CHAPTER - 2

LITERATURE REVIEW
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“Understanding contraceptive choice is essential for improving women’s reproductive health” (Kohler, 1997: 369) and assessing the gender nuances still ingrained in the decision making process of couples. The question on choice of contraception has been widely researched and rural areas and socio-economic factors have been the mainstay of these investigations.

Through this literature review, an endeavour has been made to see the path taken prior to empirical work and how the present issue is linked to it. First, a theoretical backdrop has been presented to provide a foundation for the research.

2.1 CHOICE OF CONTRACEPTIVE METHOD

An individual’s contraceptive behaviour is shaped by both his/her own characteristics and the surrounding environment (community) along with availability, cost and quality of services and information about contraceptive methods. According to Palmore and Bulatao (1989) contraceptive choice is pictured as a funnel through which a wide range of choices is reduced to a single choice by cultural, economic, technical, psychological and other factors. Moving downward, one can divide the relevant factors into four groups, technology and cost, contraceptive suppliers, socio-cultural factors, and personal preferences. Technological developments broaden the basket of choice of methods as well as render some methods obsolete. Economic costs influence decisions on whether a method will be mass produced, just as it influences decisions on whether a method will be filtered out at other stages. Contraceptive suppliers determine whether technically feasible methods become accessible to individuals. On the other hand, socio-cultural factors partly determine which contraceptive methods, among those actually within reach of the ultimate consumer, are chosen.
2.1.1 Community and contraceptive choice

Contraceptive choice as discussed earlier is a function of both individual and community characteristics. Community characteristics are explained by local reproductive cultures. A study in Nang Rong, Thailand picks on the importance of community factors in contraceptive choice. This study combines qualitative and quantitative data demonstrating the importance of village location, placement of family planning services as well as the structure of the conversational network affecting contraceptive choice (Entwisle et. al., 1996). Additionally it is seen that the fertility transition and social diffusion process is also entwined through contraceptive behaviour in southern Ghana (Montgomery et. al., 2001) and in Japan. In Japan, Rindfuss et. al., (2004) found that there was a strong positive association between knowing someone who has engaged in a particular behaviour to macro-level social change. “Social network analysis” has been incorporated by researchers to test the community effect on choice. It has two components, diffusion of innovations and communications. Diffusion research dates back to the early 1940s among rural sociologists studying the diffusion of hybrid seed corn among Iowa farmers (Rogers, 1978). This tool was developed by sociologists to measure an individual’s direct and indirect connection to others which are the channels through which the innovations are communicated in the social system (Rogers, 1978; Godley, 2001). Thus, the contraceptive choice of an individual is influenced by “information from early adopters in their social network” (Kohler, 1997:370) bringing forth the effect of interpersonal communication in contraceptive choice. The second component of social network analysis brings in the diffusion of information.
on family planning, trying to pin down the sources or channels of communication through which the innovations are spread. In the diffusion model, there is the concept of taboo communication which diffuses slowly as it is not free flowing, uninhibited interpersonal communication (Rogers, 1978). Though social network analysis talks of community effect, we cannot rule out the limitations it has. It is difficult to quantify its effect on contraceptive choice and to say which social network affects choice. Rogers (1978) has used the diffusion model to describe the particular case of choice of contraceptive sterilisation. He has emphasised taboo communication and socio-linguistic aspects of contraceptive sterilisation as barriers to its diffusion among villagers and urban poor. Kohler (1997) has added to the knowledge on social network analysis by conducting a study on a rural Korean sample, where he concludes that the information shared among network partners is limited and there is unobserved heterogeneity with respect to women's attributes and characteristics. Contraceptive choice varies across region and social strata because of informal communications, rather than in depth discussion about fertility control. In another study by Godley (2001) in Thailand's Nang Rong, the kinship network was found to be important in affecting contraceptive choice. Interaction with "modern culture" (represented by village kinship ties outside the village, many of which are likely to be to urban centres, such as Bangkok) encourages the use of modern methods of contraception. Interpersonal communication transmitted cultural change which may facilitate changes in contraceptive behaviour in many ways like information flow on modern methods, increase in access to different methods or increase in access to modern health care. In Mongolia Gereltuya, (2007) depicted community variables as important predictors in reducing variation between primary sampling unit when other modern methods were compared with traditional methods.

2.1.2 Economics of contraceptive choice

Now we look into the economics of contraceptive choice, which deals with costs, accessibility and economics of fertility control meaning decisions concerning fertility regulation and termination. Costs include time cost and also price of contraceptive method. Accessibility is the physical availability talking about the supply factors. Thus, when we apply the economic principles to choice the central issue is 'cost'. Cost can be economic, social or psychological in nature. Research has been conducted to empirically test the economic model of choice. Simmons (1978) has looked into contraceptive sterilisation and has inferred that application of
economic principles to choice of contraceptive sterilisation is based on the assumption that this particular decision and also its timing are dictated in part by economic consideration. Rational decision making involves minimising costs (Thomas et al., 1996). Thus, the decision to use sterilisation is only for the prevention of further pregnancies which entail cost. Rosenzweig et al. (1982) in a study on education and contraceptive use tried to account for the differential time costs associated with using contraceptive devices, which may be strongly correlated with schooling. This research also embodies educational differences in the costs of acquiring newly available contraceptive techniques as well as in preferences for the number and timing of births. The other aspect of the economics of contraceptive choice, and accessibility, has been worked out using spatial network analysis. The geographical information system has been used to capture accessibility and its implication on method choice (Entwisle et al., 1997). Results show that if a family planning outlet is easily accessible, people choose to use the method offered in that outlet rather than travelling further for alternatives. Quality also seems to affect choice as measured by the authors of the Nang Rong study.

In another study Ross et al. (2002) have scrutinised how contraceptive access affects choice in developing countries. They have cited that temporal information is needed on how access changes over time and its affect on contraceptive choice.

Davidson has interpreted choice with reference to personal attitudes and values (Bulatao, 1989). He brings in psychology to choice where both consumers and providers are important. These are subjective expected utility models. This is an alternative to acceptability research brought forth by Freedman and Berelson's (1976) analytical framework of the determinants of contraceptive choice (Bulatao, 1989). It highlights various attributes that different contraceptive methods need (medical, technological, ethical, logistic, economic as well as philosophical) in order to be acceptable to potential users. However, this model does not take into account the issues of contraceptive choice in a government sponsored/promoted Family Planning Programme and its influence on the user's decision making process (Visaria and Chari, 1998). Other than these, there are at least three models combining perceptions and evaluations into judgments (Bulatao, 1989). However, none of the earlier researchers have looked deeply into the individual socio-economic characteristics.
2.1.3 The Bulatao’s framework

In another theoretical framework suggested by Bulatao (1989), contraceptive method choice is affected by four types of factors, contraceptive goals, contraceptive competence, contraceptive evaluation, and contraceptive access (Bulatao, 1989).

**Contraceptive goals** involve the specific fertility effect a woman or a couple seeks to achieve through contraception. **Contraceptive competence** is the ability to use a particular method effectively. **Contraceptive evaluation** involves judgments about the practical and moral implications of using a specific method. The concept of evaluation can, in principle, be extended to cover all relevant features of a method. **Contraceptive access** is closely related to use. Promotion of a method through the media, through face to face contacts, by programme personnel, by physicians and so on can add significantly to method choice. The affordability of a method to the individual is an additional issue; clearly, affordability is affected by the presence or absence of government subsidies.

![Figure 2.2 Factors in contraceptive choice](Bulatao, 1989)

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<th>Contraceptive goals</th>
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<td>Limiting versus spacing goal</td>
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<td>Number of births to be averted</td>
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<td>Length of intended interval</td>
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<td>Flexibility in goals</td>
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<th>Contraceptive competence</th>
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<td>Understanding of method</td>
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<td>Sexual attitudes and competence</td>
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<td>Spousal ability to cooperate</td>
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<th>Contraceptive evaluation</th>
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<td>Practical preferences - side effects</td>
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<td>Practical preferences – convenience</td>
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The Bulatao’s framework shown in Fig 2.2 is a comprehensive package including both individual demand and supply factors.

Some of the field studies conducted in India as well as in many other countries have used Bulatao’s framework for analysis. In a study conducted by Bhende et. al. (1991) on determinants of contraceptive method choice, the industrial city of India, Jamshedpur, provides an interesting contrast to the all India levels. In the Jamshedpur context, the multinomial logit analysis revealed religion and caste to be important in acceptance and method choice.

A similar study (Verma and Baburajan, 1994) in an industrial township located in Greater Bombay was conducted on contraceptive use dynamics. In this study, two statistical methods, factor analysis and multinomial logit analysis were used. The study revealed that while in the selection of the oral pill, contraceptive goal related factors play an important role, in the case of condoms and IUDs, contraceptive competence appears to have a more significant influence and none of the four factors mattered for the rhythm method. This may not be true in the rural areas where self motivation to accept family planning is likely to be very low.

Rele et. al. (1989) have looked into the determinants and consequences of contraceptive method choice in India using Bulatao’s framework to make contraceptive choice operational. They have brought in programme emphasis, attributes of contraceptives, motivation for contraception as well as the influence of a couple’s background characteristics (socio-demographic factors), affecting contraceptive choice in India.

Bulatao’s conceptual framework for selecting the determinants of method choice has been used in analysing Bangladesh Demographic and Health Survey data by Mannan (2002). The results of the logistic regression analysis indicated results similar to the prior surveys done in India. Contraceptive goals are related to choosing non terminal efficient methods such as pills, IUDs, and injectables. Contraceptive evaluation determines condom use. Religion also affects the choice of contraception. Like Indian Muslims, Muslims in Bangladesh do not prefer sterilisation. This paper reveals that the programme factor significantly increased the likelihood of using pills as compared to other modern methods.
2.2 SOCIO-ECONOMIC FACTORS IN CONTRACEPTIVE CHOICE

2.2.1 Evidence from India

Various studies have been conducted in India on the socio-economic aspects of family planning method choice and to determine its acceptability. Phadnis (1960) conducted a study on patients who visited a family planning clinic in Nagpur. This study included both qualitative and quantitative methods of data collection. It was found that education and standard of living were the major factors motivating people to adopt family planning. In this study an easy method, the foam tablet was found to be most acceptable as it was inexpensive and relatively effective. Cultural factors also play an important role in choosing contraception. Whether or not couples want to have additional children at a given point of time is expected to influence their decision about the adoption of contraception (Sharma and Jain, 1974). In this context, a reduction in infant mortality along with other socio-economic factors can increase acceptance of family planning methods like sterilisation (Raju and Bhat, 1996; Sekhar and Reddy, 1994). In a government hospital in Hyderabad, the analysis of 4220 acceptors of different methods during 1971-72 was conducted (Rangachari et. al., 1977), which demonstrated that acceptance of any family planning method was directly related to literacy, more accurately, female literacy (Nair, 1982; Gulati, 1996). Religion has always been important in the choice of contraceptive method (Bhende et. al., 1991; Rajeratnam, 2000; Raju et. al.,1994; Gulati, 1996). Hindus choose mostly sterilisation while IUDs and pills found greater acceptance among Muslims. Socio-economic groups differ in their contraceptive choices. A majority of the women from lower socio-economic groups accept sterilisation in the age group of 25-35 years, with at least four children. The IUD is accepted by lower middle class women and pills by middle and higher economic groups. A survey on industrial workers (industrial units in Faridabad near Delhi) showed that income has a strong influence on the adoption of conventional family planning methods whereas impact of education was absent when all the other variables were controlled. In this paper, the methodology used was path analysis (Jesudason, 1978). This contradicts the prior findings where education played an important role in contraceptive choice. It is probably because the study covered industrial workers who are fairly homogeneous in terms of education.
In Kerala a study done in a semi-rural squatter settlement explores the type of sterilisation most acceptable among very low income households and why (Gulati, 1996). The article highlights the preference noticed among Scheduled Castes (SCs) for female over male sterilisation. The author has explained this phenomenon by saying that there is fear and suspicion that surgery on men affects their virility as well as physical strength (most of the SC people were engaged in wage employment involving manual work). Institutional deliveries have been linked to higher preference for female sterilisation “where the suggestion to undergo surgery seems to come from the doctor attending the women concerned while she is in hospital for deliveries or abortions” (Gulati, 1979:48).

Surveys conducted by the Operations Research Group (ORG), on family planning bring out the reasons for preferring or rejecting a family planning method. A Knowledge Attitude Practice (KAP) study of 3,806 currently married males randomly selected from villages of seven districts of Gujarat and another study on contraceptive behaviour of 4000 male industrial workers selected from ten industries of India (four of these industries were in Western India and the remaining in the eastern zone) bring out the reasons for preferring one particular method of family planning over another (Khan, 1977). In this area, rural people preferred vasectomy because they perceived it as simpler, whereas in an urban setting the wife’s bad health and fear of tubectomy’s side effects were the reasons cited. Reasons for preferring tubectomy over vasectomy in rural areas were husbands’ dislike for vasectomy, fear of side effects and also cash incentives offered by tubectomy camps. In urban areas the fear of side effects and the wife’s willingness to undergo tubectomy were given as reasons. Overall preference for sterilisation over non terminal methods was due to lack of faith in the latter, contrarily non terminal methods were preferred over sterilisation due to various perceived side effects and desire for more children or desire for a son as well as satisfaction with non terminal methods.

Research in Andhra Pradesh on the determinants of permanent contraceptive methods brought in a new dimension based on the data from the NSSO-42nd Round (Sekhar and Reddy, 1994). It is interesting to note that the use of spacing method was quite high (higher than the state average) in coastal regions. Sterilisation as a permanent method of family planning was prevalent in both urban and rural areas with urban couples opting for higher sterilisation percentages. Female
sterilisation was the predominant method of choice between male and female surgeries in rural areas, whereas condoms were more popular in urban areas. A review of the empirical studies with the help of logit analysis suggests that the variables that are closely associated with family planning acceptance are education of wife, caste and religion, number of living children, number of sons living, duration of marriage and economic characteristics of the household. Gulati (1996) has studied contraceptive methods and choice in Kerala and Uttar Pradesh with the help of multinomial logit analysis of NFHS data. Religion was found to have played an important role in method choice; a similar conclusion was also arrived at by Rangachari et. al. (1977). The use of terminal methods of sterilisation was almost negligible amongst Muslims. Tubectomy was rated as the most popular in the study by Raju and Bhat (1996) in Mandya District of Karnataka. This study highlights the strong gender bias in favour of males in a welfare programme like family planning. A higher proportion is aware of female methods and 95 percent of all acceptors are female. The Forum for Woman’s Health in World Conference on Women, Beijing (1995), also spoke on similar lines of gender bias in contraceptive choice. The supply side factors (discussed in the framework) like the community based distribution programme as well as Maternal and Child Health Services influence contraceptive choice in India (Rao, 1997). A case study in Goa and Kerala also attempted to assess the contribution of selected socio-cultural factors in contraceptive method choice through multinomial logit regression of the NFHS data (Rajaretnam, 2000). Similar to prior studies, education of women and religion play a major role in the use of traditional and temporary methods whereas economic factors are not very important. Further, urban residence also plays an important role in the choice of traditional methods in Goa. The study highlights that in both the states, the choice of sterilisation depends largely on the sex composition of the living children and not only on couples’ socio-cultural and economic conditions, “in case of sterilisation, a strong programme factor operates” (Rajaretnam, 2000: 11). Other authors like Visaria et. al. (1995) in a case study in Gujarat also brought out the programme factor in contraceptive use.

Decision making also plays an important role in contraceptive method use. The decision making process is influenced by socio-economic factors like place of residence, family size and, source of information and types of families like nuclear families and consanguineous marriage. A study was conducted in the G.S.V.M Medical College, Kanpur during 1975-76 with tubectomy
acceptors (Misra et al., 1977) on their decision on the method of family limitation. The authors constructed a decisiogram based on two communication patterns of joint and nuclear families. The decisiogram shows that the decision making process in nuclear families is very simple as compared to the complex process in joint families. Local doctors also play an important part in the programme. On the other hand, in joint families there is direct and indirect communication as well as numerous agencies. So, the social worker can play a vital role in channelising the options in favour of females.

Saha (1981) made an attempt to study the socio-demographic characteristics of tubectomy acceptors in a rural community of West Bengal from 1960-1976. The average family size of tubectomy acceptors was higher than the national average. Proportionately a lower number of Muslims accepted the method. Compared to earlier years, a higher proportion of SC/ST population accepted the method in recent years. In India, female sterilisation continues to be the preferred method of permanent birth control. This is followed by IUDs, which is also for women and thus women continue to disproportionately bear the responsibility of contraception in India (Chacko, 2001). In the four villages of rural West Bengal, the main factors that influence contraceptive use are age of women, the number of sons she has, her religion and village of residence (Chacko, 2001). The results of this study were similar to what Das et al. (1999) concluded using NFHS-I data (National Family Health Survey, 1992-93) of West Bengal and Assam on contraceptive choice. In another study by Mondal (2006) using NFHS, India data contraceptive choice is looked at in the light of reproductive choice and rights of women. A house to house survey in Hoogly District (Banerjee, 2004) of West Bengal gave insights into the socio-economic and cultural determinants of contraceptive sterilisation. Per capita income, female literacy, work status and family structure were likely to affect choice of sterilisation.

Baveja et al. (2000) used the method mix approach to evaluate contraceptive choice among potential clients. An interesting finding is that economic status did not influence contraceptive choice, as all the methods were offered free of cost. Illiterate women because of more children accepted sterilisation as compared to literate women. However, literacy did not affect the choice of any specific spacing method contrary to prior research. This study brings in a new edge of
encouraging potential clients to make informed choices to override the provider bias while accepting a particular type of spacing method.

Ghosh (2004) in a study of NFHS-II data on northern and southern states of India brings out the role of spousal communication as an important factor in increasing the likelihood of using condoms in Kerala, Punjab and Bihar. Younger and educated men are more likely to use condoms in backward states.

2.2.2 Evidences from outside India
The studies discussed below were conducted in very diverse countries with different socio cultural economic and political conditions. Research on the determinants of contraceptive choice based on studies outside India reveal the varying roles of a number of factors. In the United States of America, men are less likely than women to seek sterilisation, as seen from a 1991 National Survey (Forste, et. al., 1995). Male sterilisation was somewhat common in older ages. Male sterilisation was also relatively less common if the husband or the wife had less than college education. On the other hand, education and religion had little effect on the choice of the male procedures over the female. Another study by Miller et. al. (1985) on American women reveals that older, better educated, females did not go for sterilisation; on the other hand, we see tubal ligation was taken up at the time of delivery.

Bean et. al. (1983) in a study on American couples brought forth a new facet of choice, i.e., role of husband wife communication in type of sterilisation chosen. The results reveal that good husband wife communication leads to male sterilisation and poor husband wife communication leads to female sterilisation. In another study on American women, the author studies (Lamvu et. al. 2006) the consistency between the most important reasons for using contraception and current method used was examined. Only 25 percent of women who have consulted a health care provider showed the consistency between reason of use and method choice.

Results of the 1989 Bangladesh Fertility Survey show how education and decision making influence contraceptive use (Ullah and Chakraborty, 1993). Phillips et. al. (1985) in a study on rural sub districts of Bangladesh brings out the programme factors in choice of contraception. A
quantitative study on Bangladesh’s Demographic and Health Survey (1996-97) picks on individual socio-economic factors significant in the use of abstinence in comparison to other modern contraceptives (Kamal et. al., 2007).

The Fertility and Birth Control Survey of China conducted by the State Family Planning Commission of China in 1988 was used to assess the patterns of contraceptive use in China. The study reflects that the most and the least developed provinces of China have similar contraceptive patterns, characterised by a high proportion of IUDs and low sterilisation whereas, the middle level has a high proportion of sterilisation followed by IUDs. Like the Chinese, the Vietnamese also rely on a modern method, i.e., IUDs. The 1988 Demographic and Health Survey of Vietnam was used in the study to examine the effect of factors that may have played a role in determining contraceptive use and method choice in Vietnam (Dang, 1995). Logistic regression results on predictors of method choice, which in the Vietnamese context is mainly between IUDs and traditional methods, shows that husbands’ education and number of living children and sex of children were significantly related to modern method use. Preference for a traditional birth control method was related to desire for more sons. Similar studies in the urban slums of Bangladesh speak on similar lines i.e. economic status, woman’s education, religious affiliation, age, number of living children, son preference all these strongly shape contraceptive choice. Knowledge, awareness and programme factors also shape contraceptive choice (Barkat et. al.,1997). Similarly, a study on female personnel working in Cameroon’s Palm Oil Company observed that the key determinants of contraceptive choice were the number of surviving children and woman’s education (Bessala et. al., 1998). Similar findings were reached by Pejaranonda, et. al.(1986) in a choice study in Thailand.

Myntti et. al. (2002) in a study in Lebanon challenged the stereotypes and brought forth that men practiced withdrawal in the presence of effective family planning methods, because of fear of side effects from other methods.

A study using Demographic and Health Survey data from 1990-96 in 18 developing countries (13 in Sub-Saharan Africa, 2 each in North Africa and Asia and 1 in Latin America ) on contraceptive decision making reveals interesting results (Bankole and Singh, 1998).
Contraceptive knowledge is high among husbands and wives in the 18 countries. On the other hand, husbands are more likely than wives to report modern method use. Uniquely this study highlights reporting of contraceptive use adopting measures on the reporting of both partners. Usually there has been a female only approach to family planning in most of the developing countries. Accessibility has also been studied to affect choice in developing countries (Ross et al., 2002). A report on contraceptive dynamics in Guatemala highlights the demand factor, which includes a series of demographic and socio-economic variables (age, employment, education, rural-urban residence and ownership of television and radio) as well as ethnicity. The importance of female education is seen here as seen in India (Bertrand et al., 2001). The study on the Korean sample also brings in the socio-economic variables in choice. In this study, we see that female sterilisation is mostly used by younger women who have institutional deliveries and that male sterilisation is used by educated couples. IUDs and condoms are preferred by urban couples, more interestingly, condoms are preferred by educated urban couples. Traditional method use is higher among rural couples. The examination of socio-cultural and demographic determinants on Sri Lanka in an updated study is also interesting (Malhotra and Thapa 1991). The findings show that socio-demographic factors are important in choice, moreover a peculiar feature is the total lack of differentials among users of temporary modern and traditional methods.

Ringheim (1996) has given a global perspective on determinants of use of contraceptive methods for men. According to him, human factors inhibiting contraceptive use were not always recognised. Policy makers and service providers determine acceptability to some extent. Similar to earlier studies this paper also brings out the demographic, religious or cultural factors influencing contraceptive practice. Along with this, safety and efficacy are the major concerns. Supporting the earlier findings, a study examining some of the socio-cultural factors affecting the practice of contraception of a group of currently married fecund women in Metropolitan Dacca (Chaudhury, 1979) again brings forth the importance of female education. Conjugal role relationship, son preference, religiosity, exposure to mass media and work experience are also important. Socio-economic characteristics are not the only things that affect choice, Bangladeshi women weigh a variety of factors like assessment of available options (Hollander, 2003). For example results of the 1996-97 Demographic and Health Survey data on Bangladesh shows pill
users look into its cost, availability and convenience whereas condom users weigh the side effects of other methods. Adding to these studies another investigation (The International Centre for Diarrhoeal Disease Research and Bangladesh Ministry of Health and Population Control’s joint project) in two rural sub districts of Bangladesh (Phillips et. al., 1985) brings out the effect of improvement in quality and intensity of services on choice. Logistic regression analysis shows that baseline characteristics of women, their reproductive preferences, knowledge of service points along with gender of service providers are also important in shaping choice.

A study using data from 1989, 1993, and 1998 Kenya Demographic and Health Surveys to examine trends and determinants of contraceptive method choice in Kenya shows how over time, the use of modern contraceptive methods is higher in urban than in rural areas and the dramatic rise in use of injectables (Magadi and Curtis, 2003).

In a retrospective study (Ozalp et. al., 1999) on women from a maternity and a university hospital in Turkey, we again see the effect of education on choice. A higher educated woman has higher probability of using modern methods; mostly they choose combined oral contraceptives and irreversible methods. In Turkey many studies (Aytekin et. al., 2001; Yurdakul and Vural, 2002; Kulczycki, 2004; Ortayli et. al., 2005) with women as well as men bring out the determinants of traditional methods. Husband’s preference, fear of side effects, and husband’s participation in family planning were cited as important reasons for using traditional methods in the presence of modern method availability and knowledge. However, it is seen that with contact with programme personnel there is a shift to modern method choice of contraceptives.

Morroni et. al. (2006) in a cross-sectional study among women attending 26 primary health care clinics in South Africa argued that younger age, higher education and urban place of residence were the factors for choosing NET-EN over DMPA (depo medroxyprogesterone acetate). The findings also suggest that misperception which has its roots in popular discourse and individual user’s experiences, as well as poor communication with the service providers and also counselling shape choice. Another study recommends that (Oakley, 2004) clients or patients be brought forth and given informed choices as it is needed for sexual health care.
To substantiate the aforementioned study, Oddens (1997) in his research on America, Europe and Netherlands concludes that misperception about IUDs and pills lead to the choice of condoms, rhythm and withdrawal in America, Europe and Netherlands. Apart from the social influence, health safety matters a lot as there is a greater choice of condoms in the era of AIDS. In a qualitative study on condom use (Lin et al., 1996) in China, the results show that dislikes and misconceptions about condoms are common. The authors also found that few people have proper knowledge about the role of condoms in providing protection from sexually transmitted diseases and also the service provider’s bias towards vasectomy which affects choice of condoms.

On a totally different path, Arevalo (2004) views choice through the eyes of older and younger women. The author discovers that most young women can use the standard day method and two day method effectively and correctly as compared to their older counterparts. Moreover, these methods can be used by younger women who fear hormonal methods and wish to have another child in the future.

Life course approach has been the direction taken up by Edmeades (2004) on contraceptive choice. He tries to see the influence past and current household and community contexts exert on decisions regarding method of contraceptive choice in Nang Rong, Thailand. The multinomial models of contraceptive choice bring out that current individual characteristics exert considerable influence on contraceptive choice as well as past household and community level characteristics.

After looking at the factors affecting contraceptive choice, we see if choice makes a difference in the use of contraception. The results say that when choice was denied to clients there was discontinuation. In this study, importance was also placed on husband wife concurrence on choice.
2.3 FAMILY PLANNING PROGRAMMES, GENDER AND CONTRACEPTIVE CHOICE

Most of the earlier researches focus on role of family planning programme to increase contraceptive prevalence and reduce fertility but this section focuses on role of family planning programme in choosing a particular contraceptive method. A few research studies have brought out the choice scenario in a state sponsored Family Planning Programme.

In a research study based on DHS (Demographic and Health Survey) data by Steele et. al. (1999) two program variables were significant in method choice. Provision of a health centre within 10 kilometres increased the probability of adoption of modern contraceptive method within 12 months of a live birth. Besides, 12 months adoption rates are considerably higher in clusters with a choice of at least three methods than in those where a more limited range of method is available. Cohen (2000) in his quantitative research in Malawi (African) unravels the four components of family planning effort (mass media exposure, i.e, radio and print messages, accessibility of contraceptive services and service quality), which contribute to choice of modern contraceptives use, but varies among different strata of the population. Historically, China’s population programme had a focus on post-partum sterilization after first birth and sterilization after subsequent births. In a study by Brown et. al. (2007) on data from the United Nations Population Fund (UNFPA) reproductive and family planning surveys conducted during 2003-2005, the analysis revealed that the influence of family planning workers in determining women’s choices to use IUD at parity one and sterilization at parity two reduced post ICPD.

Gender analysis of the present population policies in India brings forth a highly skewed picture. After 25 years of the programme, nothing has changed significantly, only women are now the “prime targets of India’s population control programme facilitated by merging of Maternal and Child Health with Family Welfare” (Mukherjee, 2002: 71). Rizwana (1992) has highlighted the gender sensitive approach to the Family Planning Programme in India. According to her “wife willingly or unwillingly spoils her system with pills and pessaries, bears the bleeding and discomfort of the IUDs and even takes the extreme measure of getting herself sterilised simply because it is ultimately she who has to carry through the pregnancy and child rearing” (Rizwana,
Moreover, the linkage between family planning and maternal and child health has also brought the overdependence on female methods (Rizwana, 1992; Mukherjee, 2002) of contraception. This indicates "government perspective of looking only at women as agents who can reduce population growth" (Hussain, 2003: 48). Rizwana (1992) calls for dispelling the prejudice against vasectomy and condoms and equal involvement of men and women in family planning. However, one cannot assess the potential acceptability of modern methods for men without fully engaging the male partners in family planning (Ringheim, 1996). Current male methods are not comparable to existing methods for women and the development of new reversible methods for men will offer comparability to methods available to women. In contrast, Hussain (2003) in her paper shows that vasectomy, an available method for men, presently not preferred over tubal ligation for females because it affects men’s virility and their masculinity, they are the bread winners and cannot afford to be weakened and their prospects of remarriage would be reduced. Thus, method availability is not a cause for overdependence on female methods. Her field evidence from the study of two religious communities of Delhi slums also shows that religion is a less influential factor than male dominance and cultural norms. She also brings forth that the entire reproduction process is controlled and shaped by traditional gender roles and gender relations within the larger social structure through which patriarchy operates. This brings forth the patriarchal thrust in policies. Similarly, a paper by Gangoli (1998), talks about the politics of the Family Planning Programme. Other than highlighting the insensitivity of popular policies to the lives and experiences of women, concentrating mainly on filling quotas, she also brings in the issue of empowerment of women projected as a means to the ultimate end of population reduction. Gangoli (1998) brings in a feminist edge and questions the male responsibility towards contraception and also health of women.

A case study spanning five generations of a South Indian family examines the features of male involvement in contraceptive use and decision making (Karra et. al., 1997). The study highlights the fact that male involvement in contraception is not dependent upon change in gender relations, but it may lead to changes in these relations over time as female education increases. Another phenomenon which is clear is that male acceptance of family planning needs not occur in the context of woman's empowerment, but can result in greater empowerment for women. The overall motivation campaign therefore becomes particularly important for increasing
contraceptive acceptance. However, one shortcoming of the study is that it only involves one middle class Brahmin family.

Another study of male involvement in family planning was carried out in Alwar District of Rajasthan (Sharma, 2003). The study demonstrates that overdependence on female sterilisation has led both men and women to assume that contraception is only for women. Moreover, non-availability of condoms in the villages can also be a factor in decreased involvement. This study also calls forth changes in knowledge and behaviour level. On a similar note, Bose (2004) calls for social transformation for a paradigm shift.

A Knowledge Attitudes Practices and Behavior (KABP) report by the Population Council India (Khan and Patel, 1997) conducted with rural male shows various findings. There is overdependence on sterilisation due to no ‘choice’ for contraceptive methods. Moreover, the preference for tubectomy over vasectomy was due to several beliefs like ‘vasectomy makes men weak and less productive, which they cannot afford since they are the main breadwinners in the family’ (women also felt the same way). Vasectomy demands rest for several days, women do not do hard work and tubectomy is easier than vasectomy (Khan and Patel, 1997). This study also revealed that men believed that the ‘shift from vasectomy to tubectomy has taken place largely because of the side effects of vasectomy and the availability of similar and easy tubectomy methods such as laparoscopy’ (Khan and Patel, 1997: 3).

Karkal (1998) has raised the curtain on another facet of the population policy. In her view, “Government policies and their functioning strengthen the patriarchal attitudes and traditions that oppress women” (p.175). She also shows the over emphasis on female methods of contraception, “the government’s patriarchal attitude which treats women as the targets of the policy of population control” (p.175) is also clear from the paper. In addition to it, contraceptive technologies like Norplant (a sub dermal implant) injection and anti fertility vaccine, though not in use in India’s Family Planning Programme, has always violated, the proper functioning of a woman’s body (Lingam, 1998; Gupta, 2001).
Another paper brings out the importance of gender inequality in determining reproductive choice (Mukhopadhyay and Savithri, 1998). The women’s health movement in Asia has been primarily concerned with problems of demographic targeting, coercion and promotion of sterilisation, and long acting hormonal contraceptives (Petchesky, 2003). One example is China where “coerced abortion, sterilisation and contraception persist on women (Xiaorong, 1995). Apart from Asia, female sterilisation has been the leading method of contraception in Brazil (Caetano et. al., 2004).

Roberts (1981) has brought forth that family planning is a world wide institution dominated by the interest of the males and their implication on women. Women are at a disadvantaged position because of the limited choices. This led the author to conclude: “Thus men, without actually having the power to reproduce themselves, have direct power over means of reproduction” (p.7).

A survey on man’s knowledge of and attitude towards birth spacing and contraceptive use in Jordan clearly shows “nearly one third indicate a willingness to use male contraceptives and half believe that man’s contraceptive use increases if services were designed specially for them” (Nustas, 1999: 12). Furthermore, it also brings forth the effect of education and religion. Though 74 percent of the respondents reported that they discuss issues regarding family planning with their wives, it cannot be concluded that couples reach a decision together, as in Jordan men are seen as the main decision makers in the family. A limitation of the study is that men were interviewed but not their wives.

Another example of male involvement in the Family Planning Programme was taken up by the International Planned Parenthood Federation, South Asian region – Experts meeting on “Sexual Males and Responsible Ties” 6-7 September 1996, Bombay, India. A paper gives examples of three male involvement initiatives, which have proved to be successful (Kapoor et. al., 1996). For example, in Bangladesh, religious opposition was the greatest barrier against the use of family planning; however, religious leaders and opinion leaders have been used to give information on family planning and encouraged men to shoulder the responsibilities. The second example came from Columbia where the barrier was seeded in machismo-culture. Thus, services were accordingly tailored to cope with the people’s need. Finally, in Zimbabwe, a male motivation
campaign succeeded in increasing both men’s and women’s knowledge of long term contraceptive methods and awareness of male responsibility. Santhya (2004) has called for “promoting shared responsibility and active involvement of men and to re-popularise vasectomy, including information, education and communication campaigns and training surgeons in no-scalpel vasectomy” (p.33). She has also commented that even today gender inequality is plaguing India’s population programme.

2.4 KNOWLEDGE AND PRACTICE OF CONTRACEPTION

Knowledge and use of contraception are the indicators most frequently used by national and international organisations, to assess the success of the Family Planning Programmes. However, in the present scenario of over dependence on female methods we want to see if knowledge plays a role in it. We also need to ascertain if there is actually any difference between knowledge and use.

Since the 1960s, many fertility surveys and studies of contraceptive knowledge, attitude and practice (KAP) studies have been undertaken worldwide (Rutenberg et. al, 1991). A study carried out by the Demographic Research Centre (DRC), Trivandrum, on knowledge and practice of family planning in rural Kerala among currently married males below 35 years throws light on the awareness and knowledge about specific methods of family planning (DRC, Trivandrum, 1969). At that time, knowledge of sterilisation was the highest and that of diaphragm is the least, irrespective of religion, age and education. However, there was a wide gap between knowledge and practice of sterilisation. Among the Muslims, the practice of sterilisation was the lowest compared to Hindus and Christians. On the other hand, condom method was found to be more prevalent among educated people. This study was conducted only with married males, females were not interviewed. On similar lines the DRC, (1958, 1959) conducted a pilot survey in Trivandrum city on both male and female attitudes to family planning. Of the people contacted, only eight percent males and two percent females had sufficiently adequate knowledge of family planning methods. Income and education are important correlates of knowledge as seen in this paper (Shastri, 1977).
Another survey on the attitudes of couples towards family planning in Putupakham area of the city of Madras was conducted by the Institute of Population Studies, Madras. A sample of couples with at least two children was interviewed. Education was a significant factor affecting knowledge. Knowledge of vasectomy was quite widespread and couples were in favour of sterilisation. “Also the emphasis on this particular method of limiting family planning programme which preceded the survey might be an important additional factor” (Raman, 1963: 92).

Similar studies were carried out by Bhatia, in Pakhowal Community Development Block of Ludhiana District with the main purpose of studying the knowledge and attitudes of rural males towards family planning (Bhatia, 1970). The study revealed that more than half of the respondents had specific knowledge of methods of family planning. However, there was a gap between knowledge and practice.

A macro international comparison on knowledge and use of contraception, conducted by the Institute for Resource Development, highlights interesting findings (Rutenberg et al., 1991). In the countries in which DHS surveys were conducted, knowledge of at least one family planning method was extensive. In 17 of the 25 countries, over 90 percent of the women had heard of at least one method. The percentage of married women knowing five or more contraceptive methods was between 50 percent to 80 percent in Botswana, Kenya, Togo and Zimbabwe, all of the North American and Asian countries, and in Ecuador and Peru. Similar to earlier surveys, this report also brings forth a positive co-relation between contraceptive knowledge and education with greatest differentials occurring in countries where the overall level of knowledge is less than 90 percent.

2.5 RESEARCH GAPS

The literature and the surveys give a picture of the demographic, social and economic characteristics of the people with contraceptive knowledge. It also gives evidence from India about the gap between contraceptive knowledge and practice. However, these studies do not elaborate the fact whether knowledge shapes preference or overdependence on female methods,
Moreover, it also does not bring forth the reasons why there is a gap between knowledge and practice.

The literature review was conducted to understand current knowledge on the factors affecting contraceptive choice. Available evidence shows possibly religion, caste, occupation, education, contraceptive goal, decision making, and standard of living, play an important role in contraceptive choice. The review has extensively brought forth the socio-demographic factors influencing contraceptive choice. Only a few articles have highlighted the role of the programme factor and role of policy makers or service providers in influencing contraceptive choice. Studies have shown that providers have a distinct bias towards sterilisation. In a qualitative study of rural Karnataka, medical officers were biased towards sterilisation (Visaria, 2000). However, the actual mechanism of the programme factors or the provider’s bias has not received adequate attention. Thus, this area needs further research. As seen most of the research has been in a rural setting, be it India or outside India. Typically, urban choice needs to be addressed, accompanied with reasons for choice for traditional method in urban areas, even in the presence of effective family planning methods. Some studies bring forth religion and fear of side effects of other methods as a reason for use of traditional methods (Aytekin et. al., 2001; Myntti et. al., 2002; Mikolajczyk et. al., 2003). It must be noted that the demand side factors as well as the supply side factors of contraceptive choice have to be looked into to reach a conclusion on the process of choice. Though some authors have addressed the issue of gendered population policy, making women the target, they have not gone into the depth of posing a question why or tracing its reasons. Only a backlash against the post vasectomy scandals has been referred to, perhaps to put forth some reasons. At present combining the Maternal and Child Health Programme with the Family Planning Programme has been cited as a reason for the overdependence on female methods of contraception. The earlier surveys have also neglected the role of culture, patriarchy, and woman’s autonomy. For some researchers male involvement is not dependent on changes in gender relations but it can lead to changes in gender relations and women is empowerment. In a paper, it was revealed that male involvement was low because availability of male methods was not there. Thus, the supply side is also important. However, the mechanism of male involvement and contraceptive choice needs proper understanding.
Coming to the issue of knowledge influencing a particular method choice, we can see that the literature has addressed only the socio-economic factors influencing knowledge and practice. However, the Family Planning Programme talks about “informed choice” which has not been looked into. The literature review reveals that there exists a wide gap between knowledge and practice, but does not go in to the factors or reasons behind it. The social network analysis brings some insights on its effect on contraceptive choice however, its role in urban areas needs to be researched.