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## Understanding Family Planning Practices amongst young married couples of Lucknow: A Sociological Analysis

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### Abstract

*India is the first country in the world to adopt Family Planning Programme, soon after independence, more than seven decades have been passed since then and the problem of population is still unresolved. Looking at family planning in isolation will be erroneous from analytical point of view. Hence in the following study, an attempt has been made to discuss about a theoretical and conceptual framework which would help in better understanding of the concept, sociologically. The role of gynecologists, role of husband, power relations and women's autonomy to decide for her body has been analyzed in detail this study.*

### INTRODUCTION

As on 1st March, 2011 India's population stood at 1.21 billion comprising of 623.72 million (51.54%) males and 586.47 million (48.46%) females. India, which accounts for world's 17.5 percent population, is the second most populous country in the world next only to China (19.4%). (Family Welfare Statistics in India, 2011)

India set the goal of population stabilization in the very first Five- Year Plan (1951-1956) which was formulated soon after India attained independence in 1947. In spite of completing 12 Five Year Plans, the goal of population stabilization remains a challenge. The population continues to grow at a faster rate than anticipated by policy makers. India is the first country in the world to officially promote family planning in 1952 with the expressed desire for a lower rate of population growth and stabilize the population at a level consistent with the requirements of the national economy. The ground work for the policy was worked out between 1931 and 1951. Family Planning is not merely the use of contraception for limited family size. Rather it is a mode of planning family size as per requirement of time and space.

According to WHO Expert Committee (1971) 'the family planning is a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitude and responsible decisions by individuals and couples, in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a country.'

Family Planning is closely related to population policies and the population policies followed by a particular country are drawn against the background of competing population theories and are largely determined by the economic needs of the country.

Looking at family planning in isolation will be erroneous from analytical point of view. Hence in the following study, an attempt has been made to discuss about a theoretical conceptual framework which would help in better understanding of the concept, sociologically.

The process of reproducing or planning for a family is not a biological process alone. It has deeper meaning attached to it. This paper tries to understand certain sociological reasons which influence procreation amongst young married couples of Lucknow. It tries to highlight the role of medical institutions in this process and also how the married woman understand this process.

Intensive community studies helps in understanding comprehensively an intimate behavior like human fertility. This study tries to understand fertility behavior not only in the context of other demographic factors like sex, age but also social systems in general.

## **RESEARCH METHODOLOGY**

The study is based on primary data collected using a triangulation technique for which three major sources were identified and data received from all three sources were analyzed and a pattern was traced. Method of triangulation has been employed for data collection. Principle of triangulation involves considering data from at least three different sources to help ensure more dimension to the data. This means interviewing three separate individuals about a phenomenon. Researchers could analyze data from these various sources to determine whether any patterns or themes emerge consistently across them.

A sample size of 328 married women in the age group of 15-49 years of age were selected using purposive sampling. Purposive sampling is the one in which participants are deliberately selected because they are most likely to provide insight into the phenomenon being investigated due to their position, experience or identity markers (Eg. Demographics such as gender, race/ethnicity, health status). Researcher selects participants by approaching an organization constituted by the types of people required for the study. Purposive sampling helps the researcher who is hoping to investigate certain population, especially those that are otherwise difficult to locate, another method that was employed, was snowball sampling, a method in which participants were asked to recommend other similar participants to take part in the study in order to gain a larger pool of participants than the researcher originally had access to.

This study is based in Lucknow, Uttar Pradesh, India. For the purpose of collecting primary data, two medical institutions, particularly, catering to maternity services were identified. One is a government set up located in old city of Lucknow, the other one is a private clinic located in a busy locality near Charbagh railway station.

Firstly, a quasi-participant observation method was used to observe married women between 15-49 years of age visiting medical institutions and recording their responses on a schedule. The secondary source to validate the data were the findings of National Family Health Survey IV (2015-16) data, and the third source of obtaining primary data was through conduction of semi structured/ telephonic interviews with gynecologists practicing in a private or government set up.

This study is a contribution in the field of micro-level, holistic in-depth analysis of fertility behavior. This tries to combine demography and sociology.

## FINDINGS

Main findings of the study can be summarized under three subheadings

- Paradigm shift
- Rise in ‘ultramodern contraception’
- Role of “Husbands” during their visits to Gynecologists.
- The “gendered nature” and “power relations” between patient and doctor.

### Paradigm Shift

A paradigm shift can be observed when it comes to “choosing” from a wide basket of methods available for family planning. The dominant method of female sterilization which attracted a huge number of women in the previous years noted to be declining in this study. According to Family Welfare Statistics 2011, more than five million female sterilizations were performed in India, between the years 2010-11. In this study, a paradigm shift could be observed from irreversible, permanent method of family planning i.e. sterilization or more popularly, tubectomy towards use of modern methods, mostly methods used for spacing saw an increased acceptance. Gynecologists reported that 57.1% couples use male condoms, 14.3% use contraceptive pills and 28.6% prefer to insert a Copper T or IUD device to space the birth. After having desired number of children, only 28.4% women opted for sterilization. Doctors counsel the women thoroughly before they opt for this method. This paradigm shift from irreversible and permanent method to reversible and temporary method shows increased awareness and increased participation of men in planning for the family. In this study, majority i.e. 47.4% of married women belong to the age group of 27-30 years, 21.1% were under the age bracket of 23-26 years of age, 21.1% between 31-34 years of age and 10.5% 35 years and above. Very negligible number of women were less than 22 years of age. This shows a delayed initiation of reproductive career of married women in Lucknow. The data of NFHS IV, Lucknow district fact sheet too indicate that only 15.6% of females adopted sterilization as a method of family planning.

### Rise in ‘ultramodern contraception’

There is an increase in usage of traditional methods of contraception with 33.3% of women having an awareness about withdrawal method and 66.7% of women having awareness about rhythm method. The educated women, belonging to the upper middle class of society are clearly the modern users of traditional methods of contraception.

With even more education and more money, the definition of what constitutes a ‘normal’ reproductive and sexual body, becomes what Alaka Basu calls ‘ultramodern’. The most important distinction is that for the upper class women in India, as elsewhere, the body is a consumer and not a producer. So no longer is a medicalization that tells women to trust unhesitatingly in western modern modes of treatment either of illness or of unwanted fecundity to be trusted blindly.

One of the greatest factor promoting such ‘traditional’ methods of prevention and treatment is not the perceived ineffectiveness of modern methods but their unwholesome side effects- a finding consistent with the most common reason given for discontinuing contraception in family planning surveys.

### Role of “Husbands” during their visits to Gynecologists.

In the private clinic, it was noticed that most woman were accompanied by their husbands, especially those woman who were either expecting or planning their families. The patriarchal superiority of husbands and their positional superiority over their wives was clearly visible, the unequal power relations were captured very well during field visits. On entering the clinic, the men usually initiates the enquiry at the reception counter, followed by inputs given by woman, later men “looks” and “selects” a place for the woman to sit and then they go out to stand on the street, just outside the clinic to interact and have informal discussion with other men. On being called for consultation, the woman signals their husbands to accompany her. In one case, an observation was made about the doctor-patient relation inside the main chamber, a muslim couple was sitting, with the wife clad and covered in “burqua” sitting in a feeble position, the husband was responding to most of the questions, the wife was slowly whispering the responses and husband was telling them aloud to the doctor. Similarly, in other instances, when the doctor advised about some contraception like insertion of a Copper T or IUD, the first reaction of most of the woman was to look towards their husband if he is present or pushes the decision for future and tells the doctor that she will ask her husband and then decide. This “authoritative” position that men hold in patriarchy gets reinforced and reproduced within these spaces.

Although, men were not allowed inside the OPD (Out Patient Department) of the public health facility, but their role was still visible when it comes to decision making by woman for her own “body”. When the doctor advices to insert an IUD or get sterilized, they mostly could not agree with the doctors decision and had to push it for the next visit as they needed time to consult their husband’s or family. This shows the weak agency of woman towards her own physiological needs. After a “professional” advice, another “authoritative” permission had to be granted for further procedure.

### The “gendered nature” and “power relations” between patient and doctor.

In the private clinic, on entering the main chamber, the doctors was surrounded by 2-3 patients and few patients waiting for their physical examination to be done behind the curtains. The cycle of patients entering the chamber is like a process where one patient goes out, two patient enters, on entering one patient stands near the door and the other sits on the chair next to the patient already waiting for their turn as the patient sitting on the examination stool kept right next to the doctor is getting attended by the doctor. One can feel a sense of achievement when the staff calls out their name to get inside, it is like getting an “entry” to a holy place! The entire process of registration and then waiting to get attended is itself an experience.

Finally when the patient gets to sit on the examination stool, the doctor asks various questions to the patient in order to get an accurate medical history of the patient. There were many woman with blank faces and were clueless about their own bodily functions like their last menstrual cycle, if any irregularities experienced in the cycle etc. which shows the awareness level of woman. The woman were mostly very hesitant in talking about their problem, for a very personal event like pregnancy or planning for a family, which is a very sensitive area and is extremely personal requires more of elements like comfort, private space with polite communication. But in the clinic there were 3-4 patients present in front of the doctor with 2-3 patients lying inside the examination room waiting to get examined. Sometimes, the woman felt hesitant in discussing about her issue in the presence of strangers who were non-medical staff. Sometimes in the room, husbands of other patients were also present, presence of the other gender, further made them uncomfortable. Sometimes, while dealing a sensitive issue like infertility of a couple, the men too faced an embarrassing moment, when other patients stared at the couple with uncomfortable looks. In the medical institution, these woman were reduced to “mere” clients who came to seek a service. This highly objective, inorganic atmosphere of the clinic acted as a barrier for a woman in expressing her concerns to the doctor. The patriarchal societal structure of North India itself socializes a woman to become submissive and compliant. Woman easily “obeyed” the advices given by the Gynecologists and never questioned or raised any doubts. They mostly nod their heads to the advice of the gynecologist, this reflected the gendered nature of patient and doctor relationship.

There was a paucity of qualified gynecologist in the private clinic, in the entire clinic only one doctor was a qualified gynaecologist, others were either nursing staff or doctors having a degree in alternative medicines like Ayurveda, Unani etc. The gynecologist herself confessed that she is overworked and this was clearly visible in her interaction with the patients as she gets irritated easily and fails to empathize with the patients.

In the public health institution, the dynamics of patient doctor relationship is quite different compared to the private clinic. Since it is a public health space and a part of medical university, there is dedicated department solely to gynecology and obstetrics, which is visible by presence of ample amount of specialists, senior doctors, senior residents etc. It is a non-profit making body which takes minimum fee for consultation, this attracts patients from various socio economic backgrounds, particularly from poorer sections of our society. The OPD (Out Patient Department) has many senior resident doctors attending the patients and doing primary examination, they are watched and supervised by senior

doctors and hence are very careful in diagnosing the condition. This structure often benefits the patients as they get a thorough check-up. Senior residents show best of their behavior as they are being observed by their professors. Apart from the power relation between doctors and patients, there also exists a power relation between doctors themselves in a public health space, particularly a medical college.

## CONCLUSION

The term “status” was dropped in favor of the term women’s autonomy deployed in demographic studies by Dyson and Moore (1983). Later, several studies including Jeejebhoy (1995) and the collection of essays on education of women and fertility edited by Jeffery and Basu (1996) preferred the term “autonomy” to “status.” Autonomy of a women with reference to take decisions regarding her own body plays an important role while planning for a family.

Empirical research has shown diverse trends in the education of woman and their fertility rather than a convincing theory of fertility decline. Women belong to families and households and their reproductive behavior is organized in a cultural and social context.

Sociology helps us understand comparative situations. There is complexity of urban life. There is interface between different communities. Hence, one policy will not cater to the highly complex heterogeneous urban women and their decisions of family planning.

There are certain criticism of the Family Planning Policy

- Huge foreign funds directed without understanding the local context.
- Vertical approach and no focus on improving quality of life and economic conditions of people.
- Shifted from Family Welfare to Population control with coercive targets, camps, incentives.
- Emergency excesses saw shift in sterilization from male to female.
- Health facilities not improved in rural India but family planning program aggressively pushed.
- Temporary contraceptive methods not a priority- sterilization promoted as main method of contraception.

The reproductive system of women as a site of patriarchal structuring of gender roles and power relations. What all of them have in common is historical roots in paternal anxiety, wherein woman’s sexuality was viewed as dangerous on account of the threat it posed towards determining paternity and therefore, lineage and ancestry.

Government has made an attempt to address family planning with a more holistic approach through “Hum Do” a radio chat show with 52 episodes prepared by Ministry of health and family welfare.

Another interesting site of observation is the logo of Family Planning – It continued the traditional inverted red triangle with animated image of couple holding a child – Without revealing sex of child. Tagline has also changed from Hum Do Hamare Do to Jodi wahe Zimmedar Jo Plan Kare Parivar. Which stresses the role of the “couple” rather than the women alone and is promoting Planned Parenthood.

One of the gynaecologist during the fieldwork summed up the social construction of procreation beautifully, she mentioned that pregnancy is not a disease, it's a condition. Maternal mortality is highly looked down upon. Unlike surgery or any other field of medicine, where a patient already comes with a morbidity and its aware about its outcomes, pregnancy is a completely different field and require more community support and emotional support as this condition lasts for nine months.

To conclude, acceptance of family planning has entered a stage of transition from "birth control" to "birth spacing", as the department is rightly renamed as "Family welfare" from "Family Planning". The focus on the couple to make decision and involve men thoroughly throughout the parenthood journey is a positive side of the story. Although, "women", itself is a heterogeneous group and each women has a different need, different aspiration towards planning a family.

Role of medical institution, health workers and gynecologists cannot be ignored. For an urban setting, they are the primary provider of all the services related to family planning and ensuring a safe, healthy and happy planned parenthood to all couples. This area is largely unexplored and there is a need for more interdisciplinary studies which will help in getting a better understanding of family planning from all three major dimensions of community, medical institution and government policies. According to NFHS IV data, Lucknow district fact sheet, sex ratio at birth for children born in the last five years is 870 girls for 1000 boys, which is highly alarming. These studies are required and will be proved highly beneficial in analyzing the aspirations of couple towards their desired number of children and their gender along with the role of medical institutions in guiding them and counselling them about safe motherhood and also the role of government policies which promote the birth of a girl child.

According to Sample Registration System Statistical Report 2018, India has achieved a Total Fertility Rate of 2.2 which is very close to the replacement fertility level of 2.1, but these figures remains highly inconsistent throughout the nation, with Uttar Pradesh having very high Total Fertility Rate, compared to the national TFR, i.e. 2.9 children per women. This calls for a region/state specific sociological understanding which will further help in formulating state specific policy to bring the total fertility rate down.

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