CHAPTER 7

CONCLUSIONS

7.1 DETERMINANTS OF METHOD CHOICE

In West Bengal, the decline in fertility slowly started prior to Independence. Bengal has experienced fertility transition since the 1960s mostly among the elite. Earlier researchers (Basu and Amin, 2000) concluded that fertility transition in West Bengal can not be attributed to the Family Planning Programme as “West Bengal has never had the kind of aggressive or even efficient family planning campaign or programme that many other parts of the country have embraced at various times” (p:763). The other characteristic of fertility transition in West Bengal has been the wide rural - urban gap in fertility transition. Urban fertility in the state has fallen well below replacement level fertility.

In West Bengal, the overall contraceptive prevalence has increased since NFHS-1 (1992-93). Though female sterilisation has remained stagnant since NFHS-2 (1998-99) and the use of IUDs, an effective female spacing method has declined, the use of traditional methods shows an upward trend. Did this gain in the use of traditional methods come at the expense of modern methods or are the trends in prevalence rates of each type completely independent? This study sought to understand the contraceptive choice scenario in West Bengal.

The major objectives of the study were to identify the determinants of contraceptive choice at the individual as well as at the community level and differences in factors in contraceptive choice between rural and urban areas, and the roles of the government’s Family Planning Programme and social network in choice.

The findings suggest that individual socio economic factors as well as community factors are important in the choice of contraceptive methods in both rural and urban areas. Moreover, there is a difference in the determinants of the choice of method in urban and rural areas. The Family
Planning Programme factor plays a profound role in choice. In rural areas, the government's Family Planning Programme's role seems to play a major role whereas in urban areas both public and private institutions are shaping choice.

7.2 DISCUSSION

The quantitative study shows that overall age, education, number of living sons, ever having pregnancy wastage, religion and place of residence are persistent as predictors in choice of method. However, the effects of the predictors like education, standard of living, religion, work status and mass media exposure vary in the urban and rural settings. Besides, in addition to individual factors community factors also play a role in both urban and rural areas.

In both rural and urban areas, women in the age group of 25-34 years are more likely to choose modern spacing methods and traditional methods compared to younger and older women. Women with at least one living son are more likely to choose terminal methods or modern methods in both urban and rural areas. In urban areas, the significant effect of education for choice of modern and traditional methods persists. In contrast a recent research by Gereltuya et. al. (2007) on Mongolia which also has significant traditional method use shows rural couples have a higher probability of traditional method choice. The present research contributes towards understanding the bigger policy context in contraceptive choice in West Bengal. In urban areas, as education increases (primary to higher), the choice shifts towards traditional methods or modern spacing methods. In the rural areas of West Bengal, the probability of medium educated women choosing terminal methods like female sterilisation is low.

Muslim women in urban West Bengal are more likely to choose modern spacing methods and traditional methods compared to terminal methods. Similarly Muslims in rural West Bengal are less likely to choose terminal methods. In urban areas as well as in rural areas, we see that the standard of living has significant effect on choice. In rural areas as in urban areas the standard of living significantly affects the choice of modern spacing methods and traditional methods positively.
Moreover, the NFHS-3 data shows that 42 percent of currently women residing in urban West Bengal did not want any more children and were fecund, but were using traditional methods. Another interesting finding was that only 19 percentages of currently married women in urban West Bengal using traditional methods had correct knowledge of ovulatory cycle. Consequently, urban women in West Bengal are at high risk for unintended pregnancy and pregnancy wastage. Thus further research into traditional method use and the relative risk of unintended pregnancy and pregnancy wastage can inform programme. A research study in Philippines (Juarez et. al., 2005), states that Philippines also had a higher use of traditional methods in urban areas as well as a high number of unintended pregnancies and pregnancy wastage.

These research findings from the present study replicate previous research results, which discuss individual level characteristics like age, education affecting contraceptive choice (Gereltuya, 2007; Bertrand et. al., 2001; Magadi and Curtis, 2003). The present research contributes that above and beyond individual level factors, community level factors are important and it is essential to consider communities in programmes to meet contraceptive needs. Only a few researchers have factored community level variables affecting contraceptive choice. 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.

The multilevel analysis brought out the overall importance of community factors in affecting individual choice in West Bengal. Moreover, in the random intercept model for urban and also rural areas, the effect of community has turned out to be significant. Thus relating with the quantitative finding it was observed from the qualitative investigation that some community factors in urban as well as rural areas influence an individual’s choice. Discussions with providers revealed that information on the Cu-t from early adopters in the social network makes or clears misconceptions and thus affects choice. Kohler (1997) in his research paper mentioned the importance of information from early adopters in contraceptive 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.

This research could isolate community factors from the researcher’s primary qualitative research in villages like health provider bias about a particular method, misconception or knowledge about a method moving through a particular social network and presence or absence of health services. In urban poor areas, it was limited to the presence of government and NGO outreach workers affecting choice.

Generally, we see that in middle class urban areas there is a tendency among couples 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 process of sterilisation 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 the compliance related to pills. It should be noted that government family planning programme neither promoted nor provided injectables. 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 of preference in rural areas. In poor urban localities, social network also affected choice.

Previous researches concluded that community factors can be important in traditional method choice through social network. Earlier researchers have shown how a particular type of social network affects a particular method in a village in Thailand (Entwisle et al., 1996). Additionally, the Family Planning Programme’s environment capturing the supply side factors is also important in influencing individual level outcomes (Steele et al., 1999; Cohen 2000).

In villages, public service providers spoke about IUD targets and women as well as the service providers were complaining about withdrawal of female sterilization camps from villages. While targets for sterilization were emphasized in the past, after these were formally dropped the focus
seems to have shifted to IUD. Hence, though there is a distinct provider bias towards Cu-t in rural areas, 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. Besides, at one site the researcher also found the outreach worker’s bias in not promoting IUDs. These explain the declining IUD acceptance in West Bengal to some extent.

Local contraceptive use norms were also important in rural areas as laparoscopy has become the present norm, therefore to promote vasectomy couples have to defy the local norms affecting choice. This research shows that male sterilisation was opted out of in an gendered social environment and ignorance and not as a result of shift in programme bias on female methods per se in both the urban and rural areas. Older women in the present study spoke of coercion associated with higher male sterilisation in yesteryears.

The NFHS-3 data analysis demonstrates that the pattern of contraceptive method choice differs considerably by individual characteristics as well as by geographic areas. This study shows that significant variation exists between villages and CEBs in the choice of traditional methods as well as modern spacing, traditional methods versus no method choice, calling for consideration of village, CEB and also higher level cluster variables like the district in the analysis to refine our results.

The main limitation of the analysis based on secondary data source (NFHS-3), was that no community level variables either at the village level or at the level of the CEBs in the urban area were recorded. Using individual level data to create community proxies has limitations so this was avoided in this study. The community level variables created from individual level data clusters with very low number of observations can create huge standard error. Consideration of higher level community variables in the analysis would have better refined the results. Research into understanding community level factors in method choice can be explored in the future.

Further research can also look into the association of high traditional method use, knowledge about ovulation cycle, unintended pregnancies and induced abortions in West Bengal. Research
can also investigate the extent to which women use traditional methods and switch between modern and traditional methods and vice-versa.

7.3 CONCLUSIONS AND RECOMMENDATIONS

In West Bengal, traditional method use was known and prevalent for a long time, which shows a latent desire to control family size among the population.

From our findings, it was seen that the use of traditional methods like withdrawal can be promoted in combination with condom use in rural areas to increase the choice basket where women have referred to the absence of PHCs as a reason for not using IUDs.

The use of traditional methods specifically the rhythm method is high but knowledge about this is poor so the family planning programme should try and disseminate correct knowledge about the ovulation cycle based on which the rhythm method is practiced.

The use of IUDs, an effective spacing method, has been decreasing over the years in the state. Strategies other than targets can be used to revive the use of IUDs. This study shows that recurrent costs incurred in visiting health centres related to side effects was the main reason for low acceptance of IUDs in rural areas. So there should be strong follow up by outreach workers after IUD insertion to reduce recurrent costs because of visiting health centres by the woman.

Other than mass media, contraceptive promotion can be linked to women's self help groups or women's organizations network. The NFHS-3 data analysis demonstrates that the pattern of contraceptive method choice differs considerably by individual characteristics as well as by geographic areas. It shows that significant variation exists between villages and urban localities in the choice of method calling for consideration of village, urban localities and also higher level cluster variables like the district in the analysis to refine the results. Specific requirement based strategies like migration of males in specific villages should be kept in mind by health workers when counselling about specific contraceptive methods.
Contraceptive use in West Bengal is characterized by fairly high level of traditional methods choice compared to the national picture. An important finding that emerges is that community factors are very important in choosing contraceptives. Social networks/diffusion can also have negative impact-misconceptions about specific methods (Behrman et al., 2002). The programme needs to make efforts to undo such efforts. Though Family Planning literature has labelled rhythm and withdrawal as ‘traditional methods’, in West Bengal these are neither folk methods or continuation of traditions nor used out of ignorance of modern method. In West Bengal traditional methods remain preserve of the ‘elites’ because of their aversion to modern methods due to greater “body consciousness” and greater awareness and concern about side-effects (Basu, 2005). The family planning services propagated by the state are not accessed by these women which distinguishes them from the masses. Thus use of traditional methods cannot be equated with insufficient motivation to control fertility. However, the urban couples using rhythm have imperfect knowledge. Moreover, the rural couples face difficulty in accessing certain contraceptive services. Clearly the programme’s reach has not been satisfactory. Only when large basket of contraceptive methods are made available, easily accessible and with complete and correct information about use and consequences, will couples be able to make a optimum choice to meet their needs in a healthy and satisfactory manner.