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Identification of the Target Group for Vasectomy

A slower population growth rate in India through fertility reduction is a desirable goal even if it may not be a necessary condition for faster economic growth. Direct intervention through the family planning program during the last decade has not led to satisfactory results, even though the achievements have not been trivial. The Indian family planning program in its present form is unlikely to lead to a birth rate of 30 and 25 by 1979 and 1984 respectively. In this context the recent reports about 'compulsory sterilization' can be explained. Various incentive and disincentive schemes currently planned in India can enhance the motivation of husbands to undergo vasectomy. This approach can achieve India's objectives in fertility reduction especially if due consideration is given to the question of identifying the target group. This paper seeks to examine some issues related to the identification of the target group for vasectomy.

The Target Group

It is customary to define the target group in terms of such characteristics as the number of living children, age of the wife or age of the youngest child.¹

1. For example see, Srinivasan K. and Sugathan N. (1975). Fertility Potential of the Couples as a Basis for Setting Priority for Family Planning Services : An Operational Scheme. *Newsletter*, Population Centre Bangalore. Vol. I, No. 5, pp. 1-5.

Such a classification system is mainly oriented to the delivery of methods like IUDs, pills, condoms and tubectomy. Pregnant women are not deemed eligible for these services and therefore are usually excluded from the target group. Since vasectomy has been the major method of family limitation in the Indian program, the husbands of the pregnant women could be considered as the prime target group for this method. Concentrating the program effects on this group has the following advantages :

(1) Pregnancy is easily identifiable and is strong evidence of proven fecundity irrespective of wife's age or the number of living children.

(2) The changes of an accidental pregnancy following the vasectomy operation will be minimized and vasectomized men will not be required to use condoms following the operation for the remaining duration of the pregnancy.

(3) The workload for the family planning staff in identifying the target group and in motivating them can be reduced considerably.

(4) Services for vasectomy can be delivered through hospitals, clinics, camps and even mobile units.

Motivation

There is ample evidence that women are highly motivated to accept family planning methods immediately following the termination of a pregnancy. In all probability, therefore, men are likely to be motivated while their wives are pregnant. The motivation to accept vasectomy can be enhanced by offering them liberalized individual or community incentives. It might be further enhanced by offering them a package of 'gifts' for the child to be born.

Rationale

Theoretically, couples can be divided into finite priority groups by considering the number of living children, age of the wife or age of the youngest child. Priority can be arranged according to the expected returns to the society in terms of the potential demographic effects of sterilization. The incentives for sterilization could be allowed to vary directly with the expected returns. The implementation of such a system of incentives, however, might be extremely complicated. The problems in screening and maintaining any control about

the demographic characteristics of couples would be enormous because these facts are difficult to substantiate in India.²

Past experience with mass vasectomy camps with high incentives in India has clearly demonstrated their usefulness in attracting a substantial number of men for vasectomy. However, high incentives in some camps attracted a considerable number of men who were found to be ineligible.³ Similarly, offering high incentives to men whose wives are not pregnant would attract a substantial number of couples who might be subfecund or who might be already using some family planning method, and thus the potential returns to the society are likely to be substantially less. For these reasons, the nonpregnant group should not be given any incentives even though the services cannot be denied.

The problems associated with the eligibility of men opting for vasectomy can be eliminated by concentrating and limiting the incentives to the husbands of currently pregnant women. For this group, it would be desirable to link the amount of incentives to the number of living children. However, it might create problems in implementation because it would be extremely difficult to check for the number of living children the couple claims to have. It is therefore, suggested that initially the incentives be kept the same for all men with pregnant wives.

At a first glance, the approach may look pronatalistic but in reality this would not be the case, because only those couples can increase their chances of pregnancies who have been making conscious efforts to postpone them by using family planning methods, including abstinence. However, the birth rate probably would have already declined if a substantial proportion of couples in India were using spacing methods. Available evidence suggests that women

2. In the absence of incentives, the age of the youngest child can serve as a useful criterion for identifying the target group and for concentrating the family planning efforts. However, the pregnant state is one extreme of this scale—the age of the youngest child being minus X months.

3. In some camps as many as 39 percent of the vasectomized men were found to be ineligible because of various reasons : wives beyond the reproductive age group (21%), secondary sterility (12%), unmarried or separated (4%), either spouse was previously sterilized (4%). See Gandotra, M. M. 1975. "Mass Vasectomy Camp—An Evaluation", *Demography India*, Vol. IV, No. 1, pp. 158-166.

spend long periods in the nonpregnant state because of the long duration of postpartum amenorrhea associated with prolonged lactation. It is quite unlikely that a substantial proportion of these women would cease lactation to become pregnant just in order to collect incentives. Even if they do, it may temporarily increase the birth rate but the long term effect would still be a reduction in the birth rate.

It can be argued that incentives should not be offered to men with currently pregnant wives because it may not have an immediate effect on the birth rate since these women will not give birth to an additional child for about three years, on an average. This may not be a serious drawback. The dispersion around the mean has to be considered in assessing the impact of this scheme on the annual birth rate. Moreover, the wives of vasectomized men will not give birth to any additional child and the cumulative effect will increase with the duration following the operation.

Effect on Birth Rate and Size of the Target Group

Initially, the incentive scheme suggested above may attract couples with large families, but the demographic effects are still likely to be substantial. The birth order statistics in India indicate that about 44 percent of about 24 million births in any year are of the fourth or higher order, including about 29 percent that are of the fifth or higher order. This means that the birth rate could decline by about one-third if the births of fifth or higher order are averted. In India, about 51 million couples have three or more living children. About 10.5 million of them are likely to give births of fourth or higher order in a year. If all, or a substantial proportion of the husbands of these women, could be attracted to undergo vasectomy every year then most of the births of fifth or higher order would be averted in about four years. Thereafter, only those couples would enter the pool who exactly have three living children. About four million of these could be expected to be pregnant in any year. Thus, the target group would consist of about 10 million couples for about four years and about 4 million couples thereafter. However, higher incentives can be expected to attract some couples with smaller families as well, which would have additional benefits.

Frequency of Contact

In any month, about 15 percent of the women can be expected to be pregnant but the pregnancy can be easily identified only for about 12 percent, and

only these pregnancies could be detected if the couples are contacted once a year. To detect most of the identifiable pregnancies, the couples would have to be contacted twice a year at a six monthly interval. In this case, some overlap between the number of women found pregnant at two consecutive visits is quite likely.

Budgetary Implications

The budgetary implications for adopting and implementing the scheme suggested above raise a complex question, which requires detailed planning for estimating the cost of various components-services, promotion, direct incentives. However, some rough estimates can be obtained for the direct additional cost which would depend upon the average amount of incentives to be paid for a vasectomy and the number of vasectomies expected to be done during a year. Since the total cost of implementing such a scheme is likely to be substantial, some pilot projects are needed for assessing the feasibility of attracting men to undergo vasectomies while the wife is pregnant as well as for determining the optimum incentives required for this purpose.⁴

4. It is possible that motivation to accept irreversible fertility control method is at its lowest during the pregnancy period for some psychological reasons, such as uncertainty of pregnancy outcome, sex of the unborn, unlikelihood of thinking ahead and planning especially for couples with two or less living children. How much of these uncertainties for the couples with three or more living children can be overcome by incentives can only be assessed by trying this scheme on a pilot basis.