High Prevalence of Traditional Contraceptive Methods and Low Fertility: Factors Affecting Choice of Traditional Methods in Urban West Bengal, India

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Abstract:

Urban women in West Bengal, India want lesser children (1.6 children) however there is a heavy dependence (26%) on traditional method (periodic abstinence and withdrawal). This is neither propelled by religious restrictions nor by an aggressive family planning programme. This paper looks at the predictors of traditional methods use and the reasons for choice of traditional methods of contraception among women who have easy exposure to family planning programme propagating modern methods only. It is based on DHS data for urban West Bengal complemented with researcher's investigation using qualitative approach. Education and standard of living significantly affects traditional methods choice. In urban areas withdrawal preference is due to tendency to take decisions solely by husband to use withdrawal and fear of side-effects of modern methods. Only 18.5 percent of women choosing rhythm have knowledge about fertile period exposing them to the risk of unintended pregnancy which has serious programmatic implications.

Background and Rationale:

India, with its backdrop of higher population growth, was the pioneer in establishing a population policy. Historically, male sterilisation was the area of focus. However, since 1977 there has been a transition to female sterilisation. Today India's Family Welfare Programme is over dependent on female sterilisation (Gulati 1996: 205); 97 percent of the sterilisations in India are tubectomies (NFHS-3 2005-2006). Even among the reversible methods, condom, a safe male method, is not so popular as a contraception though in the recent years, it has been promoted for protection against HIV/AIDS. In theory, the programme relies on 'informed choice' and the National Population Policy 2000 affirms the commitment of the government towards voluntary and informed choice and the consent of citizens while availing reproductive health care services. However, in practice is this choice constrained by programme, cultural factors or individual characteristics? 'Woman's freedom to choose depends upon specific socio-economic relations, national policy, the political climate and culturally determined ideas regarding women' (Gupta 2000: 27). Is the lack of male acceptance a consequence of patriarchy which dictates the choice suited to males? Do programme personnel accept this social structure and accordingly direct their efforts towards promoting female methods?

Previous researchers looked into the socio-economic factors in contraceptive choice mostly among females calling for further research in the gender aspects of "choice" as a process and behaviour along with programme factors crystallising into shaping contraceptive choice among couples. Among the large states of India, West Bengal has a peculiar contraceptive choice scenario. It has a significant traditional method choice even though the programme does not propagate the use of traditional methods.

Decline in fertility started in West Bengal in the 1930s which is prior to India's Independence. Bengal has experienced fertility transition since the 1960s mostly among the elite (Basu and

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Amin 2000). According to demographic transition theories (Bongaarts and Watkins 1996), the diffusion of contraceptive attitudes started among the elite, which spread to the masses with the same language and culture. Thus we cannot attribute fertility transition in West Bengal 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" (Basu and Amin 2000: 763). Consequently, the contraceptive use scenario is not dominated by sterilisation like most other states in India, but has considerable use of traditional methods. The three surveys of Operation Research Group (ORG) included traditional methods to compute contraceptive prevalence which shows higher percentage of using such methods in West Bengal than the national average (Table-1) (ORG, 1971, 1983, 1990). Thus, we see that West Bengal had a distinct contraceptive practice compared to other states, which contributed to its fertility transition. The other characteristic of fertility transition in West Bengal has been the wide rural –urban gap in fertility transition. Fertility in rural areas, at 2.5 children, is almost one child higher than in urban areas where fertility, at 1.6 children, is well below replacement level. Recent statistics show that the use of traditional methods is higher in urban areas, (25.6 %) than rural, (19.6 %, NFHS-3 2005-2006). This brings us to examining the history of contraceptive use in West Bengal.

To understand the present contraceptive behaviour it is important to look at the past use of contraception. In Bengal, the pattern of contraceptive choice has changed through the various phases of transition and there has been a large rural urban dichotomy. The ORG estimates show that West Bengal had a higher contraceptive prevalence than India since the 1970s due to the use of traditional and modern methods (Table 1). In Table 2, the survey estimates show that the Contraceptive Prevalence Rate (CPR) of modern methods is higher than the national average, but since 1992-93, the gap started converging over the years. However, when we take into consideration traditional methods, the gap between West Bengal and the rest of the Indian states is quite wide. Traditional methods have been a preferred option among urban couples with their rural counterparts lagging behind. Yet, if we look at the rural urban dichotomy in the use of modern methods, we can see that rural people are fast catching up with urban couples. Interestingly, urban couples are below replacement level fertility. Thus, we can conclude that traditional methods had an important role to play in West Bengal's fertility decline, which has witnessed, a sharp decline in the last two decades.

Now let us look at the modern method scenario in West Bengal. Until 1990, the number of permanent method (sterilisation) acceptors was higher than reversible and temporary methods like IUDs, traditional contraceptives and oral pills. In contrast, the tendency towards the use of temporary methods became more common in recent years in the state. The present choice scenario can be explained by the decline in the use of IUDs since 1994-95 and the increase in the use of pills. In this state gender is not a crucial issue like in the northern states of India. We still see a predominance of female methods over male. On the other hand, we need to see whether among natural family planning methods withdrawal practiced by men can bring out the role of men in choice. This can also give insights in to evaluating the role of India's Family Welfare Programme, which is often termed 'gender biased', in influencing the choice of contraception.

The distinct nature of contraceptive choice can lead us to some important questions like why urban couples in West Bengal choose traditional methods when effective modern methods are available. What norms have affected this kind of behaviour? Is a particular social network carrying forward the use of traditional methods? Is it that the culture favours traditional methods even though the Family Planning Programme was not promoting natural family planning methods (traditional methods were promoted only in the first five years of the Family Planning Programme)?

Evidence from national surveys indicates that women in urban West Bengal want fewer children. Fertility levels in urban West Bengal have declined from 2.14 in 1992-93 to 1.6 in 2005-2006

(IIPS and Macro 2007) which is well below replacement level. However, they rely heavily on traditional method mostly withdrawal and periodic abstinence. About 26 % women use traditional method. This is opposite to the general trend in developing countries where people staying in urban areas are more likely to use modern method of contraception. The resistance to uptake of modern method among urban women in West Bengal and their desire to have lesser birth is quite curious. Traditional methods of contraception are equated with "ineffective" method of contraception. Family Planning programs in developing countries focus on expanding "modern" methods of contraception for fertility regulation. But urban West Bengal, India has transitioned to low fertility using most "ineffective" birth control methods that is "traditional methods" (Withdrawal and safe period method) along with female sterilization. This is neither propelled by religious restrictions as in Philippines nor by an aggressive family planning programme. In Philippines religious factors i.e. opposition of Catholic Church towards modern contraception has been resulted in use of natural methods such as safe days methods (Juarez *et. al.* 2009). In India especially West Bengal catholic population is extremely small however, religious factors could conceivably operate in particular the two major communities Hindu and Muslims may have different view points on specific contraceptives. Many Islamic Organizations do not support female sterilization. Further knowledge of contraceptives and opinions on side-effects may depend on socio-economic background particularly education and standard of living. Moreover, some information including possibly misperception is spread by diffusion within a community and thus contraceptive choice may vary by the settlement or community one lives. 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).

This paper looks at the differentials and predictors of traditional methods use among urban women and the reasons for choice of traditional methods of contraception among urban women who have easy exposure to family planning programme propagating modern methods only. Authors have argued the resistance to use modern method as "ultra modern attitude towards body" (Basu 2005). However, a significant proportion of the women practicing periodic abstinence do not know about fertile period, thus exposing them to the risk of unplanned pregnancy. Only 18.5 percent of women choosing periodic abstinence have knowledge about fertile period exposing them to the risk of unintended pregnancy. Thus this raises a question as to whether these women are combining traditional method use with induced abortion as urban areas have easy access and knowledge about abortion. In such an environment it is extremely important that the national programme should include traditional methods and enhance knowledge of traditional methods to increase choice basket and aim to give good knowledge of modern methods and remove doubt about side-effect to reduce unintended pregnancy. Thus this research is important to understand the operational barriers to uptake of modern method in urban. West Bengal and the reasons for choosing traditional method.

Setting

West Bengal situated in the eastern part of India is a major state with a population of 80.2 million (Census 2001). Though the metropolis of Kolkata is part of the state, 72.0 percent of the state's population is rural and 53.3 percent of the workers are cultivators or agricultural

labourers. Female literacy in the state is 59.6 percent which is higher than the national average (53.7 percent) and the sex ratio is 934 females per 1000 males (India Registrar General 2004a).
The TFR of West Bengal is 1.9, which is marginally lower than the replacement level fertility (TFR of 2.1) while for India the total fertility rate (TFR) was 2.68 (India, Registrar General, 2009). The Sample Registration System (SRS) reports a TFR of 1.9 for West Bengal (India, Registrar General 2009). The state has a contraceptive prevalence rate (CPR) of 32.2 percent due to all modern methods (MOHFW 2003). However, traditional use of family planning methods mostly in urban areas is high in West Bengal (18.5 percent, NFHS-2). West Bengal's natural growth rate (decadal) of population is 11.2 percent compared to 15.2 percent for India (India, Registrar General 2009).

Objectives

The broad objective of the research study is to identify individual factors affecting the process of contraceptive choice in West Bengal.
Specifically the paper addresses the following objectives.

a. To assess the role of socio-economic background of urban couples in contraceptive choice.
b. To examine whether the government's Family Planning Programme has influenced choice.
c. To understand the reasons for choosing traditional method and not accepting modern method.

Research Design

To achieve the objectives of the research both secondary and primary data sources are used. The National Family Health Survey, NFHS-3 data is analysed to see the determinants of choice among urban currently married women within the age group of 15-49 years. Secondary state level data is also examined to show to what extent contraceptive behaviour can be attributed to the regional effect. Contraceptive choice in this study is modelled as one step process where the woman chooses between not using any contraceptive method, modern spacing methods terminal methods and traditional methods. A combination of qualitative and quantitative approaches is explored. A household survey is carried out by the researcher to capture the contraceptive behaviour whereas the process of decision making in urban settings of couples is assessed by focus group discussions (FGDs) and in-depth interviews (IDI). It is known that the extension activities of the programme operate primarily in poor localities of urban areas. On the other hand, in urban upper class areas these would be minimal or absent. Therefore, in order to see whether the programme workers play a role in choice, samples are selected from poor urban localities, and other urban localities. FGDs with women and in-depth interviews with service providers sought to bring out the programme effect on the decision making process and also help examine whether there has been provider bias. In-depth interviews of family planning service providers were carried out to understand the choice dynamics in these areas.

Data and Methods

National Family Health Survey-3 (2005-2006)

The study sample is drawn from the nationally representative Demographic Health Survey (DHS) of India termed as National Family Health Survey (NFHS-3). NFHS-3 provides estimates of important indicators on family welfare, maternal and child health, and nutrition. The women questionnaire of NFHS-3 for West Bengal is used in this study to identify the socio-economic and demographic determinants of contraceptive choice. The analysis is based on currently married women aged 15-49 years who are not pregnant and fecund. The NFHS-3 sample for West Bengal consists of 4973 married women of age 15-49 years out of whom 241 were pregnant at the time of survey and 165 were infecund. Thus, the total West Bengal sample uses 4567 observations. The study sample is drawn out of the total sample which is 2274 women from urban West Bengal. The sample in urban areas is clustered into 119 Census Enumeration Blocks, in West Bengal. Census Enumeration blocks is used as community cluster in the study. Stata 10.0 software was used to analyze the quantitative data.

Measurement of variables from secondary data source

Contraceptive choice in the present study is modelled in a step where the woman/(or her husband) either chooses permanent methods, modern spacing methods, traditional methods or no method. The dependent variable is a combination of two questions, whether a woman (or her husband) is using a method and which method is being used. This has been modelled by simple multinomial logistic regression depending on the categories of response variable.

Dependent variable: For this study response variable was created based on current use of contraceptive method from NFHS-3 individual women data set and was categorized as:Not using, Modern spacing methods, Terminal methods and Traditional methods.

Explanatory variables: In the present study, some explanatory variables are used to examine the net-effect of various socio-economic variables. The following are the variables used:

Age of the women: have been grouped as:15-24,25-34 and 35-49

Pregnancy wastage: Number of pregnancies that resulted in still birth, spontaneous abortion or induced abortion. In this study we use the variable ever having terminated pregnancy which includes miscarriage, abortion and still birth to understand its co variation with choice of a particular contraceptive method. A dummy variable has been created indicating whether the mother has experienced pregnancy wastage or not.

Number of living sons:This variable has been grouped into the following categories: 0, 1, 2, 3 and 3 or more.

Education of the women has been categorized as: Illiterate, Primary, Middle and Higher

Religion has been categorized as :Hindu, Muslim and Others.

Caste has been categorized as Schedule Caste (SC), Schedule Tribe (ST), Other backward Castes (OBC) and Other Castes.

Standard of Living has been categorized as Low, Medium and High

Women's Work has been categorized as :Not Working and Working

Exposure to Mass Media has been categorized as women who listen to the radio every week or watch television every week or read newspaper once a week have been treated as those exposed to mass media, No mass media exposure and Mass media exposure

Primary data source

The NFHS-3 data are certainly valuable to a study of contraceptive choice as these give information of an individual or a couple's choice as well as on background socio-economic and demographic characteristics. However, information on the process of contraceptive choice and

on the role of social network was not collected in the NFHS. To capture the individual and social network factors in the process of choice and contraceptive behaviour on the whole, households in urban areas were surveyed by the researcher. This survey asked questions on the interaction of women with programme personnel and others relevant to the decision making process and also reasons for use of or preference for specific contraceptive methods as well as on social-economic and demographic variables (place of residence, religion, caste, educational level, age, standard of living, number of children). For the household survey, we included only women of reproductive age i.e., 15-49 years. To complement the household survey the researcher has conducted FGDs and in-depth interviews. For FGDs six to eight members from selected wards, homogeneous in characteristics such as age group, income, and caste in the study area were selected.

In order to capture the programme's effect on choice of contraception from the provider's perspective, in depth interviews with family planning service providers were conducted so as to have a clearer understanding of the role of the programme from the provider's side. These interviews covered issues on guidance given to the service providers by the departments, targets, mechanisms to achieve the targets, how they give advice to women. Besides, this also helped assess their perception on the contraceptive preference of women. 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 urban areas as well as information in the study area.

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, 2007).

In the household survey dependent and explanatory variables similar to those used for the NFHS-3 data have been used.

The study area for primary data collection is mainly urban settings. For the urban areas, four wards from Kolkata Municipal Corporation (KMC) were selected. Urban population of the state is 28.03 percentage of total population. Kolkata Municipal Area (KMA) is hosting 13.26 million population out of 22.49 million urban population accounting 59 % of state's urban population. These facts lead us to selection of wards from KMC. The urban setting is further divided into poor localities and other localities. For poor localities, two wards (urban administrative units) with the lowest literacy rates (Ward A and Ward C) and for the other, two wards above average literacy were selected (to ensure proper representation Ward D and Ward B which are at 25^{th} and 50^{th} percentile were selected). For the household survey a total of 200 households were selected, that is, 50 households from each of the four wards in the urban areas. In order to allow for non-response, 60 households were selected from each of the selected cluster so that close to 50 households would be covered. Table 3 represents characteristic of sample wards in Kolkata.

For the qualitative study a total of 8 FGDs were conducted, four from the urban poor and four from the other urban localities In-depth interviews were also proposed with service providers based on household survey. Table 4 give a detailed break-up of FGD.

The topics discussed with young women in the age group of 15-35 years were the following: Change in family size desires, reasons for change in family size desires, knowledge about contraceptive methods, Contraceptive methods preferred by women. Methods used generally, Reasons for gap between preference and use, Reasons for preference of these contraceptives over others, Awareness about side-effects, Contraceptive decision making within the household, Reason for choosing abortion over contraception.

Topics of discussion with health service professionals were:

Key responsibilities, Guidance given by the higher authorities on Family Planning (Specific method preference by the health departments), Targets on Family planning acceptors by method of contraceptives the health service providers need to achieve, Performance appraisals of health service providers, Pathways to achieve targets, Family planning advice generally give to women, Contraceptive preferences of women and reasons for preference, Queries generally asked by women on Family Planning Methods, Reasons for preferring tubectomy over vasectomy, Awareness among women about abortion and reasons for seeking abortion, Challenges/difficulties faced in the job and suggestions for improvement

Analysis

We have taken up individual level analysis to capture the effect of individual characteristics on contraceptive choice for the state of West Bengal with the help of NFHS-3 data on individual women. In the analytical framework, choosing a contraceptive method is considered a one step process. Overall, women face the choice of modern spacing methods, traditional methods, terminal methods and no method. This can be modelled by multinomial logistic regression as the response variable has more than two categories (binary response variable is modelled by binary logistic regression, multinomial logistic is a generalisation of logistic regression) and not ordered. Multinomial logistic regression is designed to use a mix of continuous and categorical variables to predict a categorical outcome.

Community factors are also important in affecting individual choice behaviour. In multilevel models, the interesting part is that characteristics from the higher level also influence or affect the lower level outcomes. For understanding overall regional effect/community factors effect generalised linear latent mixed model (GLLAMM). It is a class of multilevel latent variable model for (multivariate) responses of mixed types including categorical responses.

We have used a multilevel model as an ordinary logistic model assuming that all observations are independent. A multilevel model allows for the hierarchical nature of the data and corrects the estimated errors to allow for clustering of observations (Goldstein1995). The higher level referred to here is the community and the lower level includes the individual.

Bivariate analysis has been conducted with the household survey data to compute determinants of reasons for choosing or not choosing a particular method in urban areas.

This research study presents multinomial logistic regression results in the form of a simple bivariate table (predicted values of the response variable tabulated by values of the principal predictor variable, with other predictors held constant). Adjusted values of the response variables are considered in this research study. Adjusted values are based on the complete model including all predictor variables simultaneously.

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.

Results

Determinants of method choice in urban areas: Results from NFHS-3 analysis

The NFHS-3 data for urban West Bengal has been used to run the GLLAMM model to see the effects of both individual and community level variables in choice of method in urban areas. The sample in urban areas is clustered into 119 CEBs, in West Bengal.

The predicted probabilities are computed and presented as in multiple classification analysis (MCA) in Table 5 for the random intercept multinomial logistic regression of urban West Bengal show that the percentage choosing traditional methods in this age group25-34 years is higher

compared to younger (15-24 years) and older ages (35-49 years). In contrast the choice of terminal methods seems to have a positive association with age in urban West Bengal. The choice of modern spacing method decreases with increase in age. Number of sons has significant relationship in choice of modern spacing methods, terminal methods and traditional methods. There is a sharp increase in terminal methods when the number of sons increases from one to two.

Use of modern spacing methods and traditional methods has a positive association with educational level, which is significant. On the other hand, women with higher education in urban areas tend not to choose terminal methods. Other than education, being a Muslim still has a significant effect on choice. Muslim women in urban West Bengal tend to choose lower terminal methods compared to Hindus. Similarly, socially disadvantaged or excluded section of the population called scheduled caste women in West Bengal are more likely to choose terminal methods.

In urban areas, exposure to mass media only significantly affects choice of modern spacing methods. Standard of living has significant effect in urban West Bengal. The women with higher standard of living have higher likelihood to choose modern spacing and traditional methods compared to women with low standard of living. The intraclass correlation ρ is significant and thus it can be concluded that community factors are important in affecting contraceptive decisions in urban areas of West Bengal.

Reasons for choosing or not choosing a particular method in urban: Results from household survey

The household survey questionnaire had open ended questions to determine the reasons for choosing as well as not choosing particular methods. Tables 6 presents the reasons why the woman would consider or not consider ever choosing condoms, pills, IUDs, injections, traditional methods and female sterilisation. In urban areas, the fear of side effects of condoms is the most important reason why the woman would not consider ever choosing condoms. Though one does not normally expect any side-effects as such of condoms, and generally the IUD and oral pills are associated with side effects there is a perception among urban couples in this region about side-effects of condom. In urban areas the husband's dislike for condoms is an important reason for not choosing the method, if we take into consideration the husband's decision.

Choosing pills among respondents in the urban sample was dependent on service providers. These service providers mentioned are mostly private providers. While in urban areas "fear of side-effects" was the most quoted reason for not considering pills.

IUD users have declined in West Bengal over the decades. The urban picture from the household survey is very similar. Women cited the health service provider's advice as the single most important reason for choice in urban areas. The urban women cited fear of side effects, knowledge about the method and functional knowledge as major hurdles for not considering IUDs.

The household survey in West Bengal revealed that very few respondents have heard about injections in the urban samples. Note that injectables are not provided by the government programme outlets.

In urban areas, traditional methods were the very commonly used ones. The decision to use traditional methods (mostly withdrawal methods) was reported as that of the husband's, followed by health concerns in urban areas. Interestingly private doctors were counselling respondents to use traditional methods in urban areas. Not choosing traditional methods in urban areas was related to knowledge about the method and fear of method failure.

Terminal method choice was because of the completion of fertility goals, survey. This is followed by health service provider's advice in urban areas. In urban areas women were aware of

and feared the side effects associated with female sterilization, so did not consider female sterilisation other than the reason for desire for children. Religious prohibitions were cited as an important reason for not considering female sterilisations among the urban sample (poor localities). Mostly Muslim women have quoted religious reasons for not selecting female sterilisation.

FGDs with young urban women on the following areas

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 socially disadvantaged or excluded section of the population called scheduled caste and the scheduled tribe 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 method). 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".

Provider's perception in urban areas

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.

Conclusion and discussions

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 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 urban areas. The Family Planning Programme factor plays a profound role in choice by being active and or inactive. In urban areas both public and private institutions are shaping choice.

However, the effects of the predictors like education, standard of living, religion, work status and mass media exposure vary in the urban settings. Besides, in addition to individual factors community factors also play a role in urban areas.

In 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 urban 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.

Muslim women in urban West Bengal are more likely to choose modern spacing methods and traditional methods compared to terminal methods. In urban areas, we see that the standard of living has significant effect on choice. 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 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 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. In poor urban localities, social network also affected choice.

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 CEBs in the choice of traditional methods as well as modern spacing, traditional methods versus no method choice, calling for consideration of 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 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.
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.
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.
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. 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.

The national government should take up education strategy to demystify the side-effects of modern method and make them acceptable and popular among the urban educated middle class couples. Moreover, as traditional method use is dependent on users the state government should target couples with a definite socio-economic background and educate them about traditional method use as that can reduce unintended pregnancy and induced abortion. In all these partnership a public private partnership can be targeted through a network of private providers as urban middleclass couples tend to seek services from the private providers.

Table 1 Contraceptive prevalence in West Bengal and India (ORG estimates)

Years	Modern methods (%)		Traditional methods (%)		Total (%)	
	West Bengal	India	West Bengal	India	West Bengal	India
1970	13.8	9.7	7.3	2.7	21.1	13.6
1980	33.3	26.3	15.5	6.1	48.8	35.3
1990	40.3	39.9	12.7	5.0	54.8	44.9

Source: First, second and third rounds of ORG survey reports, India: ORG 1971, 1983 and 1990

Table 2 Contraceptive prevalence in West Bengal and India (NFHS estimates)

Years	Modern methods						Traditional methods					
	West Bengal			India			West Bengal			India		
	T	R	U	T	R	U	T	R	U	T	R	U
1992-93	37.3	37.6	36.3	36.5	45.3	33.1	20.1	18.2	25.3	4.3	3.7	5.7
1998-99	47.3	47.5	46.4	42.8	39.9	51.2	18.5	15.9	26.6	5.0	4.4	6.7
2005-06	49.9	49.9	49.9	48.5	45.3	55.8	21.3	19.6	25.7	7.8	7.6	8.1

Source: NFHS-1, NFHS-2, NFHS-3, India: IIPS and Macro, 1995, 2000 and 2007.

Table 3 Characteristics of sampled wards in Kolkata

Ward No.	Total Population	% Slum Population	% Literates
Ward A	46814	98.8	65.8
Ward C	86618	99.9	61.9
Ward B	16034	20.0	90.7
Ward D	42,245	0.0	89.2

Source: Computed from PCA, W. Bengal, Census of India, 2001

Table 4 No. of FGDs & IDIs conducted

Place/Caste groups/ Religious groups	FGDs						Total
	SC	ST	Others	Muslims	Hindu (mixed caste groups)	Health workers(HW)	
Urban							
Ward A				**2**	**2**	**2 IDIs with** NGO worker **2IDIs with** NGO worker **1**FGD with KMC workers	**9**
Ward C	**2**	**2** (mixed caste SC and ST)				**1**FGD with NGO workers(CINI) **1**FGD with NGO (FPAI) **1** IDI with AWW **1**FGD with CUDP(Calcutta Urban Development Project) HW KMC	**8**
Ward D (non-slum)			**2** (mixed caste groups)				**2**
Ward B (Non slum)*						**1** FGD with KMC HW	**1**
Total	**2**	**2**	**2**	**2**	**2**	**10**	**20**

FGDs with Women – 10 Service Providers- 10

* In the middle class localities it was difficult to gather group, so no FGD's could be conducted

Table 5 Predicted percentages of contraceptive choice among currently married women using random intercept multinomial logistic, urban West Bengal, 2005-06

	Modern spacing methods	Terminal methods	Traditional methods	Not using (RC)
	Adjusted values of P1	**Adjusted values of P2**	**Adjusted values of P3**	**Adjusted values of P4**
Total	21.7	25.8	35.4	17.1
Age (in years)				
15-24 (RC)	45.8	9.8	25.4	19.0
25-34	28.6	24.7**	35.5**	11.2
35-49	11.5**	33.3**	34.8	20.4
Pregnancy wastage				
No (RC)	21.7	26.3	35.7	16.3
Yes	21.9	23.9	33.7	20.5
No. of sons				
0 (RC)	18.9	12.3	37.1	31.7
1	23.7**	28.1**	35.5**	12.7
2	16.1**	47.3**	27.4**	9.2
3+	22.3**	44.6**	22.1	11.1
Education of women				
Illiterate (RC)	11.4	46.6	25.9	16.1
Primary	19.7**	37.0	26.1	17.3
Secondary	22.9**	21.7**	37.7	17.7
Higher	36.7**	9.1**	42.7**	11.5
Religion				
Hindu (RC)	20.4	27.9	36.2	15.5
Muslims	27.7	17.6**	29.9**	24.8
Others	20.9	21.3	38.6	19.2
Caste				
Others (RC)	21.9	24.5	35.6	17.9
OBC	27.5	21.6	32.3	18.7
SC	19.5	32.9**	34.2	13.4
ST	31.0	13.3	36.6	19.1
Standard of living				
Low (RC)	17.3	26.0	28.9	27.9
Medium	21.1**	26.7*	36.7**	15.5
High	22.8**	25.2*	35.9**	16.1
Women's work				
Not working(RC)	20.9	24.7	37.1	17.3
Working	24.0	29.2	30.6	16.2
Mass media exposure				
No mass media exp (RC)	17.8	26.3	34.8	21.1
Mass media exp	22.6**	25.7	35.4	16.3
Level 2 variance ($\sigma^2\mu$) (random effect)) Coefficient= 0.33 Standard error = 0.10				
Intra-class correlation (ρ) 0.25				

*=Significant at 5% level of significance **=Significant at 1% level of significance

RC= Reference category

Table 6.1 Reasons for choosing or not choosing a particular method: percentage distribution of women in the age group of 15-49 years ever having used a contraceptive method or not using by reasons for choice or not choosing, household survey West Bengal (urban), 2008-09

Sl. No.	Reasons for choosing and not choosing	Urban (n= 229)	
		N	%
1.	**Most important reasons why the women would consider ever using condom**	**N= 98**	
	Had side effect of IUD/ Pill	1	1.0
	Husbands decision	32	32.7
	Health service providers advice	20	20.4
	fertility desire	1	1.0
	Easy to use	8	8.2
	No side effects/side effects manageable	5	5.1
	Health problem of female so husband use	1	1.0
	Pills have side effect	24	24.5
	Relative advised to use/not use	3	3.1
	Inadvertent omission of pills	1	1.0
	Used during amenorrhea as pills are not supposed to be used	2	2.0
	saw in mass media	-	-
	Not using/Amenorrhea/fertility related reasons	-	-
2.	**Most important reasons why the women would not consider ever using condom**	**N= 132**	
	Fear of side effect	24	18.2
	Husbands decision	9	6.8
	Health service providers advice	3	2.3
	Religious prohibition	1	.8
	Fertility desire	5	3.8
	No proper knowledge how to use	21	15.9
	Not using/ amenorrhea /fertility related reasons	1	.8
	Interference in coitus	1	.8
	Fear of failure of method	13	9.8
	Psychological barriers	5	3.8
	Health problem of female so husband use	1	.8
	Husband does not like/Husband decided not to use condom/Lack of sexual pleasure	19	14.4
	Pills have side effect	3	2.3
	Using other contraceptive	18	13.6
	Have not heard	2	1.5
	Relative advised to use/not use	1	.8
	Not needed as husband stays away for work	2	1.5
	Why use pills/IUD/condom have to do operation any way	1	.8
	Abstinence	2	1.5

Table 6.2 Reasons for choosing or not choosing a particular method: percentage distribution of women in the age group of 15-49 years ever having used a contraceptive method or not using by reasons for choice and not choosing, household survey West Bengal (urban), 2008-09

Sl. No.	Reasons for choosing and not choosing	Urban (n= 229)	
		N	%
1.	**Most important reasons why the women would consider ever using pills**	**N= 96**	
	Knowledge from early adopters	6	6.3
	Husbands decision	7	7.3
	Health service providers advice	58	60.4
	Saw in mass media	2	2.1
	Easy to use	1	1.0
	Effective	1	1.0
	Husband does not like/Husband decided not to use condom/Lack of sexual pleasure	2	2.1
	Relative advised to use/not use	12	12.5
	Neighbours take pills so started	5	5.2
	Inadvertent omission of pills	1	1.0
	Had abortion so mandatory to use IUD/sterilization	1	1.0
	Had side effect	-	-
	Did not know about any other method	-	-
2.	**Most important reasons why the women would not consider ever using pills**	**N= 131**	
	Fear of side effect	75	57.3
	Knowledge from early adopters	4	3.1
	Husbands decision	6	4.6
	Health service providers advice	6	4.6
	Fertility desire	5	3.8
	No proper knowledge how to use	4	3.1
	Not using/ amenorrhea /fertility related reasons	1	.8
	Fear of failure of method	1	.8
	Health problem of female so husband use	1	.8
	Using other contraceptive	12	9.2
	Have not heard	2	1.5
	Method is costly	1	.8
	Relative advised to use/not use	2	1.5
	Not needed as husband stays away for work	1	.8
	Why use pills/IUD/condom have to do operation any way	2	1.5
	Neighbours take pills so started	1	.8
	Inadvertent omission of pills	2	1.5
	Abstinence	2	1.5
	Health problem of wife	3	2.3

Table 6.3 Reasons for choosing or not choosing a particular method: percentage distribution of women in the age group of 15-49 years ever having used a contraceptive method or not using by reasons for choice or not choosing, household survey urban West Bengal , 2008-09

Sl. No	Reasons for choosing and not choosing	(n= 229)	
		N	%
1.	Most important reasons why the women would consider ever using IUD	N= 15	
	Health service providers advice	10	66.7
	Relative advised to use/not use	3	20.0
	Inadvertent omission of pills	1	6.7
	Had abortion so mandatory to use IUD/sterilization	1	6.7
	Effective	-	-
2.	**Most important reasons why the women would not consider ever using IUD**	**N= 214**	
	Fear of side effect	87	40.7
	Inconvenient to use	4	1.9
	Knowledge from early adopters	9	4.2
	Husbands decision	5	2.3
	Health service providers advice	4	1.9
	Fertility desire	3	1.4
	No proper knowledge how to use	34	15.9
	Not using/Amenorrhea/fertility related reasons	2	.9
	fear of failure of method	3	1.4
	Other methods suits	1	.5
	Using other contraceptive	17	7.9
	Have not heard	28	13.1
	Method is costly	1	.5
	Relative advised to use/not use	2	.9
	Not needed as husband stays away for work	4	1.9
	Why use pills/IUD/condom have to do operation any way	2	.9
	Used during amenorrhea as pills are not supposed to be used	2	.9
	Abstinence	3	1.4
	The process of Cu-t insertion is tedious	2	.9
	Had abortion so mandatory to use IUD/sterilization	1	.5

Table 6.4 Reasons for choosing or not choosing a particular method: percentage distribution of women in the age group of 15-49 year having ever used a contraceptive method or not using by reasons for choice and not choosing, household survey West Bengal (urban), 2008-09

SI. No.	Reasons for choosing and not choosing	Urban (n= 229)	
		N	%
1.	Most important reasons why the women would consider ever using injection	N= 2	
	Knowledge from early adopters	1	50.0
	Health service providers advice	1	50.0
2.	**Most important reasons why the women would not consider ever using injection**	**N= 227**	
	Fear of side effect	15	6.6
	Knowledge from early adopters	1	.4
	Husbands decision	1	.4
	Health service provider's advice	2	.9
	Fertility desire	1	.4
	No proper knowledge how to use	31	13.7
	Fear of failure of method	2	.9
	Health problem of female so husband use	1	.4
	Using other contraceptive	14	6.2
	Have not heard	140	61.7
	Method is costly	14	6.2
	Not needed as husband stays away for work	1	.4
	Why use pills/IUD/condom have to do operation any way	1	.4
	Used during amenorrhea as pills are not supposed to be used	1	.4
	Abstinence	2	.9

Table 6.5 Reasons for choosing or not choosing a particular method: percentage distribution of women in the age group of 15-49 years ever having used a contraceptive method or not using by reasons for choice and not choosing, household survey West Bengal (urban), 2008-09

SI. No.	Reasons for choosing and not choosing	Urban (n=229)	
		N	%
1.	**Most important reasons why the women would consider ever using female/male sterilization**	**N= 51**	
	Had side effect	1	2.0
	Knowledge from early adopters	2	3.9
	Husbands decision	2	3.9
	Health service providers advice	10	19.6
	Fear of failure of method	1	2.0
	Easy to use	3	5.9
	Effective	1	2.0
	Relative advised to use/not use	4	7.8
	Family size desire complete and hassle free	18	35.3
	Does not want to use pill continuously	1	2.0
	Inadvertent omission of pills	1	2.0
	Had caesarean operation	3	5.9
	Neighbours went so went for operation	2	3.9
	Had abortion so mandatory to use IUD/sterilization	2	3.9
	Religious prohibition	-	-
	Fertility desire	-	-
	Pills have side effect	-	-
	All people in the village were undergoing sterilization	-	-
	Did not know about any other method	-	-
	Camp happened in the village	-	-
2.	**Most important reasons why the women would not consider ever using female/male sterilization**	**N= 176**	
	Fear of side effect	25	14.2
	Husbands decision	6	3.4
	Health service providers advice	2	1.1
	Religious prohibition	13	7.4
	Fertility desire	54	30.7
	Not using/Amenorrhea/fertility related reasons	2	1.1
	Husband does not like/Husband decided not to use condom/Lack of sexual pleasure	1	.6
	Using other contraceptive	9	5.1
	Relative advised to use/not use	1	.6
	Undergoing operation takes time and nuclear family	3	1.7
	Not needed as husband stays away for work	1	0.6
	Health service provider advised to do later	8	4.5
	Baby was/is young so not sterilized	10	5.7
	Menstruation problem	1	0.6
	Husband wants more children	1	0.6
	Have not thought may do later	30	17.0
	Abstinence	6	3.4
	Young age of the women	2	1.1

	Health problem of wife	1	0.6
	access to health facility/ mobility	-	-
	No proper knowledge how to use	-	-
	Have not heard	-	-
	Not applicable	-	-

Table 6.6 Reasons for choosing or not choosing a particular method: percentage distribution of women in the age group of 15-49 years ever having used a contraceptive method or not using by reasons for choice and not choosing, household survey West Bengal (urban), 2008-09

Sl. No.	**Reasons for choosing and not choosing**	**Urban (n= 229)**	
		N	%
1.	**Most important reasons why the women would consider ever using traditional method**	**N= 122**	
	Had side effect	7	5.7
	Knowledge from early adopters	2	1.6
	Husbands decision	45	36.9
	Health service providers advice	12	9.8
	No proper knowledge how to use	1	.8
	Fear of failure of method	1	.8
	Easy to use	3	2.5
	No side effects/side effects manageable	22	18.0
	Effective	2	1.6
	Pills have side effect	10	8.2
	Relative advised to use/not use	3	2.5
	Does not want to use pill continuously	1	.8
	Inadvertent omission of pills	3	2.5
	Use when there is scarcity of condom/pills	4	3.3
	Used during amenorrhea as pills are not supposed to be used	1	.8
	Health problem of wife	1	.8
	Neighbours advices used Traditional Methods	4	3.3
2.	**Most important reasons why the women would not consider ever using natural method**	**N= 103**	
	Fear of side effect	1	1.0
	Husbands decision	6	5.8
	Health service providers advice	2	1.9
	Husbands alcoholism	1	1.0
	No proper knowledge how to use	19	18.4

	Not using/Amenorrhea/fertility related reasons	2	1.9
	Fear of failure of method	12	11.7
	Psychological barriers	1	1.0
	No side effects/side effects manageable	1	1.0
	Using other contraceptive	13	12.6
	Have not heard	37	35.9
	Why use pills/IUD/condom have to do operation any way	1	1.0
	Used during amenorrhea as pills are not supposed to be used	1	1.0
	Abstinence	6	5.8

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