CHAPTER 6

QUALITATIVE ENQUIRY INTO FACTORS AND PROCESSES SHAPING CONTRACEPTIVE CHOICE
The analysis in the preceding two chapters indicated that the major factors that influence contraceptive choice among married women in West Bengal are the age of the women, the number of sons she has borne, whether she ever had pregnancy wastage, her schooling, religion, standard of living, work status and exposure to mass media. Besides, the random intercept models also revealed that, the community has considerable impact on individual determinants of contraceptive choice. The disaggregated analysis by rural and urban place of residence also showed the community effect to be significant. A qualitative enquiry into method choice was undertaken from the perspective of both the provider and the client to gain more insight into the pathways of effect. This Chapter presents the findings of this enquiry.

6.1 PURPOSE OF QUALITATIVE STUDY AND ANALYTIC FRAMEWORK

6.1.1 Purpose
Qualitative methods are used in this study for understanding women’s perception of different method choices and the transition from choice of male terminal method to female terminal method. Gender dimensions of contraceptive choice are also clarified by the qualitative data. Service providers both public and private were also interviewed to seek and comprehend providers’ bias, if any. During the primary household survey, the service providers generally named for having provided family planning services were chosen for conducting qualitative interviews.

6.1.2 Locale and methodology
To understand the story behind the statistics in the survey area the study area chosen was the same as that of the household survey. The focus group discussions (FGDs) with women were conducted in four villages spread over two districts and four localities from urban poor and other
urban wards of Kolkata Municipal Corporation that were selected for the household survey. In-depth interviews (IDIs), and a few FGDs were undertaken with service providers located mostly in the selected urban poor and rural localities. The focus groups of women were formed based on caste (SCs, STs and other castes), religion (Hindu and Muslim) in both rural and urban poor areas in order to ensure a fairly homogenous group in order to understand group behaviour. The focus groups were found useful in gathering information on subjects such as contraceptive preference among specific groups as the government Family Planning Programme has to some extent removed the taboo on discussions about contraception in public. The group milieu encouraged participants to discuss contraceptive choice behaviour in that area within the specific group. The gender aspect of contraceptive choice and also the causes of transition from male to female sterilization were discussed in FGDs with women in two age groups, older (36-60 years) and younger (15-35 years). Each focus group consisted of six to eight members from selected localities and was homogeneous in economic and social characteristics. A total of 36 FGDs were conducted with women across the study sites.

In order to capture the programme’s effect on choice of contraception, contraceptive service providers were identified in rural and urban areas and IDIs and FGDs were conducted with them. The service providers either private, NGOs, public and even Registered Medical Practitioners (those practicing medicine without a formal qualification but were presumed to be registered as practitioners, mostly of modern medicines) were selected based on the primary household survey responses from women (15-49 years) in rural and urban areas as well as information in the study area. Photograph 6.1 shows FGD with NGO health workers in Kolkata. Those service providers were chosen, who had been mentioned by the women in the household survey as those from whom they seek services for family planning or maternal health. However, private doctors in urban slums were not included in the study sample of service providers as not many women used their services. The NFHS-3 shows that most of the women undergoing sterilisation and IUD services in West Bengal usually utilised government services whereas for condoms and pills their most recent supplies were from the private medical sector (IIPS and Macro International, 2008).
A total of 18 service providers were included in the study. These interviews covered issues on guidance given to the service providers by the health department, targets and mechanisms to achieve the targets, and strategies adopted. The interviews and discussions were in Bengali and Hindi according to the language spoken in the area. Interviews with the women as well as the service providers were an interface where the social setting and the social factors affecting choice surfaced. Different sets of questions were used for providers and users. The length of interviews varied from half an hour to one hour. The field work was conducted by the researcher herself during January 2008 to May 2008. Atlas/ ti 5.0 software was used to analyse the qualitative data. Table 6.1 gives a detailed break-up of the FGDs/IDIs.
6.1.3 The details of the issues discussed in the field with the women

Topics of discussion with young women (15-35 years)

a. Change in family size desires.
b. Reasons for change in family size desires
c. Knowledge about contraceptive methods
e. Reasons for preference of these contraceptives over others.
f. Awareness about side-effects.
g. Contraceptive decision making within the household
h. Reason for choosing abortion over contraception.

Points of discussion with older women (36-60 years)

a. Change in family size desires.
b. Reasons for change in family size desires
c. Knowledge about contraceptive methods
e. Reasons for preference of these contraceptives over others.
f. Knowledge about tubectomy and vasectomy
g. Reasons for shift from vasectomy to tubectomy.
h. Awareness about side-effects.
i. Contraceptive decision making within the household
j. Reason for choosing abortion over contraception.

6.1.4 The details of the issues discussed in the field with the Service Providers

Topics of discussion with health service professionals

a. Key responsibilities
b. Guidance given by the higher authorities on Family Planning (Specific method preference by the health departments)
c. Targets on Family planning acceptors by method of contraceptives the health service providers need to achieve.
d. Performance appraisals of health service providers.
e. Pathways to achieve targets.
f. Family planning advice generally give to women
g. Contraceptive preferences of women and reasons for preference
h. Queries generally asked by women on Family Planning Methods
i. Reasons for preferring tubectomy over vasectomy.
j. Awareness among women about abortion and reasons for seeking abortion
k. Challenges/difficulties faced in the job and suggestions for improvement
<table>
<thead>
<tr>
<th>Place/Caste groups/Religious groups</th>
<th>FGDs</th>
<th>IDI/FGDs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SC</td>
<td>ST</td>
<td>OBC</td>
</tr>
<tr>
<td>Village A (Bardhaman)</td>
<td>1 (Young)</td>
<td>1 (Young)</td>
<td></td>
</tr>
<tr>
<td>Village B (Bardhaman)</td>
<td>2 (Young &amp; old women)</td>
<td>1 (Young women)</td>
<td></td>
</tr>
<tr>
<td>Village C (Bankura)</td>
<td>2 (Young &amp; old women)</td>
<td>2 (Young &amp; old women)</td>
<td>2 (Young &amp; old women)</td>
</tr>
<tr>
<td>Village D (Bankura)</td>
<td>2 (Young &amp; old women)</td>
<td>4 (Young &amp; old women)</td>
<td>2 (Young &amp; old women)</td>
</tr>
<tr>
<td>Urban</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward C</td>
<td>4 (2Young &amp; 2 old women)</td>
<td>2 &amp; 2 (mixed caste SC and ST)</td>
<td></td>
</tr>
<tr>
<td>Ward D (non-slum)</td>
<td></td>
<td>2 (mixed caste groups)</td>
<td></td>
</tr>
<tr>
<td>Ward B (Non slum)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>9</td>
<td>2</td>
</tr>
</tbody>
</table>

FGDs with Women – 36 Service Providers- 18
* In the middle class localities it was difficult to gather group, so no FGD’s could be conducted in one of the wards.
6.1.5 Profile of women in FGDs

Table 6.2 Young women participants in rural FGDs (15-35 years)

<table>
<thead>
<tr>
<th>Caste/Religion (FGD groups)</th>
<th>Age range (average)</th>
<th>Schooling level</th>
<th>Average family size</th>
<th>Work status</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>18-35 years (25 years)</td>
<td>Illiterate</td>
<td>2.3 children</td>
<td>Agricultural wage labourers, Daily wage labourers</td>
</tr>
<tr>
<td>ST</td>
<td>19-34 years (27 years)</td>
<td>Illiterate, a few had schooling between classes 4th - 9th</td>
<td>2.3 children</td>
<td>Daily wage labourers</td>
</tr>
<tr>
<td>OBC</td>
<td>24-30 years (29 years)</td>
<td>3rd -12th class</td>
<td>1.6 children</td>
<td>Not engaged in any economic activity</td>
</tr>
<tr>
<td>Others</td>
<td>20-32 years (27 years)</td>
<td>Mostly educated, 4th -11th class, few illiterate</td>
<td>1.7 children</td>
<td>Not engaged in any economic activity</td>
</tr>
<tr>
<td>Muslims</td>
<td>18-31 years (26 years)</td>
<td>1st - 8th class, non formal education</td>
<td>3 children</td>
<td>Embroidery work</td>
</tr>
</tbody>
</table>

The group of young women (15-35 years) in rural areas belonged to SCs, STs, other backward castes (OBC) and other castes. The ST and the SC women in this group were mostly illiterate compared to the OBC, Muslim and women from other castes. The OBC women (FGD) of a village of Bankura District were mostly educated between classes 3 to 12. Their average family size was two children and they were not engaged in any income generation activities.

In the four FGDs with SCs, in all the four villages, the young women were mostly illiterate. The average family size was more than two children. The women were generally daily wage labourers mainly in agriculture. In one of the villages of Bankura the SC women were seasonal migrants for six months in a year visiting Bardhaman District of West Bengal for rice plantation and harvesting. Some of the SC women in another village were engaged in the National Employment Guarantee Scheme Programme (NREGA) within the village.

The schooling level of the Muslim women in the young group (15-35 years) ranged between classes 1st to 8th. Their average family size was more than three children. The Muslim women in one village of Bardhaman District were involved in embroidery work. This was Kantha
embroidery, for which raw materials were supplied to individual women in their homes by middlemen from Santiniketan in the bordering Birbhum District.

The majority of the ST women were illiterate with only a few of them having had schooling between classes 4th to 9th. The average family size was more than two children. All of the women in our sample for FGDs were engaged in daily wage labour. The profile of the other caste young women at the study site was different from that of the SC, ST and Muslims. However, they had some similarities with the OBC women in the sample. Most of the women in three FGDs were educated. The schooling range was between class 4 and class 10. The average family size was more than one child but less than two.

Table 6.3 Older women participants in rural FGDs (36-60 years)

<table>
<thead>
<tr>
<th>Caste/Religion (FGD groups)</th>
<th>Age range (average)</th>
<th>Schooling level</th>
<th>Average family size</th>
<th>Work status</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>38-80 years (51.7 years)</td>
<td>Mostly illiterate, very few 5th pass</td>
<td>4.1 children</td>
<td>Mostly agricultural wage labourers</td>
</tr>
<tr>
<td>ST</td>
<td>36-58 years (45.2 years)</td>
<td>Illiterate</td>
<td>4 children</td>
<td>Not engaged in any economic activity</td>
</tr>
<tr>
<td>OBC</td>
<td>37-71 years (44.8 years)</td>
<td>4th - 9th class, a few illiterate</td>
<td>2.8 children</td>
<td>Not engaged in any economic activity</td>
</tr>
<tr>
<td>Others</td>
<td>37-65 years (44.6 years)</td>
<td>Mostly illiterate, a few attended 4th - 9th class</td>
<td>3.4 children</td>
<td>Not engaged in any economic activity</td>
</tr>
<tr>
<td>Muslims</td>
<td>40-50 years (45.3 years)</td>
<td>Illiterate</td>
<td>5.5 children</td>
<td>Not engaged in any economic activity</td>
</tr>
</tbody>
</table>

The older group across the caste categories was mainly illiterate. However, among the other castes and OBCs some of the older women had four to ten years of schooling. The average family size among the Muslims was 5.5 children followed by SCs/STs at four children. Most of the older women in our study sample were not working. Some older women among the SCs were engaged in agricultural labour and daily wage labour.
Table 6.4 Young women participants in urban FGDs (15-35 years)

<table>
<thead>
<tr>
<th>Caste/Religion (FGD groups)</th>
<th>Age range (average)</th>
<th>Schooling level</th>
<th>Average family size</th>
<th>Work status</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>17-34 years (24 years)</td>
<td>3rd - 9th class, few illiterate</td>
<td>1.2 children</td>
<td>Not engaged in any economic activity</td>
</tr>
<tr>
<td>S.T</td>
<td>18-28 years (23.7 years)</td>
<td>3rd - 8th class</td>
<td>1.7 children</td>
<td>Maid servants, packing toffees</td>
</tr>
<tr>
<td>Mixed caste group (urban non-poor)</td>
<td>17-35 years (28.25 years)</td>
<td>9th - Bachelors Degree</td>
<td>1.3 children</td>
<td>Not engaged in any economic activity</td>
</tr>
<tr>
<td>Hindu</td>
<td>26-35 years (31.6 years)</td>
<td>8th - Bachelors Degree</td>
<td>1.2 children</td>
<td>Few working: sewing work, hand work, private tuition, NGO field worker</td>
</tr>
<tr>
<td>Muslim</td>
<td>18-35 years (26.9 years)</td>
<td>50% of the women were illiterate, others were 5th class- Bachelors Degree</td>
<td>3.0 children</td>
<td>Mostly not engaged in any economic activity, a few were engaged in paper cup making</td>
</tr>
</tbody>
</table>

In the urban area, the FGDs were organised mostly in poor areas (slums); only one FGD was in a non-slum area (Table 6.1). In one slum (Ward A) the majority of the population were Muslims so FGDs were divided by religion: Hindu (mixed caste) and Muslim; in others it was based on caste (SC, and ST).

In the urban sample, all the caste groups and religious groups had some women with a few years of schooling. However, most of the Muslim women were illiterate. The SCs and STs sample in the urban poor areas was similar. In the urban areas, the average family size ranged between 1.2-1.7 children among most of the caste groups except the Muslims where average family size was 3 children. A few young women in the urban sample were economically active.

One FGD was conducted with the women in a non-slum area in Ward D. The sample characteristics were as follows. All of them were educated. The level of education varied from
class 9 to graduation. The average family size was 1.2 children. None of them were engaged in any kind of employment.

Table 6.5 Older women participants in urban FGDs (36-60 years)

<table>
<thead>
<tr>
<th>Caste/Religion (FGD groups)</th>
<th>Age range (average)</th>
<th>Schooling level</th>
<th>Average family size</th>
<th>Work status</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>36-60 years (41.4 years)</td>
<td>Mostly illiterate, few 2(^{nd}) – 7(^{th}) class</td>
<td>3.8 children</td>
<td>Maid servant, cook, sweeper, cutting beetle nut and selling</td>
</tr>
<tr>
<td>ST</td>
<td>37-47 years (43.5 years)</td>
<td>Illiterate</td>
<td>3 children</td>
<td>Rag picker, sweeper, maid servant</td>
</tr>
<tr>
<td>Muslims</td>
<td>37-60 years (44.28 years)</td>
<td>Illiterate</td>
<td>5 children</td>
<td>Paper packet making, shoe pasting, bidi making</td>
</tr>
<tr>
<td>Hindu</td>
<td>37-63 years (44.62 years)</td>
<td>10(^{th}) class-Bachelors Degree</td>
<td>2.5 children</td>
<td>Not engaged in any economic activity</td>
</tr>
<tr>
<td>Mixed caste group (urban non poor areas)</td>
<td>37-53 years (41 years)</td>
<td>5(^{th}) pass-Bachelors Degree</td>
<td>1.75 children</td>
<td>Not engaged in any economic activity</td>
</tr>
</tbody>
</table>

The older Muslim group of women in the sample was mostly illiterate having an average family size of five children. They were engaged in various kinds of household industry like paper packet making, bidi making, shoe pasting etc. In contrast, the Hindu older women sample was mostly educated with an average family size of 2.5 children. They were only engaged in household work. The SC and the ST older group sample were also similar in terms of education, but the average family size among the SCs was higher than in the STs. Most of the STs/SCs women were engaged as household help in the non-slum areas.

6.1.6 Service providers
In the slum areas (Ward A and Ward C), both NGOs and the government were providing family planning services. The population in Ward A was predominantly Muslim (Muslims were by and large migrants from Bihar). The Muslim women frequented a NGO named Bengal Social Service League and a mobile clinic of Howrah South Point for general health services, maternal health services as well as family planning requirements. The ward was also served by the Kolkata Municipal Corporation (government) outreach workers. A few women had approached private
doctors for obtaining menstrual regulation pills (these are used primarily for abortion during early pregnancy). The NGOs were providing most of the services free of cost, which tended to attract more consumers in the poor localities of Kolkata. The mobile clinic in this ward, which came once a week (Tuesday) and operated from the Muslim locality, provided contraceptive injections as well as other contraceptives and general health care services free of cost. The other NGO located in the adjacent ward was also providing immunisation to children, antenatal care and family planning services free of cost. It was reported that women from Ward A went to this NGO for the immunisation of their children where they were informed about contraceptives. This NGO also facilitated services for female sterilisation where they prepared a list of women who might need it and referred them to government hospitals (Lady Dufferin) for sterilisation, but provided incentive money to the women. None of the NGOs were providing abortion services, but the Bengal Social Service League did refer women for abortions if the women wanted to get sterilisation done after that. This NGO was generally visited by Muslim women for immunisation services for their children. The mobile clinic was also frequented by Muslim women. Kolkata Municipal Corporation (KMC) has a health unit in this ward and the KMC workers also conducted home visits.

IDIs were conducted with the German doctor at the mobile clinic and the pharmacist (Table 6.1). Male and female health workers from the NGO Bengal Social Service League were interviewed and a group discussion was held with health workers at KMC.

Ward C had a population composition of SCs and STs along with a few clusters of migrants from Bihar. Two NGOs namely CINI and the Family Planning Association of India (FPAI) are working in this ward. IDIs were conducted with field staff of both the NGOs. Additionally, the KMC health worker as well as the Aanganwadi Worker (AWW) in this ward were interviewed to understand the government supply factors.

Finally, an FGD was conducted with KMC health workers in Ward B. In non-slum areas, it was seen that women generally did not prefer government health service products for family planning, neither did they consult them. Every individual woman had a preference for a range of
private practitioners, available in the city. So health service providers in non-slum areas were not interviewed.

In the village scenario, it was learnt from the women that they primarily contacted the AWW or ANMs of the government family planning programme for their family planning needs. The women may at times not use the government supplies, but had contact with the AWW or ANM. The ANM and the other health workers conducted home visits thus the women in rural areas of the study site were in contact with health workers. The women were part of mothers’ meeting conducted on various health related topics by the AWW. Thus, IDIs were conducted with the AWW, ANM, female health supervisor and link person in all the villages where they had a presence. However, a village in Bankura District, which was in the most backward mauja (panchayat), hardly had any government outreach workers. The village had no motor-able all season roads. Accessibility was a problem and the nearest sub centre was also at a distance of approximately five kilometres.

Other than the range of government health workers there were Registered Medical Practitioners (RMPs) and quacks. One RMP and one quack were interviewed. These ‘doctors’ were frequently cited by the women in the sample during the household survey.

6.2 FINDINGS

6.2.1 FGDs with young urban women
Family size preferences: Young women (15-35 years) from different castes and religious groups were asked about present family size desires in comparison to earlier times to gauge their fertility goals. In the urban slums among the Hindu Bengali FGD desired family size is small. Rising cost of children, cost of educating children and space constraint in the house were cited as the main reasons for limiting family size to two children. Many of them noted “one is enough”. Some of the women even stated television advertisements on the two child norm were an influence. Women said that in earlier times, people had agricultural land and thus they used to have more children.
The Muslim group in the slum stated the importance of educating children, which has become expensive, as the main reason for limiting family size to two or three. They mentioned that in villages a large family was no problem. Comparing earlier times, the women stated the importance of education for children shaping their family size desires. Besides, the women in the FGDs talked about their husband’s son preference with the expectation that they would support them economically.

Among the SCs and the STs staying in the slums, quality quantity tradeoffs and cost of the children were mentioned, similar to that of the other Hindus and the Muslims for preferring small family size. Rising economic costs and dwindling incomes were their major concerns for limiting family size. However, one of the ST women stated that “tribal men still want more children but we go to hospital hence have come to know about contraceptives.”

In the non-slum cluster, among the middle class, young women were also concerned about the cost of children because of inflation.

**Contraceptive choice:** From the FGD with Hindu Bengali women in the slum, it was seen that there was no widespread preference for any single method. A few discussed the pills they had used and the side effects they had experienced. When probed, two out of eight said that their husbands were using condoms and two women also spoke about the use of the withdrawal and safe period method (Rhythm). Talk about Cu-t brought out the fear of side effects and one female even shared her negative experience.

Both the FGDs with Muslim women revealed awareness of pills and Cu-t use. Condom use was cited in one FGD. Pills were quoted as the most preferred method. However, the participants were talking about the side effects of Cu-t like swelling of uterus, excessive bleeding and white discharge. In one of the FGDs, the women had a consensus that males do not want to use condoms, so the women have to either bear children repeatedly or use pills even though it has
side-effects. Negative experiences and myths regarding Cu-t use were widely known in the network among the Muslims.

Among the two FGDs with SC women, contraceptive preference reported was that of pills. The reasons generally quoted were privacy constraints in using condoms and also non-use of condom by husband. Even intimate partner violence was reported by the women as well as alcoholism by their husbands. Family planning is considered the women’s responsibility. Thus, condom use was not a choice for these women. Women had heard a lot of negative incidences about Cu-t among relatives and neighbours. Tubectomy was also high on the preference list among women among the higher age group. For vasectomy, women stated apprehensions and concerns that as males were the breadwinners and had to do all the heavy work so women had to opt for sterilisation. The most common belief about vasectomy (Non-surgical vasectomy or otherwise) is that it will cause physical weakness and inhibit the man from working and earning money to support his family. In addition to the concern about physical weakness, a secondary belief about vasectomy is that it will cause sexual weakness or impotence. Moreover, the men in the poor urban localities were mostly engaged in daily wage labour and did not have time to forego their wages for a day and hence did not want to undergo an operation. Some of the women preferred injections to pills because of difficulties in complying with the schedule of pill use.

Similar to the SC women, the ST women also preferred pills. Yet, two women in one FGD mentioned condom use by husbands. The husband’s alcoholism was stated as a reason for non choice of male spacing method among the STs as well. Cu-t was associated with side effects. However, some ST women said that while visiting a hospital for the children’s immunisation, they had become aware of contraceptive pills and hence had started using them.

In non-slum clusters, the preference clearly was for withdrawal method as many perceived that other methods had side effects. However, one interesting thing is that everybody spoke of personal preferences and nobody would speak about other’s choices. Side effects were mainly stated as one of the reasons for not using modern spacing methods. Consultation with doctor was stated as one of the reasons for choice. Even the middle class women had the same ideas about
the side effects of vasectomy in men (vasectomy causes physical weakness, sexual weakness or impotence) as the women in the slums.

Urban middle class women were aware about both withdrawal and safe period method and said that couples preferred these because of the potential side effects of other methods. Many women switched from modern spacing method to traditional methods after experiencing side effects. The husband’s choice was cited as one of the reasons for use of traditional methods, mostly withdrawal. Sometimes withdrawal was used in combination with condoms.

**Contraception versus abortion:** It was reported that many women in the Muslim cluster underwent abortions including some women present in the FGD. One woman had had an abortion twice. When asked why she did not use contraceptives, the woman said that she did not know about contraceptives at all. Another woman said that it was difficult to have pills everyday as a reason for abortion. "How long can one have pills everyday?" The most quoted reason for abortions was compulsion because of contraceptive failure or ignorance about contraceptives or conception during amenorrhea. Over the counter supply of menstrual regulation pills (MRP) was common in the Muslim locality. Some women in one of the FGDs spoke about using MRP for abortion and paid Rs. 100 which was paid by the husband.

Among the Hindu cluster, the women said that there was abortion but it was not discussed within the community. One woman said that she had an abortion because she got pregnant during amenorrhea and the other women said that sometimes people do not want to use modern methods due to side effects, which can finally lead to abortion.

Among the young SC group of women it was stated that abortion was resorted to mainly because of mistakes (omission of having pills) or for conceiving a boy. In one of the FGDs, a point that emerged was that if a woman has two children and “she makes a mistake then she gets ligation done after abortion”.
6.2.2 FGDs with young rural women

**Family size preferences:** The desired family size is small among young rural women. The reasons cited for this among general caste women and OBC women in the FGDs were mostly related to economic cost of upbringing the children and the spiralling cost of living. Women also stated the importance of education for children for a better future. Similarly, the SC women and ST women in rural areas mentioned the importance of education for children which now affected the choice of family size. The ST women also said that they do not own land so they have to work and feed their children, so two children are fine. Muslims also said the same thing.

Among the SCs in Bankura District, infant mortality and son preference are both reasons for the desire for relatively larger families. The SCs are generally poor compared to the other castes so there is a lot of seasonal migration to the district of Bardhaman where the land is fertile and multiple crops are grown. A son is important as it is assumed that he will support the family. The bride price is also very high among this community. Having two sons is a norm reinforced by the in-laws because of infant mortality. Hence, the family size desire is relatively high.

**Contraceptive choice:** Among the general castes, sterilisation was stated as the most preferred method. Many women present in the FGD had been sterilised after two children. Sterilisation at a young age was a surprise for the researcher. The women stated that the main source of contraceptive knowledge was the ANM at the sub centre and social network as well as television and radio. The women added that pills were also used by many in their village. Sterilisation was quoted to be the most preferred method because women can forget to take pills or the condom can burst, so it is better to have sterilisation done. One woman in the FGD remarked that it was better to go for sterilisation than abortion. There were stories about the negative experiences connected with the Cu-t, as well as the recurrent cost of visiting doctors because of side effects in the backdrop of poor infrastructure. One participant of the FGD who had had surgery remarked that “it is better to get sterilisation done than use pills or different other methods...moreover I didn’t know much about use of other methods then and everybody told me to go for sterilisation so I had the operation”. The mother in law and even sister in law (husband’s elder brother’s wife) play an important role in the decision about contraceptives. It is not a matter of personal
choice. Thus, the importance of the extended family in contraceptive decisions in rural areas as well as the social network was seen.

As mentioned earlier the safe period method of contraception was difficult to use as the husband travelled in and out of the village.

The women belonging to the OBCs also had choices similar to those of the general castes at the rural study site. Ligation after two children was the most preferred contraceptive use among young women.

In another village which has predominantly Muslim population, the women in the Muslim cluster said that they prefer pills as the AWW had told them about it. The young women cited that their husband would not use condoms and if they even talked about ligation then their in laws would throw them out of the house. Cu-t had some sort of shame and fear attached to it. Few women in the FGD acknowledged the use of condoms by their husbands. Interestingly, the SCs and STs in this village also cited religious reasons for not adopting female sterilisation like that of the Muslims. Yet, in the same district (Bardhaman) in another village SC women went for sterilisation at a young age. Sterilisation is preferred by the SCs because they are scared that the Cu-t or any other method can cause health problems, which means foregoing daily wages and visiting the doctor about 25 kilometres away. One of the participants in an FGD spoke about forgetting to take a pill for a day which can result in conception, so sterilisation of females is fine for them. The researcher felt that the SC women had little knowledge about modern spacing methods. The women said that the men did not know about condoms so the couples did not use male contraception.

STs were not limiting their family by contraception due to ignorance about the modern spacing methods. Health workers did not have much influence in the village where the ST population lived.
**Contraception versus abortion:** The question on abortion was not discussed in great detail in the villages as this is a sensitive matter. Women knew that the private doctors, RMPs gave medicines or injections for abortions, but abortion in the village seemed less common as compared to urban areas. However, women noted that if somebody conceived by mistake, then she went for an abortion.

Table 6.6 lists a host of factors for the choice of different methods.

**6.2.3 FGDs with older women (36-60 years)**

In this research older women (36-60 years) were included to understand the transition from past vasectomy skewed family planning programme to tubectomy. The women were asked about their perception of change in family size desires, knowledge about contraceptives and transition from vasectomy to tubectomy. Interestingly, there were no variations in responses among old urban and rural women as well as various caste groups. When asked about changes in family size desires most of them communicated that in earlier times women used to get married at an early age and had no knowledge about contraceptives unlike the present generation. Besides, these older women had only knowledge about sterilization. When probed about the reasons for vasectomy in earlier times there was universal reporting of coercion associated with vasectomy: The participants in a FGD among Bengali Hindus in a ward in Kolkata stated “In times of Sanjay Gandhi there was coercion. School teachers had quota so they had to either coax or coerce men to undergo vasectomy.” In another FGD in a village in Bankura women narrated that “In those time men used to undergo vasectomy due to coercion”. One participant recalled observing trucks loaded with men taken from her village for vasectomy. However, the cohort of women aged between 40-50 years in the FGDs on the other hand spoke only about female sterilization not being aware of other methods.

**6.2.4 Service providers**

This Section on findings has been compiled based on various service provider’s interviews and group discussions.
6.2.4.1 Provider bias

Urban: The roles of outreach workers of the public sector and NGO service providers are mainly in the poor localities (slums) of Kolkata. The urban middle class generally seek services from the private clinics or hospitals, which does not have an outreach model. Ward A and Ward C have a high slum population. Ward A has the high concentration of Muslim population. The contraceptive choice among the Muslim women here is interesting. It was reported that the NGO mobile clinic which comes once a week gives contraceptive injections free of cost along with other contraceptives. Moreover, the providers also encourage Muslim women to take up contraceptive injections, because they are so directed by higher authorities. The service providers from NGO as well as the government service providers stated that the Muslims do not want to go for female sterilisation due to religious beliefs. It was stated that: “Among them (Muslims) after death there is a prayer that can not be chanted if somebody is ligated” (FGD with KMC Health Worker, Ward A). Thus, Muslims in this area generally choose pills even for the purpose of limiting family size. The private providers are sensitive towards the local preference for contraceptive injections in this area and thus are promoting contraceptive injections. Hence, the Muslim women are influenced mainly because of knowledge about the injection through provider bias and cost. Additionally it was remarked by a health service provider on religion effecting choice of injection, “Among them (Muslims) sterilization is prohibited so they prefer injection”.

In another slum mostly dominated by the SCs and STs, the NGO, Family Planning Association of India (FPAI) was providing contraceptive injections for Rs 200, but the women did not want to take it because it was expensive as compared to pills which came for Rs 10 a month. On the other hand, in slums where the NGO was not providing free contraceptive injections, the government health workers had little knowledge about injections nor were they promoting it.

It was also reported by a KMC health worker that awareness about AIDS through mass media has triggered condom use among Muslims.
Other than injections, IUDs also seemed to have provider bias for the Muslim population in general. It was reported by both the male and female health workers of a NGO that if they are unable to convince a Muslim woman about the benefits of laparoscopy after two children due to religious reasons, they motivate the women to opt for IUD.

One of the NGO health workers of the Bengal Social Service League (which gets government funding) remarked that “now we are told to focus on vasectomy but we cannot motivate anyone because there is tubectomy, so nobody wants to undergo vasectomy easily.”

All the providers in the urban poor site spoke about a target free approach and informed consent. Contradictorily they were promoting particular methods. One of the providers said that “at the commencement of each year we have to give a target for laparoscopy, IUD, pills and condoms but now our grants are not sanctioned on the basis of targets.”

Additionally, a provider remarked that it was not difficult for them to meet the targets of laparoscopy because nowadays the clients came to them to accept laparoscopy without outreach or home visits.

**Rural:** The AWW in a village in Bardhaman District and female health assistant in one of the villages in Bankura District specifically spoke about higher authorities ordering them to promote Cu-t, however, Cu-t is not a preferred choice in the villages. The AWW remarked “We are now told to promote Cu-t but no body wants to take it”. Besides, it was reported that “Now Cu-t is mostly discussed in the monthly meetings with mothers as we have to fulfil targets”.

After Cu-ts, the providers promote vasectomy in the rural areas, Camps are held in the BPHC (Block Primary Health Centre) but it was reported that none of the men were interested in these. In four study villages, it seemed that the target approaches still persist. The female health assistant and AWW of two villages said that they were given targets mostly for Cu-t and vasectomy. Interestingly the health providers said that now they did not have to go from house to
house to convince women about laparoscopy and bring them to camps, as the women are motivated enough to come to the camps on their own.

Interestingly in another village, the ANM narrated that she always had negative experiences with Cu-t. The service provider’s own sister had also suffered so she personally does not suggest it to anybody. She also stated that there had been a negative incident with Cu-t in the village, so people were scared to use it. Besides, she feels that the poor people who choose Cu-t face difficulties in case of any problem as they have to make recurrent visits to the government doctors who are as far as 15 kilometres away.

6.2.4.2 Provider perception on women’s preference

Urban: In urban slum areas, provider perception on the choices became clear. According to the providers pills were the mainstay among the Muslim population as well as the SC and ST population. On the other hand, among the Bengali Hindus the preference was for traditional method of family planning methods.

The pill was preferred among various groups (Muslims, SC and ST) but the reasons for the preference were different. Among the Muslims, pills were mostly preferred because the men did not want to use condoms as they felt that it interfered with sexual pleasure. Moreover, Muslim women used pills for limiting family size since many perceived laparoscopy as a “sin”. It was also reported by service providers that Muslim women complained about Cu-t which did not suit them as also because of the misconceptions that had been spread in the social network, so they were left with no option but to use pills. Discussions about contraceptives are very common in the poor urban areas. Women share their problems first within the immediate social network and then seek services either from private doctors, NGO or Government outreach workers to attend to the problem. At NGO health clinics (private) where women generally go for immunisation of their children, contraceptive discussions among clients and providers were common (researcher’s observation). In NGO clinics located in wards with a high slum population, the providers counselled women on family planning at the point where regular child immunisation was being provided. Discussions with providers revealed that information on the Cu-t from early adopters
in the social network creates or clears misconceptions and thus affects choice. A male health worker of an NGO told us that Cu-t is generally adopted through motivation in the social network, “somebody who is satisfied after using Cu-t motivates another woman and brings her to us. Motivation by early adopters in the social network is better than us motivating them to use Cu-t”. Hence, community social networks have a distinctive role in choice. A particular social network in a particular community affects the adoption of a particular method.

Contraceptive injections provided by a mobile clinic free of cost triggered the choice for injections in the Muslim cluster. A health worker logically pointed out the preference for injections among Muslims in a slum of Kolkata. A KMC health worker remarked, “husbands don’t want to use condoms, pills create health problems and if they forget to take then they may conceive but if they take injection they feel that there is no problem any more, Cu-t doesn’t suit them and ligation they will not do”. In another slum (Ward C) in Kolkata, which was dominated by SC inhabitants and migrants from Bihar and Uttar Pradesh the preferred method was pills. It was learnt from the providers that this preference for pills had a different reason. The NGO health workers in that slum stated that alcoholism among the males was a big problem so the women could not depend on condoms. In these poor localities, the NGO’s health workers said that the women preferred contraceptive injections because of non-compliance to the pills schedule. However, the NGO’s health workers in that particular slum had no knowledge of injections so they were not able to guide the women.

The health workers reported that among the SCs and STs that after pills, sterilisation of females was the most preferred method as the women themselves did not want their husbands to undergo sterilisation as they were the breadwinners for the family. Incorrect notions about the side effects of vasectomy as discussed earlier are prevalent among all the castes in the slum areas.

As discussed earlier, adopters of Cu-t who are not satisfied with its use generally spread the word about their bad experiences in their social network (neighbours in slums) which deters other people from using it.
One health worker in the slum quoted the contraceptive preference of SC women as follows. “Just after marriage condom use is more, after one baby they shift to pills and after two they go for female sterilisation”. Sterilisation of females is the preferred method after two or three children. In these slums, the women are working as domestic helps so these women are taking care of restricting their family size themselves by either using pills or getting sterilised as men’s participation in family planning is generally absent.

The providers also spoke about the influence of television advertisements about pills, emergency pills and condoms on the choice of method in urban slums.

**Rural:** In villages, the social network was very important in the adoption of contraceptives. This can also be explained by the dominance of a particular method like pills along with a particular brand (social marketing brand) in the study site in West Bengal. Most of the villagers did not rely on the government supply of the pill called Mala-D, but bought a low cost pill with a brand name “Sukhi” (social marketing brand). The health supervisor remarked that,

“Even though I try to convince them to accept Cu-t, women tell that they want to use pill. Further, the woman must have learnt that her neighbour is using pill or else she must have asked her husband’s elder brother’s wife about pill use and thinks that it is good so she tells that she will use pills”.

Clearly, at the rural study site of West Bengal, women preferred methods about which others already had positive experience and knowledge. The providers reported that pills were easy to obtain and use and many women did not even inform their husband about the use. Moreover, natural family planning methods (safe period method) were difficult to adopt in the village because men migrated for work and did not visit their homes regularly.

Other than the social network, social norms are also important in contraceptive choice. One of the link persons from a village in Bankura District quoted that males were not ready for vasectomy as it was a norm in society that females undergo tubectomy.
The government health service providers reported that the women in the villages were going for tubectomy after completing the desired family size of two children at a very early age. However, in the present context tubectomy camps in the villages have stopped so this has affected women’s choice as travelling long distances for tubectomy entails costs and also means forgoing wages for those engaged in wage labour. The ANM of a village noted that “In the PHC ligation camps have stopped so mothers come to us enquiring about ligation....since March around 30 ligations would have been done if camps had been held.”

The main reason stated by health service providers in villages about non-use of condoms was the low level of schooling among men. Moreover, government health service workers were females who convinced the females and usually did not try to motivate men to use contraception. Generally, the female health workers in the village had contact with women as men were away for work during their duty hours. Besides, female providers were more comfortable speaking to women than to men on contraception. In a village in Bardhaman District of West Bengal in which most women belong to castes other than SCs, the ANM stated that the women preferred that males use condoms. In contrast, the SC women were mostly uneducated so the workers felt that it was very difficult to make the women understand about contraception. The female health worker also said that operation of females, i.e., sterilisation is also high among SCs, but as government camps are not being held at present so they are not opting for it. Interestingly the health service provider in village C which had a significant Muslim population said that both SC and ST women were also citing religious norms as a reason for not undergoing sterilisation similar to that of the Muslims. It seems that there is some amount of diffusion in ideas about sterilisation.

6.3 DISCUSSION

From the multilevel analysis, the overall over importance of community factors affecting individual choice in West Bengal is seen. Moreover, the random intercept model for urban and also rural, community affect has come out to be very significant. Thus relating this with the
qualitative findings discussed above, it is observed that some community factors in urban as well as rural areas influence the choice of an individual.

In our study population, women in urban settings also frequent private facilities for contraception, but in rural areas, usually public facilities are the only option.

A few proxies could be isolated for community factors in villages like health provider bias, misconception or knowledge about a method moving through a particular social network, migration within a village and presence or absence of health services. In urban areas, it is limited to the presence of government services or NGOs affecting choice. In poor urban localities the social network also affects choice.

Generally, we see that in the middle class urban areas there is a tendency among couples preferring not to use modern methods because of the fear of side effects. Pills were preferred among various socio-economic, religious groups and the place of residence, but for different reasons. Pills were chosen as a terminal method among older Muslim women in urban slums as the sterilisation operation was perceived by many to be a sin. The presence of NGOs in urban poor areas has created a demand for injectables mostly among the Muslims as a relief from compliance related to pills. In urban poor areas, women from socially disadvantaged groups cited the husband’s alcoholism as the reason for choosing female methods. Contraceptive decision making in rural areas also depended on extended family members (in-laws). Moreover, social network through diffusion impacted method preference in rural areas. Local contraceptive use norms were also important in rural areas as laparoscopy has become the present norm. So to promote vasectomy couples have to defy the local norms affecting choice. Also, because of poor infrastructure (roads) and health facilities in and around the villages, rural women are apprehensive of using IUDs, anticipating further costs and its imputative side effects.

The research shows that male sterilisation was opted out of in an environment of gender disparity and ignorance and not as a result of shift in programme bias on female methods per se in both urban and rural areas. Older women in our research site spoke universally about coercion
associated reasons for higher male sterilisation in yesteryears. Female sterilization camps were being withdrawn and fresh targets followed for IUD as in West Bengal IUD figures are decreasing over the last decade.

Thus this chapter brings out the policy environment existing in West Bengal very clearly and in such a context how individual and community factors operate shaping contraceptive choice. Program bias has changed from vasectomy to tubectomy and now to IUD according to service providers in rural West Bengal. Providers have bias towards promoting IUD but women are not accepting IUD due to the above discussed reasons in rural West Bengal.
<table>
<thead>
<tr>
<th>Preferred Methods</th>
<th>Preferred Methods</th>
<th>Preferred Methods</th>
<th>Preferred Methods</th>
<th>Preferred Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reason for preference</strong></td>
<td><strong>Reason for preference</strong></td>
<td><strong>Reason for preference</strong></td>
<td><strong>Reason for preference</strong></td>
<td><strong>Reason for preference</strong></td>
</tr>
<tr>
<td>Relative is using, Sister is using, Neighbours take pills, Doctor/health service provider advised to use it, easy to use</td>
<td>Husband has understanding, Ease of use, Saw from TV, I have health problems so cannot use any other methods, Husband’s decision, Health service providers advised</td>
<td>Mother told to use (Muslims), Private doctor/health service provider advised, Relative advised</td>
<td>Husband decided as pills were creating problems (withdrawal method), Husband knows about the method (withdrawal method, Urban areas), Relative told to use periodic abstinence, Husband decided as discontinued condom</td>
<td>Women stay at home and have time to rest, Does not have to do heavy work, Caesarean section delivery, Doctor persuaded due to health reasons, Unaware of vasectomy operations at present, Husband can remarry, Headache of contraceptive end once and for all, Have not seen males undergoing operation, Family size desire complete</td>
</tr>
<tr>
<td><strong>Reason for not preferring</strong></td>
<td><strong>Reason for not preferring</strong></td>
<td><strong>Reason for not preferring</strong></td>
<td><strong>Reason for not preferring</strong></td>
<td><strong>Reason for not preferring</strong></td>
</tr>
<tr>
<td>Pills</td>
<td>Fear of side effects (heart problem cited by Muslims), Inadvertent omission of pills, Used during amenorrhea as pills are not supposed to be used</td>
<td>Need of daily intake so scared of inadvertent omission, Side effect due to pills use.</td>
<td>Scared because of side effects, menstruation problem, Discontinued because of side effects, Doctor told not to use</td>
<td>Need of daily intake, High probability of inadvertent omission</td>
</tr>
<tr>
<td>Condom</td>
<td>Scared if it burst, leaks, Disposal problem, privacy needed, Scared about skin diseases, Husband’s alcoholism (urban slums SC/ST), Husband does not want to use because of aversion, Husband does not want to use because of religious reasons (Muslims), No proper knowledge how to use condom</td>
<td>Husband told “no”, She doesn’t like Husband doesn’t like it, Had side effects (rashes in vagina)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td>Relative had side-effects, Ashamed because to get fitted by provider (rural females)</td>
<td>Fear of side effects, Suspicion of inconvenience in</td>
<td>Relative one of the early adopters told not to use</td>
<td>Fear of side effects</td>
</tr>
<tr>
<td>Method</td>
<td>Problems</td>
<td>Solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional</td>
<td>Distrust of efficacy, Husband's alcoholism, Does not know how to use</td>
<td>Husband doesn't know about it (withdrawal method)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>methods</td>
<td></td>
<td>Does not know how to use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectons</td>
<td>Did not know about it, Does not know where to get but wants to use as pills</td>
<td>Private doctor told not to use, Need a lot of money, Fear of side effect</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Need a lot of money, Fear of side effect, Do not know about it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>Religious reasons (Muslims, Scheduled Tribes and Scheduled Caste women in</td>
<td>No time to go to hospital as nuclear family (urban slums)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sterilisation</td>
<td>rural areas, Husband doesn't allow because of religious reasons (Muslims),</td>
<td>Scared of operation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Want more children, Women cannot work (rural areas), Government camps not</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>taking place in villages at present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Qualitative discussions and primary household surveys, West Bengal.