

MODERN AND TRADITIONAL CONTRACEPTIVE CHOICES FOR MUSLIM WOMEN IN INDIA

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ABSTRACT:

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

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

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Introduction:

While there is widespread dispute over the correct interpretation of the quotation, by various pro and anti- birth control scholars and activists, the larger section of Muslims in India adhere to the more conservative view against birth control. This can be evidenced by their much higher fertility rate in comparison to Hindus, the other large religious majority (Guilmoto, 2005). Muslims constitute an underprivileged minority in India, ranking below Hindus in many respects. In 2005, a committee was gathered to conduct a systematic study of the social, economic and educational status of the Muslim community of India. The report of this commission, referred to as the Sachar report, concludes that Muslims “exhibit deficits and deprivation in practically all dimensions of development” (Sachar, 2006, p. 237). The deficits are particularly salient in the areas of female schooling and economic status.

Muslims in India have a much higher total fertility rate (TFR) compared to that of other religious communities in the country. Demographers have put forward several factors behind high birth-rates among Muslims in India. According to sociologists Roger and Patricia Jeffery (2004), socio-economic conditions rather than religious determinism is the main reason for higher Muslim birth-rates. Indian Muslims are poorer and less educated compared to their Hindu counterparts. However, other sociologists point out that religious factor can well explain high Muslim birth-rates. In a recent study Jeffrey et al (2008) showed how the differential in religious views between Muslim and Hindu women is consequently the reason for differentials in contraception usage. Surveys indicate that Muslims in India have been relatively less willing to adopt family planning measures and also, Muslim girls get married at a much younger age compared to Hindu girls. According to Paul Kurtz (2010), Muslims in India are much more resistant to modern contraceptive measures compared to Hindus and as a consequence, the decline in fertility rate among Hindu women is much higher compared to that of Muslim women. The reason for the lower willingness to adopt family planning can be explained by the religious restrictions which ordain no use of family planning by individuals following Islam. The early marriage and concurrence with this religious decree can be rooted with the lower level of education attained by Muslims, especially by Muslim women.

The low status of women and a strong preference for male children are two most patriarchal constraints in India. Women want to have children but it is very difficult to take

decisions when they face an unplanned pregnancy (Tayabba and Khairkar, 2011). It was found in the study that, despite unwillingness to conceive, most of the couples do not use any method of contraception. Health concerns, side effects, failure of the method and some socio-demographic issues such as education, age, residential region, number of living children, status of women and religion play a major role in the use of contraception. A study by Zachariah (1990) found that 40 percent of women from Southern India were not using any contraception because their husbands objected to their doing so. Men most commonly knew of female sterilization, followed by male sterilization and knowledge of the other available contraceptives was even more limited (Balaiah et al 1999). In attempt to practice some sort of contraception, it was seen that Muslim couples often practice coitus interruptus, the act where the man withdraws the penis during intercourse, before ejaculation (Sharma and Pasha, 2011a). The current scenario shows a high usage of methods like Rhythm and Withdrawal which are counted as Traditional methods and a markedly high usage amongst Muslim women over Hindu women. Given this tendency, we examine the trends in usage of traditional methods and especially their high use amongst Muslim women within our current study as well.

In a recently published article, the authors examined the DLHS data and found that amongst the sample, there is a relatively insignificant effect of religiosity on contraceptive choices (Sharma and Pasha, 2011b). This paper is a description of the differences in the contraceptive choices, and the current trends according to the 2011 census data as well. We determined the occurrence in the Use of contraception between two cohorts of women distinguished by religion, focusing on both Hindu and Muslim women. This paper also intends to identify those factors that affect the use of contraception by these women to augment future policy decisions.

Data Source and Analysis

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

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

Materials and Methods

It is often seen that the habits of one community are adopted by the other if they live and interact in close proximity. To understand the effect such relations have on contraceptive behaviour, we selected 8 states in India on the basis of the religious composition of the population, with the states Chhattisgarh, Gujarat, Madhya Pradesh and Orissa having a very low percentage composed of Muslims. The four states of West Bengal, J&K, Kerala and Uttar Pradesh have the highest percentages of Muslim residents in India. Through this distinction we wanted to determine whether, in those states that are predominantly populated by members of either community, there exist any differentials in contraceptive prevalence. We next established the knowledge of contraception given the various factors that influence awareness of contraceptives.

Our study continued into the various socio-economic aspects that induce changes in the use of contraception, modern and traditional. The chi square results further prove that our initial hypothesis can be rejected in favour of a new explanation for the difference in the contraceptive usage.

Within the study we investigated the reason women gave for not using contraception, and divided all the given reasons into 6 major categories. Within the category termed as Fertility Related, we combined reasons like not having sex, infrequent sex, absence of husband, menopause, hysterectomy, post-partum amenorrhoeic and subfecundity/infecundity under one head. These were basically responses for wanting to use contraception, but finding no need for use, either by the respondent or her husband. The reasons listed as Opposition to Use listed the objections from the husband, religious restrictions, other individuals or factors and lastly maybe the respondent herself. Within Lack of Knowledge, we included no knowledge about either the method or the sources for contraceptives. This includes those 4% of the population that is

entirely unaware of contraception, as well as those who find it nearly impossible to procure any contraception. The latter however, would stand to reason only in case of modern contraceptives. The reason headed as Method Related Issues deals with all aspects of the method from health concerns to inconvenience in usage as well as high cost. Herein, the respondents gave the various flaws that may exist in a certain method and may need looking into. Lack of Access is another issue that may turn out to be a major deterrent to the widespread use of contraception and was put under a separate heading. The category Up to God is simply the answer given by the respondent. All other reactions were put under the category, 'Other'. Lastly an analysis of the grounds to discontinue the usage of the previous method of contraception by respondents was also investigated. These reasons are combined into 4 categories on the basis of the similarity of the responses- Method Related, Fertility Related, Side-effect related and Other.

Results

Despite nearly universal Knowledge in all 8 states that we looked at, we found that Use of contraceptives is not very high in India. Only around 61.5% women, Muslim and Hindu, aged 15 to 49 years declare to have used any contraceptive method once in their life at least. While 62.6% of these women were Hindu, only 54.1% of the Muslim women claimed to have ever used contraceptives. The highest Ever-Use of Contraceptives was found in West Bengal and Kerala.

Table 1: Contraception Knowledge and Usage within the 8 States

States		All Methods		Modern Methods		Traditional Methods	
		Knowledge	Use	Knowledge	Use	Knowledge	Use
Chhattisgarh	Hindu	99.4	53.9	99.4	50.7	42.2	6.4
	Muslim	100.0	58.1	100.0	53.4	54.7	9.7
Gujarat	Hindu	97.8	69.1	97.6	59.3	59.7	25.1
	Muslim	96.9	69.3	96.7	57.9	61.4	26.2
Madhya Pradesh	Hindu	98.6	61.2	98.6	56.7	44.2	10.4
	Muslim	99.4	60.9	99.4	56.3	51.9	11.4
Orissa	Hindu	98.5	56.7	98.4	47.1	63.0	18.4
	Muslim	100.0	65.1	100.0	47.9	77.1	30.1
West Bengal	Hindu	99.8	87.5	99.7	70.2	86.9	58.4
	Muslim	99.8	82.2	99.7	59.9	91.2	61.3
J & K	Hindu	99.0	66.6	98.7	53.5	67.6	21.8
	Muslim	97.7	56.2	96.9	45.1	72.7	18.8

Kerala	Hindu	99.8	80.2	99.8	69.7	83.4	38.5
	Muslim	99.9	68.1	99.9	55.9	76.8	30.7
Uttar Pradesh	Hindu	99.3	55.9	99.1	38.0	73.9	31.5
	Muslim	99.5	46.3	99.3	29.4	72.8	28.6
All India	Hindu	99.0	62.6	98.9	54.3	57.0	18.8
	Muslim	98.6	54.1	98.2	41.2	65.2	24.3

It is found that Traditional Methods are also used more frequently in Muslim predominated states as compared to Hindu dominated. The effect is visible in the total traditional contraception usage which is much higher among Muslim women (24.3%) than Hindu women (18.8%). 54.3% of Hindu women use modern methods as compared to only 41.2% Muslim women. On average, the women in the Muslim dominated states are shown to have higher usage than women in Hindu dominated states.

A factor has a significant sway on contraceptive use decisions, and that is complete and accurate knowledge of contraception methods. The next Table describes several socio-economic variables that can influence the knowledge that respondent possess of the various contraceptive methods. We have especially focussed here on a few factors that can provide significantly different results based on the religious beliefs of the respondent. Several studies have shown that Muslim women as well as Muslim men have a lower level of education as compared to any other religious community within India as shown by Roger and Patricia Jeffery (2004). According to Rakshanda Jalil, who conducted a study on Muslim female enrolment, she found it is at a low 40.66% in 201. The situation is improving but not as steadily.

“The right to education, especially at the primary level is mandated by the Constitution, yet over six decades after Independence less than 50% of Muslim women in India are literate. Compare this with other women from other minorities: 76% literacy among Christians, 64% among Sikhs, 62% among Buddhists and a whopping 90% among Jain women!”

We also examined the difference due to urban or rural households, wherein there is a definitive difference in contraceptive knowledge and usage of women living in the rural areas versus those in the urban; the latter having a higher usage of both traditional and modern methods of contraception (Sharma and Pasha, 2011b).

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

Variables	Any Method		Modern Methods		Traditional Methods	
	Muslim	Hindu	Muslim	Hindu	Muslim	Hindu
Education of Woman						
No Education	98.1	98.5	97.5	98.3	62.9	50.5
Primary	98.7	99.1	98.3	99.0	64.3	55.3
Secondary	99.5	99.5	99.3	99.4	67.9	62.4
Higher	99.9	99.9	99.8	99.9	76.5	75.6
Education of Husband						
No Education	98.0	98.2	97.3	97.9	62.3	46.9
Primary	98.6	99.0	98.1	98.8	63.8	53.2
Secondary	99.1	99.2	98.8	99.1	66.8	59.1
Higher	99.3	99.6	99.2	99.6	70.5	68.4
Surviving Children						
0	96.6	97.0	96.1	96.8	55.5	47.6
1	98.5	98.8	98.1	98.6	66.4	60.2
2	99.1	99.4	98.7	99.3	67.1	59.4
3+	98.9	99.3	98.5	99.2	66.1	57.0
Place of Residence						
Rural	98.2	98.8	97.7	98.7	66.0	54.9
Urban	99.5	99.7	99.4	99.7	63.5	65.0
Wealth Index						
Poor	97.4	98.1	96.6	97.8	62.5	49.9
Middle	98.3	99.2	97.8	99.1	63.2	53.6
Rich	99.5	99.7	99.4	99.7	67.8	65.1

From Table 2, it can be perceived that generally the knowledge of any contraceptive is higher among Hindu women than Muslim except in this case of Traditional Methods, where Muslim women are shown to possess greater awareness than Hindu women.

Depending on the socio-economic variable, knowledge about contraceptive in both religious sects shows almost the same correlation as in a regular sample. With an increase in the woman's age, her education, her husband's education, the number of live births she currently has and lastly, her standard of living, her knowledge about contraception rises. A relation also exists with the household type, where women in rural areas can be seen to have a lower knowledge of modern contraceptive methods, but a better grasp on the traditional methods. It can be seen that a rural women (98.2%) has lower chances of knowing about contraceptives than urban women (99.5%). Interestingly, throughout the table we observe that as the variable changes, the knowledge of traditional methods increases much faster for Hindu women than Muslim.

In our previous study, we also found that Sterilization was found to be one of the most effective methods of contraception, with the lowest records for dissatisfaction amongst the users. However its usage was one of the lowest, despite a sizeable population having knowledge of the same (Sharma and Pasha, 2011a).

We now study the variables that impact the use of contraceptives, as they change. Given the various variables that affect the knowledge for contraception, we use the same assumptions as Table 2 to extrapolate from this data for the use of contraceptive methods. Table 3 provides usage figures for contraception, given socio-economic variables like Age, Educational level of either of the partners, Standard of living, area of residence etc.

Table 3. Socio-Economic Factors Affecting the Use of Contraceptives

Variables	USE OF CONTRACEPTION					
	Any Method		Modern Methods		Traditional Methods	
	Muslim	Hindu	Muslim	Hindu	Muslim	Hindu
Education of Woman						
No Education	48.9	59.0	35.5	50.8	22.6	16.0
Primary	58.1	65.4	44.7	57.8	26.6	18.7
Secondary	60.9	65.0	48.9	56.7	26.0	21.1
Higher	61.3	68.7	50.2	59.2	25.0	25.7
Education of Husband						
No Education	47.7	56.4	34.1	48.9	23.1	14.4
Primary	56.0	64.0	42.7	56.0	25.9	17.9
Secondary	57.5	63.3	45.0	54.8	24.5	19.8
Higher	59.0	67.7	47.8	58.6	24.3	23.0
Surviving Children						
0	13.9	12.8	6.8	7.5	9.4	7.2
1	41.0	41.9	26.7	30.4	23.3	20.5
2	61.8	73.4	48.8	65.8	26.8	20.8
3+	62.3	74.5	48.7	66.2	26.4	19.9
Place of Residence						
Rural	51.0	60.3	36.6	51.8	25.7	18.2
Urban	61.0	71.3	51.5	63.9	21.0	20.9
Wealth Index						
Poor	43.6	51.7	27.9	43.0	25.4	15.8
Middle	52.5	63.4	39.4	55.2	24.3	17.8
Rich	61.5	72.0	50.4	64.2	23.5	22.0

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

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

A similar trend is not observed among Hindu women, where with increase in education and wealth, the use of traditional methods has also climbed. Moreover, living in an urban setting, Hindu women (20.9%) tend to use traditional methods more compared to their rural counterparts (18.2%). This may be due to increasing use of both methods by urban women. This can be affirmed if we check the usage data for modern contraceptives, which is also seen as higher among urban Hindu women (63.9%) compared to rural (51.8%). Muslim women however are shown to shift towards modern methods of contraception with an increase in standard of living and improvement in socio-economic factors.

Multivariate Analysis

We find that between the first four states (having a large Hindu majority with very little other religious composition) and the last four states (having a high composition of Muslims amongst the population) the p value is very low showing that the results are statistically significant.

Table 4. Chi-square testing for the effect of religiosity on Contraceptive methods

States		All Methods		Modern Methods		Traditional Methods	
		Use	Chi Square(χ^2)	Use	Chi Square(χ^2)	Use	Chi Square(χ^2)
Chattisgarh	Hindu	53.9	$\chi^2 = 2.3$, d.f.= 2,	50.7	$\chi^2 = 2.9$, d.f.= 2,	6.4	$\chi^2 = 12.9$, d.f.= 2,
	Muslim	58.1	p=.31	53.4	p=.22	9.7	p=.00
Gujarat	Hindu	69.1	$\chi^2 = .85$, d.f.= 2,	59.3	$\chi^2 = 1.4$, d.f.= 2,	25.1	$\chi^2 = 16.3$, d.f.= 2,
	Muslim	69.3	p=.65	57.9	p=.49	26.2	p=.00
Madhya Pradesh	Hindu	61.2	$\chi^2 = 32.4$, d.f.= 2,	56.7	$\chi^2 = 28.7$ d.f.= 2,	10.4	$\chi^2 = 8.5$, d.f.= 2,
	Muslim	60.9	p=.00	56.3	p=.00	11.4	p=.01
Orissa	Hindu	56.7	$\chi^2 = 73.9$, d.f.= 2,	47.1	$\chi^2 = 54.4$, d.f.= 2,	18.4	$\chi^2 = 45.5$, d.f.= 2,
	Muslim	65.1	p=.00	47.9	p=.00	30.1	p=.00
West Bengal	Hindu	87.5	$\chi^2 = 97.2$, d.f.= 2,	70.2	$\chi^2 = 196.7$ d.f.= 2,	58.4	$\chi^2 = 16.4$, d.f.= 2,
	Muslim	82.2	p=.00	59.9	p=.00	61.3	p=.00
J & K	Hindu	66.6	$\chi^2 = 206$, d.f.= 2,	53.5	$\chi^2 = 259$, d.f.= 2,	21.8	$\chi^2 = 109$, d.f.= 2,
	Muslim	56.2	p=.00	45.1	p=.00	18.8	p=.00
Kerala	Hindu	80.2	$\chi^2 = 297$, d.f.= 2,	69.7	$\chi^2 = 217$, d.f.= 2,	38.5	$\chi^2 = 196$, d.f.= 2,
	Muslim	68.1	p=.00	55.9	p=.00	30.7	p=.00

Uttar Pradesh	Hindu	55.9	$\chi^2=553$, d.f.= 2, p=.00	38.0	$\chi^2=592$, d.f.= 2, p=.00	31.5	$\chi^2=49$, d.f.= 2, p=.00
	Muslim	46.3		29.4		28.6	

Table 4 presents the Chi square results of preferences in using traditional, modern and all methods of family planning. Results show that there is a significant difference in the preferences of using traditional methods for Hindu and Muslim in Chhattisgarh as well as in Gujarat. Moreover, the preferences for different methods (i.e., traditional, modern and all) of family planning used by Hindu and Muslim differs significantly at 1% level of significance in Madhya Pradesh, Orissa, West Bengal, Jammu & Kashmir, Kerala and Uttar Pradesh, respectively.

The test results are significant in all the Muslim states, which mean that we can reject our null hypothesis. In this case, there is a significant difference in the usage of modern, traditional and all methods of contraception between Hindu and Muslim women. (This is against our study motive??? As I had told you the day I met you, I had confused the p value and meaning of significance. If we reject our null hypothesis this means we are saying that Muslim women are actually not using contraception, especially in the given states.)

When deciding which contraception to use, there are several factors that come into play. For the same, we have categorized all the reasons given within the questionnaires into major categories.

Table 6. Reasons cited for not using contraception

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

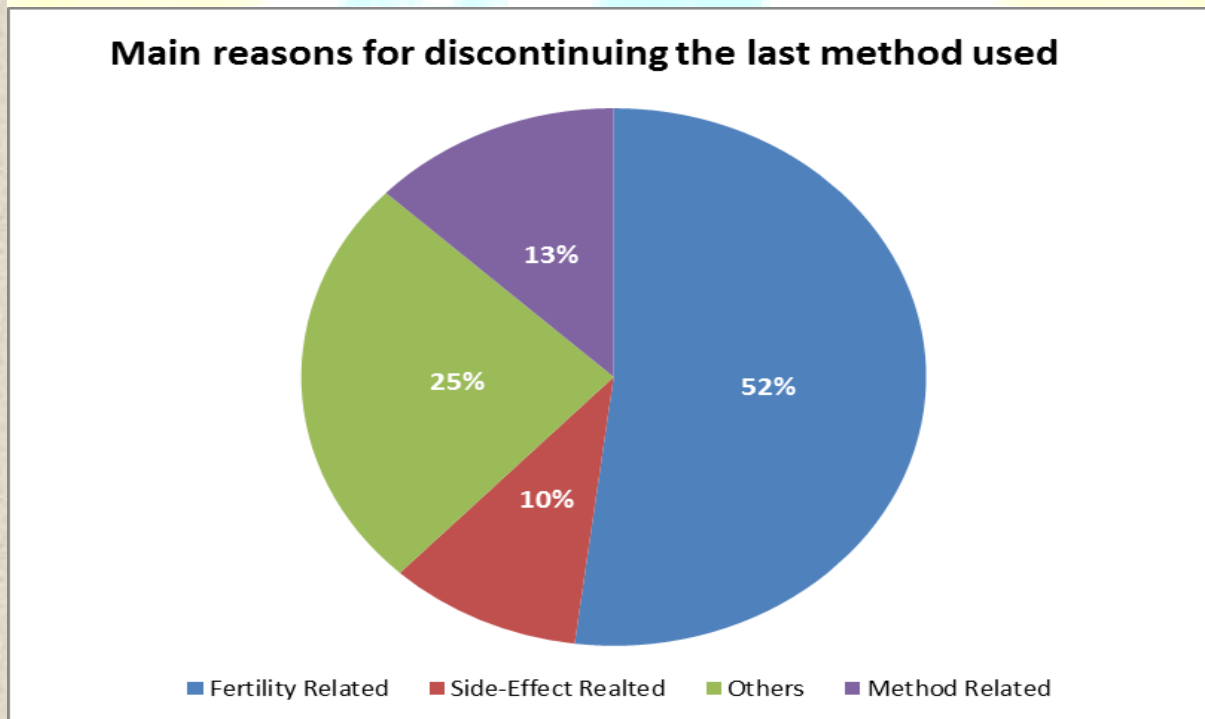
When we looked at the various reasons that were given for not using contraceptives, the reason that emerged as the highest reported by the respondent was “Up to God”.

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

and 14.1% respectively.

Some respondents stopped using a method of contraception either entirely or by shifting to another method. Figure 2 depicts the various reasons for discontinuing a contraceptive method by the frequency of the responses.

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



Another 10% of the women reported the side-effects they may have actually or perceivably suffered from as the reason to desist from using contraception.

Discussion

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

predictable conclusions, especially with respect to economic status. The low socio-economic status of Muslims is now well-known; like the Scheduled Castes, they are disproportionately represented among the poor and have the lowest per capita income indicators. This is ascribed not only to the lack of access to asset ownership, but also to poor educational attainment and occupational patterns, which show clustering in low-paid activities, as well as the concentration of the Muslim population in the economically backward regions of the country (Ghosh, 2004). The same findings are clearly visible in our data, where with an improvement in the living standards and the ascension into a wealthier, more informed way of life leads to higher use of contraceptives.

What was made amply clear through this Table-1 is that any state having a high or low composition of Muslim population didn't affect the usage or knowledge. For the same reason, Chhattisgarh, having a population composed 95% by Hindus, is shown to have a lower usage than J&K, where 65% of the population is Muslim. If we control for certain variables in any State, then the use of contraceptives comes to nearly the same despite different composition of population. Iyer's (2002) model, controlling for other socio economic factors, shows that there is no statistically significant difference between Muslim and Hindu women in the effect of religious perceptions on contraceptive adoption.

Within our study, nearly 14% women opposed the use of contraception due to religious restriction. Jeffery et al (2008) in their study have taken up the exact argument as from Bhat and Zaveri (2005) that the 8% higher religious opposition to use is explanatory for the differential in contraceptive usage for the Muslim community versus the others. However, this difference can also be significantly explained by the disparity in education. Ghosh (2004) writes that one of the standard assumptions about Muslim women is that religion prevents them from getting more equal access to education. Muslim women are more likely to be illiterate than Hindu women though this is shown to be essentially the result of low socio-economic status, rather than religion. Indeed, in those regions where Muslims are better off (as in the south and to a lesser extent in the west), Muslim women also have higher levels of education. The high usage of contraception among Muslim women in Kerala (Table 1), is one of the clearer examples.

As Ghosh has shown, there is no apparent community-wide variation in women's decision-making, mobility and access to public spaces. Rather, she points out, most women in India - across communities and regions - have very little autonomy and control over their own lives.

These are obviously extremely important results, which point to a different direction for public policy as well. It also holds great importance in her decision regarding family planning and contraception.

Another startling result is visible in Tables 1, 2 and 3, where we see that Muslim women not only possess higher traditional method knowledge but also prefer using Traditional Methods. This has already been discussed in Sharma and Pasha (2011), where Muslim women are found to have much higher usage of traditional methods in comparison to other religious communities. The same paper also shows that amongst Modern methods, Sterilization is one that is the most highly used amongst women across religions. Mishra (2004) in his article rationalizes this with the view that preferring traditional and hence less permanent methods (like sterilization) is an indirect and lesser opposition to their religious tenets. He however concludes that raising the socio-economic situation of Muslim women is the fundamental key in lowering their high birth rate and encouraging use of contraception.

In Table 6, we found that women all over India are shown to substantially prefer private sources for availing contraception, in view of their privacy needs privacy as also discussed in Mishra (2004). However, the role of private sector in this regard is abysmal and has to be stimulated. Within Figure 2, a lot of women gave side effects and methods related issues as reasons for discontinuing contraception. If the issue is of high cost, then a more targeted subsidy on contraception should be made available. If it is due to the side effects accompanying the method, or the inconvenience of usage, a probable solution is to generate more knowledge and understanding of the pros and cons of these methods.

Conclusion

This paper intended to delve into the methods and the reasoning behind the contraceptive choices Muslim women in India make. We found that though they are conversant with contraceptive methods as much as any other woman in India, their use is nearly 5% lower than Hindu women. Moreover, their preference for Traditional Methods is another curious result. This inclination to use traditional methods may stem from the fact that these methods may be perceived as “neither here nor there”. At the same time, the preference for temporary and hence traditional methods by Muslim women subsequently calls for greater promotion of temporary modern methods of contraception. The need to illuminate the lower effectiveness of traditional methods as well as

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

The principal recommendation however, is to empower women through education and bring about a strong rise in their independence and autonomy, a much required resource for contraceptive decisions and choices amongst households.

References:

- Balaiah D, Ghule M, Hazari K, Juneja H, Naik D and Parida R. (1999). Contraceptive knowledge, attitudes and practices of men in rural Maharashtra. *Advanc. Contracept.* 15: 217-234.
- Balasubramanian K. (1984), Hindu-Muslim differentials in fertility and population growth in India. *Artha Vijnana.* 26: 189-216.
- Dasgupta S. (2004, Sept 13). [India as an Ostrich](http://www.rediff.com/news/2004/sep/13swadas.htm). Rediff News, Rediff.com. <http://www.rediff.com/news/2004/sep/13swadas.htm>.
- Ghosh J. (2004). *Frontline: India's National Magazine from The Hindu.* 21(19)
- GoI (Government of India). (2006). *Social, economic and educational status of the Muslim community of India- The Sachar Committee Report*, New Delhi, Government of India.
- GoI (Government of India). (2001). *Census Data (2001): India at a glance Religious Composition*. Census of India. Office of the Registrar General and Census Commissioner, Ministry of Home Affairs, Government of India.
- http://www.censusindia.gov.in/Census_Data_2001/India_at_glance/religion.aspx.
- IIPS (International Institute of Population Science). (2010). *District level household and Facility survey 2007-08. DLHS-3*. International Institute of Population Science, Mumbai, India. <http://www.rchiips.org/PRCH-3.html>
- IIPS (International Institute of Population Science). (2007). *National Family Health Survey (NFHS-3), 2005-06*. International Institute of Population Science, Mumbai, India. <http://www.nfhsindia.org/nfhs3.html>

- Iyer S. (2002). Religion and the Decision to Use Contraception in India. *J. Sci.Stud. Relig.* 41(4): 711-722.
- Jalila, R. (2011), "Educating Muslim Women in Modern India: Problems and perspectives", Submitted on 3 July 2011, Retrieved from <http://twocircles.net/2011jul03/educating_muslim_women_modern_india_problems_and_perspectives.html>; Accessed at April 2012.
- Jeffery P, Jeffery R and Jeffery C. (2008). Disputing Contraception: Muslim Reform, Secular Change and Fertility. *Mod Asian Stud.* 42: 519-548.
- Jeffery R and Jeffery P. (1997). *Population, Gender, and Politics*. Cambridge University Press. ISBN: [0521466539, 9780521466530](https://doi.org/10.1017/CBO9780521466530)
- Kurtz P. (2010). *Multi-Secularism: A New Agenda*. Transaction Publishers. ISBN: 9781412814195 1412814197.
- Mishra V. (2004) Muslim/Non-Muslim Differentials in Fertility and Family Planning in India. *Population and Health Series, East West Centre Working Paper No. 112*. East West Centre, Honolulu
- Pew Center's Forum of Religious and Public Life. (2009). Mapping the global Muslim population: A report on the size and distribution of the world's Muslim population. Pew Research Center .Washington, DC.
- Rediff News (2006, Dec 1) [Muslim population could decline: Sachar report](http://www.rediff.com/news/2006/dec/01sachar1.htm). Rediff News, Rediff.com. <http://www.rediff.com/news/2006/dec/01sachar1.htm>.
- Sharma S and Pasha A. (2011a). Degree of Pervasiveness of Traditional Contraception in Indian Women. *Shodh Prerak*, 1(2): 158: 179.
- Sharma S and Pasha A (2011b). Are Muslim Women Behind in their Knowledge and Use of Contraception in India?. *Journal of Public Health and Epidemiology*. Vol. 3(13), pp. 632-641.
- Tayabba S and Khairkar VP. (2011). Obstacles in the Use of Contraception among Muslims. *Researchers World- Journal of Arts Science and Commerce*. Vol. 2, Issue 1.
- Zachariah K.C. (1990). Some comments on the demographic transition in Kerala. *Demography India* 19: 183.
- Zissis C. (2007, June 22). India's Muslim Population. Council on Foreign Relations Backgrounder. http://www.cfr.org/publication/13659/indias_muslim_population.html.