them. The other three factors being, Socio-economic changes, declining infant and child mortality, and diffusion of the idea of fertility control and its practice.

OVERALL TRENDS IN ACCESS

Throughout the developing world, revolution in reproductive behavior is under way. Today, over half of all couples in developing countries use a contraceptive method, compared to one in ten couples in the 1960s. This is because, all the developing regions have made substantial progress in improving access to contraception. Despite this progress, many couples in developing countries still lack access to the full range of contraceptive methods. Access to contraception is strikingly better in developed countries than in the developing world. Although, higher income levels make it easier to obtain contraception, especially from private sources, government policies make a difference. In general, wealthier countries do better on the developing country index but some relatively poor countries strongly committed to family planning have very high success. Improvements in access in Kuwait and United Arab Emirates however, reflect the increased availability of contraception from private as well as government sources.

No one method is adequate to meet the needs of every couple. Some couples want a temporary method to space the birth of
their next child, while others do not want any more children and want long-term methods. Individuals vary in their personal preferences and in their assessment of the risks and benefits of each contraceptive method. Therefore, the number of different contraceptive methods offered on a consistent basis is important because access is enhanced when couples can choose from alternatives.

A choice of method is also important from a health perspective. Many women find birth control pills satisfactory, while others experience unacceptable side effects. Some hormonal methods are inappropriate for breast feeding mothers and their babies. Intra Uterine Devices pose potential health problems for women at risk of sexually transmitted infections, while condoms provide protection from both pregnancy and disease.

The availability of range of methods provides alternatives for individuals dissatisfied with their current choice of contraceptives. The ability to change methods is important since a third of all couples discontinue a method within a year of initiating use and about half, discontinue use within two years.

Access to a choice of contraceptive methods is thus a key element of quality health care. By helping each couple find a method that fits their needs, the availability of multiple methods contribute to improved child spacing and enhance the health of mother and children. Moreover, a greater choice of method increases contraceptive continuation and effectiveness as well as overall use of family planning. Thus, expanded method choice, also contributes to the efforts to slow population growth and advance social and economic development.(Contraceptive Choice,1997)

**KEY ELEMENTS OF ACCESS AND CHOICES:**

The Report on progress towards world population stabilization (Contraceptive Choice,1997) regarding key elements of access and choices is as follows:
• Government policies have a powerful impact on the availability and accessibility of methods. Policymakers decide which contraceptive methods will be available yet these decisions are often based on out-dated laws, misperceptions about health risks or biases about scientific methods.

• The distance and time required to obtain contraceptive services and supplies are among the most important elements of access. The proximity of sources is particularly important for methods such as birth control pills, which require re-supply on regular basis. Even where services are available, however, cultural factors such as the ability of women to travel freely to clinics many limit access and use. Similarly, poor quality of care can deter use of existing services.

• The availability of methods through multiple channels enhances choices. A combination of complimentary approaches is usually needed to make a full range of contraceptive services widely available, since public health services rarely reach the entire population. Different delivery systems are appropriate for different contraceptive methods and can help to reach different groups within a society. For example, the middle class may prefer private service to the public health system, often precise as less convenient and lower quality.

• Awareness of range of methods and of their risks and benefits is essential to informed choice. While knowledge of family planning has increased in many countries in others it is still limited. Moreover, many women discontinue using family planning methods because of inadequate information and unfounded fears about side effects.

• Among the different strategies suggested in the report the private sector is emphasised. It has been envisaged in the report for the use of a variety of public and private channels to provide reasonably equal access to a range of methods. Clinics and trained health staff are needed to provide IUDs, contraceptive
implants and sterilization. However, various communities network can help ensure the widest possible availability of pills, condoms and other non-clinical methods. Involving private groups such as commercial distributors, voluntary agencies doctors, midwives and pharmacists can expand access while reducing the financial burden on the public sector.

Many people are using a family planning method other than the one that they prefer. Most often the reasons were that the preferred method was too expensive, too difficult to obtain, or not available at all. Other reasons included medical ineligibility and family disapproval.

WHO guidelines on contraceptive method mix do not mention specific methods that program should offer. They state that "Program should provide a variety of types of methods to meet the different needs of different individuals or couples." Other experts advise programs to offer.

- Contraception option both for men and for women
- Temporary methods and permanent methods
- Hormonal methods and non-hormonal methods
- Supply methods and fertility awareness based methods.
- Procedure-controlled methods and user controlled methods
- Contraceptive option for breast feeding women including the Lactational Amenorrhoea Method (L.A.M.) and
- Emergency contraception.
- Broadening the types of services delivery can provide more choices, especially for people whom conventional program have difficulty in serving. These include people with low incomes, those in rural areas, women who can not leave their norms and others who want their contraceptive use to remain private. In addition with more services delivery outlets, people who want a particular contraceptive for example, a specific brand of condom or pill formulation can more easily find it.
Access for different contraceptive methods also depend upon the proximity of the provider to the clients. Many people base their choice of family planning on how accessible a method is particularly if visiting a clinic requires long travel. A nearby source can even make the difference between using contraception and not using it at all. In Morocco for example, a survey of women who in 1992 had not intended to use contraception found that by 1995 those who lived close to a hospital, clinic, doctor or pharmacy were more likely to be using family planning than those who lived farther away, while such other factors as social and economic differences or changes in reproductive intentions could explain the difference, the researchers concluded that proximity to a source of supply was the most likely reasons. (Magnani, R-J et al, 1999) If a General Medical Practitioner is made more steady and sure messenger resourceful person and technically competent – proximity to people can improve the access there by increasing the acceptance of contraception. People can get more accurate advice and supply of methods in time.

Apart from proximity there can be problems in service delivery of contraceptive methods. Government limitations as service delivery can make it difficult for people to obtain contraceptive methods, for example, if the pill is available only by prescription, if condoms can be sold only through pharmacies (Kenney, G.M.1993). Tax and import policies that increase commodity costs, for example, import tariffs quotas and exchange controls often limit choice and access by deferring private and non-profit sectors providing contraceptives. (Dadian M.J., 1997, Feeley.F, 1997, Ferreros,1995). Similarly, policies supporting decentralization or local decision making however, can increase access to family planning by responding better to needs specific to the community (Heicheihei. J, et al, 1998). Although the Government of India now advocates a wider contraceptive method mix, some family planning providers still are ill equipped to offer the pill and other temporary methods (Gandotra M M et al,1996 and IIPS,1998-99)
Khan et al, 1989 in their study of access to health and family planning services in rural Uttar Pradesh did a micro-level evaluation. This study investigates the accessibility of health care services to people living in a typical North Indian Village of Uttar Pradesh. The public health centres, subcentres and dispensaries were found to be ill-equipped, supplies of medicine were far less than required, and the staff did not function properly with late arrival and non availability being common occurrence. Poor transportation further reduced accessibility. These Government services also appear to be less cost effective than services offered by village practitioners. Village health practitioners though unqualified were found to be reasonably effective is treating common ailments. Their understanding of the cultural values shared by villagers and their personal touch in dealing with patients make them reasonably effective as well as acceptable. These private village practitioners are not competent in treating serious or chronic diseases, the provision of pre or postnatal care, the protection of children against infectious diseases and the provision of family planning methods. GMPs can have this personal touch and make family planning methods acceptable on similar basis.

Along with the difficulties in delivery of contraceptive methods, proximity to the family planning providers educational status of women and cultural restrictions are also important factors related to the status of access. The female literacy and education are crucial to contraception and reproductive health. For its success, contraception should be affordable and accessible to all who need it. The choice or cafeteria approach is necessary, as no one method is fully satisfactory. Different methods are indicated at different stages of life or under different conditions. Equally important is the quality of service with well-trained providers and regular follow up. GMPs if trained properly quality of services will improve and their clinics will act as centres for follow up purposes too (Sadik, 1994). Cultural restrictions on woman's personal freedom limit dramatically her access to health care. Women's mobility under these conditions is
severally restricted. Having male doctors and health care workers limits women's ability to avail their services. Male dominance is sexual relation and non-access to contraception makes women to have no control over pregnancies and childbirth and on contracting diseases. (Malini karkal, 1996)

The status of access when considered at the clinic level, the issues are clinic timings, availability of a physician, length of wait to see a physician, availability of medication, and users' source of contraception supplies. The physical accessibility of a clinic is location specific and further depends on a client's residence as well as on factors such as availability of transportation. At the same time accessibility is also determined by clinic timings. Whether those houses are convenient to clients and whether these stated working hours are actually observed. (Gillian H C. Foo, 1995)

Access to the knowledge of details of contraception to GMPs in equally important. Knowledge of ways to improve reproductive health has rapidly grown in the past decade, generating internationally recognised standards for care and guidelines, training manuals and tools to enhance reproductive health. However challenges remain. Established standards and guidelines do not necessarily reach people who need them. Also there is a need to adopt internationally established recommendations to produce national guidelines that reflect local policies, practices and cultural norms. GMPs are close to cultural practice and norms of people so that they can contribute to this program more effectively. To meet these challenges, a recently formed consortium composed of the WHO and 10 partner agencies has launched and initiative to facilitate the introduction and use of ‘Best Practices’ in reproductive health care programs at international, regional and country levels. The consortium will support its initiative called ‘Implementing Best Practices’ (IBP), by systematically reviewing and cataloging reproductive health practices and various innovative approaches to
help policy makers, program managers, and providers determine what works and discard what does not and learn from others. The IBP initiative also stresses the need for change from within established systems, with programs using their own experiences to develop ways to introduce best practices and improve performance (Kim Best, 2002)

Family Planning Services: Status of Private Sector.

In India, family planning services are to be provided yearly to 27 million pregnant women, 25 million deliveries are to be conducted and 25 million infants looked after. These are mind-boggling figures. The government of India is making a valiant effort to do that. But, government cannot do it alone. It needs the support of the international community, dedicated health professionals and their national and regional societies and above all, the people and NGOs who are close to people (Coyagi, 1996). Governmental efforts alone cannot substantially lower the birth rate and make the family welfare programme a people's programme. To this end, it would be useful to involve the vast and yet untapped agents of social transformation such as, general medical practitioners, who work at the grass root levels and who have over the years, earned the trust of the people.

According to Nandraj and Duggal (1996) the private sector is a large and important constituent in the country's health care delivery system. It has expanded greatly in the post independence period, especially in the 1980s. Various studies conducted by organisations such as NSSO (National Sample Survey Organisation), FRCH (Foundation for Research in Community Health,) KSSP (Kerala Shastra Sahitya Parishad) and NCAER (National Council of Applied Economic Research) bring out the fact that between 60 to 80 per cent of people utilise private health facilities in the country in both rural and urban areas. The findings also show that a substantial financial burden born by households for meeting health care needs. The private household expenditure is nearly four to five times more as

Provision of health care services is complex in India. It is provided mainly by the public and private sectors. The public sector provides health services through the Central Government, State Government, Municipal Corporation and other local bodies. The private health sector consists of the 'not-for profit' and the 'for profit' health sector. The 'not for profit' health sector which is very small includes various health services provided by non-government organisations (NGOs), charitable institutions, missions, trusts etc. Health care in the 'for profit' health sector is provided by various types of practitioners and private institutions. The 'informal' sector consists of practitioners not having any formal qualification, like the tantriks, faith healers, bhagats, hakims, vaidyas and priests who also provide health care.

Private medical practice flourishes almost everywhere. The range of providers is also varied. From the herbal and witch doctor to the modern unqualified or quasi-qualified 'quack' and to the qualified practitioners of different systems of medicine, many of who also indulge in quackery. There is no firm data available on the entire range of practitioners. Estimates from various studies or indirect extrapolations are the only methods for fixing a proximate size of medical practitioners.

The diversity and complexity of the nature and status of the general medical practitioners become a serious concern in the context of the fact that an overwhelming majority of them, including unqualified are practicing allopathy. A major question, which needs to be addressed, is how to view practitioners of different systems of medicine, how should they be distributed in the population and what types of care should each group allowed to administer. The non-
allopathic and unqualified are in reality largely, practicing modern medicine even when they are not trained for it.

The private sector plays a significant role in the provision of health services in all countries of the south Asian region except Bhutan. For example, private hospitals in India accounted for two third of all hospitals and for one third of all hospital beds in 1993. The development of the private sector has been rapid and visible in many countries. Traditional and indigenous system of medicine also plays an important role in meeting people’s health needs. Unfortunately, these categories of health workers are rarely taken into account in the assessment of country’s human resources for health. For example, in India, three fifth of the registered physicians are from non-Allopathic system of medicine. There are 4.0 and 1.8 Ayurvedic and Homeopathic physicians respectively as compared to 4.8 allopathic physicians per 10,000 population (Gopalan S et al, 1999). Most of the practitioners of traditional and indigenous systems of medicine operate in the private sector. As in the case of practitioners of modern medicine, the majority of physicians in the indigenous system of medicine are men (Women of South Asia, 2000).

There are over five lakh qualified practitioners of Indigenous systems of medicine and Homeopathy who have practically no role at all in this family planning program at present. In addition, there are several registered medical practitioners (RMPs) who also have no role to play and infact, looked down by many as ‘quacks’ yet these very practitioners have the trust and support of the communities they serve and can be involved as partners in making this a people’s program by first giving them some training. In case, they are involved in the national health programs particularly in the family welfare program, they could play an important role in educating the local people in motivating them to accept the small family norm (State on India’s Health, 1992).
For the eight lakh non-allopathic doctors (Homeopathy and Ayurvedas etc) there is hardly any proper Continuing Medical Education (CME). Most of them prescribe allopathic medicines (Cross prescription) and depend more or less solely on Medical Representatives of drug companies for their knowledge of allopathic drugs (Phadake, 1994). Public health sector, which comprises of Government, Municipal hospitals, PHCs and other governmental health facilities, contribute as much as 79 per cent whereas the private medical sector including private hospitals, clinics, private doctors and chemists supply only 15 per cent of users. The blend of public and private sources varies according to the method of contraception. In rural areas, the usage of public sector is more predominant than in urban areas especially for sterilization services (Vadair and Khanvilkar, 1995).

TRAINING PROGRAMS FOR PRIVATE PRACTITIONERS:

Several studies have been conducted to know the status of private sector in India, in relation to family planning services. Efforts are on to improve the capacities of private practitioners in the promotion of Family Planning Programme.

A study on training and evaluation of private practitioners conducted in Uttar Pradesh (Luoma, 2002) reveals that there is a potential of improving the capacities of private practitioners in family planning programme. The performance of these practitioners in counseling the clients had improved substantially after the training (up to 80 percent, on improvement score) which indicates that the planned training and orientation programme for private practitioners can make them as important service providers in the family planning programme.

Figure for the current percentage of eligible clients begin counseled are not available. Quality of care seems to be high: Simulated clients and self-reporting show that 80 per cent of the
practitioners are meeting the criteria for good counseling (Luoma, M, 2002).

The Indian Medical Association (IMA) organized another training programme in 1992 for private practitioners. They observed encouraging results of such training programs. Short training sessions for private sector physicians with the aim of improving their perception of oral contraception and of increasing the proportion of women seeking family planning with services from private practitioners. Baseline and end line surveys were conducted among private practitioners to assess the training project. Physicians recommending OC pills to clients increased from 55 per cent to 78 per cent. Trained physicians were more likely to provide alternative choices of family planning methods than untrained physicians. Their clients were more likely to be satisfied with the quality of service and the amount of time the physician spent with them than those of untrained physicians. The number of clients who accepted OC pills increased slightly after training. Yet the improved competency and proficiency enhanced the images of the program and the quality of care. The trained physicians advised the OC pills more favorably after training. For example only, 30 per cent considered OC pills to be effective before training but after training 98 per cent did. They were also more likely to rate OC pills as easy to use. Despite strong improvements in technical knowledge, many private practitioners were still not clear about timing of first pill and the transition between packets of OC pills. Most physicians found the training to be helpful and of good quality (Population Council, 1995)

A couple of studies are found in the literature, which deal with Pharmacies and other private sector providers along with private practitioners. Pharmacies, private practice physicians and other private sector providers are blending sources of family planning supplies and services. In developing countries, the commercial sector serves 20 per cent of women who use contraceptive methods. In
some countries people perceive that private family planning services offer better quality than public services, and people increasingly and willingly pay full price for the services (Khalifa M.A, 1993, Leoprapai B.1999). Similarly, a study conducted by Storey D et al, (1994), aims to expand the involvement of the private sector in the Indian family planning programs. This multi year initiative aspired to upgrade the quality of private family planning services and publicize the increased availability of such services. In addition, this social marketing campaigns have aided in the identification of officers of trained private provides and attempted to associate quality family planning with those trained physicians. Senanayake P.(1996) while reexamining the role of government and non-government organizations and the private sector in Family Planning, in her study emphasizes the role of private sector in family planning involves pharmaceutical companies to determine demand, private doctors and pharmacists to provide services and information, social marketing of contraceptives and employment based programs.

According to an international study, the ‘for-profit’ commercial sector is also important source of Family Planning. In Latin America and near East for example, in 10 of 15 Latin American countries surveyed since 1985, the commercial sector services a higher percentage of contraceptive users than does the Government. In Brazil, Paraguay and Egypt, private providers supply more than two third of family planning users. (Robby, B., et al, 1992; Population Report, 1995)

In 1996, Dr Amrita Dass (Chairperson, The Hunger Project, UP) stated the importance of ‘immense potential for the provision of reproductive health services’ by the private sector.

Silla M.B, (1999) after Cairo conference, stated regarding the relationships that the object of partners is to work in the expansions and improvement of reproductive health services and family planning in a self initiated and sustained manner through a climate of mutual
trust, respect and openness. Moreover, partners pursue strategies for integrating governmental and non-governmental structures in the reproductive health field. It strives to encourage the whole spectrum of civil society from research and training institution to the private sector in forming partnerships to impact on the reproductive health of the poor.

Regarding sterilization services in private sector Dilip T.R. (1999) observed in his study that the participation of private sector in providing sterilization services was limited as compared to their interest in delivering other health care services. In fact, persons from higher educational and economic strata mostly, availed these services. Though quality of private sector was better than public sector, it was found that a considerable proportion of women who used private sector resources were still dissatisfied with the quality of services they received even after paying for these services.

STATUS OF PRIVATE SECTOR IN MAHARASHTRA

Family planning methods and services in Maharashtra are provided primarily through a network of Government hospitals and urban family welfare centers in urban areas and Primary Health Centers (PHCs) and sub centers in rural areas. Private hospitals, clinics as well as non – government organizations (NGOs) also provide Family Planning services. Sterilization and Intra Uterine Device (IUD) insertions are carried out mostly in government hospitals and PHCs. Sterilization Camps, organized from time to time also provide sterilization services. Modern spacing methods such as the IUD, pill and condom are available through both the government and private sectors.

The Government health infrastructure is the source of contraception for 75 per cent of current users of modern methods. The private medical sector, including private hospitals or clinics, private doctors, private paramedicals, and pharmacies or drug stores, is the source for 21 per cent current users.
68 percent in urban areas for in-patient services. In case of outpatient care, the private sector was already accounting for three forth share in 1987 and this increased marginally to 77 per cent in 1996. (Duggal, 2002)

In Maharashtra, physician’s availability in the private as opposed to the public sector is accentuated by the fact that in some cases, physicians are not available at government facilities because they are carrying out their private practice during government hours. (Gillian HC. Foo, 1995)
Two per cent of current users obtain their methods from other sources such as shops, friends and relatives and one percent from NGO or trust facilities, Government / Municipal hospitals are the main sources (48 per cent) for female sterilization followed by Community Health Centers, rural hospitals or Primary Health Centers (PHCs-31 per cent) and Private Hospitals or Clinics (15 per cent). By contrast, 64 per cent of current pill users, 63 per cent IUD users, and 58 per cent of condom users obtain their supply from the Private Medical Sectors. Pharmacies or drug stores are the main sources for pills (55 per cent) and condoms (50 per cent) while 45 per cent of IUD users obtain the method from private hospital or clinics.

Eighty six per cent of rural users obtain their contraceptives from the public medical sector, compared with 59 per cent of urban users. Although the public medical sector is the main source for female sterilization in both urban and rural areas, in urban areas the private sector also plays a substantial role. Twenty eight per cent of female sterilization were performed in the private medical sector in urban areas, compared with only 9 percent in rural areas. For pills, the private medical sector is also a more important source in urban and rural areas, while for condoms, the private medical sector is a
more important source in rural areas than in urban areas. A large majority of users of pills and condoms obtain their supply from private pharmacies, drug stores, or shops in both urban and rural areas.

The above Pie diagram shows unsatisfactory status of motivators for contraceptive users in Maharastra. The figures show that there is dearth of motivators in private sector and if GMPs are involved appropriately in this programme, they can act as motivators and improve the number of contraceptive users in Maharashtra.

During the same survey in the year 1998 – 99 the respondents were asked if they had been examined properly at government clinics and whether they considered the treatment they had received to be effective. Respondents rated these aspects of providers' competence less favourable at government facilities than that at private clinics.

The smaller studies done at different points of time in Maharashtra also indicate a very large and growing share of private health sector. The two NSSO surveys clearly show that between 1987 and 1996 private health utilization in Maharashtra increased from 56 percent to 68 percent in rural areas and from 54 per cent to 68 percent in urban areas for in-patient services. In case of out
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