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Moving Targets: Routine IUD Insertion in Maternity wards in Tamil Nadu, India

Cecilia Van Hollen

In l995, nurses and doctors in many of the public maternity ward in the state of Tamil Nadu in India were routinely inserting IUDs immediately following childbirth and abortions, as part of the target-orientated family, planning policy. This practice, sometimes carried out unbeknownst to women or against their will, has received little public attention. Tamil Nadu's success in reaching state targets for IUD acceptance far exceeded those of all other states and territories in India. This paper reports on an ethnographic study in 1995 of Tamil Nadu women's experience of routine IUD insertion and why health workers considered the policy necessary. Based on information from a follow-up visit in 1997, it describes how the change in national and state policy in 1996 to a target-free approach, with local determination of needs, is being implemented, but only in some hospitals and by some health workers. Reproductive health policy in India has been dominated by family planning and driven by numerical targets for a long time; it will take more time to assess the effects of the new policy.

Since 1995 India has been undergoing a transformation in the conceptualization and implementation of its family planning policies and programs, moving away from a target-based approach at central and state government levels towards a border reproductive health agenda with the locus of decision-making, moved to the local level.

Under policies initiated in the late 1960s, government health workers have been required to 'motivate' set numbers of eligible men and women to 'accept' contraception. Similar numerical targets were established for public hospitals and district and state governments, creating an elaborate system of competition to attain the requisite number of acceptors.

The All India Post-Partum Program was established in 1970 as a 'maternity-centered hospital approach to family welfare' in national state and district hospitals. The Program was later extended to the sub-district (taluk) hospitals as well. The Program's mandate was 'to motivate women within the reproductive age group 15-44 or their husbands to adopt the Small Family, Norm (two-child family) particularly during the antenatal, natal and post-natal periods.'

This Program was intended to supplement other maternal-child health (MCH) programs such as immunization and the distribution of iron pills in hospitals, but its primary goal was to involve all hospital staff attending births and abortions in the family planning campaign [1]. It was within this Program that contraceptive targets were set for post-partum and post-abortion women attending these hospitals.

During the raid-70s, especially during the political emergency in India (1975-77), family planning became a priority at the top-most level of government. Public officials as well as public service employees of virtually every type were directed to fulfil family planning targets and were penalized for failing to do so. Many of them eventually resorted to coercive means in order to achieve these targets. The 'Emergency' is often remembered for the ways in which human rights were, flouted, and particularly for the forced sterilization of men [2].

Family planning tactics have not been as draconian since the Emergency, however, the system of targets continued until l996 though confined to the health sector. Targets were set for many categories of health workers, and for hospitals, zones, districts and states. Punishments and rewards were meted out based on achievement rates. The Post-Partum Program was able to be effective in Tamil Nadu because a high percentage of women in the state, unlike in other parts of India, give birth in hospitals.

As part of a study on the medicalisation of childbirth in Tamil Nadu carried out in 1995. I asked women about the kind of care they and their families sought and about other practices during pregnancy, delivery and the post-partum period. Family planning was clearly a central issue for them, both in terms of the ways in which they thought about childbirth and maternal health care and in terms of how health workers treated them during childbirth. Routine insertion of IUDs was one of the topics of concern raised by many of the women I spoke to during this research and is the subject of this paper.

Family Planning in Tamil Nadu

The Tamil phrase for family planning is kutambam katappaatu. Kutambam means family; katappaatu means self-control and is also translated as bounden duty, obligation and indebtedness [3]. It is understood to mean the duty of the family to limit reproduction for the sake of the family itself, the state and the nation. Many of the women I interviewed had internalized this moral prerogative, and many opted to use modern contraceptive methods for the sake of their own health and well-being.

Tamil Nadu's success in reaching state targets set, for IUD acceptances far exceeded those of all other states and territories in India in the second half of the 1980s. In 1986-87 Tamil Nadu reached 197.7 per cent of its IUD target rate and in 1987-88 this figure was 171.4 per cent. Following this excellent performance, target rates were more than doubled for Tamil Nadu, yet in l988-89 the state still reached 101.2 per cent of its target A.

Contraceptive prevalence in Tamil Nadu remained so impressive in 1990 that the Government of India stated that what the nation was set to achieve by the year 2000, Tamil Nadu could aim to achieve by 1991-92 A. By 1995, the total fertility rate (TFR) for Tamil Nadu was 2.2 while the national TFR was 3.6. Furthermore, by 1995 the disparity between the urban and the rural TFR in Tamil Nadu was only 2.4 and 2.5, respectively, while in the nation as a whole, the TFR in rural areas was 36 percent higher [4].

Policymakers and others have argued that Tamil Nadu's success in reducing fertility rates has been due to the co-operative nature of the state family planning campaign [5]. However, the evidence presented in this paper supports Padmini Swaminathan's view that this was not always the case, [6] and Sundari Ravindran's observation that Tamil Nadu success in achieving fertility decline seems to have distracted attention from the limitations in the quality of MCH and family planning services [7].

In Tamil Nadu, the system of targets was supplemented by an elaborate information, education and communication campaign. One health administrator put it succinctly.

'We are insisting on sterilization after two children. We also encourage, use- of the IUD for three years' spacing. If they don't accept family planning we may have to brainwash them better.' [In English] [8].

Although these words sound extreme, the sentiment expressed was widespread, particularly among multi-purpose health workers (MPHWs), whose mandate was to motivate women to accept a method. The state's tactics also included pressure and coercion, not in an overt or public way, as under the Emergency, but in a more individual and private way immediately following births and abortions, within public institutions. In 1995, 70 per cent of all women leaving hospital after delivery were supposed to be covered either by sterilization or by an IUD [9]

Methodology

In a year-long project in 1995, I carried out ethnographic research in two low income, urban communities in Madras (Nochikuppam and Bapu Mastan Dargha) [10] and in the semi-rural town of Kannathur-Reddikuppam on the outskirts of Madras. This was supplemented by brief visits to other regions of Tamil Nadu, including Chengalpattu, Madurai, Dindigul, Vellore, Kanchipuram and Adiramapattinam (Tanjavur District). This project was greatly facilitated by the Working Women's Forum (WWF) of Madras, an NGO working on women's economic and health issues.

The methodology consisted primarily of structured and unstructured interviews with over 70 pregnant and post-partum women and their families, in their homes and in public maternity wards K. Detailed notes were taken in all interviews and most were also taped, transcribed and translated with the help of research assistants in Madras. In addition, I interviewed a range of medical practitioners, including doctors, nurses, hospital ayahs (midwifery helpers), both government and non-governmental MPHWs, and local midwives. I also observed interactions between these workers and women who were their patients in hospitals and in the women's homes. Finally, I interviewed governmental and non-governmental administrators working on women's health policy at state and national levels.

In a month-long follow-up visit in May 1997, I interviewed seven of the women and health workers from Madras and Kannathur-Reddikuppam who had been key informants in 1995. Health workers living in these communities from the WWF and Voluntary Health Services, and doctors and nurses at the Santhome Corporation Hospital in Madras, were particularly insightful regarding the effects of the changing family planning policy. I also talked with several key people in Delhi working for international organizations and others in Madras who are involved in the policy changes at national and state level L.

Routine IUD Insertion: Women's Experiences

The responses of the women I interviewed to the practice of routine insertion of IUDs were varied. By 1995 many women in Tamil Nadu were indeed accepting and choosing to use various forms contraception, including IUDS. Some of them were satisfied to have an IUD as they did not want to get pregnant again soon.

There were also women who did not choose to use an IUD, but who received an IUD nonetheless because of a policy of routine insertions. These women suffered socially and psychologically because the IUD was inserted against their will and/or without their knowledge, and this was made worse if any adverse effects were experienced. For example, the following conversation took place in the fishing community of Nochikupparn in Madras in 1995. The women involved were Kasthuri (an NGO health worker), a young mother named Selvi and an older woman named Thilakkam, all from that community, and my research assistant and myself M.

Kasthuri: 'They don't tell us before they put in the loop [IUD]. They don't ask us. When we are still almost unconscious they do it. As soon as the delivery is over they come and ask whether we want the operation [sterilisation]. If we say yes, they make us pus out signature. If not, they put in the loop. They don't ask us whether we want a loop or not.... If we say we don't it, they say: "Why should we listen to you? This is government law. If you want the operation, tell us and we'll remove it". The minute the baby is born, they insert the loop. They remove the placenta and stitch us up, and then they put in the loop and send us to the ward 15 minutes later. If there are in the ward, all ten have to, have it. Even if they forget one or two they record it as if they had put them in.

CVH: Do you think it is good that they are inserting the loop without your permission?

Kasthuri: It is good. But for some people it becomes difficult (kashtam). For some people it does not agree with them (ottuvaraatu).

Selvi: I had pains for eight months after my first delivery. I was bleeding a lot. When I went for check-ups they told me nothing was wrong. Finally I went to a private hospital. They told me I had a loop and removed it for Rs.30. For eight months I had a loop without knowing it. For those eight months I was using condoms which those health workers gave me.

Thilakkam: If she had got it removed in the government hospital she could have saved Rs.30.

Kasthuri: It's all right to go to the government hospital to get the loop. It is very difficult to get them to remove it. There must be something wrong with it. They don't simply (summaa) revome it. The private hospital will remove it if you pay them. They aren't bothered whether you have another baby or not.

Thilakkam: There was a girl who delivered her first baby at Gosha Hospital. They put in a loop but she didn't know they had done it. For two years she didn't conceive so she thought she must have a loop and she went back to Gosha to have it removed. They told her there was no loop. Two more years passed and still, she didn't conceive. Her husband and her mother-in-law started mistreating her, saying they would find another wife. Finally she went to a private clinic. They did a scan, found the loop and removed it. She conceived again right away.'

Another young woman with a baby, in the same housing block as Kasthuri, came running up to us one day and told us:

This child is seven months old. She was born in Gosha Hospital. They sent me home without a loop and now I am pregnant again!....I had a caesarean. I thought they had put in a loop. Don't they put one in for everyone? I thought they had put one in and I was careless. Now they won't do an abortion. I went back to them and they said if they did an abortion the uterus would get perforated and they might have to do a hysterectomy. I said that I would sign the papers. But they said I must sign a paper saying I didn't ever want another child. So my husband and I hesitated and came away. We decided to see a private doctor, even if it is expensive.'

Although abortions are done free of charge in public hospitals, in 1995 some hospitals in Tamil Nadu would only perform an abortion if women with one child accepted an IUD and those with two or more children accepted sterilization following the abortion N. This practice is also reported in a paper on women's experiences of, the family planning program in some rural districts of Tamil Nadu.

Three other women IInterviewed had the following experiences:

'I didn't have any children for the first five years after my marriage. After my first was born (a girl) I had a loop put in. It came out but I didn't realize it and I got pregnant again. After the second baby was born (in a Madras hospital), the doctors wanted me to be sterilized. I was on the delivery table and I said "No, I want a boy." They said, 'What if the third is a girl?" So they put in a loop without saying anything about it. Then three days later my husband decided I should be sterilized. He said it was, too expensive to have more children, dress and educate all of them. During the operation, they didn't take out the loop. A year later, after my first period, I had stomach pains and went to see Janaki [an NGO health worker]. Janaki realized I had a loop in and removed it herself '.

'Doctors in Gosha Hospital inserted an IUD against my will twice following miscarriages. I was married when I was 16 and had four miscarriages before I finally gave birth to twins by caesarean. After my third and & fourth miscarriage the hospital staff insisted on insisted on inserting an IUD. But I told them I didn't want the IUD because I hadn't even had a baby yet. They said it was good to delay pregnancy so that my womb would have time to recover from the miscarriages. Still I refused, saying it would cause me abdominal pain. They repeatedly beat me when I refused and they went ahead and inserted the IUD both times. Each time I went to a private hospital and paid to have the IUD removed. When I conceived the fifth time I refused to go to back to Gosha Hospital. Instead I went to the Santhome Corporation Hospital.'

'I told the doctors in Gosha Hospital that I had only three children - two sons and a daughter. I didn't want to tell them I already had six children because I was afraid they would beat and scold me... I also said I wanted to be sterilized following this delivery. But after the delivery they said I was very anaemic and they would not be able to do the sterilization right away. So they wanted to insert a loop. I told them I didn't want a loop because I was going to be sterilized. But they didn't ask my opinion; they put it in.... and said I could have it removed when I was sterilized.'

Women who had negative experiences such as these were sometimes unwilling to use hospital services for deliveries and abortions afterwards at all, or felt they had to seek care in private hospitals, even if the means to do so.

Moving Targets: The Health Workers' Views

The following interviews with hospital personnel who were working or had worked in hospitals where routine IUD insertion was practiced reveal that many of them did not give a second thought to the fact that they were inserting IUDs without women's consent. As they saw it, they were just doing their jobs, meeting the targets laid down for them.

CVH: 'Do you usually put in a loop after the first delivery?

Doctor: A Copper-T, on the day they go home. Earlier we did it after the placenta was expelled. This way the patients are comfortable. Those who don't undergo sterilization get a Copper-T.

CVH: Do they ask for it?

Doctor: We brainwash them from the start. One or two flatly refuse. We tell them after insertion and then get their signatures. They have to return after a week for a check-up.' (Doctor [in English], Thousand Lights Corporation Hospital, Madras)

'Most women coming to the hospital are aware of family planning. Only about 10 per cent are resistant. We will not routinely insert an IUD. We try to get women to accept an IUD on the 15th day after delivery when they come for their first postnatal visit. Actually we are supposed to do it before they are discharged, but to avoid the risk of expulsion we do it on the 15th day. This is possible now as it is only now that women are themselves motivated. In the Government hospitals they routinely insert IUDS. Sometimes they, even insert two without realizing it - one in the delivery ward and one in the post-natal ward! I know because I have done it myself, when I was working as a doctor there. The patient doesn't know about it... This was three years ago. Why? Because we are given targets. Patients who have an IUD inserted in Gosha Hospital often get referred to Santhome if they have problems. At Santhome we will check and correct the IUD but we will not remove it unless there is a problem. For removal we tell them they should go back to the government hospital but they won't go back to the government hospital because they know they will not remove it there. Instead they go to a private clinic to have it removed....Problems do happen, with IUDs because women often don't come for check-ups.' (Doctor [in English], Santhome Corporation Hospital, Madras)

'When I worked at Gosha Hospital we always put a loop in as soon as the baby was delivered. In some cases we would even put in two loops by mistake. Here it isn't possible to put in the loop without the woman's permission because in the rural areas the families will complain. We are more restricted here than in Gosha or the large government hospitals in Madras where they don't have to worry about what other people will say. (Doctor [in English], Chengalpattu Medical College Government Hospital)

'At the time of delivery we try to get women to agree to get a loop put in, at least within 45 days after delivery. At Gosha Hospital they put in a loop immediately after delivery, before the woman goes back to the maternity ward, while she is still on the delivery table. This is because there are so many patients at Gosha Hospital that there is no time to ask ahead of time, so they just put it in. Sometimes it will come out. Some women then come to Santhome Corporation Hospital saying that their loop is causing them to have stomach pains and causing their body to be weak so they ask to have the loop

removed, but often it has already come out. At Santhome Hospital aye put the loop in on the third day after delivery. We ask the woman if she wants it. If not, we follow up with MPHW motivation to try to get them to accept it within 45 days. This is another difference between the approach of Corporation hospitals and government hospitals. For women who deliver at government hospitals there is no follow up visit to try to motivate them after they are discharged. So there is a sense that they must insert the IUD right away because there will be no second chance. Whereas at the Corporation hospitals we have MPHIVs to do follow-up work.' (Maternity assistant (nurse), Santhome Corporation Hospital, Madras)

It would appear from these accounts that it is generally in generally in the large government hospitals urban centers, such as Gosha Hospital in Madras, where IUDs are inserted routinely without women's consent. Because they lacked an outreach system through which they could trace the women and try to motivate them after they left hospital, they tended to view them as 'moving targets' difficult to reach.

How Widespread is the Practice?

I do not have figures on the proportion of women I interviewed who experienced routine IUD insertion in the various hospitals, as the subject did not come up in every interview and the data were not collected in a structured questionnaire format. However, women reported this practice in at least half the interviews I conducted. Almost all of them were women who had delivered their babies in Gosha Hospital in Madras, but these were not necessarily the only women who experienced this.

Two women's organizations working in Tamil Nadu provide corroborative evidence that routine IUD insertion was taking place in other parts of Tamil Nadu as well. The Rural Women's Social Education Center (RUWSEC), based on a study of the quality of family planning services in three rural sites around the town of Chengalpattu, reported that: 'the incidence of involuntary "acceptance" of a method of contraception - the epitome of lack of choice - was not uncommon. This was especially true in the case of IUD insertions.... Vijayalakshmi, who had pain and heavy menstrual bleeding following insertion of an IUD without her knowledge after her first delivery, went to a private doctor, who charged 50 rupees to remove the IUD. "After some days, I had unbearable pain; my cousion took me to Madras for a check-up with a doctor.... The doctor said that the T part of the IUD was stuck in the cervical canal."

The WWF, who have a large membership of urban and rural poor women, collected data in Madras, Kancheepuran, Vellore, Dindigul and Adiramapattinam (all large

towns), which point to widespread routine IUD insertion in urban areas of Tamil Nadu as well. >From April 1990 to March 1995, among women participating in WWF activities in these five cities, there were 15,704 women who accepted an IUD. Of the 8770 women whose IUD was inserted after their first delivery, the insertion had taken place without their knowledge for 5714 (65 per cent). Of the 5604 who accepted an IUD after their second delivery, nearly 2337 (42 per cent) reported they had not been given a choice and would have preferred sterilization. From March 1995 to December 1996, 52 per cent of the 2343 women who reported they had an IUD inserted (in the same five cities plus the town of Dharmapuri), said they had not been given any option P.

The statistics for the Santhome Corporation in Hospital zone Madras show that for 1994-95 the IUD target achievement rate was 145.9 per cent. Given this and other hospitals' practice, it is not surprising that the statistics for Tamil Nadu show well over 100 per cent achievement of targets for IUD acceptors.

Impact of Recent Policy Changes

The NGO sector has long been critical of the violation of women's rights resulting from the target orientation of the Indian family planning program. For example, RUWSEC have long been conducting educational campaigns for rural women in their area to expose practices like this, and their community workers support local women to challenge abuse wherever it occurs.

In 1994, representatives of the WWF met with the Secretary for Health in Delhi to discuss the problems of routine and sometimes forced IUD insertions in Tamil Nadu under the target-based policy. In September 1995 the organization invited the Tamil Nadu Health Secretary to a State Advisory Committee Meeting at the WWF to discuss these issues and to hear women's own experiences of routine IUD insertions in government hospitals R.

The consensus at the 1994 ICPD in Cairo to move away--from -narrow demographic approaches was another important factor helping to precipitate a change in policy. In March 1995 the Minister of Health and Family Welfare for Tamil Nadu declared that from April 1995 onwards the target approach to family planning would be stopped S. In December 1995, the central government announced its intention to end the system of national targets T, and formal announcement to this effect was made in mind- 1996.

Under this new 'target-free' approach, local outreach health workers, are to be active in the planning process, since they are in a position to analyse the health needs of the specific communities they work and sometimes live in. MPHWs and village health nurses are expected to assess a community's health needs and devise targets based on these needs. Goals are to be established primarily at the district level rather than at state and center, government levels.

The policy has called for an end to numerical family planning targets and such targets are no longer being generated at state level. Yet this does not mean that targets are necessarily extinct. In May 1997, the women I spoke to in Nochikuppam, Reddikuppam said that MPHWs and NGO health workers were no longer chasing targets with the same vigour as in the past. Yet governmental and non-governmental health workers said that despite the new policy they were still being directed to reach numerical family planning targets. One doctor in a hospital in Madras said that she tells MPHWs attached to the hospital that despite reports to the contrary, they are still required to establish and meet numerical family planning targets under the new policy. She explained that she did this because, without targets, she was concerned that these outreach workers would have no motivation themselves to get anyone to use contraception. This concern was in fact voiced by many policy planners in both Madras and Delhi.

There is no longer officially a 70 per cent target set for post-delivery contraceptive acceptors, and some government orders state that IUDs must not be inserted immediately post delivery and that sterilization or IUD acceptance must not be required of women seeking abortion in government hospitals. In May 1997 it was also encouraging to find that these new policies were indeed being implemented in some of the Corporation hospitals.

For example, a nurse at the Santhome Corporation Hospital explained that under the new policy, they are only inserting IUDs 42 days after deliver, and that the MPHWs attached to the hospital are required to go out to local communities to visit post-parturm women 42 days after delivery to motivate them to return to the hospital to have an IUD inserted. MPHWs were finding it difficult, she said, to convince women to accept IUDs at that time. If women refused an IUD, the MPHWs were advocating the use of condoms and said that the condom acceptance rate was high. This nurse also concurred that the hospital was no longer stipulating that women seeking abortions accept sterilization or IUDS. They had accepted the government's recognition that under the previous policy, some women had been forced to seek out untrained abortionists or to have larger families than they wanted.

However, four of the seven women I spoke to in Madras and Kannathur-Reddikuppam reported that in Gosha Hospital in Madras, routine post-delivery IUD insertions were still taking place and women with four children were still being pressured to undergo sterilization. Health workers from the WWF thought that this is because many doctors in Tamil Nadu feel it is only due to their efforts and their pressure on women to accept contraception that the fertility rate had come down as much as it has in Tamil Nadu.

Attitudes towards the new policy seem to include a healthy mixture of guarded optimism and cynicism. Reproductive health policy in India has been dominated by family planning and has been driven by numerical targets for a long time; it will take more time to assess the effects of the new policy.

The present policy, unlike earlier ones, is not merely a top-down instrument of propaganda. The principles of participatory planning and abolition of targets have in fact long been brewing at local level. Regardless of whether or not the central and state governments are committed and able to implement the new policy in a way that reflects a fundamental re-orientation towards women's health, the rhetoric of the policy resonates with the concerns of women as recipients of health services.

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10. Madras has recently changed its name back to its original name Chennai; it was still called Madras when I began my research.