Journal of Public Health and Epidemiology Vol. 3(13), pp. 632-641, 29 December, 2011
Available online at http://www.academicjournals.org/JPHE
DOI: 10.5897/JPHE11.153
ISSN 2141-2316 ©2011 Academic Journals

Full Length Research Paper

Are Muslim women behind in their knowledge and use of contraception in India?

Suresh Sharma*and Atika Pasha

Institute of Economic Growth, Delhi, India.

Accepted 23 September, 2011

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 obligations 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 the 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.

INTRODUCTION

India's population includes adherents to a large variety of religions, including Hindus, Muslims, Sikhs, Christians, Parsis, Buddhists, Jains, and others. Hindus constitute the majority of the Indian population, comprising 80.5% of Indians as of the 2001 census. Given India's large population of over one billion, however, many other religious groups form sizeable minorities. Muslims form the largest of these minorities. The 2001 census enumerated 138 million Muslims, representing 13.4% of the total Indian population. India's Muslim population is the third largest in the world (Pew, 2009). Only Indonesia and Pakistan have larger Muslim populations. 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: 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. Because of higher birth rates and an influx of migrants from neighboring Bangladesh, the percentage of Muslims in India has risen from about 9.9% in 1951 to 13.4% in 2001. The Muslim population growth rate is higher by 9.3% of the total growth compared to that of Hindus.

Demographers have put forward several factors behind high birth rates among Muslims in India. According to sociologists Roger and 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 Kurtz (2010), Muslims in India are much more resistant to modern contraceptive measures compared to Hindus

*Corresponding author. E-mail: suresh@iegindia.org.

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.

Male attitudes to family planning can often be negative and women are powerless to motivate their husbands into using condoms for example, let alone female contraceptives. 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's knowledge of contraceptive methods is lacking behind females', which itself is limited. 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).

This study was conducted with the aim to examine the knowledge and awareness of contraception among Muslim women in India. 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.

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 Chattisgarh, Gujarat, Madhya Pradesh and Orissa having a very low percentage composed of Muslims. The four states of West Bengal, Jammu and Kashmir (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 exit any differentials in contraceptive prevalence. We next established the knowledge of contraception given the various factors that influence awareness of contraceptives. To understand the changing dynamics between these two communities over the years, we further examined the trends using District Level House Survey (DLHS) and National Family Health Survey (NFHS) data sets since 1992. Our study continued into the various socio-economic aspects that induce changes in the Use of contraception, modern and traditional.

The binary logistical analysis follows these results and we examined the data controlling for several variables. Contraceptive use was measured as a dichotomous variable. In the model, Muslim women who were practicing contraception at the time of the survey were coded 1 and those who were not using any method were coded 0. Use of any method was measured as a dichotomous variable. In the model, we used the independent variables- women's age, place of residence, number of living children, household wealth index, both wives' and husbands' educational qualifications, mass media and awareness of RTI/STI- were used as control variables for predicting contraceptive use. The continuous variable for the woman's age was replaced by five age groups: 15 to 19, 20 to 24, 25 to 29, 30 to 34 and 35 to 49 years, represented and 15 to 19 years reference categories. The place of residence used categories from the urban and rural. The variable for the number of living children was constructed into four groups: 0, 1, 2 and more than 3 children. Household wealth index was a discrete variable including three categories: lowest, middle and highest. Women's and husband's educational levels were grouped into four categories: no education, primary, secondary, and higher.

In India, public hospitals, PHC's and CHC's provide contraceptives. They are likewise available with private vendors and NGO's, private clinics and hospitals. We categorized all these sources into 3 categories- private, public and others- and tabulated them according to the percentage of women who accessed them. Within "others" we included friends and family members.

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 infrequent sex, absence of husband, menopause, hysterectomy, subfecundity/infecundity, etc., - basically responses for wanting to use contraception, but finding no need for it. The reasons categorized as 'opposition to use' listed the objections from the husband, the religious restrictions, restrictions from other individuals and factors and lastly maybe the respondent herself. Within 'lack of knowledge', we included no knowledge about either the method or the sources for 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. 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'.

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 to 1999 and DLHS-2 in 2002 to 2004. 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 to 2008) 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 and 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 to 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.

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 at least once in their life. 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).

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.

One factor has a significant sway on contraceptive use decisions, and that is complete and accurate knowledge of contraception methods. Table 2 describes several socio-economic variables that can influence the knowledge that respondent possess of the various contraceptive methods. From Table 2, it can be perceived that generally, the knowledge of any contraceptive is higher among Hindu women than Muslim except in the 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, awareness about RTI/STI as well as the source of information on contraceptives. It can be seen that a rural women (98.2%) has lower chances of knowing about contraceptives than urban women (99.5%). If she gets her information on contraceptives from TV, radio or the newspapers, the chances are that she is less aware than those women who are informed through doctors, AWW, ANM, health workers etc., - 97.5% of the former in comparison to 99.9% of the latter. Interestingly, throughout the table, we observe that as the variable progresses, the knowledge of traditional methods increases much faster for Hindu women than Muslim. It can be seen that knowledge about RTI/STI significantly impacts the awareness of traditional methods of contraception, by nearly 21%.

Given knowledge, the use pattern for either community has been heartening if we look at the broad overall picture emerging from the NFHS and DLHS data. Figure 1 depicts the trends that have emerged for contraceptive usage since the last two decades.

From the 1992 to 1993 NFHS-1 data to the 2005-05 NFHS-3 data, we see that there was an increase in the use of contraceptive regardless of religious differentials. Sterilization has nearly identical trends as the overall usage of any method of contraception. The DLHS-3 data from 2007 to 2008 however shows a decline in the use of contraceptives compared to 2005 to 2006 NFHS data. Likewise for sterilization, the 2007 to 2008 data also dips from 21.3 to 19.5% for Muslims and 39.9 to 39.1% for Hindu. It does the same in the shift from 1998 to 1999 NFHS to 2003 to 2004 DLHS data. However, this decline in data can also be accounted for by the difference in methodology and objectives of both these surveys. If we just examine the trends across one survey alone, NFHS as well as DLHS figures show an upward movement through the different time periods.We now study the variables that impact the use of contraceptives, as they change. Table 3 provides usage figures for contraception, given socio-economic variables like age, education, standard of living, access to mass media and awareness of RTI/STI. As has been shown, 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 to 8%. Their usage of modern contraceptives is lower by around 12 to 13%. Ages, education of the spouses, the number of surviving children and wealth status has all been shown to positively affect the use of contraceptives. As with knowledge, usage has shown nearly the same trends. An 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 to 8% between both sample populations.

A reassuring fact that can be perceived from Table 3 is that as the social and economic condition of Muslim women tends to increase, probably as an outcome of 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 in addition to usage of modern contraception. 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

Table 1. Contraception knowledge and usage within the 8 States.

State		All methods (%)		Modern methods (%)		Traditional methods (%)	
		Knowledge	Use	Knowledge	Use	Knowledge	Use
Chattisgarh	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

in standard of living and improvement in socio-economic factors.

Multivariate analysis

In the analysis, the dependent variable was contraceptive use at the time of the survey. Odds ratios from logistic regression analysis were applied to identify associations between contraceptive use and the selected demographic and socio-economic characteristics of women (Table 4).

From the results of the logistic regression analysis, it appears that the place of residence is the most important factor affecting the use of contraception among Muslim women. Women who live in urban areas are 1.041 more likely to use than those who live in rural areas. So, women who live in urban areas are more likely to have access to these services than those who live in rural areas. The results of the study found that women's age affects the risk of ever or currently practicing female contraception. Females between 35 and 39 years are 1.045 times less likely to use than those aged between 15 and 19 years. Thus, the older the female is the lower the probability of her being a user or non user of a female contraceptive method. The results also show that, with the increase in number of living children, the odds of contraceptive use also significantly increases. When we include other variables in the model, the effect of living children is even greater on the contraceptive use. In terms of contraceptive use, exposure to mass-media also plays a determining role; compared to women who are not exposed, women who are fully exposed are more likely to use contraception. From this result it can be surmised that providing knowledge about various family planning methods, exposing Muslim women to different mass media and greater husband wife communication would be able to increase the contraceptive use among the married Muslim women in the country.

Given the various sources from where women can procure contraception, we decided to seek out the most recurrent source. It can be seen from Table 5 that there is no religious distinction as far as source of contraception is concerned. Nearly 64% of the women got their

Table 2. Awareness of contraceptives given several socio-economic factors.

Variable	Any method (%)		Modern methods (%)		Traditional methods (%)	
	Muslim	Hindu	Muslim	Hindu	Muslim	Hindu
Age						
15-24	97.9	98.1	97.4	97.9	61.6	52.5
25-29	98.8	99.2	98.6	99.1	66.5	59.2
30-34	99.0	99.4	98.7	99.2	67.7	59.5
35-39	98.9	99.4	98.6	99.3	67.1	58.2
40-49	98.8	99.3	98.3	99.2	64.6	56.9
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
Mass media						
TV, radio or newspaper	97.5	98.2	96.8	98.0	59.1	48.0
Other	99.9	99.9	99.8	99.8	71.9	66.6
Aware of RTI/STI						
Yes	99.8	99.9	97.6	99.9	79.6	74.3
No	98.1	98.6	98.2	98.4	58.5	49.3

contraceptives from private sources with 68% Muslim women preferring these due to a greater need for them.

What was seen as the source most approached by married women to obtain contraceptives was private pharmacy/drugstore with nearly 33.7% women acquiring their contraceptive from there. Next were shops, which accounted for 16.2% of the women, and was listed under the category ‘others’. Given that only 61.5% of the entire population was using contraception, we examined the reasons why Women abstain from using contraception. We clubbed all these reasons together into 7 categories to provide a general understanding of the motive behind the respondents’ decision in Table 6.

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”.

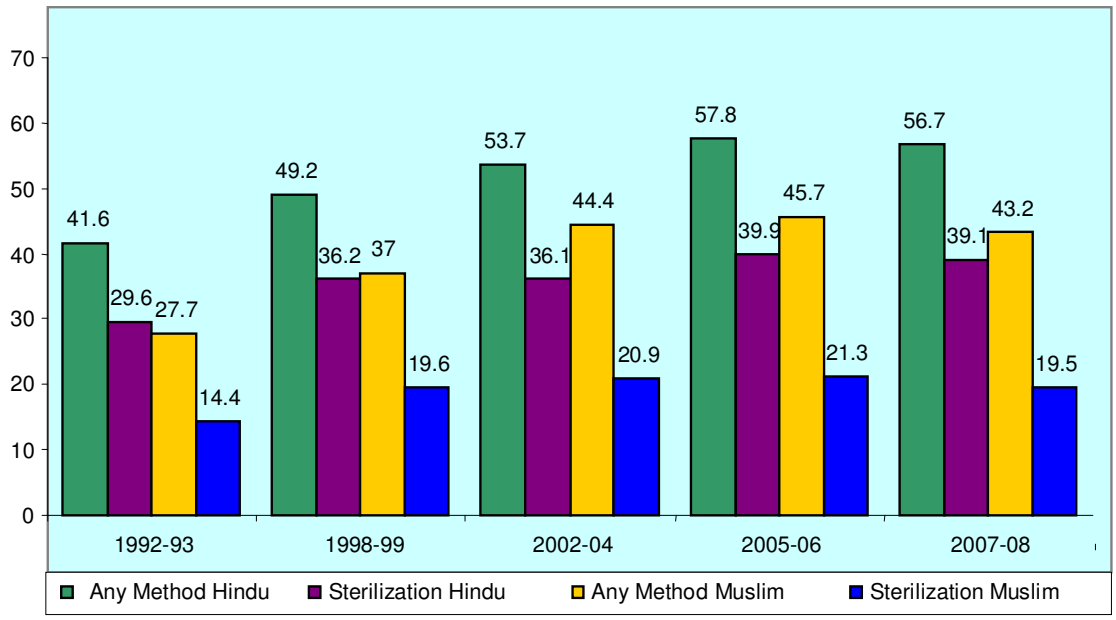

Figure 1. Trends in contraceptive usage between Hindu and Muslim women in India (sources: 1992 to 1993 (NFHS-1), 1998 to 1999 (NFHS-2), 2002 to 2004 (DLHS-2), 2005 to 2006 (NFHS-3), 2007 to 2008 (DLHS-3).

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 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 Table 1 is that any state having a high or low composition of Muslim population did not affect the usage or knowledge. For the same reason, Chattisgarh, having a population composed of 95% 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

Table 3. Socio-economic factors affecting the use of contraceptives.

Variable	Use of contraception					
	Any method		Modern methods		Traditional methods	
	Muslim	Hindu	Muslim	Hindu	Muslim	Hindu
Age						
15-24	36.7	33.3	24.1	24.4	20.9	14.7
25-29	55.5	62.9	42.3	53.9	25.5	20.2
30-34	63.0	74.4	50.0	66.4	26.5	21.1
35-39	64.6	77.1	51.8	69.3	26.6	20.5
40-49	58.0	73.3	45.1	65.8	23.3	18.8
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
Mass media						
TV, radio or newspaper	47.1	56.4	33.2	48.4	22.7	15.3
Other	61.9	69.2	50.1	60.6	25.9	22.5
Aware of RTI/STI						
Yes	60.9	69.3	46.8	60.1	29.8	24.7
No	51.0	59.6	38.7	51.8	21.7	16.2

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

Table 4. Logistic regression analysis of the Muslim women using contraception.

Independent variable	Odd ratio	SE	95% CI	
			Lowest	Highest
Age group				
15-19®				
20-24	1.106	0.026	1.050	1.164
25-29	1.353	0.029	1.278	1.432
30-34	1.402	0.030	1.321	1.488
35-49	1.045	0.029	.987	1.106
Place of residence				
Rural ®				
Urban	1.041	0.020	1.001	1.082
Mother education				
Illiterate®				
Primary	1.550	0.024	1.479	1.624
Secondary	1.708	0.024	1.629	1.791
Higher	2.002	0.043	1.841	2.176
Husband education				
Illiterate®				
Primary	1.183	0.024	1.129	1.239
Secondary	1.108	0.022	1.061	1.157
Higher	1.004	0.032	0.943	1.068
Surviving children				
0®				
1	4.307	0.039	3.988	4.653
2	10.010	0.039	9.270	10.810
3+	12.561	0.039	11.628	13.568
Wealth index				
Lowest®				
Middle	1.278	0.023	1.222	1.337
Highest	1.504	0.023	1.437	1.575
Awareness of RTI/STI				
No®				
Yes	1.236	0.018	1.193	1.281
Mass media				
No®				
Yes	0.666	0.018	0.643	0.690

R- reference category of independent variable; all are significant at $p<0.000$ except mass media.

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

Table 5. The source for given contraceptive by religion.

Religion	Source of contraceptive		
	Public	Private	Other
Hindu	25.3	62.7	11.9
Muslim	19.5	68.5	12.0
All India	25.2	63.6	11.2

Table 6. Reasons cited for not using contraception.

Reason	Hindu	Muslim	All India
Fertility related	12.5	17.1	12.8
Opposition to use	4.3	8.5	4.7
Lack of knowledge	0.8	1.0	0.8
Method related issues	9.3	10.9	8.0
Lack of access	0.5	0.6	0.6
Up to God	14.5	15.4	14.6
Other	1.4	1.5	1.4

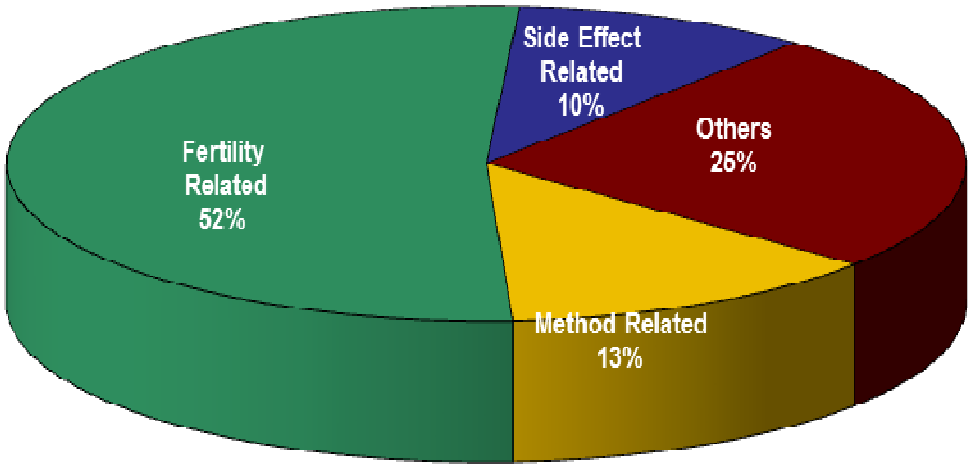

Figure 2. Main reasons for discontinuing the last method used.

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. Adv. 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). India as an Ostrich. 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 (2006). Social, economic and educational status of the Muslim community of India- The Sachar Committee Report, New Delhi, Government of India.

GoI (2001). Census Data: 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.

Jeffery P, Jeffery R, Jeffery C (2008). Disputing Contraception: Muslim Reform, Secular Change and Fertility. Modern Asian Stud., 42: 519-548.

Jeffery R, Jeffery P (1997). Population, Gender, and Politics. Cambridge University Press. ISBN: 0521466539, 9780521466530

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). Muslim population could decline: Sachar report. Rediff News, Rediff.com. http://www.rediff.com/news/2006/dec/01sachar1.htm.

Sharma S, Pasha A (2011). Degree of Pervasiveness of Traditional Contraception in Indian Women. Shodh Prerak, 1(2): 158: 179.

Tayabba S, Khairkar VP (2011). Obstacles in the Use of Contraception among Muslims. Res. World- J. Arts Sci. Commer., 2: 1.

Zachariah KC (1990). Some comments on the demographic transition in Kerala. Demogr. India, 19: 183.

Zissis C (2007). India’s Muslim Population. Council on Foreign Relations Backgrounder. http://www.cfr.org/publication/13659/indias_muslim_population.html.