The Failure of Family Planning in Mauritian "Cités"

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Abstract

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Although the Republic of Mauritius was one of the first African developing countries to have reduced its birth rate and experience genuine economic development beginning in the 1970s, historically, there is another side to this success story. The research reported in this chapter explored the socio-cultural and economic factors influencing the take up of contraception amongst economically deprived populations living in the "Cités" environments of Mauritius in the 1980s. Results from the research, which adopted the same methodological approach as other research projects reported in this book, indicated often sporadic and ineffective contraceptive use, due to a complex set of factors including religious beliefs, inaccurate perceptions and knowledge of the human anatomy and gendered expectations about responsibilities for birth control. These micro-level factors operated in a context of service delivery which at times, was unable to respond to the complex nature of contraceptive demand.

Keywords

Republic of Mauritius
"Cités"
Contraceptive use

Demographic Evolution

Most of the following text was written seventeen years ago as part of a PhD research project undertaken during the 1990s in the "Cité" environment of Mauritius (Hillcoat-Nallétamby 2002). At that time, the issue of demographic change, notably population control, was still at the fore of the country's strategic development goals. The project had received the support of the United Nations Fund for Population Activities and the Mauritian Ministry of Health, indicating that the topic was recognised as relevant to the country's strategic development. Today, the

offices of the UNFPA are closed since the demographic situation of Mauritius no longer warrants the support or action of this agency. Indeed, both fertility and demographic growth have been curtailed. In 1997, the total fertility rate was 2.03, but it then fell rapidly below the replacement threshold to reach 1.4 in 2012. In parallel, the annual rate of population increase, which was 1.44% and 0.80% in the 1980s and 1990s respectively, fell to 0.4% at the end of 2012 (Statistics Mauritius 2012). However, reducing fertility does not imply de facto the absence of reproductive and sexual health problems. Similar to the situation of the 1990s, by the beginning of the new millennium, despite high levels of contraceptive prevalence with nearly three quarters of women aged between 15–49 years old using a contraceptive method, in 2002 almost a third of couples were still using withdrawal, the use of modern methods having fallen to 40% (MHQL 2008: 1), whereas it had been almost 50% in 1985 and 1991 (Hillcoat-Nallétamby 2002: 56). As a consequence, in 2007 the Mauritian Government set up a programme focusing on sexual and reproductive health (MHQL 2008: 1–2). Its objective was to increase the proportion of women using modern contraceptive and sympto-thermal methods, reduce adolescent pregnancies, as well as the proportion of women with unmet needs for contraception (MHQL 2008: 6). Similar to the 1990s (MFPA 1993), recourse to abortion was still a problem, as was the discontinuation of contraception (MFPA 1989; Rajcoomar and Wong, 1982).

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The particular context in which this research was completed was that of the “Cités”. This housing stock had been built as temporary shelter in the 1960s following a series of cyclones which had devastated the island. These rudimentary infrastructures were not equipped with sanitation or running water and at the time, housed socio-economically deprived families. Although they had been designed as a stopgap measure, this housing stock was still inhabited at the time the research was completed. No precise data were available on the quality of this stock, nor the living conditions of its inhabitants in the 1990s, but more recent national-level statistics show that this type of shanty town dwelling has declined. For example, the proportion of housing built with corrugated sheet metal fell from 8 to 4.5% between 2000 and 2011 (Statistics Mauritius 2011: 4). Dwellings were also better equipped, those with running water inside rising from 84% to 94% over this period with similar increases for dwellings equipped with a bathroom and toilet with running water, and with interior kitchens (Statistics Mauritius 2011: 8). The previously widespread use of wood, coal and kerosene for cooking food was now

rare. In 2011, preliminary census results highlighted that 1400 dwellings were still not equipped with basic amenities (no running water).

Economic Development Since the 1990s

In the 1990s, the country was experiencing a period of strong growth and economic change. During the 1960s and 1970s, the impact of family planning measures had been felt (Xenos 1977) and the economy, which up until then had been based on the sugar industry, was undergoing radical transformation, with investment being redirected to tourism followed more recently by telecommunications (Chittoo & Suntoo 2012). With the emergence of a knowledge-based economy, Mauritius has now positioned itself as a strategic centre by establishing links between telecommunications, financial services, transport and fishing (Greig et al. 2011). In terms of its economic prosperity, in 2005 the GNP of Mauritius was 300% higher than that of the Africa region and 13% higher than the world average (Statistics Mauritius 2009: 4–5), and by 2013 had increased by 3%.

Nonetheless, today the economic success of the liberal policies implemented in Mauritius remains fragile in a context of fierce global competition. Other countries in the region, notably Madagascar, have become more competitive in terms of productivity due to cheaper local labour and the use of migrant workers, and they offer better investment conditions (NESCM 2013). The country has succeeded in reaching the UNDP Millennium development objectives (Statistics Mauritius 2012), remaining well placed in the Human Development Index ranking compared to other countries of Sub-Saharan Africa. The Mauritian Government continues its investment in developing rural regions in particular, and provides free secondary and higher education.

This progress notwithstanding, socio-economic inequalities have become apparent. The Gini coefficient for example, rose from 0.371 in 2001–2002 to 0.413 in 2012, reflecting increasing inequalities in the distribution of household incomes (Statistics Mauritius 2013). In parallel, by 2013 unemployment rates had increased to about 9% for the total population of working age, and 40% for those aged 25. The Government has acknowledged the country’s problems of poverty and social exclusion, notably through the establishment of its Ministry of Social Integration (Chittoo and Suntoo 2012).

Rupture and Continuity

What factors then stand out in terms of the changes and ruptures that have occurred since the research undertaken at the beginning of the

1990s? Generally, improvements in the quality of life have been progressive and sustained as noted previously. From a demographic perspective, reducing fertility per se has ceased to be a concern, but in terms of contraceptive use, despite high levels of prevalence, there is still heavy reliance on withdrawal, and estimates indicate that abortion is still used as a means of birth control. More recently, the Government has drawn attention to increases in the proportion of adolescents aged 15–19 pregnant or having a first child (Republic of Mauritius, 2015).
With below-replacement fertility levels, these declines have shaped the way for population ageing, and a more recent pro-natalist message from the country's politicians that it must now find ways of addressing these age structural shifts by increasing annual birth rates (Republic of Mauritius, 2015). In Mauritius as in many other countries, the consequences of population ageing are likely to be felt more acutely by women, partly because they outlive men and risk poverty, but also because they have only recently become more fully integrated into the formal labour market. Population ageing also poses challenges for health, housing and social services, and in a society where the care of older people was previously the domain of the family, the changing nature of intergenerational relations calls into question the robustness of kinship solidarity as a basis for the provision of informal social care (Hillcoat-Nallétamby 2010). As yet, these questions have not been the subject of any extensive research (Suntoo 2012).
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Going Back in Time – The Other Side to a Success Story

In 1991, Mauritius received the United Nations Population Award in recognition of the efficiency of its family planning programme launched in the 1960s. The average annual rate of population growth had been 3.12% in 1962 before falling to less than 1% in 1990 (0.80%). The progressive control of population growth was attributed to the country's family planning programme, to the later age of marriage of Mauritian women and, to a lesser extent, the effects of its emigration policy. During the 1980s however, certain changes in contraceptive practices led national leaders to question whether flaws existed in its population policy, notably in terms of its family planning services, which hitherto had not been the object of scrutiny in terms of their role in achieving the demographic goals set by the Government. Four problems were identified: the discontinuation of contraception by women registered with

family planning centres; the use of withdrawal as a means of birth control; the choice made by certain couples to practice no birth control method (neither modern or traditional); recourse to abortion.

On the basis of these observations, my research was undertaken amongst two, purposively selected rural and semi-urban "Cités" populations living in temporary housing stock which had been erected following the damage caused by cyclones in the 1960s (Hillcoat-Nallétamby 2002: 102). The main aim of the research was to explore the socio-cultural and economic factors influencing the take up of contraception amongst these economically deprived populations, using a mixed-methods approach previously implemented in Senegal (Charbit et al. 1994). At the time of this research, only one other study about life in the "Cités" populations of Mauritius had been undertaken (Desforges, 1970). The socio-economic deprivation of this context was identified in terms of socio-demographic factors at the level of families (housing conditions, large families) and individuals (low level of education, conjugal instability).

One key reason for selecting this research context was that contrary to the rest of the country's population, contraceptive use was at the time, thought to be lower in the "Cités" populations than amongst other groups. The research posited three possible explanations for this:

a disadvantaged socio-demographic environment which prevented these communities from benefitting fully from the social and health services located in the "Cité" context or elsewhere;

a lack of knowledge and understanding about elementary notions of physiology and health, leading to the proliferation of rumours about contraceptive side effects, and greater risks of discontinuation;

a disparity between the objectives and resources of family planning service providers and the expectations of the populations of the "Cités".

Cumulative Socio-Demographic Disadvantages

The two "Cités" populations which were studied (Cité A: 321 inhabitants, of whom 74 were women aged 15–49; and Cité B: 554 inhabitants, of whom 163 were women aged 15–49), were characterised by several cultural and socio-demographic disadvantages compared to the village and district level populations to which they belonged: their dwellings were of poor quality (e.g. heavy reliance on corrugated sheeting for roofing and walls); a significant proportion lacked basic sanitation facilities (e.g. at least 20% of households did not have any bathroom) and they were more over-crowded. In terms of individual characteristics, the level of education was lower; partnerships or marriages were unstable;

and fertility was higher than the national average (Hillcoat-Nallétamby 2002).

Taking as an example the living arrangements, these had changed little since the 1960s (Benedict, 1961) particularly in Cité A, although in both contexts households had become more complex through the addition of "satellite" households. Young adult children often lacked sufficient financial resources when marrying or starting co-habitation with partners, so were obliged to set up home in their parents' courtyards where they could build small dwellings, thus densifying the habitat. Women living in Cité A in particular, spent a lot of time on domestic tasks as they were still heavily reliant on fuel sources for cooking which required preparation (e.g. wood or charcoal). When asked what they would most like to change in their lives, most had expressed the desire to have a larger house equipped with an inside bathroom and a kitchen with running water.

In terms of contraceptive behaviour, in each Cité, between 61% and 65% of women in union (Cité A: n = 30; Cité B: n = 54) were using contraception compared to a national-level prevalence rate of 75% (MoH 1987). Amongst them, about 8 out of 10 in Cité A were using modern methods (hormonal and barrier methods), the remainder using either withdrawal or the symptom-thermal method. The picture was quite different for Cité B where only 5 out of 10 were using modern methods, with 3 out of 10 reliant on the symptom-thermal method and just under 2 out of 10 withdrawal. This meant that over a quarter in each Cité had an unmet need for contraception – they did not wish to have more children but were not using a reliable form of birth control.

Despite the fact that the health centres offering family planning services were only a few minutes away from the "Cités" and were permanently staffed, staff working there recognised that one of the main problems hindering the efficiency of these services was the fact that women living in the Cité environment were very occupied with domestic chores, which meant they had little time to spare for consultations. In reality, whilst a lack of time would certainly not have been the sole cause of irregular or non-use of contraception, the daily activities of these women were governed by relatively rigid domestic routines, accentuated by their rudimentary living conditions, all of which contributed to difficulties in attending clinics at prescribed times. In sum, prioritising visits to family planning clinics over the demands of daily domestic responsibilities would not have been a real choice for these women.

Religion, Marriage and Contraceptive Practices

The Catholic Religion

Although Mauritius is a multi-religious society, the populations of Cité A and B encompassed either Catholics or those of Hindu faith (84.6% Catholics in Cité A and 61.0% Hindus in Cité B). Qualitative interviews with Catholic women highlighted the challenges they faced with marital problems and the impact this could have on contraceptive use. The main reasons mentioned for the break-up or instability of partnerships was primarily the violence or infidelity of men, leading to inconsistent use of contraception whilst couples were apart. For these women, the challenges of unstable relationships did not work well with the recommendations of the Catholic Church for the use of natural, symptom-thermal methods (Action Familiale, 1988); this approach to fertility control, requiring a long term commitment by both partners to ensure its effectiveness, had been recognised by the Church as an acceptable form of birth control in the context of the country's national family planning campaign.
This notwithstanding, at the time of data collection in the Cités, only 3 women reported using this method. Interviews showed that although this low take up did not reflect a rejection of natural birth control per se, and was seen as perfectly compatible with the women's personal religious beliefs, they recognised that such practices were not compatible with the realities of conjugal instability. The ongoing incompatibility between religious doctrine and the realities of unstable relationships placed many of the women in situations of personal conflict and fear of reprimand, some to such an extent that they were reluctant to ask for information about the symptom-thermal method for fear of being found to be users of modern methods.

Hinduism

Qualitative interviews revealed that the regulation of birth control for Hindus could be influenced by a set of cultural values shaping the organisation and management of social roles. An interview with a young Hindu woman in the process of preparing for her marriage reflected this well. When asked whether she wanted to have children following her imminent marriage, the young woman answered that her parents had planned the date of the marriage for a long time, but she was unsure whether it would correspond with her menstrual cycle. This was a significant consideration, she explained, because as a Hindu woman she would not be permitted to go to the temple during menstruation. She had therefore decided to use the contraceptive pill before marriage on a continuous basis, not as a means of birth control, but as a way of

controlling the timing of her menstrual cycle and to avoid any conflict with her marriage ceremony. It was her mother who had suggested this solution, something she herself had learned from her own mother, one of the first women in the village to have taken the pill. The importance of Hindu cultural values would also play a part in her subsequent decisions about the timing of her own pregnancies and use of contraception; she would have to postpone pregnancy and childbirth until her older brother who was also to marry shortly, had had his first child. Had this study participant not participated in qualitative interview, she would have been recorded in a classic demographic survey as a contraceptive user, and her answers to questions about desired fertility and future use of contraception would have been considered incoherent.

Perceptions of the Body and Gender Relations

Rumours About Contraception

Individual interviews with women showed that one of the reasons for the irregular practice or discontinuation of different contraceptive methods was the fear of side effects, with poor knowledge of the female anatomy and the menstrual cycle contributing to the proliferation of rumours about their side effects. During fieldwork, women in the Cités had recently received a new brand of contraceptive pill *Ovrette* distributed free of charge through their local family planning clinic. This particular brand of pill, and the only one available to them at the time free of charge, had to be taken on a continuous basis and could have the effect of supressing menstruation or stimulating irregular bleeding. Using this pill raised two problems for the women. First, they did not understand why it had to be taken continuously which they found very demanding. “Too tired” to adhere to this, some had adopted different practices: taking two or three pills the same day and nothing the following days; using the pill only on the days when they were sexually active; or taking several doses simultaneously to make up for any days missed. Some were also concerned about the effect that this pill had in supressing menstruation because they thought this would led to an accumulation of blood in the uterus ("cage bébé" in Créole), giving them a sensation of being bloated. During interviews, women used the créole terms for stomach and uterus interchangeably, and when prompted on this, some said they understood that the digestion of food and menstruation occurred in the same part of the body. Women also rationalised headaches, vertigo and weight gain as the consequence of the retention of the pill in the stomach. Although a recognised side effect of some contraceptive pills, they did not associate

weight gain with poor dietary patterns. Troubled by their perceived and lived experiences of the side effects of this particular brand of pill, some had decided to purchase other brands available in pharmacies, on the assumption that paying for them would ensure a “better” contraceptive pill without side effects. Whilst this option did empower women to exercise choice, it nonetheless carried with it the possibility of other complications because at the time they could be purchased without a medical prescription or examination. Furthermore, given their economic impoverishment the long term cost of purchasing the pills would also have become prohibitive over a sustained period of time.

Similar concerns were mentioned regarding the use of hormonal injections, the coil and condoms. The latter method was frequently rejected by male partners, or because the women did not like to use the contraceptive barrier creams with them which they found painful, and believed could cause burn abrasions to the vaginal area. Some also voiced the fear that the condom could enter, and remain lodged in the “cage bébé”.

In sum, these qualitative insights illustrate how the experience of side effects associated with the use of modern contraception can fuel often erroneous perceptions and representations which are then proliferated through rumours at the community level. Some of the explanation for this particular social construction of the fertility control experience stems from a lack of knowledge about the female anatomy, as well as an incomplete understanding of the effective use of modern contraception. What this pointed to was a need for much more investment in family planning education campaigns which were sensitive to the cultural and socio-economic profiles of these particular populations.

What the Men Think: The Image of the “Woman Star”

Undertaking individual or focus group qualitative interviews with men proved difficult in the Cités communities, but with the help of a local family planning worker, it was possible to bring together a group of twenty adult men of varying ages. When asked why they had been reticent to participate in the research, it became clear that the presence of a Caucasian, female researcher (myself) had initially been a barrier. Communication with the community beyond the Cité environment therefore appeared genuinely compromised for these inhabitants because of the importance they placed on ethnic and gender identities.

Once the male participants had engaged in the discussion with the researcher and family planning worker, it became clear that the majority were in favour of “family planning methods” because they recognised they helped to avoid poverty. This notwithstanding, the men harboured fears about their effect on the health and well-being of their partners. The pill for example they considered “un mauvais medicament” (a bad drug) because it could lead to health problems. The concerns they expressed about each method echoed those mentioned by the women in the Cités, although they were much more troubled by use of the contraceptive pill and hormonal injection; it was unhealthy they considered, for women not to menstruate. They also found that their partners could not work as effectively in the home with their domestic chores because of headaches and general anxiety, both of which they considered to be direct side effects of the contraception.

After further probing, the men also noted that they did not like their partners to gain weight as this detracted from the popular sitcom representation of women as beautiful and slim. Similar to the interviews with the women, the men in the focus group did not make any link between diet and obesity, but were readily accepting of the idea that it was linked to contraceptive use. During their interviews, the women had also frequently alluded to the importance of maintaining physical attractiveness (regardless of cost and time) as a means of ensuring their partners remained faithful, and to bearing their children as a means of avoiding marital disruption.

A Poorly Adapted Supply of Contraception

An important component of the research was to understand whether the supply of contraception and family planning information was adapted to the milieu of the Cité. For women currently or previously using contraception, in Cité B similar proportions (about a third) had first learnt about family planning either through informal networks of friends, family and neighbours; the media, schooling or formal family planning services. In Cité A, the situation was different, with over two thirds relying on media or schooling and less than 2% on formal service providers. For the actual supply of contraception however, the majority of women in both Cités (72% and 62% respectively) were reliant on formal services, but well over a quarter in Cité B (and 7% in Cité A) sourced methods themselves (either using withdrawal or purchases from a pharmacy).

Part of the mixed-methods approach adopted in this research had involved the researcher spending extensive periods of time in the family planning clinics observing interactions between staff and clients. These

observations generally revealed a very functional approach to service delivery (e.g. blood pressures checks and prescriptions) with very little time being given to addressing client queries, concerns or their efforts to obtain more information. Discouraged by the lack of opportunity to talk to the physician, some women had decided to discontinue a method until such times as they could receive more information and advice.

This shortfall in information and advice aspects of service provision was a significant finding, given the broader context of community-level rumours about the negative aspects of modern contraception, which interviews with women and men had so clearly highlighted. Furthermore, any desire to change methods was frequently not met through the formal service channels. At the time of the research, the UNFPA funded contraception through government family planning centres by subsidising the cost of the modified sympto-thermal method provided through the Catholic association *Action Familiale* or the provision of hormonal injections (*Depo-Provera*). The other contraceptive methods available at the time were donated in kind by USAID (pills, condoms, coils, spermicides). The variety in the supply of contraception at any one time was therefore determined by donations or subsidies. As this research showed with the example of the side effects of the contraceptive pill *Ovrette*, the choice of method did not always match client preferences. This meant that family planning service providers were often faced with a situation of inadequate supply, and hence obliged to advise their clients to turn to the local private pharmaceutical sector.

As the fieldwork progressed, clear evidence emerged of an unmet demand for more information and advice about contraception. First, women in both Cités approached the researcher very frequently on the subject, particularly to ask about the pill and hormonal injection. At one point, they asked her to speak to their local family planning clinic staff on their behalf to seek more information about the menstrual cycle and the female anatomy. Second, some wanted the information, but had been hesitant to approach the service providers if they were catholic either because they were cohabiting but not married, or were using contraceptive methods not recommended by the church. Third, some had become aware that several other types of pill existed, either because they had come into contact with them through their work environments, for example in the hospitality industry, or worked as domestic staff for the wealthier Mauritian families; or had seen them mentioned in French TV programmes broadcast in the region. Thus they knew that it was possible to obtain brands other than those supplied by the government-run family planning centres.

Family Planning, Deprivation and Social Exclusion

What do these findings highlight with regard to the three postulates advanced at the outset of the research?

The first postulate was that the socio-economic characteristics of the Cité environment and its populations acted to marginalise these communities from the rest of the village and the district in which they were situated, and prevented them from benefiting fully from the social and health services available on site and elsewhere. This postulate was evidenced through the data collected on the living conditions in the Cités; poor housing, lack of space and basic amenities such as running water, meant that the women had very little time to devote to the schedules of family planning visits offered in the local health clinics as their time was taken in organising and managing the rudimentary conditions of household life.

The second postulate was that a lack of elementary knowledge about human physiology and health could be a key contributing factor to the proliferation of rumours about side effects, leading to low levels of contraceptive use or increased risk of method discontinuation. Interviews with women and men in each Cité confirmed this. There were significant concerns about the side effects of different contraceptive methods, exacerbated by a lack of knowledge and misconception of the female anatomy, a clear example being their frequent representation of the "cage bébé" or uterus as encompassing the entire abdominal cavity. Others demonstrated a lack of understanding about the correct and regular use of modern contraception, notably the pill; whilst others assimilated their use with personal weight gain, something which both genders saw as incompatible with the images of women portrayed through media and to which they aspired.

The final postulate was that a disparity existed between the objectives and resources of family planning service providers and the expectations and needs of the women and couples in the Cités – in other words, a disparity between the supply and demand for birth control. As for demand, although the majority of Cité A dwellers were catholic very few in fact used the natural methods promoted by the ecclesiastical authorities as they required couples to remain monogamous and practice the method together, requirements which many of the residents themselves recognised were far from the reality of their lives. Furthermore, women could not fully benefit from the information and training available about the symptom-thermal method either because they were compromised by

time or feared being judged because some were using modern methods rejected by their religion.
For the question of supply from government run services, the research highlighted inadequate consultation time, coupled with lack of choice of different pill brands, which together, could lead to unmet demand and discontinuation of practices or purchasing expensive brands from the private sector.
Together, these challenges of family planning supply and demand experienced by the Cités populations were perceived by prominent members of the village and district communities who had been interviewed as part of the research (e.g. local government district representative) as reflective of a broad pattern of socially dysfunctional population groups. This was mentioned in some of the more in depth qualitative interviews with Cités inhabitants, who felt that such attitudes perpetuated their social isolation and marginalisation from the broader village and district communities to which they belonged.
To conclude, findings from this research suggest that multiple socio-economic disadvantages, coupled with the influence of cultural and religious factors, have together influenced contraceptive use and discontinuation in the two Cités population studied. The mixed-method approach adopted has enabled family planning practices to be seen as a multi-faceted and complex phenomenon. Data collection at the meso-level of the community and micro-level of the individual have added insights which would otherwise have been lost through reliance on population-based, quantitative data collection approaches such as the standard contraceptive prevalence surveys. The latter are nonetheless vital for the broader contextualisation of the meso- and micro-level findings from this study.
There are however, several challenges in developing this type of mixed-method approach to data collection and analysis, not least the need to train local inhabitants familiar with language and cultural contexts, rather than relying on researchers who will be unaware of many of the context specific constraints and realities influencing their fieldwork experience.
Perhaps most important for the demographic community, is that this research, along with other chapters in this volume, point to the necessity for inter-and cross-disciplinary collaboration between demographers and researchers from other fields if we are to more fully embrace the multi-dimensional nature of contraceptive behaviour in different settings around the world.

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