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Are Muslim Women Behind in their Knowledge and Use of Contraception in India?

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ABSTRACT

This paper uses District level House Survey (DLHS) and National Family Health Survey (NFHS) data to investigate the use and knowledge of contraceptive methods within two religious communities in India, Muslim and Hindu. The religious obligation and tenets of their religion require Muslim women to defer from using any contraceptive method. Such commitments to ones faith may turn out to be a deterrent in the use of contraception by this community. Given the data for Hindu and Muslims, it was found that use and knowledge of Traditional methods was significantly higher within Muslim women compared to Hindu Women. Consequently, Traditional use also showed a higher prevalence among Muslims. Multivariate logistic regression was used to determine the factors affecting use of traditional methods. The results showed that education significantly contributed to the use of traditional contraception in India. Age, rural residence, and wanting another child were significant in the socioeconomic factors examined. The results also suggest that education does not affect traditional method use among women contraception when controlling for other factors.

Key words: Muslim Women, Contraceptive usage, Traditional Methods, Trends,

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Introduction

India's population includes adherents to a large variety of religions, including Hindus, Muslims, Sikhs, Christians, Parsis, Buddhists, Jains, and others. Hindus constitute the majority of the Indian population, comprising 80.5% of Indians as of the 2001 census. Given India's large population of over one billion, however, many other religious groups form sizeable minorities. Muslims form the largest of these minorities. The 2001 census enumerated 138 million Muslims, representing 13.4% of the total Indian population. India's Muslim population is the third largest in the world (Pew, 2009). Only Indonesia and Pakistan have larger Muslim populations. Muslims constitute an underprivileged minority in India, ranking below Hindus in many respects. In 2005, a committee was gathered to conduct a systematic study of the social, economic and educational status of the Muslim community of India. The report of this commission, referred to as the Sachar report, concludes that Muslims "exhibit deficits and deprivation in practically all dimensions of development" (Sachar, 2006, p. 237). The deficits are particularly salient in the areas of female schooling and economic status.

Muslims in India have a much higher total fertility rate (TFR) compared to that of other religious communities in the country. Because of higher birthrates and an influx of migrants from neighboring Bangladesh, the percentage of Muslims in India has risen from about 9.9% in 1951 to 13.4% in 2001. The Muslim population growth rate is higher by 9.3% of the total growth compared to that of Hindus.

Demographers have put forward several factors behind high birthrates among Muslims in India. According to sociologists Roger and Patricia Jeffery, socio-economic conditions rather than religious determinism is the main reason for higher Muslim birthrates. Indian Muslims are poorer and less educated compared to their Hindu counterparts. However, other sociologists point out that religious factors can well explain high Muslim birthrates. Surveys indicate that Muslims in India have been relatively less willing to adopt family planning measures and also, Muslim girls get married at a much younger age compared to Hindu girls. According to (Paul Kurtz), Muslims in India are much more resistant to modern contraceptive measures compared to Hindus and as a consequence, the decline in fertility rate among Hindu women is much higher compared to that of Muslim women. The reason for the lower willingness to adopt family planning can be

explained by the religious restrictions which ordain no use of family planning by individuals following Islam. The early marriage and concurrence with this religious decree can be rooted with the lower level of education attained by Muslims, especially by Muslim women.

The low status of women and a strong preference for male children are two most patriarchal constraints in India. Women want to have children but it is very difficult to take decisions when they face an unplanned pregnancy. Despite unwillingness to conceive, most of the couples do not use any method of contraception. Health concerns, side effects, failure of the method and some socio-demographic issues such as education, age, residential region, number of living children, status of women and religion play a major role in the use of contraception.

Male attitudes to family planning can often be negative and women are powerless to motivate their husbands into using condoms for example, let alone female contraceptives. A study by Zachariah 1990 found that 40 percent of women from Southern India were not using any contraception because their husbands objected to their doing so. Men's knowledge of contraceptive methods is lacking behind females', which itself is limited. Men most commonly knew of female sterilization, followed by male sterilization and knowledge of the other available contraceptives was even more limited (Balaiah et al 1999).

This study was conducted with the aim to examine the knowledge and awareness of contraception among Muslim women in India. We determined the occurrence in the Use of contraception between two cohorts of women distinguished by religion, focusing on both Hindu and Muslim women. To understand the changing dynamics between these two communities over the years, we examined the trends using data sets from different periods of time. This paper also intends to identify those factors that affect the use of contraception by these women to augment policy decisions.

Data Source and Methodology

The information collected by District Level Household Survey (DLHS-3) is the third in the series preceded by DLHS -1 in 1998-99 and DLHS-2 in 2002-04. DLHS-3, like two earlier rounds, is designed to provide estimates on maternal and child health, family planning and other reproductive health services. District Level Health Survey (DLHS-RCH III: 2007-08) round third

survey is used to examine the level of knowledge and use of contraception among Muslim Women in India. We also used NFHS Data (I, II & III) in collaboration with the DLHS data to determine the trends in the use of modern and traditional methods. The present analysis is based on ever-married women aged 15-49 years in India. Most of the analysis was carried out with help of SPSS statistical package and results are presented in univariate and bi-variate tables. The logistic regression analysis is used to study the significance of variation in knowledge and use of contraception by background characteristics of ever-married women.

Through this paper we ascertained the use and knowledge of methods of contraception in various Indian states, based on the population composition of each state. We next determined the knowledge of contraception given the various factors that influence awareness of contraceptives. Our focus then shifted to the trends in contraception since 1992 using NFHS and DLHS data and continued into the various aspects that induce changes in the use of contraception, modern and traditional. The binary logistical analysis follows these results and we examined the data controlling for several variables. Near the end we have also determined the major sources individuals choose to procure modern and traditional contraceptives from as well as the diverse categorical reasons stated by them for not using contraception. An analysis of the grounds to discontinue the usage of the previous method of contraception by respondents was also investigated.

Results

India being a highly secular democracy, it has several religious communities cohabiting. It is often seen that the habits of one community are adopted by the other if the live and interact in close proximity. To understand the effect such relations have on contraceptive behaviour, we looked at 8 states in India and determined the extent of use and knowledge of contraceptives within them. These states were selected on the basis of the religious composition of the population, with the states Chattisgarh, Gujarat, Madhya Pradesh and Orissa having a very low percentage composed of Muslims. The latter four states of West Bengal, J&K, Kerala and Uttar Pradesh have the highest percentages of Muslim residents in India. Through this distinction we wanted to determine whether, in those states that are predominantly populated by members of

either community, there exits any differentials in contraceptive prevalence. Despite nearly universal Knowledge we can see that Use of contraceptives is not very high in India. Only around 61.5% women aged 15 to 49 years declared to have used any contraceptive method once in their life at least. Out of this figure, we found that the highest Ever-Use of Contraceptives was found in West Bengal and Kerala. For the latter however, a substantial segment of the population being educated may explain the significant usage. In West Bengal, a considerable share of the elevated usage can be explained away by the soaring percentages of the population using traditional contraception.

Table 1: Reasons Given for Not Using Contraception by State

States		All Methods		Modern Methods		Traditional Methods	
		Knowledge	**Use**	**Knowledge**	**Use**	**Knowledge**	**Use**
Chattisgarh	Hindu	99.4	53.9	99.4	50.7	42.2	6.4
	Muslim	100.0	58.1	100.0	53.4	54.7	9.7
Gujarat	Hindu	97.8	69.1	97.6	59.3	59.7	25.1
	Muslim	96.9	69.3	96.7	57.9	61.4	26.2
Madhya Pradesh	Hindu	98.6	61.2	98.6	56.7	44.2	10.4
	Muslim	99.4	60.9	99.4	56.3	51.9	11.4
Orissa	Hindu	98.5	56.7	98.4	47.1	63.0	18.4
	Muslim	100.0	65.1	100.0	47.9	77.1	30.1
West Bengal	Hindu	99.8	7.5	99.7	70.2	86.9	58.4
	Muslim	99.8	82.2	99.7	59.9	91.2	61.3
J & K	Hindu	99.0	66.6	98.7	53.5	67.6	21.8
	Muslim	97.7	56.2	96.9	45.1	72.7	18.8
Kerala	Hindu	99.8	80.2	99.8	69.7	83.4	38.5
	Muslim	99.9	68.1	99.9	55.9	76.8	30.7
Uttar Pradesh	Hindu	99.3	55.9	99.1	38.0	73.9	31.5
	Muslim	99.5	46.3	99.3	29.4	72.8	28.6
All India	Hindu	99.0	62.6	98.9	54.3	57.0	18.8
	Muslim	98.6	54.1	98.2	41.2	65.2	24.3

What was made amply clear through this Table-1, is that the state having a high or low composition of Muslim population didn't affect the usage or knowledge. For the same reason,

Chattisgarh, having a population composed 95% by Hindus, is shown to have a lower usage than J&K, where 65% of the population is Muslim. If we control for certain variables in any State, then the use of contraceptives comes to nearly the same despite different composition of population. But one factor has a significant sway on contraceptive decisions, and that is complete and accurate knowledge of the same contraceptives. The next Table describes several variables that can influence the knowledge that respondent possess of the various contraceptive methods.

Table 2. Awareness of Contraceptives Given several Socio-Economic Factors

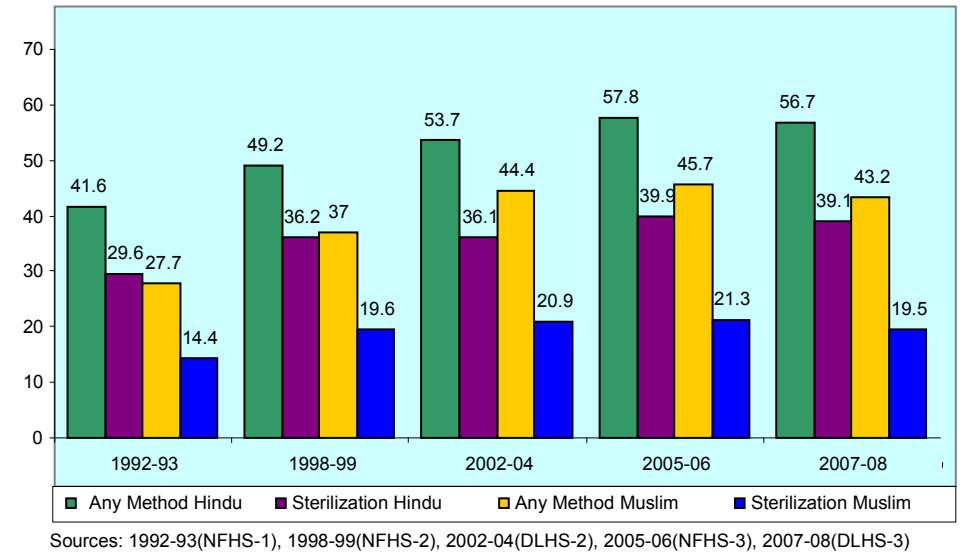
Variables	Any Method		Modern Methods		Traditional Methods	
	Muslim	Hindu	Muslim	Hindu	Muslim	Hindu
Age						
15-24	97.9	98.1	97.4	97.9	61.6	52.5
25-29	98.8	99.2	98.6	99.1	66.5	59.2
30-34	99.0	99.4	98.7	99.2	67.7	59.5
35-39	98.9	99.4	98.6	99.3	67.1	58.2
40-49	98.8	99.3	98.3	99.2	64.6	56.9
Caste						
SC	98.2	99.1	97.7	98.9	60.3	56.4
ST	97.7	97.3	96.4	96.9	68.0	44.6
OBC	98.7	99.2	98.6	99.1	60.1	56.9
Others	98.7	99.6	98.3	99.5	67.6	64.7
Education of Woman						
No Education	98.1	98.5	97.5	98.3	62.9	50.5
Primary	98.7	99.1	98.3	99.0	64.3	55.3
Secondary	99.5	99.5	99.3	99.4	67.9	62.4
Higher	99.9	99.9	99.8	99.9	76.5	75.6
Education of Husband						
No Education	98.0	98.2	97.3	97.9	62.3	46.9
Primary	98.6	99.0	98.1	98.8	63.8	53.2
Secondary	99.1	99.2	98.8	99.1	66.8	59.1
Higher	99.3	99.6	99.2	99.6	70.5	68.4
Surviving Children						
0	96.6	97.0	96.1	96.8	55.5	47.6
1	98.5	98.8	98.1	98.6	66.4	60.2
2	99.1	99.4	98.7	99.3	67.1	59.4
3+	98.9	99.3	98.5	99.2	66.1	57.0
Place of Residence						
Rural	98.2	98.8	97.7	98.7	66.0	54.9
Urban	99.5	99.7	99.4	99.7	63.5	65.0
Wealth Index						
Poor	97.4	98.1	96.6	97.8	62.5	49.9
Middle	98.3	99.2	97.8	99.1	63.2	53.6
Rich	99.5	99.7	99.4	99.7	67.8	65.1
Mass Media						
TV, Radio or Newspaper	97.5	98.2	96.8	98.0	59.1	48.0
Other	99.9	99.9	99.8	99.8	71.9	66.6
Aware of RTI/STI						
Yes	99.8	99.9	97.6	99.9	79.6	74.3
No	98.1	98.6	98.2	98.4	58.5	49.3

From Table 2, it can be perceived that generally the knowledge of any one contraceptive is

higher among Hindu women than Muslim. The exception in this case is for Traditional Methods, where Muslim women are shown to possess greater awareness than Hindu women. Depending on the socio-economic variable, knowledge about contraceptive in both religious sects shows almost the same correlation as in a regular sample.

With an increase in the woman's age, her education, her husband's education, the number of live births she currently has and lastly, her standard of living, her knowledge about contraception rises. A relation also exists with the household type, awareness about RTI/STI as well as the source of information on contraceptives. It can be seen that a rural women has lower chances of using contraceptives than urban women. If she gets her information on contraceptives from TV, Radio or the Newspapers, the chances are that she is less aware than those women who are informed through doctors, AWW, ANM, health workers etc. Interestingly, throughout the table we observe that as the variable progresses, the knowledge of traditional methods increases much faster for Hindu women than Muslim. It can be seen that knowledge about RTI/STI has a significant impact on the awareness. However, there is either an error in reporting or a low level of awareness about RTI/STI reflected throughout the data. The use of Traditional Method increases for both religious cohorts while that of Modern Method decreases. Since condom is the only method that is helpful in preventing RTI/STI, Modern Method usage should have gone up while Traditional Method usage should have remained the same or gone down.

Figure 1. Differentials in Contraceptive Usage between Hindu and Muslim Women in India



Sources: 1992-93(NFHS-1), 1998-99(NFHS-2), 2002-04(DLHS-2), 2005-06(NFHS-3), 2007-08(DLHS-3)

Given knowledge, the Use pattern for either community has been heartening if we look at the

trends emerging from the NFHS and DLHS data. Figure 1 depicts the trends that have emerged for contraceptive usage since the last two decades. From the 1992-93 NFHS-1 data to the 2005-05 NFHS-3 data, we see that there was an increase in the use of contraceptive regardless of religious differentials.

Sterilization has nearly identical trends as the overall usage of other methods of contraception. The DLHS-3 data from 2007-08 however, shows a decline in the use of contraceptives from 2005-06 NFHS data. Likewise for Sterilization, the 2007-08 data also dips from 21.3% to 19.5% for Muslims and 39.9% to 39.1% for Hindu. However, if we just examine the trends across the same survey, NFHS as well ad DLHS figures show and upward movement through the different time periods.

We now study the variables that have an impact on the use of contraceptives as they change. Table 3, shows the Use data and it can be seen that there is significant influence of several variables on the use of contraceptives. Modern and Traditional methods both are affected by these variables, although the relation may not be the same in all cases. This Table provides use with the usage figures for contraception, given socio-economic variables like Age, Education, Standard of living, access to Mass Media and awareness of RTI/STI.

As we have seen, despite nearly universal knowledge, use of contraceptives is not so high amongst women in India. While nearly 40% of the population has never used contraceptives, for the Muslim women, this percentage is additionally lower by around 7-8%. Their usage of modern contraceptives is lower by around 12-13%. Age, Education of the spouses, the number of surviving children and wealth status have all been shown to positively affect the use of contraceptives. As with knowledge, Usage has shown nearly the same trends. An interesting point that has reared up again within use data, is that like knowledge, even the use of Traditional Methods is higher in Muslim women. Depending on the factors and conditions, this difference may occur from 6-8% between both sample populations.

A reassuring fact that can be perceived from this Table is that as the social and economic condition of Muslim women tends to increase, as an outcome of maybe increased education, the usage of modern contraceptive goes up while that of traditional methods shown a decline.

Table 3. Socio-Economic Factors Affecting The Use Of Contraceptives

Variables	USE OF CONTRACEPTION					
	Any Method		Modern Methods		Traditional Methods	
	Muslim	Hindu	Muslim	Hindu	Muslim	Hindu
Age						
15-24	36.7	33.3	24.1	24.4	20.9	14.7
25-29	55.5	62.9	42.3	53.9	25.5	20.2
30-34	63.0	74.4	50.0	66.4	26.5	21.1
35-39	64.6	77.1	51.8	69.3	26.6	20.5
40-49	58.0	73.3	45.1	65.8	23.3	18.8
Caste						
SC	50.2	60.2	39.0	51.3	19.2	19.6
ST	44.1	55.4	30.5	48.4	17.9	14.4
OBC	48.7	61.1	38.9	52.8	18.4	17.8
Others	57.6	71.6	44.2	63.4	25.9	22.3
Education of Woman						
No Education	48.9	59.0	35.5	50.8	22.6	16.0
Primary	58.1	65.4	44.7	57.8	26.6	18.7
Secondary	60.9	65.0	48.9	56.7	26.0	21.1
Higher	61.3	68.7	50.2	59.2	25.0	25.7
Education of Husband						
No Education	47.7	56.4	34.1	48.9	23.1	14.4
Primary	56.0	64.0	42.7	56.0	25.9	17.9
Secondary	57.5	63.3	45.0	54.8	24.5	19.8
Higher	59.0	67.7	47.8	58.6	24.3	23.0
Surviving Children						
0	13.9	12.8	6.8	7.5	9.4	7.2
1	41.0	41.9	26.7	30.4	23.3	20.5
2	61.8	73.4	48.8	65.8	26.8	20.8
3+	62.3	74.5	48.7	66.2	26.4	19.9
Place of Residence						
Rural	51.0	60.3	36.6	51.8	25.7	18.2
Urban	61.0	71.3	51.5	63.9	21.0	20.9
Wealth Index						
Poor	43.6	51.7	27.9	43.0	25.4	15.8
Middle	52.5	63.4	39.4	55.2	24.3	17.8
Rich	61.5	72.0	50.4	64.2	23.5	22.0
Mass Media						
TV, Radio or Newspaper	47.1	56.4	33.2	48.4	22.7	15.3
Other	61.9	69.2	50.1	60.6	25.9	22.5
Aware of RTI/STI						
Yes	60.9	69.3	46.8	60.1	29.8	24.7
No	51.0	59.6	38.7	51.8	21.7	16.2

A similar trend is not observed among Hindu women, where with increase in education and wealth, the use of traditional methods has also climbed. Moreover, living in an urban setting, Hindu women tend to use traditional methods more compared to their rural counterparts. This discrepancy may be a direct consequence of the women in the larger sample responding affirmatively to the use of traditional methods along with modern methods, rather than the use of

only traditional methods. Simply, this implies that these women are not trading traditional methods for modern methods, but are increasingly using both. This can be affirmed if we check the usage data for modern contraceptives, which is also seen as higher among urban Hindu women compared to rural. Muslim women on the contrary are shifting to modern methods with an improvement in education, wealth and living conditions.

Multivariate Analysis

In the part of the analysis, the dependent variable was contraceptive use at the time of the survey Odds ratios from logistic regression analysis were applied to identify associations between contraceptive use and the selected demographic and socio-economic characteristics of women.

Contraceptive use was measured as a dichotomous variable. In the model, Muslim women who were practicing contraception at the time of the survey were coded 1 and those who were not using any method were coded 0. Use of any method was measured as a dichotomous variable. In the model used independent variables Women's age, place of residence, number of living children, household wealth index, both wives' and husbands' educational qualifications, religion, surviving desire for more children, view on family planning were used as control variables for predicting contraceptive use. The continuous variable for the woman's age was replaced by five age groups: 15-19, 20-24, 25-29 and 40-49, represented and 15-19 reference categories. The place of residence used categories from the urban and rural. The continuous variable for the number of living children was constructed with three groups: less than three children, three and four children, and more than four children. Household wealth index was a discrete variable including three categories: lowest, middle and highest. Women's and husband's educational levels were grouped into four categories: no education, primary, secondary, and higher. Religion had three categories: Hindu, Muslim, and other. Family planning exposure was defined as being able to recall a family planning message heard or seen on radio, television, or the newspaper during the last month.

Table 4: Logistic Regression Analysis of the Muslim Women using Contraception

Independent variable	Odd ratio	SE	95% CI	
			Lowest	Highest
Age Group				
15-19®				
20-24	1.218	.030	1.148	1.291
25-29	1.560	.032	1.465	1.660
30-34	1.622	.033	1.520	1.731
35-49	1.219	.032	1.144	1.299
Place of Residence				
Urban®				
Rural	1.242	.020	1.193	11.293
Mother education				
Illiterate®				
Primary	1.431	.026	1.360	1.506
Secondary	1.604	.026	1.525	1.686
Higher	1.927	.045	1.766	2.102
Husband education				
Illiterate®				
Primary	1.193	.026	1.133	1.255
Secondary	1.164	.024	1.110	1.220
Higher	1.066	.034	.997	1.139
Surviving Children				
0®				
1	5.123	.057	4.583	5.726
2	13.686	.055	12.279	15.256
3+	17.241	.056	15.459	19.227
Caste				
SC	.895	.052	.807	.991
ST	.470	.041	.434	.509
OBC	.784	.018	.756	.812
Other®				
Wealth Index				
Lowest®				
Middle	1.645	.026	1.562	1.732
Highest	2.112	.026	2.016	2.232
Mass Media				
No®				
Yes	.654	.019	.630	.679

Note: R- Reference category of independent variable.
All are significant at p<.000 except mass media.

Compared to their urban counter parts, rural women who do not discuss family planning with their husbands are less likely to know all the modern methods of contraception. Compared to Hindu's, the Muslim women are more likely to know all modern methods. Whereas, compared to SC women, the ST women are less likely to know all modern methods. This result further strengthens the fact that the message of family planning has not reached the deprived (tribal) section of the country, so there is a need to provide knowledge about family planning to tribal

women with specifically designed programs.

The results also show that, with the increase in number of living children, the odds of contraceptive use also significantly increases. Among those women who know all the modern methods of contraception, the odds of using contraception are higher than those who are not aware of any modern method. So, when we include only these two variables in the model, influence of both the variables on the contraceptive use is highly significant. However, weight age of the number of living children surpasses the weight age of knowledge of all modern methods of contraception. When we include other variables in the model, the effect of living children is even greater on the contraceptive use, although the knowledge of contraceptive methods still play a great role but its influence slightly decreases. Compared to SC women, general caste women are more likely to use contraception, and it is statistically highly significant. On the other hand, compared to SC, ST and OBC women are less likely to use contraception, but the result is statistically not significant. Compared to Hindu adolescent women, women from other religion are more likely to use contraception. In terms of contraceptive use, exposure to mass-media also plays a determining role, compared to women who are not exposed, and fully exposed women are more likely to use contraception. From this result it can be surmised that providing knowledge about various family planning methods, exposing Muslim women to different mass media and husband wife communication would be able to increase the contraceptive use among the Muslim married women in the country.

Given the various sources from where women can procure contraception, we decided to seek out the most recurrent source. In India, public hospitals, PHC's and CHC's provide condoms. They are likewise available with private vendors and NGO's, private clinics and hospitals. We categorized all these sources into 3 categories and tabulated them according to the percentage of women who accessed them for availing contraceptives. Within "Others" we also included friends and family members as they are also sources where women obtain contraception.

Table 5. The source for given contraceptive by religion

Religion	Source of Contraceptive		
	Public	Private	Other
Hindu	25.3	62.7	11.9
Muslim	19.5	68.5	12.0
All India	25.2	63.6	11.2

It can be seen from the former table that there is no religious distinction as far as source of contraception is concerned. Nearly 64% of the women got their contraceptives from private sources with Muslim women preferring these to a high degree. What was seen as the source most approached by married women to obtain contraceptives was private pharmacy/drugstore with nearly 33.7% women acquiring their contraceptive from there. Next were shops which accounted for 16.2% of the women, and was listed under the category 'Others'. That the Indian mindset that hesitates in asking or discussing openly about contraceptives is slowly changing can be gleaned from these percentages.

Given that only 61.5% of the entire population was using contraception, we examined the reasons why Women abstain from using contraception. We clubbed all these reasons together into 7 categories to provide a general understanding of the motive behind the respondents decision in Table 6.

Table 6. Reasons cited for not using contraception

Reasons	Hindu	Muslim	All India
Fertility Related	12.5	17.1	12.8
Opposition to Use	4.3	8.5	4.7
Lack of Knowledge	.8	1.0	.8
Method Related Issues	9.3	10.9	8.0
Lack of Access	.5	.6	.6
Up to God	14.5	15.4	14.6
Other	1.4	1.5	1.4

Within the category termed as Fertility Related, we combined reasons like not having sex, infrequent sex, absence of husband, menopause, hysterectomy, post-partum amenorrheic and subfecundity/infecundity under one head. These were basically responses for wanting to use contraception, but finding no need for use, either by the respondent, her husband or otherwise.

The reasons listed as Opposition to Use occurred due to the objections from either the husband, religious restrictions, other individuals or factors and lastly maybe the respondent herself. Within Lack of Knowledge, we included no knowledge about either the method or the source. This includes those 4% of the population that is entirely unaware of contraception, as well as those who find it nearly impossible to procure any contraception. The latter however, would stand to reason only in case of modern contraceptives.

The reason headed as Method Related Issues deals with all aspects of the method from health concerns to inconvenience in usage as well as high cost. Herein, the respondents gave the various flaws that may exist in a certain method and may need looking into. If the issue is of high cost, then a more targeted subsidy on contraception should be made available. If it is due to the side effects accompanying the method, or the inconvenience of usage, a probable solution is to generate more knowledge and understanding of the pros and cons of these methods. Lack of Access is another issue that may turn out to be a major deterrent to the widespread use of contraception and was put under a separate heading. The category Up to God is simply the answer given by the respondent to the question. All other answers were put under the category, 'Other'.

When we looked at the various reasons that were given for not using contraceptives, the reason that emerged as the highest reported by the respondent was "Up to God". This reason reinforces the need for a social and cultural change within the mindset of the population. The age-old thinking of children as security for old age has to be altered.

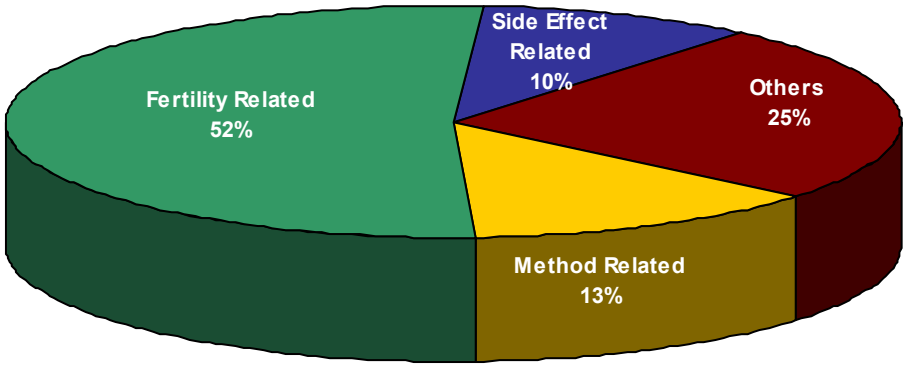
The two other reasons that were also cited by a large number of women were Fertility Related Issues and Method Related Issues. Within the former, post-partum amenorrheic and Breastfeeding were reported most often. Within Method Related Issues, we found that 10.7% of the women stated health concerns as the major reason for them not using contraception. What is to be noted here is that for Muslims, the reason Opposition to Use was found fairly common. Within this reason, Religious Opposition and Respondent Opposition were both high at 13.6% and 14.1% respectively.

Some respondents stopped using a method of contraception either entirely or by shifting to another method. Figure 1 depicts the various reasons for discontinuing a contraceptive method

by the frequency of the responses. In the figure, the numerous responses were clubbed under four categories based on the similarity of the basis of the answers.

About 52% of the respondents stopped using contraceptives because they wanted to conceive again. Amongst the population, 13% of the women declared several issues with the method itself- be it the inadequate supply, the difficulty in access, the inconvenience in usage or the high cost associated with the method. A large segment of this population also said that because the method had failed and they had conceived anyways, they had ceased to use that contraceptive method.

Figure 1 Main Reasons for Discontinuing the Last Method Used



Another 10% of the women reported the side-effects they may have actually or perceivably suffered from as the reason to desist from using contraception. Body aches, cramps, dizziness, nausea/vomiting, weight gain, spotting, excessive bleeding etc. are all effects that may accompany certain modern methods. For these women what is most important is the need to understand completely the use and the associated pros and cons of each method that they may make an informed decision about contraceptives.

Discussion

This is the first such study of this magnitude, covering the whole country, and obviously therefore, the findings deserve attention. But perhaps even more interesting than the results themselves are the insights that are drawn into the interplay of various factors that determine the conditions of Muslim women's lives. Of course, there are some easily predictable conclusions,

especially with respect to economic status. The low socio-economic status of Muslims is now well-known; like the Scheduled Castes, they are disproportionately represented among the poor and have the lowest per capita income indicators. This is ascribed not only to the lack of access to asset ownership, but also to poor educational attainment and occupational patterns, which show clustering in low-paid activities, as well as the concentration of the Muslim population in the economically backward regions of the country.

This economic differentiation constitutes probably the primary source of differentiation in status between Muslim and Hindu women in the aggregate, since the household's level of assets ownership, occupation and income possibilities critically determine the basic conditions of life of the women. However, there are significant regional differences in this: Muslims are generally poor in the north (especially rural areas) and the east, but less so in the south.

One of the standard assumptions about Muslim women is that religion prevents them from getting more equal access to education. It is certainly true that Muslim women are more likely to be illiterate than Hindu women had never attended school and less than had completed school. However, the study shows that this is essentially the result of low socio-economic status, rather than religion. Across the survey, among all communities and caste groups, financial constraints and gender bias dominate over other factors in determining levels of education. Indeed, in those regions where Muslims are better off (as in the south and to a lesser extent in the west), Muslim women also have higher levels of education.

However, two other features that are more specific to the Muslim community may have operated to devalue continuing education for girls. The first is that Muslim men also have very low educational attainment in general. The study found that educated Muslim women had illiterate husbands. Low marriage age has a number of other adverse implications: it is usually associated with high early fertility, which affects women's nutrition and health status; it tends to reduce women's autonomy and agency in the marital home and to create conditions of patriarchal subservience that get perpetuated through life, and it thereby often reduces self-worth. Such activities - self-employed in low-productivity activities in the informal sector, as casual labourers and domestic servants - imply poor working conditions and low wages. It is, therefore, possible

that Muslim women are kept out of the paid workforce not only by religious or *purdah* type motivations, but perhaps more significantly by low education, lack of opportunity, low mobility and the inability to delegate domestic responsibilities.

There is no apparent community-wise variation in women's decision-making, mobility and access to public spaces. Rather, what the survey indicates is that most women in India - across communities and regions - have very little autonomy and control over their own lives. These are obviously extremely important results, which point to a different direction for public policy as well. There are clear indications of the need for a new, less predetermined conception of community and especially of the status of women within a community. This would go beyond the patterns of special group recognition, in which notions of "identity" (however patriarchal) are maintained at all costs. It would also have to avoid getting bogged down by controversies over claims of the minorities of enhanced representation in government jobs and the like.

Conclusion

This paper intended to delve into the methods and the reasoning behind the contraceptive choices Muslim women in India make. We found that though they are conversant with contraceptive methods as much as any other woman in India, their use is nearly 5% lower than Hindu women, the next largest religious community. This trend exists in all cases except when we look at traditional methods, where Muslim women not only are much more knowledgeable, but also apply these techniques tat a higher frequency. This inclination to use traditional methods may stem from the fact that these methods are not as concrete a method of family planning as compared to the modern methods. With the religious opposition that most respondents adhere to, they may perceive these methods as “neither here nor there”. This may be one of the several reasons that the limiters may perceive or actually consider and thus choose to employ traditional methods rather than modern. Other reasons may vary from the health concerns, the inconvenience and lack of access pertaining to the method, the desire to use these methods for spacing rather than preventing pregnancy or the fear of overstepping given cultural definitions and norms.

What would have been most worrisome was if Traditional methods were used in the stead of more effective methods like condom, IUD and Sterilization. However, trends show a rise in the

use of modern method usage also, except in the DLHS-III data, where overall contraceptive usage shows a drop compared to previous data.

Given the trends and the percentages, there is a need to design the current family planning programmes to answer specifically to the doubts and misconceptions in the minds of most women. The need to illuminate the lower effectiveness of traditional methods as well as the grave need for a well-structured and designed programme for planning their families has to be put out clearly for the individuals to judge and rationalize accordingly.

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