Men's participation in reproductive health

A study of some villages in Andhra Pradesh

G Rama Padma

**Small Grants Programme on Gender and Social Issues in Reproductive Health Research,
Achutha Menon Centre for Health Science Studies,
Sree Chitra Tirunal Institute for Medical Sciences and Technology,
Thiruvananthapuram 695 011, Kerala.**

A project supported by the Ford Foundation

* Centre for Economic and Social Studies, Begumpet, Hyderabad 500 016, India

Published by

Achutha Menon Centre for Health Science Studies (AMCHSS)

Sree Chitra Tirunal Institute for Medical Sciences and Technology

Medical College

Trivandrum- 695 011

Kerala, India

www. sctimst.ac.in

Recommended citation:

G Rama Padma;
Men's participation in reproductive health:
A study of some villages in Andhra Pradesh,
Trivandrum,
Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal
Institute for Medical Sciences and Technology, 2005.

Members of the Small Grants Programme Team:

TK Sundari Ravindran, Honorary Professor, AMCHSS, Trivandrum:
Co-ordinator

Tara Sadasivan, Jr. Research Assistant, AMCHSS, Trivandrum.

Team of resource persons:

Amar Jesani, CEHAT, Mumbai;

Mala Ramanathan, AMCHSS, Trivandrum;

Renu Khanna, SAHAJ, Baroda;

Shagufa Kapadia, MS University Baroda;

TK Sundari Ravindran, AMCHSS, Trivandrum,

Sunita Bandewar, CEHAT, Pune;

KR Thankappan, AMCHSS, Trivandrum;

Uday Shankar Mishra, Centre for Development Studies, Trivandrum.

Occasional technical support was also provided by

Geetanjali Misra, CREA, New Delhi and

Radhika Chandiramani, TARSHI, New Delhi.

Acknowledgements

I consider it my primary duty to express my deep sense of gratitude to those without whose cooperation this project would not have seen the light of day. First of all I am indebted to the Small Grants Programme on Gender and Social Issues in Reproductive Health Research, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute of Medical Sciences and Technology, Thiruvananthapuram, without whose assistance this study would not have been feasible.

I wish to express heartfelt thanks to Dr Sundari Ravindran, Dr Mishra, Dr Mala Ramanathan, and Dr Renu Khanna for their suggestions and support during the study.

I would like to express my sincere thanks to Professor Mahendra Dev, Director, Centre for Economic and Social Studies, for his cooperation and encouragement.

The extensive discussions held with Dr Kameswari, obstetrician and gynaecologist, helped in understanding the concepts and classification of various aspects of reproductive health and morbidities. The discussions with medical officers of the RCWHC, namely, Dr P V Ramani and Dr Radhika Rani, helped in understanding the field-level situation. The help rendered by all the health staff, especially Mr Chari, Mr Illaiah, Ms Subbayamma, and Ms Prabhavathi, is remarkable.

My thanks to the research supervisor and the entire field staff who worked with commitment.

Lastly, this project would not have been feasible without the cooperation of the respondents. I am indebted to them.

Contents

Executive summary

In the context of the new perspective that looks at men as potential partners in reproductive health, this study focuses on how men's participation encourages women to utilise health services for improving their own reproductive health. Reproductive health covers an array of issues; the present study examines the contraceptive, obstetric, and reproductive tract-related health of women. Men's participation in the present study is examined in terms of spousal communication on family planning, contraceptive usage, support extended during obstetric period, and sexual healthcare.

The study was carried out in rural areas of Andhra Pradesh. A stratified random sampling technique was used to select the villages and 223 couples for the study. The study shows that one-third of the couples were exposed to messages related to reproductive health while in 13 per cent of cases neither of the couple was exposed to any messages. Gender norms restricted women's access to information related to contraceptives, AIDS, and gynaecological health. Men were more exposed to information on AIDS. Education of couples was able to break the barriers of gender restrictions in acquiring knowledge.

The psychological perspectives of couples were examined on locus of control over pregnancy, the couples' efficiency related to use of contraception, and avoiding pregnancy. Many women assumed that they had no control over their bodies whereas men thought that they had control over their wife's body. Women had low efficiency in obtaining a temporary contraceptive method but were confident of using terminal methods. Men did not perceive matters similarly.

More than half of the couples had communication related to planning of their family. Men found it convenient if women volunteered for a tubectomy. More educated men, from forward castes, nuclear families, and with fewer children initiated the discussion. Women preferred men to initiate a discussion because they were cautious of being seen as promiscuous.

A little more than half of the couples had adopted tubectomy. More men reported usage of condoms and periodic abstinence than women. Nearly one-fifth of the women reported suffering from illness after sterilisation. Women's relatively low position and the expected gender

roles within the family did not permit them to take adequate rest after tubectomy. One-fourth of the women never sought treatment because of demanding household work and lack of support from husband/family members.

The repercussions of early marriage for women are rarely viewed in the context of their health. In this study, more women underreported pre-term pregnancies for fear of being blamed in their natal families. Almost every woman had received antenatal care (96.8 per cent). When husbands decided on the need for antenatal care, women received physical, nutritional, and emotional support. Most of the husbands (64.4 per cent) were not even aware of the morbidities faced by their wives during pregnancy.

Seventy-five per cent of the wives delivered in an institution. Apart from other socio-economic conditions, the husbands' initiative was a significant indicator in favour of wives' institutional delivery. Awareness of husbands about intrapartum morbidities was low because culturally most of these problems are not revealed to men. Only 12 per cent of women had a postpartum check-up. A majority could not take adequate postpartum care because of the expected gender roles within the household. Though women expected support from their husbands during all three phases, most husbands never realised their need.

Premarital sexual contacts (28.7 per cent) were higher than extramarital relations (13 per cent) among men. Many men had incorrect knowledge about the need to use condoms. Seventeen per cent of men who had premarital sexual relations suffered from STDs, but only 6.2 per cent sought treatment. A majority of the women said it was their duty to fulfil their husbands' sexual desires. Most of the couples were ignorant about STDs.

Nearly 30 per cent of women suffered from menstruation-related ill health prior to marriage. One-fourth of the women were suffering from reproductive tract infections at the time of the study. Two-thirds felt it was necessary take their husbands' permission for seeking health care. Only half of them discussed illnesses with their husbands. A higher probability of seeking treatment is associated with communication between couples.

Husbands expected wives to behave appropriately with them and with elders/in-laws. Wives thought similarly. One-third of the husbands believed in controlling their wives by verbal abuse or by beating. More than half of the husbands, and one-fifth of the wives, reported family violence. A few women had to seek medical help after the violence. Domestic violence is significantly associated with contraceptive morbidity, home delivery, and postpartum morbidity.

Chapter 1
Introduction

The World Health Organisation defines health as a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity. [1]. Reproductive health addresses the reproductive processes, functions, and system at all stages of life. Good reproductive health, therefore, implies that people are able to have a responsible, satisfying, and safe sexual life with the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the rights of men and women to be informed of and to have access to safe, effective, affordable, and acceptable methods of fertility regulation and to appropriate health care services.

Thus the definition of reproductive health is broad, unlike the definition of reproductive morbidity, and lends itself less readily to measurement. This is more than mere semantics. Addressing issues of reproductive or women's health is, in many ways, beyond the capability of health professionals. Reproductive morbidity, on the other hand, is more easily definable, measurable, and amenable to intervention.

Although reproductive (and women's) morbidity includes some consequences of women's social status, it does not include low social status *per se.* Reproductive (and women's) health, on the other hand, includes the power to make personal decisions related to health, including sexual behaviour and reproduction. For both women and men, reproductive health reflects the impact of health in infancy and childhood as well as in adult life, and beyond reproductive age as well as within it. Reproductive health sets the ground for human sexuality, regardless of whether it leads to reproduction.

The programme of action of the International Conference on Population and Development not only endorsed this view of reproductive health but also helped to define what reproductive health care services should include. It said, "Reproductive health care in the context of primary health care should, *inter alia*, include: family-planning counselling, information, education, communication, and services; education and services for prenatal care, safe delivery, and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education, and counselling, as appropriate, on human sexuality, reproductive health, and responsible parenthood." [2].

1.1 Men's participation in reproductive health

The 1994 International Conference on Population and Development, held in Cairo, reminded the world that good reproductive health is the right of all people, men and women alike, and that together they share the responsibility for reproductive matters. By emphasising the gender-prescribed roles men and women play in society, the conference drew attention to the fact that if men are left out of the reproductive health equation, they are unlikely to be able to exercise responsibility. The consensus reached was that neither women nor men are likely to enjoy good reproductive health until couples are able to discuss sexual matters and make reproductive decisions together.

1.1.1 *Communication between couples and reproductive health*

When both partners jointly take decisions about reproductive health, the decisions are more likely to be implemented. Men become more supportive by helping their partners to receive reproductive health care services when needed and providing the resources required for this purpose. Thus couple, or spousal, communication can be a critical step towards increasing men's participation in reproductive health. [3,4,5,6]. Communication enables husbands and wives to know each other's attitudes towards family planning and the use of contraceptives. It allows them to voice their concerns

about issues of reproductive health such as worries about undesired pregnancies or sexually transmitted diseases. Communication also can encourage shared decision-making and more equitable gender roles.

Many couples rarely discuss fertility and family planning. Several studies suggest that spousal communication about family planning usually begins only after the birth of one or two children. [7,8,9]. A study conducted in Uttar Pradesh showed that women basically agreed with the decisions taken by their husbands. Silent concurrence or lack of protest by women was interpreted as having arrived at a joint decision. Women almost never question the decisions of their husbands, nor do they enter into any discussion with them. [10].

Some women become pregnant only because they believe their husbands want more children. But this may not always be true. Surveys in several developing countries show that only slightly more men than women want another child. Increased communication between partners improves the understanding of each other's reproductive preferences and decreases some of the consequences of poor communication, such as unintended pregnancies and large families.

A few studies [11,12] have found that communication and open disagreement on sexual and reproductive matters between spouses are uncommon, and that men rarely discuss family planning and related issues with their wives. To a great extent, this prevents couples from acting on a common preference. The second all-India survey by the Operations Research Group of Baroda observed that two-thirds of couples did not communicate with each other either on the number of children they should have or on family planning. Seventy per cent of couples in rural areas and 50 per cent in urban areas just did not discuss these issues. At the national level, in half the cases, the husband took the decision. In only one-third of the cases the decision was taken jointly. [13].

Many obstacles prevent men and women from talking about sexual and reproductive issues. While research is slight, it suggests that a complex web of social and cultural factors impedes such discussion. [14]. In many societies it is taboo for men and women to discuss sex. Also, men and women are often afraid of rejection by a partner, especially at the beginning of a relationship. Consequently, they may not bring up uncomfortable issues such as sexual history or the use of contraception. [15].

As with decision-making in general, women's status and lack of power limits communication between couples. [16,17,18]. For many women traditional gender roles mean they have little say in sexual matters and lack the status to influence their partner's behaviour. [9,18,19,20]. Even when men and women discuss issues of reproductive health, it is usually not on equal terms. [21].

Traditional cultures often discourage married women from starting discussions about contraception. For their part, men may feel that there is nothing to discuss. In countries such as India, Kenya, and Nigeria, male dominance is a major obstacle to spousal communication on family planning. [22,23,24]. Also, a husband might consider his wife promiscuous or unfaithful if she tries to discuss contraception with him. [9]. In some cultures it is easier for unmarried women and prostitutes to negotiate sexual activity with men, including the use of condoms, than for married women to do so with their husbands. [25].

Increasingly, health care providers and researchers are realising that the most appropriate client for reproductive health information and services may be the couple rather than the individual. [3,11,26]. For example, men who discuss family planning with their wives are more likely to use contraception or support their wives' use of it.

1.2 Men's role in family planning

Data on men's attitudes towards family planning suggests that in many regions men view family planning favourably and can have a strong influence on the use of contraception. For example, research in Kenya suggests that contraception is two to three times more likely to be used when husbands rather than wives want to cease childbearing. [27].

A study of male involvement among five generations of a south Indian family found that men readily accepted the use of condoms and vasectomy even though they may not have liked some of the specific characteristics of the method. Karra, et al, [28] examined male involvement in the practice of family planning and related decision-making in one Indian family over five generations. Data were collected from 152 living family members; information about an

additional 26 members who had died or were unavailable for interviews was gathered using interviews with their children and siblings. The majority of the contraception used in this family consisted of male methods (condoms, vasectomy, and natural family planning). Older generations particularly had limited access to contraceptive methods for women.

The participation of men in this family was not necessarily dependent upon changes in gender relations, such as increased spousal communication. Many men reported being motivated to use male methods by external factors such as a desire for the improved economic status of a smaller family.

The traditional responsibility of providing economic support for their families was clearly a motivating factor for fertility regulation among male respondents of all age groups. Economic pressures had forced the men from land ownership to private sector and public sector employment, a trend initiated by the oldest generation and continued by the following two. Economic pressure, combined with the transition to new sectors of employment, contributed significantly to the men's desire for smaller families.

Moreover, the move to formal employment demanded that the men obtained higher education. The men in this family had pursued higher education, because education (whether of the formal Western or informal religious type) was traditionally valued among Brahmins as a means to increase income and acquire status. As a result, the men pursued education to compete in the marketplace.

Their sons also required a good education to compete for jobs. As economic demands increased with each generation, fathers adopted the strategy of having smaller families to ensure a college education for their sons. As male education assumed greater importance for defining security and status, the desire to educate daughters to enable them to attract educated and financially successful sons-in-law followed. Once they became involved in the urban marketplace, men learned of contraception and had the option of attaining the desired family size. Their choice was influenced by the effectiveness of a contraceptive method, and satisfaction with the method.

A man's support often also contributes to better use of methods by women. One of the frequent reasons given by women for not starting or continuing to use contraception is their partner's opposition. Men who are educated about reproductive health are more likely to support their partners' decisions and to encourage public policies that result in women receiving the reproductive health care they need. A project in rural Mali addressed this goal by using men to promote family planning in local communities. Many women reported that male community workers had changed their husbands' attitudes towards family planning and generated more open communication about it between spouses. [29].

Family planning programmes have conventionally focused on women as the primary beneficiaries of the service. Men have been considered "silent partners" [30] while research on acceptance of contraceptives has concentrated on the effect of methods on women and factors affecting choice of method. [31,32]. Further, few studies examine the broader social, economic, and cultural forces affecting individual decisions to regulate fertility or the decision-making dynamics between couples. [33,34,35]. Indeed, consideration of the potential for involving men in family planning and contraceptive decision-making is a recent concern that has developed largely as a result of efforts to prevent the transmission of HIV/AIDS. [30]. Moreover, a review of studies of the behaviour of couples indicates that reproductive health interventions targeted at couples have greater impact than those aimed at one sex. [6].

Unfortunately, perspectives on male involvement are often rooted in negative assumptions. Programme planners view men as gatekeepers, potential obstructionists who, if involved in making decisions, will defeat women's efforts to regulate fertility. Yet, the limited evidence to date suggests that the most successful family planning programmes target men as well as women [36,37] and promote communication about contraception between spouses. [38].

1.3 Men's influence on women's health

The ways in which men influence women's health are numerous. Men can have a positive effect on women's health by:

- Using or supporting the use of contraception such that sexual partners are able to control the number and timing of pregnancies.

- Encouraging women to have adequate nutrition during pregnancy and providing the needed physical, financial, and emotional support.
- Supporting women during pregnancy, delivery, and the postpartum period.
- Supporting the physical and emotional needs of post-abortion women.
- Preventing all forms of violence against women.
- Working to end harmful traditional practices such as female genital mutilation.

Men who are involved in the health of their families may also enjoy better health and closer relationships with family members. [27].

1.3.1 *Men's role in maternal health*

• **Helping pregnant women stay healthy:** Men can help protect the lives and health of women as they become mothers and attend to their children. The WHO estimates that 585,000 women die each year from complications of pregnancy, childbirth, and unsafe abortion. That is about one death every minute [39,40], almost all of them preventable. Pregnancy-related complications cause a quarter to half of deaths among women of reproductive age in developing countries. In some countries complications related to pregnancy are the leading cause of death for women of reproductive age. [41,42,43]. Many thousands of women in developing countries suffer serious illnesses and disabilities, including chronic pelvic pain, pelvic inflammatory disease, incontinence, and infertility, caused by pregnancy or its complications. [44].

Safe motherhood consists of ensuring good health for the woman and her baby during pregnancy, delivery, and the postpartum period. The man plays a key role in all these phases. His decisions and actions often make the difference between illness and health, life and death. [45,46,47].

Involving men in reproductive health has been found to have a positive impact on women and children's health in many ways, including improving maternal and child (MCH) health care. A study in India on providing antenatal education to prospective fathers noted a significant impact with higher frequency of visits to antenatal clinics and significantly lower perinatal mortality among women whose husbands received such education. Further, men with antenatal education knew more about methods of family planning and were more concerned about their partner's nutritional needs during pregnancy. [48].

Good nutrition and plenty of rest are important during pregnancy. Men can help women have safe pregnancies and healthy babies by ensuring that they receive nutritious food, especially food strong in iron and fortified with vitamin A. [45,46,49,50]. Anaemia, while not a direct cause of maternal deaths, is a factor in almost all such mortalities. An anaemic woman is five times more likely to die of pregnancy-related causes than one who is not anaemic. [51].

Vitamin A is important for the health of both the mother and her foetus. [49,50]. Women need to get enough vitamin A to support the healthy development of their babies and to protect their own health, particularly the eyesight and the immune system. Night blindness among pregnant women is a symptom of vitamin A deficiency. Antenatal vitamin A supplements, often provided in pill form, can greatly reduce maternal and child deaths. [50]. A study of pregnant women in southern Nepal found that low-dose vitamin A or supplements of beta-carotene, the nutritional precursor of vitamin A, reduced maternal deaths by an average of 44 per cent.

To solve the practical problem of getting pregnant women to antenatal care clinics, the Deepak Charitable Trust started the Pati Sampark (literally, "contact the husband") programme. This contributed to a rise in women's attendance. Also, women in the project area where husbands were contacted had a better understanding of antenatal services. Although the exact role of the men remains unclear, qualitative research shows that husbands in the project area held a more positive view of their potential role in assisting their wives during pregnancy.

In an attempt to increase hospital referrals for high-risk pregnant women, the Society for Education Welfare and Action sent postcards to the male members of the families of such women. They found that hospital referrals did increase and that there was a tangible increase in the awareness of the family members. About 65 per cent responded to suggestions for appropriate care as outlined in the postcards. [52].

Bhalerao et al, evaluated the involvement of prospective fathers in the care of pregnant women attending a clinic in Bombay, India. [53]. Beginning in

October 1982, pregnant women attending the clinic were told to ask their husbands to meet the centre's resident medical officer. The outcome of the maternal health care programme for the 270 women whose husbands were invited and came (Group 1) was compared with the outcome of the same programme for 405 women whose husbands could not be invited (Group 2).

The husbands who attended the centre were educated individually and in groups about their role in the nutrition and health of their wives during pregnancy and their responsibilities in child-rearing. The physiology and complications of pregnancy and the possible ways and means of preventing them were explained. The husbands were also told to encourage their wives to attend the antenatal clinic at the centre as often as possible.

The difference between the two groups was significantly lower perinatal mortality in Group 1. More women in Group 1 than in Group 2 accepted postpartum sterilisation. This effort confirms that the involvement of prospective fathers is possible and pays good dividends even in an uneducated community of low socio-economic status.

• **Arranging for skilled care during delivery:** In developing countries most women give birth without skilled assistance, helped by untrained traditional attendants or by family members. The presence of a trained attendant during childbirth can mean the difference between life and death. Men can help by arranging and paying for a trained attendant to be present for the delivery. They also can arrange ahead of time for transport and buy supplies.

• **Helping after the baby is born:** Most maternal deaths occur within three days of delivery, owing to infection or haemorrhage. To prevent such deaths, men can learn about potential postpartum complications and be ready to seek help if the need arises.

Men can also ensure that women get good nutrition. While they are nursing, women continue to need extra vitamin A to ensure that they pass enough of it to the infant. In the postpartum period men can help with heavy housework, such as gathering wood and water and taking care of other children. They can encourage breastfeeding, which helps the uterus to contract. Finally, they can begin using contraception, either a temporary method to space the next birth or a vasectomy if no more children are desired. [45,46].

Men can join in post-pregnancy family planning and care at several levels. They can support their wives' choices and use of contraceptives. During the post-pregnancy period, all male methods – condoms, vasectomy, periodic abstinence, and withdrawal – are appropriate for nursing women since these methods do not affect breast milk.

1.3.2 *Men's involvement in abortion care*

Post-abortion counselling of men can help to prevent repeat abortions by stressing the need for consistent use of reliable contraception to prevent unwanted pregnancies. Postpartum contact with male partners offers an opportunity to educate men about the value of spacing children, an important factor, since a man often has substantial influence in a couple's decision to use family planning. One study found that three out of four Turkish women who sought abortions were using the withdrawal method at the time of conception. In addition many couples do not realise the potential health risk of repeat abortions, which can impair fertility.

In Egypt, a Population Council study found that women who entered hospitals for treatment of incomplete abortions worried about being pressured by their husbands or families during recovery. [54]. They especially feared castigation for not being able to carry a pregnancy to term. They did not expect support from their spouses, but simply hoped they would not become a source of worry.

1.4 Men's involvement in RTIs and STDs

In most developing countries, the health care system only attends to women when they are the targets of family planning programmes. Little attention is given to the reproductive health of women who are not pregnant. One reason for the relative neglect of gynaecological care is the failure to appreciate the extent of unmet needs in rural areas [55].

In the overwhelming majority of cases, it is clear that initiatives to include men were motivated by concern for women's reproductive health, which showed little improvement without men's support and active involvement. Men's inclusion was part of an evolutionary process, a consequence of the ground realities within the context of women's health.

For example, a number of NGOs found that merely by providing women-friendly health care services, sexually transmitted infections (STIs) could not be treated. For women, a more crucial question was that of social access, which invariably included what men in the family had to say. As high as 50 per cent of the women in a tribal area of Gujarat who had STI symptoms and had agreed to get themselves examined and treated backed out because the male family members did not allow them to attend the camp. [56].

In the course of their intervention, the Community Aid Sponsorship Programme in alliance with Foster Parents Plan International realised that many women with STIs attending their gynaecology clinic were not showing satisfactory improvement. Closer inquiry made it clear that these women required "partner compliance," which was lacking. The women often insisted that their husbands be contacted and sensitised to the fact that their behaviour has a bearing on their wives' reproductive health.

A common refrain was: *"Aap hame to samjha dete ho, par hamare aadmi ko kaun samjhayega?"* ("You have explained everything to us, but who is going to make our men understand?"). [57]. Data collected by the Rural Women's Social Education Centre on reproductive health problems showed that a significant proportion of reproductive tract infections (RTIs) among women was a direct result of the promiscuity of their men. [58].

The effect of men's attitudes and behaviour on women's health is perhaps most evident in preventing and treating sexually transmitted diseases (STDs). For prevention programmes to be effective, they need to educate and treat both partners. Increasing condom use and changing high-risk sexual behaviour are primary STD prevention strategies. Where condoms have been heavily promoted by social marketing campaigns, use has gone up markedly. Increasing use of condoms is a step towards changing men's behaviour in a way that directly affects their own health as well as that of their partners. But surveys show that use of condoms is much higher outside of marriage than with spouses, and husbands can infect wives who have little power to negotiate the use of condoms.

Abstinence, use of condoms, monogamy, and other safe sex practices are some of the methods of preventing STDs. Often these practices assume a context of rationality and concern for disease and prevention of pregnancy. Sexual negotiation between partners assumes that there must be a process of bargaining to reach an agreement about sexual behaviour that is, for whatever reason, not acceptable to one of the partners.

1.4.1 *Sexual communication between couples*

Literature in India on sexual behaviour and negotiation, particularly within marriage, is sparse. Mumbai has the highest number of diagnosed HIV/AIDS cases in India [59] and heterosexual intercourse is thought to be the primary mode of transmission. Studies on adult sexual behaviour indicate that premarital and extramarital sex occurs across all social strata and with a range of partners. [60]. Sexual violence and coercion are found to be widespread in marriage in rural India [56], but information about the nature and extent of that coercion is absent.

There seems to be little doubt that in many sections of Indian society (as in other cultures) a number of men assert a dominant roles in family life through insistence on their right to sexual intercourse "on demand," regardless of the responsiveness of their partners. Some studies give the impression that the overwhelming majority of women are therefore unhappy and unwilling participants in sexual intercourse and that they have very little power of negotiation in relation to the use of condoms or the timing and situations in which their husbands desire sexual satisfaction from them.

On the other hand, the focus of attention on the negative side of sexual communication and widespread prevalence of sexual violence and coercion within the family may be presenting a distorted picture. Most of the findings are based on single-contact interviews, which perhaps tends to make women project a negative "I don't like sex" attitude and coercion. These responses may represent normative responses rather than actual behaviour. Some studies have even indicated that it would be a shameful act if women were to initiate, or express their desire for, sex. [10]. Yet, contrary to the general belief that sexual interaction in conservative Indian society is always initiated by the husband and the wife remains a passive partner, a study shows that women also communicate to husbands their desire for sex. In the few studies of

sexual communication in the literature, most of the initiating signals or messages are non-verbal or indirect.

A study in 1995 [61] showed that the following all serve to constrain women's ability to control their sexual and reproductive lives: economic dependence on men, poverty, partilocal kinship patterns and married women's restricted contact with their natal families, legitimacy of male authority and female submission, limited opportunities to influence sexual and contraceptive decision-making, limited knowledge of bodily processes, limited discussion between spouses about sexual and reproductive concerns, and the threat and use of violence by husbands.

In a review of anthropological and socio-cultural studies on sexual behaviour, networking, and transmission of HIV, Dyson [62] hypothesises that the initiation of sexual intercourse at an earlier age, higher frequency, and a greater number of partners, are related to a decline in customary restraints on sexual behaviour. Dyson suggests that change in the notions of what constitutes acceptable parameters of sexual behaviour has resulted from a wider worldview, itself a result of migration, education, urbanisation, mass media, and increased economic autonomy for women.

Research on sexuality, especially related to HIV/AIDS, has highlighted the inadequacy of strategies that only target women. Because of unequal gender power relations, women are especially vulnerable, but are unable to negotiate changes in sexual behaviour without their partners' cooperation. Research on sexual negotiation strategies has dramatically underscored the need to involve men in programmes that aim to change sexual behaviour to prevent infection. Changes in sexual behaviour are also needed to promote contraception and address other reproductive health problems. Men's involvement as responsible sexual partners is therefore essential to improve the reproductive and sexual health of women. [63].

Programmes to encourage men's participation in reproductive health face a major challenge in the area of safe sex negotiations. Women often lack sufficient power to negotiate safer sex with their partners, whether they be married or involved with commercial sex. A young woman's emotional involvement with her partner may prevent her from discussing sex or using condoms. [64]. Married women are particularly at risk in some areas. A study in Kigali in Rwanda indicated that 20 per cent of HIV-positive women had only had one sexual partner, with 45 per cent contracting the virus from their husbands. [65]. For those men, married or single, who do wish to use condoms, having greater power in the relationship does not always translate into action; hence, interventions are needed to help men overcome their behavioural barriers to negotiating use of condoms. [66].

1.5 Women's utilisation of health services

Women's access to health care is a complex issue, because it is both the outcome of their status in society, including society's response to their health needs, and a determinant of their health and productivity, and so, ultimately, of their status.

Four sets of factors influence women's access to health care, broadly termed need, permission, ability, and availability. [67]. An interplay of these factors results in women's use of health services. Permission and ability interact with need to result in demand for health services. Where this demand overlaps with availability, that is, with supply, use of health services occurs. Severely constrained permission and ability restrict women's demand for health services. Effective demand for or use of health services is further reduced by the inadequate fit between needs and services available.

Khan and Prasad [13] reported that in the UP villages they studied, treatment was sought only in nine per cent of female illness from the nearby primary health centre (PHC) or government health facility. The vast majority of women simply used traditional remedies. Few women ventured to health centres, clinics, and hospitals, which are the repositories of medical information.

Data on the extent of utilisation of health services definitely indicate differences between males and females. Despite higher morbidity among females, more treatment is sought for males, a higher percentage of ailing men than women get treatment, and a higher proportion of services is provided to men [68]. Cause-specific mortality data reveal that female mortality from common, major diseases is consistently higher than that of males. Although these diseases are easier to recognise and are diagnosed more

frequently among females, they are also fatal more often among females because of the failure to treat them.

Miller [69] lists several studies of hospital admissions in different parts of the country, which demonstrated higher ratios of male to female admissions in the north than in the south, though boys were favoured in all areas. This is explained by the cultural belief that scarce resources of time and money should not be spent on girls, who must tolerate the pain and suffering that is their lot. Hospital and clinic attendance records invariably show a preponderance of males receiving treatment. The proportion of medical treatment provided to women is lower, whether one considers outpatient attendance or admissions. For example, in Safdarjung Hospital, Delhi, only 35 per cent of admissions were female. [70]. Similarly, Khan, et al, [71] reported that a larger number of males were treated at the PHCs in Uttar Pradesh, Gujarat, and Rajasthan.

Low rates of treatment exist despite the availability of free government health facilities in both rural and urban areas. A household health survey in Madhya Pradesh found that while treatment had been sought for about half of all reported "current serious illness" only 15 per cent of patients had approached government facilities, the rest had sought private allopathic or traditional care. [72]. Only one-third of the women respondents knew the location of the nearest sub-centre and about 40 per cent knew the location of the nearest PHC. Knowledge of the timings of these facilities was poorer. Only one-quarter of the women had actually ever visited the local sub-centre and less than 20 per cent had visited the PHC. Women did not attend sub-centres or PHCs for antenatal care or for delivery. [13,71,72].

The latter group of researchers has reported that between three and 11 per cent of pregnant women interviewed in Bihar, UP, and Rajasthan received MCH services such as antenatal check-ups, tetanus toxoid, iron fortification, birth attendance, or postpartum family planning counselling. [73]. In Kerala almost 40 per cent of women received the first three of these services, but fewer obtained the last two. Gujarat had the best coverage and 35-43 per cent of women received the various services in the state.

Official statistics maintain that three-fourths of deliveries in rural areas are conducted within homes with the help of female relatives, friends, or traditional *dais*, but micro-level studies generally report a rate closer to 95 per cent. Dyson and Moore [74] have pointed to geographical differences in birth attendance by trained personnel. It is lowest in the north and northwest, and highest in the south. This coincides with the status of women in the different regions and is inversely related to mortality.

A recent study by Ramalinga Swamy [75] in the southern state of Andhra Pradesh found that only two per cent of women in tribal villages and 24 per cent in non-tribal villages were delivered by an auxiliary nurse midwife or at a hospital, and 16 per cent and 62 per cent, respectively, received tetanus toxoid in the prenatal period. In contrast, over 95 per cent of all women had been approached for family planning, and everyone knew of the malaria worker. Ramalinga Swami concludes that while great differences exist in the reach of government services in rural areas, where there is a desire to reach women (for example, for family planning), the services succeed in getting there.

1.5.1 *Factors influencing women's utilisation of health services*

A few studies in India support the view that female literacy goes hand in hand with reduced mortality and, perhaps, better use of health facilities. Krishna [76] found literacy an important variable to explain differences in mortality rates in all states. He examined overall death rates in terms of literacy, doctor, hospital and bed to population ratios, and per capita expenditure on medical and health services. While literacy was the most important factor, the health service ratios also had some explanatory power.

The influence of female education on the use of health care services is also important in urban settings where the services are more accessible, as in Kerala. Khandekar [77] found that within middle income and low income groups in Mumbai, education had an impact on the utilisation of MCH services.

In most rural areas, one in three women lives more than five kilometres from the nearest health facility, and 80 per cent of rural women live more than five kilometres from the nearest hospital. The scarcity of transport, especially in remote areas, and poor roads, make it extremely difficult for women to reach these facilities. Walking is the primary mode of transport, even for women in labour. In rural Tanzania

84 per cent of women who gave birth at home intended to deliver at a health facility but could not because of the distance and lack of transport.

A study done in Nigeria found that the shift from free to fee-based services for obstetric care reduced admissions overall, but significantly increased emergency cases. The number of maternal deaths rose correspondingly. The poorer women are, the more likely it is that fees will affect their use of health services.

Many women also describe providers in the formal health care system as unkind, rude, brusque, unsympathetic, and uncaring. Where health workers are seen as hostile and unfriendly, many women rely on traditional healers or traditional birth attendants (TBAs) for antenatal care, delivery, and postpartum care. This can lead to fatal delays in seeking adequate care for complications. In Tanzania, a study found that 21 per cent of women delivered at home because of the rudeness of the health staff, even though they thought delivering in a health facility was safer.

In Ghana, a study of women who died of pregnancy-related complications found that 64 per cent had sought help from a herbalist, soothsayer, or other traditional provider before going to a health facility. Families cited cost and the belief that the woman's condition would improve or that the woman was not ill enough to justify the cost involved, as the main reasons for not taking her to hospital. [78].

In many parts of the world, women's power to make decisions is extremely limited, particularly in matters of reproduction and sexuality. The mother-in-law, husband, or other family members often make decisions about maternal care.

1.6 Objectives of the study

As gender inequalities favour men in patriarchal societies and men make sexual and reproductive health decisions, there is a growing realisation that unless men are reached programmes will have a limited impact. While focusing on women and addressing their reproductive health needs, special efforts should be made to encourage men to take responsibility for reproductive health as responsible sexual partners, husbands, and fathers.

Given the situation, the present study intends to proceed with the following objectives:

- To understand the influence of gender on the reproductive health of women.
- To investigate the role of men in promoting the reproductive health of women.
- To learn the extent to which women use health services for improving their reproductive health.

Chapter 2

Influence of gender on reproductive health of women

Gender refers to the array of socially constructed roles and relationships, personality traits, attitudes, values, behaviour, and relative power and influence that society ascribes to the two sexes on a differential basis. Gender is relational and refers not simply to women or men but to the relationship between them. [79]. All societies are divided along the "fault lines" of sex and gender [80] such that men and women are viewed differently with respect to their roles, responsibilities, and opportunities, with consequences for access to resources and benefits. Gender roles and norms are culture-specific and thus vary greatly around the world. Almost everywhere, however, men and women differ substantially in power, status, and freedom. In virtually all societies, men have more power than women. [22,81,82,83,84].

The term "power" is often used when describing gender differences. "Power" is a broad concept that describes the ability or freedom of individuals to make decisions and behave as they choose. [84,85,86,87,88]. It can also describe a person's access to resources and ability to control them. When the term "power" is associated with gender, it usually refers to inequities between men and women.

Two types of power help to describe the inequities in male and female gender roles – "power to" and "power over." "Power to" describes the ability of individuals to control their lives and use resources for their benefit. For instance, a man is more likely than a woman to have the power to go where he wants, find a good job, and earn money. "Power over" means that individuals can assert their wishes, even in the face of opposition, and force others to act in ways that they may not want to act. [84,87]. In many cultures, for example, men make reproductive decisions, such as how many children their wives will have, that can have consequences for women's health and well-being. [22,36,89].

The facts of gender inequality – the restrictions placed on women's choices, opportunities, and participation – have direct and often negative consequences for their health, education, and social and economic participation. Yet, until recent years, these restrictions were considered unimportant or non-existent, accepted or ignored. The reality of women's lives has been largely invisible to men. This invisibility persists at all levels, from the family to the nation. Though they share the same space, women and men inhabit different worlds.

2.1 Reproductive health – the gender dimension

For both women and men, reproductive health reflects the impact of health in infancy and childhood as well as in adult life, and during as well as beyond reproductive age. Reproductive health sets the ground for human sexuality, regardless of whether it leads to reproduction.

Gender differentials with regard to poor reproductive health stem, in part, from biological factors. Other gender differentials stem from social, economic, and cultural factors. Women's lack of autonomy in sexual relationships can lead to early and excessive childbearing as well as exposure to STDs and violence. Women who lack decision-making power and control over money within the family are often cut off from essential health services such as emergency obstetric care. Cultural practices such as female genital mutilation may lead to life-long disability. Although the burden of ill-health associated with reproduction affects women to a larger extent than it does men, and few of the reproductive health problems that men face are life-threatening, these problems do affect men's quality of life and may have serious repercussions for women's health.

Women, particularly those who are poor, face a number of reproductive health problems such as reproductive tract infections, complications of pregnancy, foetal wastage, sexual violence, and poor maternal nutrition. The fact that many women still face reproduction-related morbidity and mortality – both preventable – owing to both social and economic factors and gender-related antecedents

reveals a lack of access to adequate health services. The young woman who dies in first childbirth at age 15 probably incurred obstructed labour, haemorrhage associated with malnutrition, or chronic anaemia. Chances are she received less food and health care than her husband. Few programmes for child survival or maternal and child health even recognise such gender differentials as a problem, let alone seek to combat them.

The older, higher parity woman who dies in childbirth may not only have accumulated the disadvantages from adolescence, but may also have been weakened or depleted by previous pregnancies. Lack of information about her physiology, sexuality, and reproductive health makes her vulnerable to both physical and emotional abuse. Equity and a strong sense of dignity are precluded. [90].

Gender inequality and discrimination thus directly and indirectly harm the health of girls and women throughout the lifecycle; neglect of their health needs prevents many women from taking a full part in society.

2.1.1 *Gender and acceptability of contraception*

Gender differentials in knowledge and use of contraception may arise for a number of reasons. They may reflect actual differences in knowledge and use, gender-related differences in the accuracy of reports (deliberate or unintentional), or a mix of the two.

"Acceptability" of a contraceptive method refers to how well, given existing choices, the method meets user preferences. Acceptability is therefore relative, conditional, and utility-driven. Couples who are keenly dissatisfied with other methods have a felt need for alternatives. They are more likely than others to be satisfied with a method that fulfils that need.

In all likelihood, men and women have somewhat different criteria for whether a method is acceptable, yet clinical and acceptability research on contraceptive methods has largely excluded partners, whether male or female. Failure to recognise that the male partner may have the final say on the method to be used has been detrimental to expanding contraceptive choices for women. Ignoring the perspective of the female partner may be equally damaging to the prospects of methods for men. Women have been responsible for contraception for too long not to take a critical interest in the development of such methods.

Social and cultural factors, including gender norms, condition women's reproductive intentions – that is, the number of children they want and how they want their births spaced. If women could have only the number they wanted, the total fertility rate in many countries would fall by nearly one child per woman. The fewer children women want, the more time they spend in need of contraception, and the more services are required.

Women do not always get the support they need to fulfil their reproductive intentions. In some settings, fearing reprisal from disapproving husbands or others, many resort to the clandestine use of contraception. [91]. Women interviewed in a five-year project carried out in eight countries by Family Health International said that to attain their family planning objectives, they need supportive partners, adequate information, unobtrusive methods, and respectful services. [92].

Most modern contraceptives rely on women to initiate and control their use: oral contraceptives, intra-uterine devices (IUDs), diaphragms, cervical caps, and injectables have no counterpart methods for men. Among the 58 per cent of married couples practising contraception worldwide, less than one-third relies on a method requiring male participation (condom and vasectomy) or cooperation (rhythm and withdrawal). In less developed regions, nearly two-thirds of contraceptive users rely on female sterilisation or IUDs. [93].

2.1.2 *Gender differences in reporting of contraceptive usage*

Research on gender differences in reporting the use of specific methods has shown that women consistently under-report the use of male methods. [36,94]. One explanation may be that they are too shy to report the use of condoms or withdrawal. Alternatively, women may think that they should not report use of condoms or withdrawal because they are not the ones actually using them. Although the Demographic Health Survey (DHS) questionnaire is designed to avoid this misunderstanding, it may still happen. On the other hand, it could be that men are using withdrawal without their wives knowing it.

Any of these factors could explain the higher reported use of male methods by men.

Differences in reporting by sex may also be due to doubts whether a particular behaviour constitutes contraception. Men report higher periodic abstinence than women. One explanation for this is that men may interpret periodic abstinence, e.g. after a birth, as a means of avoiding another pregnancy, while women primarily consider it to be for other reasons, like ensuring the newborn's health. Equally, men and women may differently report condom use that is intended primarily to prevent HIV/STD infection and not pregnancy. An analysis of the Tanzanian DHS found that reported condom prevalence increased by 300 per cent among women when a probe was added that asked about condom use with any partner in the last month but did not specifically mention preventing pregnancy. The comparable increase among men was 18 per cent. [95].

Men also reported higher than expected current use of female methods. It is unlikely that the same arguments would hold for women under-reporting female methods. More research is needed. It may be that men are over-reporting use of both male and female methods, which would compound the reporting error. As female methods are generally less immediately visible during the sexual act (e.g. injection, IUD, and pill), it is possible that men may be unaware that their partner has ceased to use a method, leading them to over-report current use.

If the differences by sex reflect real differences in use as opposed to reporting error, and given that our sample is limited to the currently married population, the explanation must lie in one or the other of the partners using contraception outside the marital union. Men are often assumed to use condoms for extramarital relations. Large differences in ever-use of condoms might suggest past use by males with sexual partners prior to marriage as well as with past and current extramarital partners. Men are generally older than the women they marry, e.g. in Pakistan men are on average 6.7 years older than their spouse. Thus, men may have a number of years prior to marriage in which sexual activity could occur.

Supporting evidence for this comes from the DHS conducted in Zimbabwe in 1994, which contained a module on HIV/AIDS and sexually transmitted diseases. Although not part of the male questionnaire, the module included questions to currently married men and women about their use of condoms both within and outside the marriage. Of those men having sex in the last four weeks with their spouse, 12 per cent had used a condom, whereas of those men who had had sex with a non-spouse, 60 per cent had used one.

2.1.3 *Gender and adolescent pregnancy*

One important development in adolescence is coming to terms with one's sexual identity. Recognising one's sexuality has been viewed as a male sphere in the country. The media often presents sex as hedonism with the exhortation that it is "dirty" and "immoral." On the other hand, the age of menarche has dropped because of improved nutrition. This indicates a lengthening of the reproductive span and earlier exposure to pregnancy.

But little attention has been given to the problem of malnutrition during this difficult period of transition in life. Puberty means increased nutritional requirements, which are recognised more for male adolescents, the potential workforce. In the 1992 National Nutrition Survey, females aged 13 and above had higher rates of anaemia and iodine deficiency than males. A mother with iodine deficiency runs a higher risk of delivering a child with congenital anomalies, including mental retardation. Biologically and psychologically, the female adolescent is still unprepared for pregnancy. These handicaps remain for young mothers who survive subsequent pregnancies. A relatively high prevalence of foetal loss among adolescents has been observed. Among those less than 20 years of age, 12.2 per cent of the women reported some foetal loss.

Adolescent contraceptive use remains low. The Philippines National Demographic Survey in 1993 revealed that the contraceptive prevalence rate for women 15-19 years of age was 1.3 per cent. [96]. Among women aged 15-19, seven per cent had begun childbearing, five per cent were already mothers, and one per cent were pregnant for the first time at the time of the survey. At exact age 18, 10.3 per cent had begun childbearing; at age 19, nearly a fifth of the group (19 per cent) had started building their family. Rural teenagers were twice as

likely to experience teenage pregnancy as their urban counterparts.

In western Mindanao, cultural factors impinging on women's roles and status partially explain the high proportion of teenagers bearing children (13 per cent). Teenagers in urban areas with recreational and educational facilities have alternatives other than childbearing. Teenagers in the city may also have more exposure to information and methods regarding family planning and safe sex. The Philippines data showed that education tends to depress fertility in the earliest childbearing years. The percentage of childbearing was 15 per cent among women with no education, compared to two per cent among women who had higher education. Despite the overall low teenage pregnancy rate, the magnitude is immense in light of the fact that in the 1990 census, about 5.5 per cent of the country's population was 15 to 19 years of age. [96].

The phenomenon of teenage pregnancy is a fast emerging concern in many societies. The disadvantaged status of the teenage mother affects the health and welfare of her children. Her underprivileged position tends to be repeated in the lives of her daughters. With modernisation and urbanisation, traditional systems such as extended family networks that once regulated sexuality have eroded. Young people become exposed to diametrically opposed messages regarding sex roles from peers and the family.

2.1.4 *Gender and safe motherhood*

Women's gender roles do give them some power. Usually, however, it is much more limited in scope than men's. [97]. Like a man's power, woman's power is influenced by such factors as her culture, age, income, and education. Some studies have found that women's power increases as their status in the community improves. In Nigeria, for example, Yoruba women who have many children, especially sons, have greater say than their husbands in whether to have more children. With Yoruba women having few children, however, their husbands' fertility desires usually prevail. [98]. But to attain this "power" many women tend to take risks. It is not uncommon for women in Africa, when about to give birth, to bid their older children farewell.

Ninety-nine per cent of the approximately 500,000 maternal deaths each year occur in developing countries where complications related to pregnancy and childbirth take the life of about one in every 48 women. As many as 40 per cent women in some settings suffer from serious illness following a birth. [44].

Avoiding unwanted pregnancy through family planning and proper antenatal care reduces maternal mortality. But only 70 per cent of births in the developing world are preceded by even a single antenatal visit. Each year, 38 million women receive no antenatal care. Only about half of all pregnant women receive tetanus injections.

The vast majority of studies that have any information on women's utilisation of pregnancy and delivery care reveal overwhelming evidence that women distrust or dislike delivery in a hospital, prefer natural childbirth, and believe that antenatal care is not necessary. A study in rural Rajasthan [99] reported that a large proportion of pregnant women referred to tertiary centres did not avail of the facilities because of lack of money, transport, or time. Those who did go were better off and/or had their own means of transport. The interplay of gender and social status is borne out by this study, which also showed that when relatives were able to provide support in terms of taking over a pregnant woman's domestic responsibilities, there was a higher likelihood of her availing of the referral, even among the better off. Similar findings are reflected in another study, also from Rajasthan [100], which found that work and lack of social support impede access to health services.

A study of women from a fishing community in southern Tamil Nadu [101], which examined why women did not use delivery services, found that the reasons cited included a prolonged stay in hospital disrupting their gender-based domestic responsibilities, caste gap between provider and user, harsh treatment by delivery staff, and needless medical interventions. Studies examining the association of various socio-economic factors with utilisation of services indirectly through statistical analysis (as opposed to direct questioning) have found that women using antenatal care are economically better off, have more years of education and are married to men with more years

of education, are non-working women, and do not belong to the scheduled castes. [102].

Interestingly, though, these associations are interpreted as implying the ignorance of women. The studies then argue for educating the illiterate women about the need for antenatal care and for trained attendance at birth, without probing further the ways in which socio-economic status may act as a barrier to utilisation of services. The conclusions drawn from the findings leap far beyond available hard evidence and, in some sense, appear to reflect gender, social and medical biases in interpretation – that antenatal and delivery care is inherently good for women irrespective of their quality, and that anyone who does not see this "truth" has to be ignorant.

In terms of choice of provider for reproductive health care, a preference for *dais* (TBAs) for delivery care has been indicated by many studies. The low cost of services appears to be an important consideration. In the only study that actually documented cost of care, from Vellore in Tamil Nadu [103], the average expense incurred by a household for a delivery by the *dai* was reported to be Rs. 25, an amount that would be inadequate even for getting a woman in labour to a health facility.

This may be interpreted in two ways – as reflecting the inability of households to pay more, or their unwillingness to invest in childbirth, a reflection on the value placed on a life-and-death situation for women by their families and society. Cost was a consideration in choice of provider for induced abortion for one-third of the respondents, according to one study. [104]. The study also reported that women's heavy workload at home made them prefer abortion providers who did not insist on repeated visits or an overnight stay.

2.1.5 *Gender and reproductive tract infections*

Little is known about the dynamics of couples' sexual and reproductive decision-making or about how gender roles affect these decisions. Such decisions can include whether to practise family planning, choosing when and how to have sexual relations, engaging in extramarital sexual relations, and using condoms to prevent STDs.

Male gender roles harm men's health as well as women's. A mix of cultural norms, social expectations, and men's sex drive encourages risky male sexual behaviour. [85]. Some societies, as in Haiti and Thailand, accept that married men will have extramarital sex, either with girlfriends or prostitutes. [25,105]. Similarly, in many Latin American and Caribbean cultures, the concept of machismo encourages men to be promiscuous to prove their masculinity. Such male gender roles can contribute to their contracting STDs and passing them on to wives and girlfriends.

The occurrence of RTIs has a strong gender dimension. Sexual contact, usually intercourse, is necessary for transmission. Thus, lessons learned on how to modify unsafe sexual practices can be applied to reduce the risks. Second, RTIs discriminate biologically against women. Anatomic differences make RTIs more easily transmissible, yet more difficult to diagnose in women. STDs are more frequently asymptomatic in women than men, and clinical symptoms are subtler in women. Worse, the long-term complications in women are far more common and serious. The intrinsic gender breakdown also exists with unplanned pregnancy, as women obviously bear the entire burden of associated health risks.

Third, a power imbalance between the sexes favours men. Women frequently have little power over when, with whom, and under what conditions sexual intercourse occurs. This situation influences whether any preventive measures are used against RTIs. The woman's status depends on her role as a wife and mother. If RTIs impair her reproductive capability, she is stigmatised.

Fourth, the groups most likely to be affected by RTIs and unplanned pregnancy are younger women with lower incomes. The poor represent those at greatest risk for sexually transmitted infections. If men are willing to use condoms properly, then preventing direct contact with semen, genital discharge, genital lesions, and infectious secretions ensures protection against transmission. [106].

2.1.6 *Gender violence and reproductive health*

Gender violence, until recently a marginal subject among themes related to health, has such a significant impact on women's health that it is responsible for one in every five potential years of healthy life lost. [107].

Contrary to the common sense that imagines pregnancy as a sanctified state of peace and beatitude, violence does not necessarily decrease in this period, tending in many cases to increase in intensity or frequency. The prevalence of physical and sexual violence during pregnancy tends to be higher than in the previous year among non-pregnant women. This leads some authors to postulate that pregnancy could be considered an increased risk factor for violence. Sexual violence leads to unwanted pregnancies not only in the context of rape by strangers but also in forced intercourse within intimate relationships, and seems to have important consequences. [108].

Studies suggest that the younger the women, the more vulnerable they are to violence during pregnancy, which affects 24 per cent of all pregnant adolescent women. Unplanned pregnancies are also associated with violence. In a study conducted by Stewart and Cecutti in 1993 as cited by Diniz [109], 88 per cent of the women who referred to sexual abuse during pregnancy declared that it was not planned, whereas just 30 per cent of the women who did not refer to abuse had unplanned pregnancies. Younger women are more vulnerable to unwanted pregnancies.

Domestic violence during pregnancy can have an adverse effect due to direct physical trauma that in most cases seems to be directed particularly to the abdomen. In a study of 203 pregnant women assisted for physical traumas, 31.5 per cent were victims of intentional violence. [110]. The consequences of these traumas are several direct obstetric outcomes, which affect both the mother and the child's health. In a study of 218 women who suffered domestic violence and were assisted at an emergency room, five per cent declared the abortion was because of violence, and 16 per cent declared that they had attempted suicide previously. [111]. These aggressions have also been blamed for abruptio placentae, rupture of the uterus, liver, or spleen, pelvic fractures, premature births, rupture of the membranes, foetal infection, and fractures. [112,113].

Indirect repercussions on the health of the newborn are equally important. Lowweight births have been associated with violence, an effect that, in turn, is associated with other risk factors such as smoking, drug abuse, and inadequate prenatal care, as well as other health problems. [114].

2.1.7 *The harm to reproductive health caused by gender roles*

Traditional gender roles can jeopardise the reproductive health of both women and men. Inequities in power often make women vulnerable to men's risky sexual behaviour and irresponsible decisions. Because of their gender roles, many women around the world have trouble talking about sex or mentioning reproductive health concerns. [12,20,25].

Women may submit to men because they are afraid of retaliation, such as being beaten or divorced, and because their gender roles place them in subordinate positions in society. [19]. For women worldwide, the impact of gender inequality is apparent in many of their reproductive health problems. [89,92,115,116,117,118,119]. Thus gender has a powerful influence on reproductive decision-making and behaviour. [12,120].

Gender is just one of many factors that influence couples and their reproductive decisions. Education level, family pressures, social expectations, socio-economic status, exposure to mass media, personal experience, expectations for the future, and religion also shape such decisions. [87,121]. Consequently, no two couples' "decision-making environments" are identical. [122].

Some researchers have suggested that personal reproductive decisions result from many smaller, incremental decisions. [123,124,125]. Other researchers suggest that in fertility decisions, social and cultural norms and expectations often prevail over individual preferences. [122].

At the same time men's control over reproductive decision-making may be weakening, particularly among younger generations and in certain cultures. In many societies, as social, economic, and educational opportunities for women increase, traditional gender roles are starting to change. As a result, power is being redistributed between men and women. Evidence from several countries demonstrates that, increasingly, reproductive decisions are being made jointly by couples, and not by men alone. [126].

Chapter 3
Design and methodology

Historically, Andhra Pradesh has been a diverse state in terms of socio-economic and demographic levels. Of its three main regions, Telangana is the most backward. Demographically, if coastal Andhra is close to the levels of Kerala, Telangana can be compared to the backward states of India.

Rangareddy is a district in the Telangana region. Geographically, Hyderabad, the capital of the state, is in the midst of Rangareddy district. Hyderabad is one of India's fastest growing cities, not only in terms of population density but also in terms of facilities such as health care, accessibility, and communication. Yet, this development has not percolated into surrounding Rangareddy. According to the latest census, it remains backward in terms of developmental indicators. Due to this existing socio-economic situation, a study in the rural areas of Rangareddy district was reasoned as being useful and interesting.

3.1 Design of the sample

The sampling for the study was done at two levels: sampling of the area and sampling of couples. There are 29 PHCs in the rural areas of Rangareddy district. Of these, 20 are known as round-the-clock women's health centres (RCWHC). The rest are ordinary PHCs. A RCWHC is an upgraded PHC created to provide comprehensive reproductive health care and make maternal health services available at all times. The government has made it mandatory to appoint at least one woman gynaecologist at these centres, either on regular service or on contract. These centres are upgraded in terms of equipment, medicines, and manpower.

The current study focuses on utilisation of reproductive health services by women. Among various factors that determine this is the availability of health facilities. Therefore it was decided to select a few villages that are covered by an RCWHC. According to state government officials, the RCWHC at Shamirpet has adequate health facilities and it has been identified as one of the best performing centres over the years. For the present study, villages covered under the Shamirpet RCWHC made up the study area.

3.1.1 *Profile of the health centre*

Shamirpet is located at a distance of 20 kilometres from Hyderabad city. It is one of Andhra Pradesh's older PHCs. In 1983-84 this PHC was selected for an upgrade. As part of this upgrade, the centre got a new building. In 1999, under the RCH programme, the Shamirpet PHC was converted into an RCWHC. It is well equipped with both equipment and manpower. It has 30 beds for patients. All the equipment is in good condition. The centre regularly receives medical supplies. It has been chosen for various special programmes, both by the government and by voluntary units. Frequently, students of the Gandhi Medical College visit the centre for training.

The Shamirpet RCWHC covered a population of 96,109 as on April 2003. Nine sub-centres and 30 villages come under this RCWHC. Of the total population, 47 per cent are main workers, three per cent are marginal workers, and 51 per cent are non-workers.

3.1.2 *Selection of the villages*

The villages were selected by random sampling. First, three of the nine sub-centres were selected at random. These were Shamirpet, Devaryamjal, and Aliabad. From each of these sub-centres, one village was selected at random. The selected villages were Shamirpet, Pothaipally, and Turkapally. According to the village administrative boundaries, one hamlet each is attached to Pothaipally and Turkapally. Yelgalguda is the hamlet of Pothaipally and Thanda of Turkapally.

3.1.3 *Selection of couples*

The main objective of the study was to see the influence of gender on reproductive health. Also, literature suggests that traditional gender roles are starting to change. A stratified random sampling

technique was adopted to examine the dynamics of changed gender roles. The unit of the study was couples, i.e. wives, in the reproductive age group (13-49 years).

In the Indian setting, "duration of marriage" is assumed as an important variable in deciding power differences within couples. So, as a first step, all the couples were house listed by duration of marriage in the sampled villages. Subsequently all the couples were categorised on the basis of "duration of marriage" at five-year intervals. Broadly, the couples were classified as: (i) those married less than or equal to five years ago; (ii) those married between 6 and 10 years ago; (iii) those married between 11 and 15 years ago; (iv) those married between 16 and 20 years ago; (v) those married between 21 and 25 years ago; and (vi) those married more than 25 years ago.

In each of these categories 10 per cent of the couples were randomly selected for the study, so that 10 per cent of the total couples in the reproductive age group in all the study villages comprised the sample. The selected number of couples for the study was 223. Table 3.1 gives the particulars.

- **Focus Group Discussions** (FGDs) were carried out at two different stages. The first round was conducted with men and women to understand the "power" relations within the community. The information collected by these discussions not only helped in understanding the gender relations in the study areas but also in the preparation of individual interview schedules. The FGDs also helped in building a rapport with the community. The second round of FGDs was conducted with groups of husbands and wives, separately, on their perceptions of reproductive illness and the need for medical care.

- **Individual interviews** were conducted separately for couples, both husbands and wives, with the help of an interview schedule. This structured tool helped in bringing out information about knowledge, access, and gender roles with respect to reproductive behaviour, health, morbidity, and utilisation of health services by women. Views about the support wives expected and received from their husbands were also collected.

Table 3.1 Number of couples by duration of marriage in each of the villages and the final sampled couples selected for the study.

Village	Number of couples by duration of marriage (Years)						Total couples
	<= 5	6-10	11-15	16-20	21-25	> 25	
Shamirpet	278	275	172	155	139	91	1110
Yelgalguda	12	18	6	6	8	14	64
Pothaipally	65	72	39	29	38	72	315
Turkapally	162	135	125	94	85	77	678
Turkapally Thanda	10	10	5	6	7	1	39
Total couples	527	510	347	290	277	255	2206
Number of selected couples	53	51	35	29	29	26	223

3.2 Tools of data collection

A review of methodologies on male participation has been largely based on qualitative methods of data collection. A few other researchers have used both structured tools as well as in-depth case studies. The present study attempts to collect information using both structured schedules as well as qualitative techniques such as focus group discussions and in-depth interviews.

- From the collected data, a few couples, either one or both partners suffering from reproductive health problems were selected for in-depth interviews.

While designing the tools, care was taken to incorporate appropriate validity checks for editing the information at the field level. Discussions with a programmer helped to modify the schedules suitable

for entry checks. Similarly, discussions with a statistician were held to check whether all the information could be pooled for appropriate analysis.

3.3 Preparatory work prior to main survey

A lot of preparatory work was done prior to actual data collection. First, discussions were held with gynaecologists to enable the researchers to get familiar with various components of reproductive morbidity and health. After the initial FGDs, the information collected helped in the preparation of interview schedules. These schedules were developed in English, translated into Telugu, and translated back into English to check for ambiguity in expression. Subsequently, the questionnaires were pre-tested before finalising and printing.

Meanwhile, permission was sought from the directorate of health and family welfare and the district collector for cooperation at the district level. This helped in obtaining permission from the district medical and health officer to collect relevant information from the selected RCWHC. Subsequently, interaction with village heads and prominent persons in the village took place. This exercise helped in explaining the purpose of the study and facilitated the conduct of FGDs before the main survey.

3.4 Selection and training of field staff

Persons with a graduate or post-graduate degree in social work/sociology/home science were recruited as field investigators. For interviewing both wife and husband, both female and male investigators were recruited. The principal investigator trained the field staff. The training covered several aspects, including an understanding of the scope of the study, the research design, explanation of the questionnaires, and development of rapport and interviewing skills. During training special lectures were held on gender perspectives in health, basic knowledge of the female reproductive organ and its function, components of reproductive health, and morbidity. Mock interviews, role-play, and discussions were organised to improve the investigators' skills. At the end of the training the best performing candidates were selected for the survey.

3.5 Operation of fieldwork

3.5.1 *Participatory approach*

Before starting the data collection, village social maps were prepared with the help of some local people and multipurpose health workers. First, the maps were drawn on a mud floor. Sketches were drawn to identify houses and other landmarks such as water tanks, school, temples, any other religious places, health facilities, and so on. These sketches were done with coloured powders, different types of leaves, pebbles, and blocks of wood. Thereafter a similar map was drawn on paper and the local persons were asked to make corrections, if any. This participatory technique helped the field staff to interact with the local people, which subsequently helped in building a rapport. These social maps helped in the door-to-door field survey.

3.5.2 *Survey method of data collection*

The social maps helped the investigators to have spatial clarity, enabling them to move from one household to another without missing any during the house-listing exercise. Particulars of the couples by duration of marriage were collected from each household. This list formed a pool from which to select the sample. Once the sample was identified, the couple was separately interviewed.

3.5.3 *Qualitative method of data collection*

A few of the investigators were trained in techniques of qualitative methods of data collection. The principal investigator, with the support of these investigators, conducted FGDs. The first round was organised to understand the "power" relations between men and women within the community and the existing gender preferences. This information helped in designing the interview schedules.

The second round of FGDs was organised for wives and husbands separately to understand their knowledge, attitudes, and obstacles in seeking health services. Gender dimensions and constraints hindering the utilisation of health services were focused upon. Suggestions from the couples' point of view to improve their reproductive health were noted.

In addition to the FGDs, 25 in-depth interviews of a few selected couples were conducted.

The selection of these couples was based on information collected through the interview schedules. Couples among whom one or both partners were suffering from any reproductive morbidity were selected at random for these interviews.

3.5.4 *Quality checks of the data*

During the survey the field editors simultaneously edited the questionnaires. Care was taken regarding validation, mistakes, and missing information. All the filled questionnaires were again edited at the office and open-ended questions were coded before entry. The data was then scrutinised and validated before analysis.

3.5.5 *Coverage of women*

All the 223 women identified for the survey were interviewed. None of them refused to give information. A few women did refuse initially, but repeated assurances of the confidentiality of the information and the interest shown by the investigators in clarifying their doubts resulted in complete coverage.

3.5.6 *Ethical concerns*

Before proceeding with the survey the interviewers obtained the informed consent of all respondents. Since a majority of them were either illiterate or had low literacy levels, their written consent was difficult to obtain. Therefore, oral consent was considered adequate. The field team assured them about the confidentiality of their responses and promised that the information would be used only for research. Care was also taken to see that no other person was present during the interview.

Despite all efforts, if the respondents' privacy was at stake, the interviewers were instructed to shift from sensitive to general topics. The interviewers returned to sensitive topics only after re-establishing privacy. Especially when young women were being interviewed, if the mother-in-law or any other elder of the family came and sat with them, the interviewer tried to explain to them the purpose of the study and to see that they left.

Since the study was based on the personal information, a refusal to answer midway through the interview was anticipated even if the respondent had initially agreed. One woman investigator had this experience when the respondent became unwilling to give further information after realising that she was unmarried, and questioned her competence to collect information on reproductive behaviour. It was explained to the respondent that the training obtained by the investigator was adequate for her to discuss reproductive issues.

Barring this incident, there was no other vociferous refusal. The interview took more than an hour and, in a few cases, required repeated sittings at the respondent's request. No money was paid to the respondents, as the form of data collection did not disturb their daily economic activity. The ethical committee for the project approved the study.

Chapter 4
Profile of the couples and the study area

As mentioned, three villages, Shamirpet, Pothaipally, and Turkapally, were selected for the study. Yeligalguda and Turkapally Thanda are hamlets attached to Pothaipally and Turkapally, respectively.

4.1 An overview of the villages

4.1.1 *Transport*

All the villages are well connected by road and have both public and private transport facilities. Transport is available at a frequency of 10 to 15 minutes from each of the villages. All the villages are located at a distance of 20-35 kilometres from Hyderabad, the capital city of Andhra Pradesh.

4.1.2 *Availability of health facilities*

Pothaipally, Yeligalguda, and Turkapally Thanda have no health care providers in the village. Shamirpet has a primary health centre and a few private clinics. Turkapally has a sub-centre and one private clinic. A few unqualified rural medical practitioners residing in Shamirpet and Turkapally are the other health care providers.

4.1.3 *Basic household amenities*

All the villages have piped drinking water supply. But most of the residents have to get water from a public tap. Eighty per cent of the households get water from a distance of 100 metres, 14 per cent have to go to a distance of nearly 200 metres, and six per cent have to go beyond 200 metres. More than half the households (51.4 per cent) do not have toilet facilities. Forty-six per cent have a toilet facility. The rest use a shared facility. A village-wise analysis shows that all the houses in Turkapally Thanda and 83 per cent of the households in Yeligalguda have no toilets. Almost all the households use electricity for lighting at night.

4.2 Socio-economic characteristics of the couples

4.2.1 *Education*

There were differences in the educational levels of wives and husbands in the villages studied. More than half of the wives (57 per cent) were non-literate whereas the corresponding percentage among husbands was 28.7 (Table 4.1). Fifteen per cent of the wives were educated up to the primary and 28 per cent beyond the primary level. Among husbands, 26 per cent had studied up to the primary and 45 per cent beyond the primary level.

4.2.2 *Religion and caste/tribe*

A majority of the couples in the study were Hindu (91 per cent), six per cent were Muslim, and a small section (2.7 per cent) was Christian. Almost two-thirds of the couples were from backward castes (62.8 per cent). Nearly a fifth were from the scheduled castes and 3.6 per cent from the scheduled tribes. Twelve per cent belonged to the forward castes.

4.2.3 *Type of family*

Nearly three-fourths of the total families were nuclear (72.6 per cent), i.e. they consisted of a husband, a wife, and their unmarried children. The remainder were extended or joint families.

4.2.4 *Work status*

More than half of the wives worked outside the home for daily wages (58.7 per cent) as agricultural labourers, skilled workers, or in petty businesses. All men were engaged in income-generating activities. A majority were occupied in agricultural activities (58.7 per cent). Of these, 15 per cent cultivated their own land, while the rest worked as landless labour. Of the other men, 17.5 per cent were engaged in skilled work, 16.6 per cent in clerical jobs, and 11.2 per cent in business.

Table 4.1 Socio-economic characteristics of the couples

Socio-economic Characteristics	Percentage of Couples			
	Shamirpet	Pothaipally	Turkapally	Total
Wife's education				
Non-literate	53.6	55.3	63.0	57.0
Up to primary	17.0	7.9	15.1	14.8
Above primary	29.5	36.8	21.9	28.3
Husband's education				
Non-literate	26.8	18.4	37.0	28.7
Up to primary	24.1	31.6	27.4	26.5
Above primary	49.1	50.0	35.6	44.8
Religion				
Hindu	90.2	97.4	89.0	91.0
Muslim	5.4	0.0	11.0	6.3
Christian	4.5	2.6	0.0	2.7
Caste/Tribe				
Scheduled caste	16.1	47.4	15.1	21.1
Scheduled tribe	3.6	0.0	5.5	3.6
Backward caste	70.5	44.7	60.3	62.8
Others	9.8	7.9	19.2	12.6
Type of family				
Nuclear	74.1	73.7	69.9	72.6
Non-nuclear	25.9	26.3	30.1	27.4
Wife's work status				
Household Work	48.2	34.2	34.2	41.3
Working for wages	51.8	65.8	65.8	58.7
Husband's work status				
Agricultural	55.4	55.2	52.0	54.3
Non-agricultural	44.6	44.8	48.0	45.7
Total	**50.2**	**17.0**	**32.7**	**100.0**
(number)	**(112)**	**(38)**	**(73)**	**(223)**

4.3 Demographic characteristics of the couples

4.3.1 *Age distribution*

Sixty per cent of the women were below 25 years of age; the corresponding percentage for the men was 31. Seventeen per cent of the women and 22 per cent of the men were in the age group of 26-30 years. Nine per cent of the women and 20 per cent of the men were above 40 years of age. (See Table 1 in Annexure 2)

4.3.2 *Marriage particulars*

The median age at marriage as well as cohabitation for women in all the villages was 16 years. Distribution of couples by duration of marriage shows that 23 per cent were married for less than two years ago, 21 per cent were married three to five years ago, and 16 per cent were married 21 years ago.

4.3.3 *Parity*

One-fifth of the couples were childless at the time of the survey and another one-fifth had a single child. Twenty-two per cent had four or more children.

Chapter 5

Exposure and access to reproductive health services

Adequate utilisation of health services is attributed to a multiplicity of factors such as availability, access, quality of care, social structure, and health-related beliefs. Many of these factors are intertwined with awareness and gender inequality. This chapter looks at the couples' awareness levels from a gender perspective. Awareness levels were examined in terms of exposure to messages relating to reproductive health such as family planning, pregnancy care, delivery care, postpartum care, AIDS, and other reproductive health problems. The couples were asked separately whether they recalled hearing or seeing any of the messages in a month prior to the survey, and, if so, the type and source of message. In addition to exposure to availability of health services, their information on access to these services was also collected.

5.1 Exposure to various messages related to reproductive health

Differences existed in the couples' exposure to messages on reproductive health (Table 5.1). Comparatively more men (75.3 per cent) than women (59.6 per cent) recalled hearing or seeing at least one message over the period in question. Though more than half of the women and men were exposed individually to messages on reproductive health, when taken as couples, only in 35.4 per cent of cases were both exposed to at least one message. Among 13 per cent of couples, neither partner was exposed to any message related to reproductive health. More women were exposed to messages related to obstetric and gynaecological health than men. Men were more exposed to messages on family planning and AIDS.

5.1.1 *Family planning*

Only 13.5 per cent of women were exposed to any message related to family planning. Relatively more men (23.3 per cent) were exposed. Among the women who were exposed, 33 per cent were exposed to a message about how to stop having more children, 27 per cent were exposed to a message on how to space their children, 23 per cent were exposed to a message about postponement of first birth, and the rest to a message about how many children a couple should have. Among men 81 per cent were exposed to a message on how many children to have, and the rest to a message about how to stop having children.

The educational level of a woman and the type of family in which she lived showed a significant association to exposure to messages related to family planning; i.e. a relatively higher percentage of literate women from nuclear families were exposed to messages on family planning (Table 2 in Annexure 2). Unlike women, men's exposure was significantly associated with their socio-economic and demographic characteristics. Table 3 in Annexure 2

Table 5.1 Couples exposed to messages related to reproductive health

Messages relating to reproductive health	Percentage of couples exposed to media			
	Women	Men	Both	Neither
Family planning	13.5	23.3	4.0	67.3
Pregnancy care	31.8	18.4	13.0	62.8
Delivery care	17.0	10.3	4.5	77.1
After childbirth	36.8	16.1	9.9	57.0
AIDS	25.6	71.7	20.6	23.3
Other reproductivehealth problems	9.4	4.0	0.4	87.0
At least one of the components	**59.6**	**75.3**	**35.4**	**13.0**

shows that younger, literate men working in non-agricultural activities, belonging to the forward castes, living in non-nuclear families, who are recently married with low parity were more exposed to messages on family planning.

5.1.2 *Pregnancy care*

Nearly one-third of women and barely one-fifth of men were exposed to messages related to pregnancy care. Health care to be taken by a mother during pregnancy was the main message to which 63 per cent of the women were exposed, whereas 46 per cent of men had been exposed to messages about the health of the foetus. Exposure to pregnancy care was observed more among women who were less than 25 years of age, were in younger marriages, were educated above the primary level, and had low parity. Fewer men were exposed to pregnancy care.

There was a clear association of the couple's socio-economic and demographic status with exposure to pregnancy care. If the couple was literate, young, and recently married with fewer children, they were more exposed to messages related to pregnancy care. Relatively more men working in non-agricultural activities and women not engaged in income-generating activities were exposed to these messages.

5.1.3 *Delivery care*

Only 17 per cent of the women and 10 per cent of the men were exposed to information relating to delivery care. Of these women, one-fourth had heard or seen a message about the need for institutional delivery; the corresponding figure among men was 41 per cent.

Women's socio-economic characteristics did not show any association with exposure to delivery care. Such an association was clear among men. Literate, younger, recently married men with fewer children were more exposed to messages related to delivery care.

5.1.4 *Postpartum care*

Messages related to postpartum care drew the attention of women. However 65 percent of these women were actually exposed to messages on child's vaccination. Only 15 per cent of women were exposed to messages on postpartum care. Similarly more men were exposed to messages related to vaccination of children.

A significant association was observed between exposure to messages relating to health care after childbirth and the couple's age, education, duration of marriage, and parity. It was clear that younger couples with fewer years of marriage and low parity were more likely to have been exposed to the messages because of current reproductive experiences. In addition, more literate couples were exposed to the messages than non-literates. Comparatively, women from forward castes and men working in non-agricultural occupations were also more exposed to these messages.

5.1.5 *AIDS*

Government and non-governmental organisations have been working to bring awareness about AIDS and these efforts have been successful with men. Among all types of messages on reproductive health, more men (71.7 per cent) were exposed to messages related to AIDS. Only 25.6 per cent women were exposed to these messages. Literate women from forward castes were more exposed to AIDS messages than the others. Younger, recently married men with fewer children, who were literate and engaged in non-agricultural activities, were more exposed to messages related to AIDS.

A majority of the couples (90 per cent) were exposed to messages related to the prevention of AIDS, but few (less than 5 per cent) were exposed to messages about its spread.

5.1.6 *Other reproductive health problems*

Very few women and men were exposed to messages related to reproductive health problems other than family planning, obstetric care, and AIDS. A significant association was observed between high parity women and exposure to messages related to gynaecological health. Only four per cent of men reported exposure to messages about other reproductive health problems. Younger men, working in non-agricultural activities, and recently married with no children had this exposure.

5.2 Types of exposure

The media of exposure for women and men in the study areas were different. Women were more exposed through interpersonal communication while more men were exposed through the mass media. Fewer women than men were exposed to multiple sources. Media of exposure among women also differed with the type of message. More than 80 per cent of the exposed women had heard about issues related to pregnancy and childbirth or other reproductive health problems through interpersonal communication. The mass media were the main source for a majority of women for messages on family planning and AIDS (66 per cent and 94 per cent, respectively). In other words, women found it convenient to talks, in interpersonal communication, about issues that are socially acceptable in conversation.

Despite decades of efforts, it is still not commonly acceptable for women to initiate or participate in a conversation about family planning. Conversing about AIDS is further disapproved of in the community, especially for women. Thus women largely rely on the mass media as the major source of information.

Though the mass media were the chief source of information for all types of messages for men, more than half were also exposed to these subjects through interpersonal communication and group meetings. The men had fewer inhibitions to talk about these issues. Amongst the topics, men were less interested in messages related to pregnancy and childcare as many felt these were areas confined to women.

5.3 Access to reproductive health services

The reproductive health of women is affected by social, psychic, and economic costs of care. Access to services can be assessed in two ways, cognitive and physical. Cognitive access refers to a couple's awareness about the availability of services. Physical accessibility refers to the distance covered and time taken to reach a facility.

Reproductive health services are broadly categorised as services related to temporary methods of contraception, medical termination of pregnancy, permanent sterilisation, pregnancy care, delivery care, postpartum care, gynaecological health problems, sexually transmitted diseases, and AIDS.

5.3.1 *Cognitive access*

The cognitive levels of men and women on components of health care are controlled culturally. More women than men respondents reported better knowledge of obstetric and gynaecological health care. More men reported better knowledge of services related to family planning, STDs, and AIDS. Table 5.2 shows the levels of cognitive knowledge about access to various components of reproductive health care.

Every woman was aware of the availability of pregnancy and delivery care. Almost every woman also knew of facilities for postpartum care and other gynaecological health problems. Ninety one per cent of women knew about availability of sterilisation facilities. On the contrary, only 19 per cent of women were aware of the availability of temporary methods of contraception. Services related to medical termination of pregnancy were known to 36 per cent

Table 5.2 Cognitive knowledge of couples about access to various reproductive health services

Reproductive health services	Percentage of couples with knowledge			
	Women	Men	Both	Neither
Temporary contraceptives	18.8	64.6	12.1	28.7
Medical termination of pregnancy	35.9	55.6	23.3	31.8
Sterilisation	91.0	95.5	87.9	1.3
Pregnancy care	100.0	73.9	74.0	0.0
Delivery care	100.0	77.1	77.1	0.0
Postpartum care	99.1	58.7	57.8	0.0
Other health problems of women	96.9	51.6	49.8	1.3
STDs	28.3	50.2	15.7	37.2
AIDS	12.6	36.3	4.5	55.6
Total	**223**			

of women. Only 28 per cent of women were aware of STDs. Very few women knew about the availability of health care facilities for AIDS.

A majority (96 per cent) of men were aware of sterilisation facilities. Nearly three-fourths of the men knew about pregnancy and delivery care facilities. Two-thirds had cognitive knowledge of temporary methods of contraception. Though more men than women knew about STDs and AIDS, the knowledge was restricted to one out of every two men.

Apart from understanding individual cognitive levels, it is useful to view the couple as a unit. If both partners are aware, the situation is the better than one in which neither partner has any knowledge. The cognitive level of both partners was high about access to services such as sterilisation and obstetric care; but more than half the couples were ignorant of services related to AIDS. Nearly a third were ignorant of access to services pertaining to STDs, medical termination of pregnancy, and temporary methods of contraception.

5.3.2 *Physical access*

Cognitive levels of access to various components of reproductive health were similar to the levels for physical access for both women and men. That is, the couple that was aware of the existence of health facilities for various components of reproductive health was also certain of their location (Table 5.3). All the women who professed awareness about physical access named the round-the-clock women's health centre at Shamirpet as the main source for reproductive health services.

But while three-fourths of them knew that sterilisation and obstetric health services were available at the RCWHC, less than a tenth knew it was a source for temporary contraceptives and AIDS prevention. Only one-fifth knew that services related to medical termination of pregnancy and STDs were available at the RCWHC. The next most recognised health facility was the private clinic/hospital.

Unlike women, men did not refer to the RCWHC as the main reproductive health facility. A considerable percentage recognised private clinics/ hospitals as such. For temporary methods, men relied equally on medical shops. They mentioned *aanganwadi* workers as a source of supply for temporary methods of contraception. None of the women ever mentioned them, despite the probability of more women interacting with the workers.

5.4 Synopsis of findings and gender inferences

In the study area, although more than half the women and men were exposed as individuals to at least one message on reproductive health, only a third of the couples (35.3 per cent) were exposed to such a message. The topic and content of the message to which they were exposed was largely controlled by gender norms. More wives were exposed to messages on obstetric health, while husbands were more exposed to information on AIDS. Wives largely received messages through interpersonal communication, whereas husbands received them through the media. Despite the huge expenditure on AIDS awareness, the spread of messages was not uniform for both sexes in a community.

Focus group discussions amongst women and men revealed that wives were more comfortable discussing obstetric care, but not contraception, AIDS, or gynaecological health. If they tried to learn about these, they ran the risk of being seen as "uncultured" or "lacking in modesty." They found it convenient to rely on the media for this information.

Most of the women were exposed to the mass media, especially television, but they were not exposed to reproductive health information because they preferred to watch channels that did not carry these messages. A few women mentioned having seen billboards or posters with information on AIDS, but they felt embarrassed to stand and read the complete message. Husbands got exposed more through the media and were more interested in subjects like AIDS. A majority were not interested in obstetric health because they felt it did not concern them.

Gender differences were also reported on knowledge about cognitive as well as physical access to various reproductive health services. Every woman was aware of the availability of obstetric care, gynaecological health care, and the availability of sterilisation facilities. On the contrary, few women were aware of the availability of temporary methods of contraception and medical termination of pregnancy, or about STDs. Ninety six per cent of husbands were aware of sterilisation facilities. Nearly three-fourths knew about obstetric care. Although information about temporary methods of contraception, STDs, and AIDS was available to more husbands than wives, only half of the husbands were aware of them.

Table 5.3 Knowledge of couples about physical access to reproductive health services

Reproductive health services	Percentage of couples with knowledge	
	Women	Men
Temporary methods of contraception	**18.8**	**64.6**
• PHC/Sub-centre/MPHAs	10.3	22.4
• Private clinic/Hospital	2.7	14.3
• Medical shops/Depot holder	5.8	23.3
• Aanganwadi workers	—	4.5
Medical termination of pregnancy	**35.9**	**55.6**
• PHC/MPHAs/Sub-centre	20.2	30.0
• Private Clinic/Hospital/Voluntary agency	14.8	24.2
• Government Medical College Hospital	—	1.3
• Medical shops	0.9	—
Sterilisation	**91.0**	**95.5**
• PHC/Sub-centre/MPHAs	71.3	68.2
• Private clinic/Hospital/Voluntary Agency	17.9	25.6
• Government Medical College Hospital	1.8	1.8
Pregnancy care	**100.0**	**73.5**
• PHC/Sub-centre/MPHAs	73.1	47.5
• Private clinic/Hospital/Voluntary agency	25.6	24.2
• Government Medical College Hospital	1.3	1.3
• Aanganwadi workers	—	0.4
Delivery care	**100.0**	**77.1**
• PHC/Sub-centre/MPHAs	72.6	51.1
• Private hospital/Voluntary Agency	24.7	23.3
• Government Medical College Hospital	1.3	1.8
• TBAs (*dai*)	1.3	0.9
Postpartum care	**99.1**	**58.7**
• PHC/Sub-centre/MPHAs	73.5	34.5
• Private clinic/Hospital/Voluntary agency	23.8	22.4
• Government Medical College Hospital	1.3	1.8
• TBAs (*dai*)	0.4	—
Gynaecological health problems	**96.9**	**51.6**
• PHC/Sub-centre/MPHAs	66.4	25.6
• Private hospital/Voluntary Agency	30.0	24.7
• Government Medical College Hospital	0.4	1.3
STDs	**28.3**	**50.2**
• PHC/Sub-centre/MPHAs	22.9	25.6
• Private clinic/Hospital/Voluntary agency	4.9	23.3
• Government Medical College Hospital	0.4	1.3
AIDS	**12.6**	**36.3**
• PHC	10.8	22.0
• Private clinic/Hospital	1.3	13.9
• Government Medical College Hospital	0.4	0.4
Total number of couples	**223**	

Chapter 6
Contraceptive health

The contraceptive behaviour of a couple has a direct bearing on the reproductive health of the woman. Contraceptive behaviour depends on various factors such as the cognitive levels of the couple about pregnancy and planning the family. This section discusses the perspectives of couples towards family planning. Apart from individual planning, combined planning of a couple is likely to bear directly on their reproductive health and can be viewed as men's constructive participation. This section also examines the role of the husband in terms of spousal communication on reproductive health and contraception.

6.1 Psychological perspectives of couples on family planning

A look at individual cognitive levels on family planning is essential to understand a couple's reproductive behaviour. This also helps to recognise the extent of gender differences towards reproductive control. In the present study, the psychological perspectives of couples are analysed from three broad points of view. First, the couples' perspectives on locus of control over pregnancy; second, their self-efficiency related to the usage of contraception; lastly, their perception related to pregnancy avoidance.

6.1.1 *Locus of control over pregnancy*

Table 6.1 gives details of the couples by locus of control over pregnancy. The couples were asked whether they agreed with various traits of control over pregnancy. The responses were analysed on a scale of four: strongly agree, agree, disagree, and strongly disagree. The responses indicated that nearly nine out of ten women and three out of four men agreed that if one of the couple does not desire it, they could not have sex. Though the statement actually refers to both partners, both men and women seemed to have associated it with the husband. That is, they believed that if the husband does not desire it, a wife cannot have sex.

A majority of women (95 per cent) and men (90 per cent) agreed that most often it is not possible to prevent a pregnancy. If a woman is meant to be pregnant, she will be pregnant. In other words, most of the couples felt that a woman's body is destined to become pregnant and so prevention of pregnancy is not in one's control. Nearly all the couples agreed that a woman is synonymous with pregnancy.

While acknowledging the association between woman and pregnancy, all the women also agreed that a couple could limit the number of children they want. One-fourth of the men disagreed. At the same time nine out of ten women thought luck plays a big part in determining whether a woman can avoid getting pregnant. Comparatively fewer men thought that luck plays a role. Despite their reliance on luck, women also accepted the role of individual behaviour. Nine out of ten women agreed that if a couple were careful, an unwanted pregnancy would rarely occur. Eight out of ten men agreed.

Table 6.1 Percentage of couples by locus of control over pregnancy

Aspects related to locus of control over pregnancy	Women	Men
If one of the couple does not desire, they cannot have sex		
o Strongly agree	48.4	35.9
o Agree	39.9	47.1
o Disagree	7.6	15.7
o Strongly disagree	4.0	1.3
Most often it is not possible to prevent a pregnancy. If a woman is meant to be pregnant, she will be pregnant		
o Strongly agree	21.5	17.9
o Agree	72.2	73.1
o Disagree	5.8	9.0
o Strongly disagree	0.4	0.0
A couple can limit the number of children they have		
o Strongly agree	73.1	48.9
o Agree	21.1	27.4
o Disagree	5.4	23.3
o Strongly disagree	0.4	0.0
Luck plays a big part in determining whether a woman can avoid getting pregnant		
o Strongly agree	49.3	24.7
o Agree	30.5	34.1
o Disagree	17.5	38.1
o Strongly disagree	2.7	3.1
If a couple is careful, an unwanted pregnancy will rarely happen		
o Strongly agree	62.3	18.8
o Agree	31.4	58.3
o Disagree	5.4	21.1
o Strongly disagree	0.9	1.8
Total number of couples	**223**	

These figures show that the women had contradictory opinions on the subject. But the figures also indicate that a majority of the women believed in having control over pregnancy, provided they had control over their bodies. The reactions of men on control over pregnancy were not so varied, probably because they assumed that a woman's body is in their control.

Table 6.2 Percentage of couples by self-efficiency related to use of contraception

Aspects of self-efficiency on use of contraception	Women	Men
Capable of obtaining a method of family planning		
o Strongly agree	2.9	42.7
o Agree	16.5	52.4
o Disagree	35.0	3.9
o Strongly disagree	45.6	1.0
Difficulty in always remembering to use contraception		
o Strongly agree	40.8	23.3
o Agree	47.6	65.0
o Disagree	10.7	11.7
o Strongly disagree	1.0	0.0
Can refrain from sexual activity in absence of contraception		
o Strongly agree	1.9	3.9
o Agree	19.4	40.8
o Disagree	63.1	52.4
o Strongly disagree	15.5	2.9
Capable of using contraceptive method every time		
o Strongly agree	3.9	23.3
o Agree	18.4	53.4
o Disagree	39.8	22.3
o Strongly disagree	37.9	1.0
Negotiating use of family planning method impossible		
o Strongly agree	2.9	1.9
o Agree	39.8	35.0
o Disagree	31.1	48.5
o Strongly disagree	26.2	14.6
Can persuade husband to avoid extramarital sexual contacts		
o Strongly agree	21.1	9.9
o Agree	61.4	61.4
o Disagree	17.0	25.6
o Strongly disagree	0.4	3.1
Capable of seeking treatment for reproductive health problems		
o Strongly agree	39.0	13.0
o Agree	55.6	83.4
o Disagree	4.9	3.6
o Strongly disagree	0.4	0.0
Total number of couples	**103 (46.2)**	

6.1.2 *Self-efficiency related to usage of contraception*

Cognitive levels on self-efficiency in usage of contraception not only elicit individual capabilities but also reflect the gender differentials in a community. Self-efficiency was addressed only to couples not using any method of contraception (Table 6.2). The responses were categorised in a manner similar to the responses for locus of control over pregnancy.

Perceptions related to capability to obtain a method of family planning indicate that more than 80 per cent of women were unaware that they had this capacity. But among men 95 per cent felt they had the capacity. One of the reasons for not favouring a temporary method of contraception was

reflected in the fact that nearly 90 per cent of both men and women admitted it was difficult to remember to use contraception to avoid pregnancy.

Although the opinion of couples was similar with respect to memory, it differed in terms of coital behaviour. Faced with the statement, "If I cannot get contraception, I can still keep myself from contributing to pregnancy by refraining from sexual activity," there was a vast difference of opinion between women and men. Nearly 80 per cent of women said they could not refrain from sexual activity. In other words, women had no control over their bodies. Nearly half the men, however, felt that they could refrain from sexual activity.

Similarly, perceptions of women and men differed about their capability to use a contraceptive method every time they wanted to use it. Nearly 80 per cent of women disagreed with the statement, that is, they felt they did not have the capability, whereas 77 per cent of men said they have the capability to use contraception as and when they desired.

More than half the women (57 per cent) disagreed with the statement that "Negotiating with the spouse about the use of a method of family planning would be impossible for me." In other words, 57 per cent of the women felt they could negotiate with their husbands. Slightly more men (63 per cent) felt they could negotiate with their wives.

One way to maintain better reproductive health is to have a single sexual partner and impress upon one's spouse to do likewise. This also reflects the level of confidence in the other. Although 82 per cent of the women said, "I am capable of persuading my husband from extramarital sexual contacts," fewer men (61 per cent) felt that they could restrain themselves from such contacts. More encouragingly, nearly 95 per cent of couples as a unit said they were capable of seeking treatment if they had any reproductive health problems.

The findings suggest that women had low self-efficiency in the use of contraception. This was an outcome of restricted information, poor cognitive access to contraception, and little say in matters related to sexual activity. In contrast, women seemed to have confidence in negotiating with their husbands for usage of a family planning method. They were probably indicating terminal methods. In a society where, by and large, the small family norm has been accepted, negotiating with husbands in favour of terminal methods, especially tubectomy, was probably not felt to be difficult. But it was difficult to negotiate the use of temporary contraceptive because of unequal power relations in the family. Unlike women, more men were self-efficient to obtain and use a method they desired.

The self-efficiency of women in negotiating with their husbands against extramarital sexual relations needs to be understood with caution. Did the women really have the capability or were they assuming they did?

6.1.3 *The value of avoiding pregnancy*

Table 6.3 gives the couples' perceptions on the value of avoiding pregnancy. The couples were asked how they valued each of the statements related to avoidance, that is, whether and how much they felt it was important. The responses were categorised as unimportant, mildly important, moderately important, and very important. This opinion was sought only from those women who had not adopted a permanent method of contraception.

Couples who were uncertain about a future need for children were asked to react to the statement, "How important is it to you to have no more children?" Almost every woman said it was very important. But the men differed. Fifty per cent agreed with the women, 33 per cent agreed moderately, while 11 per cent felt it was unimportant. That is, these men felt that it was necessary to have more children.

Though all the women said that it was very important for them not to have more children, not all could agree with the statement, "Because I do not want to have more children, I make sure that I am protected from getting pregnant." The men's opinion was, by and large, in coherence with their answer to the previous question. This in turn reflected upon the capability of the women to have a say in future pregnancies. Despite their unwillingness, they were not certain about acting in accordance with their will.

Couples intending to have more children were asked, "How important is it to delay the birth of your next child?" and, "Because I want to delay having more children, I make sure that I am protected from getting pregnant." Eighty-seven per cent of the

women felt it was very important for them to delay the birth of their next child, yet all women could not protect themselves from getting pregnant. This indicates that not all women were capable of either obtaining contraception or persuading their husbands to postpone pregnancy.

6.2 Communication between husband and wife

An understanding between the husband and wife is necessary to avoid untimely and unnecessary pregnancies, which may result in deterioration of the woman's health in general and reproductive health in particular. Table 6.4 gives details about spousal communication. The table draws attention to two points. Nearly six out of ten couples had ever discussed issues related to fertility. Secondly, there were differences in reporting between women and men. These differences varied by topic. More women than men said they had a discussion related to the number of children the couple wanted; on whether to use a contraceptive method; the type of method to be used; and who should use it. Relatively more men said they had discussions on spacing and postponing children.

Table 6.3 Percentage of couples by value of avoiding pregnancy

Aspects related to value of avoiding pregnancy	Women	Men
Extent of importance to self to have no more children		
o Unimportant	0.0	11.1
o Mildly important	0.0	0.0
o Moderately important	0.0	33.3
o Very important	100.0	55.6
Because I do not want more children, I make sure I am protected against getting pregnant		
o Unimportant	0.0	11.1
o Mildly important	12.5	0.0
o Moderately important	0.0	44.4
o Very important	87.5	44.4
Total number of couples who answered	8	
Total number of couples who answered Extent of importance to delay the birth of next child		
o Unimportant	0.0	66.3
o Mildly important	12.5	12.9
o Moderately important	0.0	7.9
o Very important	87.5	12.9
Because I want to delay having more children, I make sure I am protected against getting pregnant		
o Unimportant	75.5	63.4
o Mildly important	11.8	15.8
o Moderately important	6.9	8.9
o Very important	5.9	11.9
Total number of couples	**101 (45.3)**	

Table 6.4 Details of spousal communication about fertility and contraception

Various aspects	Percentage of wives	Percentage of husbands	Disagreement between couples
Total number of children required	47.5	37.7	9.8
Discussed prior to first pregnancy	22.9	21.1	1.8
Postpone children	2.7	4.0	1.3
Space between children	3.6	10.3	6.7
Whether to use a contraceptive method	46.2	22.9	23.3
Type of method	47.1	38.1	9
Who should use contraception	45.3	36.8	8.5
Availability of contraceptive method	38.1	35.4	2.7
Health problems as a result of contraceptive usage	17.9	10.8	7.1
Consulting a medical person before using a method	8.1	8.5	0.4
Couples who ever discussed these issues	**57.8(129)**	**55.6(124)**	**2.2(5)**

Differences in reporting were greater about whether to use a contraceptive method. An analysis of the in-depth interviews indicates that on many occasions the women assumed that they had discussed the matter with their husbands whereas the men did not feel the same. Actually in many situations, the men's silence was taken as agreement. No couple ever discussed postponement of pregnancy or spacing between children. All this in turn reveals that couples who ever initiated a discussion talked more about usage of terminal rather than temporary methods. These were couples that had already attained the desired family size.

Further analysis of the couples who ever had a discussion indicates that educated couples from forward castes, nuclear families, and with fewer children showed a significant association (Table 4 in Annexure 2). Non-working younger women could participate in communication. For men, duration of marriage showed an association with communication.

6.3 Current use of contraception

A little more than half of the couples (53.5 per cent) were using contraception at the time of the survey (Table 6.5). A majority had adopted permanent methods, with 92.4 per cent using female sterilisation and 0.8 per cent (one person) using male sterilisation. Only a few couples (6.8 per cent) used temporary methods of contraception, and reporting between the partners differed. More men reported use of condoms and periodic abstinence than women. Couples who were using temporary methods were married for less than five years; were living as nuclear families; were educated (the husbands had studied above high-school and the wives had studied above primary-school); and had one or no children.

The median age at sterilisation for women in the villages was 21 years. Table 5 in Annexure 2 gives details of the couples who opted for permanent sterilisation. Nearly six out of ten were illiterate. Relatively more working women preferred sterilisation than non-working women. A relatively higher percentage of couples living in nuclear families and those who had communication with their spouse adopted sterilisation.

6.3.1 *Situations leading to use of contraception*

The motivations of couples to use a method of contraception differed. Nearly half of the men were self-motivated. Comparatively fewer women (30 per cent) were self-motivated. In other words, women depended more on others for use of contraception. This was more so if they had to use temporary methods. Only a third of the couples as a unit were motivated to use a method of contraception. Once motivated, however, there was an improvement in women making their own decisions (41 per cent). Thus, individually or in consultation with their husband, 71 per cent of women could decide to use a contraceptive method. The corresponding percentage for men was 79.

Table 6.5 Current use of contraceptives as reported by couples

Type of contraceptive method	Percentage according to:	
	Wives	Husbands
Type of method		
Permanent method		
- Female sterilisation	94.0	92.4
- Male sterilisation	0.9	0.8
Modern temporary method		
- IUD	1.7	1.7
- Oral pills	0.9	0.8
- Condoms	1.7	2.5
Traditional method		
- Periodic abstinence	0.9	1.7
Total number of users	**52.5 (117)**	**53.5 (119)**

Couples opted for a contraceptive method mainly to stop further pregnancies. Thus 97 per cent of the total users of contraception adopted sterilisation. One woman in the villages studied opted for a hysterectomy due to problems of prolonged menstruation. Three men said their wives had opted for a tubectomy to postpone pregnancy or to space pregnancies. This suggests a lack of adequate knowledge about contraceptive methods.

6.4 Contraceptive morbidity and utilisation of health services

Of the women who had used some method of contraception, 16.7 per cent reported some illness after its use. All of these women used the terminal method, tubectomy. The reasons for the women suffering from contraceptive morbidity were analysed to understand the non-medical factors determining the morbidity.

The findings of the logistic regression analysis (Table 6.6) reveal that "marriage between non-relatives," "husband and wife communication," "type of family," "caste," and "having a health centre in the village," were significant determinants of a woman's chances of contraceptive morbidity. In other words, if a woman was not related to her husband prior to marriage she was more likely (0.331) to suffer from contraceptive morbidity than a woman who was related to her husband before marriage. If she was living in a joint family, she was more likely (0.111) to suffer morbidity than a woman living in a nuclear family. A working woman was more likely (4.0756) to be affected than a non-working woman. Women from scheduled castes or

Table 6.6 Logistic regression analysis of contraceptive morbidity

Dependent variables	Contraceptive morbidity		
	B	S.E.	Exp (B)
Women's age	.221	.546	1.248
Women's education	-.447	.630	.639
Women's work status **	1.559	.744	4.756
Men's age	-.039	.720	.962
Men's education	.473	448	1.605
Men's work status	-1.511	818	.221
Type of family **	1.511	.948	4.529
Duration of marriage	.404	.856	1.497
Parity	-.038	.594	.963
Husband-wife communication *	1.303	.719	3.681
Consanguineous marriage **	-1.106	.664	.331
Caste **	1.319	.861	3.739
Having property	.042	.709	1.043
Availability of health centre **	1.203	.720	3.329

* Indicates significance at .01 per cent level.**Indicates significance at 0.1 per cent level

tribes were more susceptible (3.739). Communication with the husband (0.070) showed a positive association with contraceptive morbidity, as did a health centre in the village (0.095).

These findings lead to the inferences that women living in joint families or married to non-relatives were likely to feel hesitant or not be in a position to express the need for rest after a tubectomy. This was more likely in deprived communities where working outside the home did not empower the woman but was a requirement, even at the cost of her health. The relationship between husband-wife communication and the presence of morbidity probably indicates that the morbidity drove the couple to communicate. Similarly, having a health centre in the village might have encouraged the woman to acknowledge the problem.

Three out of every four women who suffered from contraceptive morbidity sought treatment. A review of those who did not seek treatment indicated that most were from non-nuclear families, either younger women or those reaching menopause, from deprived communities (the scheduled castes/tribes or backward castes), and who had never discussed their problem with their husbands. A higher percentage of working women did not seek treatment as compared to non-working women.

This suggests that younger women living in non-nuclear families probably felt hesitant to seek treatment, because they had to take the permission of the head of the household. Women from deprived classes and those working for wages did not want to forgo their wages for the day. A few women were not in a position to spend money to seek treatment in the face of other immediate needs. Two out of three women who did seek treatment preferred private clinics or hospitals to public health facilities like the RCWHC.

6.5 Future reproductive planning

Nearly half of the women (50.2 per cent) in the villages studied had not adopted a permanent method of contraception. A majority of these women wanted to have more children. But after achieving the desired number, 89 per cent were interested in using a method of contraception. Half of the women preferred tubectomy, because they wanted to stop further pregnancies. Of the rest, though a few did not want more children, they were uncertain about the use of contraception. They had never discussed this with their husbands and were uncertain about their reaction.

6.6 Synopsis of findings and gender inferences

This study examined the psychological perspectives of couples on locus of control over pregnancy and the couples' efficiency in terms of using contraception and avoiding pregnancy. The perceptions of wives and husbands differed on locus of control over pregnancy. Many women assumed they had no control over their bodies whereas men thought they controlled their wives' bodies. Even though 94 per cent of the women thought that if a couple were careful, they could avoid an unwanted pregnancy, they relied largely on luck. Men relied less on luck, but they believed that women were meant to be pregnant. One-fifth of husbands believed that an unwanted pregnancy could happen.

Information about self-efficiency was elicited only from those who had not used any method of contraception. A majority of the wives expressed an inability to obtain and use a method of contraception or refrain from sex, unlike their husbands. In other words, these women found it difficult to cross the barrier of gender to obtain and use temporary contraception. In addition, they confessed to a lack of control over their bodies. These perceptions were reiterated by their opinions on the value of pregnancy. A majority agreed that they could convince their husbands to limit the number of children, but they lacked efficiency in postponing or spacing pregnancies.

More than half the couples had communicated on matters related to planning of their family. But wives and husbands differed in their reporting of certain topics. More couples had discussions if they were educated, from forward castes, nuclear families, and with fewer children. More men initiated the discussion with an increase in duration of marriage. Although some socio-cultural aspects facilitated spousal communication, the initiation of the discussion was largely determined by gender-specific behaviour. Perceptions about such

discussions showed that all women wanted a discussion, but preferred that the men initiate it for fear of the woman being seen as promiscuous. Half of the men never felt it necessary to discuss the matter, but those who had a discussion never thought the woman could initiate it.

A little more than half of the couples were using contraception at the time of the survey; a majority had opted for tubectomy. Although only a few couples used temporary methods of contraception, reporting between the partners differed. More men reported usage of condoms and periodic abstinence than women. The reason for using condoms was not for avoiding pregnancy; rather, the husbands were suffering from STDs. This was probably why the wives did not want to reveal the use of condoms. Cultural restrictions compelled women not to disclose illnesses related to STDs whereas men were not so conditioned.

Motivations to use a method of contraception differed. Women depended more on others than on themselves for use of contraception. They felt that without their husbands' approval they could not use contraception. This was more so if they had to use temporary methods.

Nearly one-fifth of contraceptive users reported having suffered from illness after the adoption of the method. All of these were women who had undergone tubectomy. Generally tubal ligation does not result in any complication after surgery. But women living in joint families, especially those married to non-relatives, where their position is low, were unlikely to have adequate rest after tubectomy. This was more likely in deprived communities.

A strong notion persisted within the community, among both men and women, that a woman's health would deteriorate after tubectomy. Yet all men as well as women wanted only the wives to be sterilised. While men believed that women must take the burden of ill health in the interest of the family's financial situation in terms of the number of children, the women agreed with the men's view. Women wanted tubectomy also to get protected once and for all against pregnancies, aware as they were of their inability to get a temporary method or refrain from sex.

Three out of four women who suffered contraceptive morbidity sought treatment. Those who did not seek treatment were influenced by social reasons and their relatively low position in the family.

Chapter 7
Fertility behaviour and obstetric health

This chapter discusses the fertility behaviour of couples and its impact on the obstetric health of women. The chapter first focuses on certain aspects of marriage, since in the Indian context fertility largely occurs within the marital union.

7.1 Particulars related to marriage

The median age at marriage for women in the villages sampled was 15 years. For men, it was 21 years. An increase in age at marriage for both women and men had only been marginal over the years. The median age at marriage for women aged between 20 and 25 years was 16 years and that for women aged between 40 and 49 years was 15 years. Eighty-nine per cent of these women were aware that the minimum legal age at marriage for girls in India is 18. More men (95 per cent) were aware of this requirement. Yet, both sexes justified early marriage for their daughters for fear of rising dowry demands with time.

Opinions were mixed about marriage at a young age. A few women admitted that early marriages curtailed "freedom." In contrast, others said marriage gave them mobility, expression, relative decision-making power at home, and, in a way, "freedom." In either case, the gender conditioning of girls by family members made them view marriage as either an arena of restrictions or liberty, but none actually worried about the repercussions of early marriage. Rather, everyone felt that a girl's happiness lay in her being married.

Consanguineous marriage was a practice in the villages studied. More than one-third of the couples (36.3 per cent) were related to each other before marriage. Many had married first cousins, and a few women had married their maternal uncles.

Parents played a major role in deciding the marriage of daughters. Ten per cent of the women were not consulted by their parents before marriage. The rest were consulted as a formality. The girl's parents decided the marriage according to their choice and assumed that they were making the best decision for their daughter. Most of the daughters felt the same.

7.2 Fertility behaviour

Of the total of 223 couples in the study, 178 women (79.2 per cent) had had at least one live birth. The median age at first pregnancy for these women was 17 years and median age at last pregnancy for sterilised women was 21 years. The median number of children born per woman was three. The median number of children born to women who had been married for more than 16 years was four. Twenty per cent of the women had never had a live birth – 11.7 per cent had never conceived while 8.5 per cent had become pregnant, but never had a live birth. All these were women below 30 years of age; 68.9 per cent of them were aged between 16 and 20, 13 per cent were below 16, while the rest were between 20 and 30.

Responses to particulars about pregnancy are given in Table 7.1. By and large men and women reported similar information related to the successful outcome of a pregnancy: that is, information about the number of live births, number of currently surviving and non-surviving children, knowledge about date of last birth, and timing of last pregnancy.

The mismatch in reporting was related to stillbirths, abortion, and current pregnancy. An analysis of the in-depth interviews of the couples that reported differently revealed that the women did not want to acknowledge stillbirths while husbands did not mind giving details. Women insisted the stillbirths were infant deaths. The community felt that the death of an infant could occur due to various "external" reasons, but a stillbirth was associated only with the mother. So the women probably did not want to be held responsible.

For the same reason, fewer men knew about their wives' abortions. Three women had not informed their husbands or parents-in-law about the abortions that they underwent. Perhaps for this reason one woman did not disclose her pregnancy to her husband, as she wanted to wait for a certain period to confirm its continuance.

The differences in reporting also pointed to existing gendered attitudes. The woman's relative position in the family and society was related to her

Table 7.1 Mismatch of information reported by couples on fertility and obstetric experiences

Aspects related to fertility and obstetrics	Number reported	
	Women	Men
Number of live births	178	178
Currently surviving children	172	172
Number of non-surviving children	137	137
Knowledge about date of last birth	178	178
Number of times wife had stillbirths	2	4
Whether wife had stillbirths	2	4
Whether wife had abortion	18	15
Number of times wife had abortion	18	15
Outcome of abortion	18	15
Currently pregnant	30	29
Month of pregnancy	30	29
Number of times conceived after Diwali 2001	101	102
Outcome of the pregnancy after Diwali 2001	74	74
Timing: wanted to be pregnant at that time	94	93

reproductive capabilities. Hence the desire to conceive among women, especially soon after marriage, which was apparent in their response to the question about the timing of the pregnancy. Women who were pregnant during the reference period were asked if they wanted to be pregnant at that time. All said yes. Although most of the husbands agreed, one man admitted his wife had become pregnant accidentally. His wife, however, wanted to be pregnant and have her first child.

7.3 Obstetric health

This section discusses various aspects of obstetric health in terms of the realisation of the need for care, the persons deciding to promote the care, and actual care taken by the women during three specific periods – antepartum, intrapartum, and postpartum. It also discusses the women's expectation of support from their husbands versus actual support received. Other than women who had recently gone through a pregnancy, women's expectation of care during specific periods of obstetric health is also discussed in this section.

7.3.1 *Characteristics of the women*

Of the total of 223 couples identified for the study, 94 women (42.2 per cent) had experienced pregnancy during the reference period of two years. Of them, seven had been pregnant more than once in this period. Table 6 in Annexure 2 gives the socio-economic details of these women. A majority (56.4 per cent) were below 20 years. One-fifth of them were pregnant for the first time, and another one-fifth were of parity three or more. Forty-three per cent of these women were illiterate while 38 per cent were educated above primary level. Most of the women belonged to the deprived sections; 58 per cent were from backward castes and 30 per cent from the scheduled categories. Three out of every four were living in nuclear families. Thirty-seven per cent were related to their husbands prior to marriage. More than half (52 per cent) were engaged in income-generating activities.

7.4 Antepartum period

The safe motherhood initiative proclaims that all pregnant women must receive basic, professional antenatal care. [127]. Ideally, antenatal care should monitor a pregnancy for signs of complications, detect and treat pre-existing and concurrent problems of pregnancy, and provide advice and counselling on preventive care, diet during pregnancy, delivery care, postnatal care, and related issues. The Reproductive and Child Health Programme recommends that as part of antenatal care, women must receive two doses of tetanus toxoid vaccine, adequate amounts of iron and folic acid tablets or syrup to prevent and treat anaemia, and at least three antenatal check-ups that include blood pressure checks and other procedures to detect pregnancy complications. [128,129].

7.4.1 *Details of antenatal care and role of the husband*

The study indicated a high rate of utilisation of antenatal care by women (96.8 per cent) in the

villages (Table 7 in Annexure 2). All of them had received antenatal care from one or more qualified health personnel; 89 per cent went to allopathic doctors, 27.5 per cent to a multi-purpose health worker in the RCWHC, and two per cent to other health personnel. Elder female family members or husbands were the main persons to advise the women to seek treatment. The actual decision to seek treatment rested with the husbands in more than half the cases (51.6 per cent). Men from nuclear families, forward castes, engaged in non-agricultural activities with low parity took interest in their wives' antenatal care.

The next main person involved in making decisions was a female elder in the family. Less than one-tenth of the women could decide by themselves on the need to seek treatment. It is interesting to know that there was an apparent difference in the venue of antenatal care sought by women and the deciding person. When the husband or a female elder in the family decided on the need for antenatal care, the woman went to a private allopathic doctor or a government maternity hospital. When the woman made the decision, she almost always went to the RCWHC or the sub-centre.

Nine out of 10 women who got antenatal care were tested for risk pregnancy (Table 8 in Annexure 2). Relatively more women who sought care from private doctors were tested for risk pregnancy. Ninety-eight per cent were given iron folic acid (IFA) tablets, and 96 per cent took tetanus toxoid (TT) injections. Nine out of ten had weight, height, and blood pressure measured and blood and urine tested. A majority (98 per cent) received advice on diet followed by advice on dangerous signs during pregnancy (65 per cent).

7.4.2 *Antepartum morbidities and treatment-seeking behaviour*

Of the women who were pregnant in the reference period, 47.8 per cent suffered from antepartum morbidities. Table 7.2 gives the details. It also provides information about the awareness levels of husbands about different antepartum morbidities. The findings reveal that a majority of husbands (64.4 per cent) were unaware of the morbidities faced by their wives during a recent pregnancy. Seven per cent thought their wives had not faced any morbidity, though the women concerned had suffered from illnesses.

Table 7.3 gives information about women who suffered from antepartum morbidities and the role of their husbands in the decision to seek antenatal care. For morbidities such as fits and bleeding, all husbands saw a need to seek treatment and advised their wives accordingly. For other morbidities like fever for more than three days, severe vomiting, and varicose veins, more than half the husbands decided to seek treatment. For the rest, other members of the family, mostly any older woman at home, decided on the need to seek treatment. Irrespective of the ailment, a majority of women sought treatment from a qualified health professional, that is, an allopathic doctor.

Table 7.2 Antepartum morbidities suffered by women and husbands' awareness

Morbidities during antepartum period	Percentage of women who suffered	Percentage of husbands who knew
Swelling of hands and feet	46.7	4.4
Blurred vision	15.6	0.0
Giddiness	26.7	11.1
Fits	4.4	4.4
Urinary problem	15.6	6.7
Varicose veins	4.4	4.4
Fever for more than three days	15.6	2.2
High blood pressure	11.1	0.0
Severe vomiting	22.2	2.2
Diabetes	0.0	2.2
No movement of foetus	2.2	0.0
Bleeding	2.2	2.2
Other morbidities	0.0	4.4
None	11.1	6.7
Do not know	0.0	64.4
Total number of women	**47.8% (45)**	

Table 7.3 Antepartum morbidities suffered by women and person who decided on the need for antenatal care

Morbidities during antepartum period	Decision made by (%):	
	Husband	Others
Swelling of hands and feet	38.1	61.9
Blurred vision	28.6	71.4
Giddiness	33.3	66.7
Fits	100.0	0.0
Urinary problem	42.9	57.1
Varicose veins	50.0	50.0
Fever for more than three days	57.1	42.9
High blood pressure	40.0	60.0
Severe vomiting	50.0	50.0
No movement of foetus	0.0	100.0
Bleeding	100.0	0.0
Total number of women	**47.8% (45)**	

7.4.3 *Support of men for wives during pregnancy: expectation versus reality*

This section unveils the differences in opinion of women and men regarding the role of husbands towards wives during pregnancy. It also looks at the disparities in the expectations of women who were pregnant during the reference period in terms of the actual support extended by their husbands.

Table 7.4 reveals that almost every woman, irrespective of age or parity, expected her husband to extend care. Expectations were especially high regarding emotional support, and health and nutritional care. Less than three per cent of the women felt there was no need for their husbands to physically help with managing older children or assisting with housework.

Forty-eight per cent of the men felt the need to support to their wives during pregnancy. A majority reported that they had to extend emotional support and care for their wives' health by either taking them for antenatal check-ups or arranging for someone to accompany them. Only one out of 10 men perceived their role in terms of physical help.

All the women who had been pregnant during the reference period felt that husbands should extend emotional support as well as health and nutritional care (Table 7.5). Only two percent felt it was not necessary to extend physical care.

Table 7.4 Men's perceptions of types of care they should extend towards pregnant wives

Types of care	Perceived by husbands (%)
Emotional	
Talk affectionately	48.0
Express concern for health	25.6
Health	
Take wife for antenatal check-up	27.4
Arrange with someone to go for antenatal check-up	30.0
Arrange/Assist in transportation	7.6
Monitor intake of medicines	13.0
Nutritional	
Get fruits/sweets	21.5
Take interest in wife's diet	9.4
Physical	
Manage older children	13.5
Assist in housework	12.6
Total number of couples	**47.8% (45)**

The opinion of the husbands, however, was far below these expectations. Nearly half the men felt that they should behave affectionately when their wives are pregnant and saw their responsibility in terms of providing necessary support to get antenatal

Table 7.5 Perception of need versus actual care during pregnancy

Type of care	Perceived by husbands (%)	Actual care by husbands (%)
Emotional		
Talk affectionately	46.8	23.4
Express concern for health	28.7	14.9
Health		
Take wife for antenatal check-up	27.7	46.8
Arrange with someone to go for antenatal check-up	29.8	7.4
Arrange/Assist in transportation	4.3	6.4
Monitor intake of medicines	12.8	24.5
Nutritional		
Get fruits/sweets	25.5	44.7
Take interest in wife's diet	6.4	13.8
Physical		
Manage older children	11.7	8.5
Assist in housework	17.0	19.1
Total number of couples	**94**	

care. But while not many men felt they needed to extend support to their wives during pregnancy, more women felt that their husbands had extended support related to health, nutrition, and even physical help. There was a shortfall, however, in opinion related to emotional support.

7.5 Intrapartum period

Intrapartum is the shortest phase compared to the antepartum and postpartum periods. This phase is unpredictable. At any time during labour, complications may develop.

7.5.1 *Place of delivery*

Once a woman was pregnant, the family planned the place of delivery. It was assumed that if the actual place of delivery was different from the planned place, then an emergency had occurred to force the change. Table 7.6 shows that a majority of the women were delivered as per plan. About seven per cent of women who had initially planned a home delivery had to go to an institution, 2.8 per cent to the RCWHC, and 4.3 per cent to a private hospital due to prolonged or difficult labour.

Table 7.6 Planned place of delivery versus actual place of delivery

Planned place of delivery	Actual place of delivery (percentage of women)		
	RCWHC/Govt. hospital	Private hospital	Home
PHC/Govt hospital	20.3	0.0	0.0
Private hospital/clinic	1.4	46.4	1.4
Home	2.8	4.3	23.1

Table 7.7 Determinants of use of institutional healthcare for delivery: Logistic regression analysis

Explanatory variables	Institutional delivery		
	B	S.E.	Exp (B)
Women's age	0.194	0.649	1.215
Women's education	-0.017	0.454	0.983
Women's work status **	-1.199	0.709	0.302
Men's education	-0.053	0.443	0.948
Men's work status	-0.147	0.800	0.864
Type of family **	-1.662	0.965	0.190
Parity	-0.625	0.487	0.535
Caste	-0.321	0.720	0.725
Possession of vehicle **	1.784	0.778	5.956
Person deciding on place of delivery **	1.553	0.930	4.725
Family violence	0.805	0.703	2.236

**Indicates significance at level of 0.1 per cent

Analysis by place of delivery shows that nearly 75 per cent of the women delivered at an institution. Despite a high level of utilisation of health services during the antepartum period, institutional healthcare for delivery in the villages declined. Analysis by background characteristics of the women shows that type of family and type of marriage had a significant association with the place of delivery (Table 9 in Annexure 2). When the husband was the main decision-maker, the chances of the woman delivering at an institution were higher.

A logistic regression analysis shows similar results (Table7.7). Among socio-economic variables, women's work status (0.302), type of family (0.190), having a vehicle in the house (5.958), and the person deciding on the place of delivery (4.725) emerged as significant determinants of utilisation of health facilities for delivery. If a woman was not working outside the house, belonged to a nuclear family, her husband was the decision-maker, and the household had a vehicle, she had greater chances of an institutional delivery.

7.5.2 *Intrapartum morbidity*

The morbidities suffered by women during delivery are shown in Table 10 in Annexure 2. Of the women who gave birth during the reference period, 39 per cent suffered from intrapartum morbidities. Of these, nearly 60 per cent had to undergo a Caesarean section, 22 per cent experienced labour for more than 18 hours, 15 per cent suffered from excessive bleeding, and in another 15 per cent of cases the child was not born five hours after the sac had burst. One out of 10 women was recorded with high blood pressure and the baby was in a breech position. Despite such experiences, 74.3 per cent of the husbands concerned reported that their wives had no problems during delivery. Three per cent of men admitted ignorance about their wives' intrapartum morbidities. It is likely that in a majority of cases it was the elderly women who took decisions when the situation was critical. Husbands took decisions only on visible morbidities such as extended labour and the need for a caesarean section (Table 11 in Annexure 2).

7.5.3 *Support of men towards wives during delivery: expectation versus reality*

This section looks at the differences in opinion of women and men regarding the role of husbands towards wives during delivery. It also looks at the disparities in the expectations of wives who were pregnant during the reference period in terms of the actual support extended by their husbands.

The study showed that 99 per cent of women of all ages expected their husbands to extend care. Expectations were equal with respect to physical, health, and financial care. Expectations declined marginally about emotional support.

Table 7.8 Difference of opinion between women and men on type of care to be extended by husbands towards wives during delivery

Type of care	Opinion of husbands (%)	Opinion of wives (%)
Call for an assistant/health personnel	40.6	99.5
Arrange for transport	22.6	98.0
Get necessary items/medicines	23.6	99.5
Financial help	74.1	99.0
Emotional support	8.0	97.0
Not necessary	4.9	8.1
Total number of couples	**223**	

On the other hand, three out of four men saw their support only in terms of finance (Table 7.8). Less than half thought they could support by calling a healthcare professional. Even less than a quarter realised their responsibilities in terms of getting necessary medicines or arranging transport. The least number thought of support on the emotional front. happy with whatever emotional support they received even though the husbands themselves did not think of it as support.

7.6 Postpartum period

The postpartum period is not officially defined. It is supposed to be the period after the

Table 7.9 Perceived versus actual care extended by husbands towards wives during recent delivery

Type of care	Perceived care by husbands (%)	Actual care by husbands (%)
Call for an assistant/health personnel	39.7	5.9
Arrange for transport	25.0	17.6
Get necessary items/medicines	19.1	32.4
Financial help	75.0	57.5
Emotional support	11.8	23.5
Did not help at all	0.0	29.4
Total percentage	**69**	**69**

As compared to the opinions expressed by men, actual support extended by them during a recent delivery fell short in all respects except emotional support (Table 7.9). In other words, though 75 per cent of men felt that their major role lay in extending financial support during delivery, far fewer (57 per cent) actually provided this support. This was probably because in some cultures the cost of the first, and at times second, delivery of a woman is borne by her parents.

Differences were similarly noted with respect to emotional support. While only 11.8 per cent of men felt the need to extend emotional support to their wives, as many as 23.5 per cent of the women said they had received such support from their husbands. This needs to be interpreted with care. Probably the men, without realising it, extended emotional support to their wives, or the women were

delivery of the placenta to the following six weeks.

7.6.1 *Postpartum care*

Table 12 in Annexure 2 provides details of knowledge and practices related to postpartum care. In terms of knowledge, the women mainly knew only about diet. Fifty-nine per cent felt that they should continue a nutritious diet, while 48 per cent believed in following certain restrictions. About 35 per cent believed in having adequate rest and not indulging in heavy work. Few women, 1.4 per cent, thought regular check-ups were essential.

Of the 94 women who had been pregnant during the reference period, nearly 85 per cent resumed household work two weeks after delivery. The physical activity they indulged included cooking (83 per cent), carrying older children (78 per cent), lifting water (52 per cent), washing clothes (47.8 per

cent), fetching water from a distance, and lifting heavy items (4.3 per cent each).

Only 12 per cent went for a postpartum check-up. Most of these women had check-ups done by qualified health personnel 20 days after delivery. Table 13 in Annexure 2 shows that among the women who were delivered during the reference period, older women (2.120) and those working for wages (4.712), if their husbands were educated beyond primary school (2.521), had a greater chance of going for postnatal health check-ups. This may be because a majority of women and men did not realise the need for such check-ups, but with an increase in the husband's level of education, he was more likely to support his wife in getting a check-up. If the women were older or working outside the house, they could probably see or express the need to go for a check-up.

7.6.2 *Postpartum morbidity*

Of the women who delivered during the reference period, 49 per cent suffered from postpartum morbidities (Table 7.10). A majority experienced pain in the lower abdomen, 20 per cent suffered from depression, 17 per cent had fever for more than three days, an equal percentage experienced pain and a burning sensation while urinating, and 14 per cent had excessive bleeding. The husbands' knowledge of these morbidities was as poor as in the case of intrapartum morbidities. Less than three per cent even knew about their wives' postpartum illnesses.

7.6.3 *Support of men towards wives after delivery: expectation versus reality*

Women expected their husbands' support during the postpartum period (Table 7.11). Everyone hoped their husbands would help them to get regular check-ups, provide physical help, and see that they did not strain themselves during this period. In addition women wanted their husbands to be responsible fathers by managing the older children in this phase and extending adequate emotional support to their wives.

But the men did not seem to be sensitive to their wives' needs. Only half of them felt it was necessary to extend physical help and take care of their wives' health after delivery. One-third perceived their role as fathers, and one-quarter felt the need to provide physical help. Five per cent did not perceive any role in terms of support to their wives after delivery.

Table 7.10 Postpartum morbidities suffered by women and husbands' knowledge about the morbidities

Morbidities after delivery	Mismatch in reporting postpartum morbidities (%)	
	Women	Men
Pus formation in tare	10.3	0.0
Fever for more than three days	17.2	2.9
Pain in lower abdomen	69.0	1.4
Pain or burning when urinating	17.2	0.0
Changes in mental make-up	10.3	0.0
Fits/convulsions	0.0	1.4
Smelly discharge	6.9	0.0
Breast abscess	6.9	0.0
Excess bleeding	13.8	0.0
Depression	20.0	0.0
Backache	10.3	0.0
Total number of couples	**42.0 (29)**	

Table 7.11 Difference of opinion between women and men on care to be extended by husbands towards wives after delivery

Types of care	Differences in reporting intrapartum morbidities (%)	
	Husbands	Wives
Arrange/take her for a health check-up	45.5	100.0
Manage older children	36.5	98.6
Do not allow wife to strain herself physically	28.4	100.0
Provide physical help	50.7	100.0
Extend emotional support	0.0	94.2
Any other	0.0	1.2
Not necessary	5.4	0.0
Total number of couples	**223**	

Although many men felt that their role lay in extending health support (45.7 per cent) after delivery, far fewer (4.3 per cent) actually provided it (Table 7.12). This may be because they probably felt it more necessary to extend support to the newborn child rather than its mother. But the support extended by husbands in managing older children increased, as did not allowing their wives to strain themselves, and emotional support.

Table 7.12 Perceived versus actual care extended by husbands towards wives after recent delivery

Type of care	Perceived care by husbands (%)	Actual care by husbands (%)
Arrange/take her for a health check-up	45.7	4.3
Manage older children	24.3	34.8
Do not let her strain herself physically	35.7	44.9
Provide physical help	50.0	31.9
Extend emotional support	4.3	31.9
Any other	0.0	1.4
Total number of couples	**69**	

7.7 An understanding of abortion and healthcare

Abortion literally means "premature delivery." Abortion may take place due to the unhealthy condition of the pregnant woman or because the pregnancy is unwanted. The present study examined the perceptions of women and men about abortion and the use of health facilities for this purpose.

Table 14 in Annexure 2 shows the opinion of women and men on various aspects of abortion. As a first reaction, a majority of women and men in the villages under study did not appreciate a decision to induce abortion. Among couples, relatively more men (83 per cent) than women (62.8 per cent) were not in favour. But 95 per cent of women and 81 per cent of men said abortion would be acceptable on grounds of health. Every alternate woman and one out of three men said that a woman could abort the foetus to avoid further children. Nearly one-third of the couples agreed that abortion could be used to space the birth of children. But a majority of the couples, especially women, were not in favour of induced abortion to postpone the first child.

To have an abortion, a majority of the couples (95 per cent of women; 81 per cent of men) felt it was necessary for the wife to take her husband's permission. More women (78.9 per cent) than men (38.1 per cent) felt that the permission of their parents-in-law was also needed. But both partners did not think much of the need to take the woman's parents' consent. Although none of the women felt the need to take permission from health personnel, 21.5 per cent of the men thought it was necessary. At the same time almost every woman and man felt the need to consult a doctor.

All the women and 80 per cent of the men felt a discussion between the partners prior to abortion was necessary. Every alternate woman said

the discussion should focus on the health consequences for the woman and the need for the abortion. One-fifth of the women thought the couple should discuss the place of abortion, future fertility, and social consequences. Men gave importance to the need, place, financial cost, and method of abortion, in that order.

More than 80 per cent of the couples felt that the husband should accompany his wife at the time of the abortion. The main reason, they said, was to give written consent at the hospital. Most of them felt that unless the husband signed the consent forms a woman could not undergo an abortion. The other reason for wanting husbands with their wives at the time of abortion was financial support. Other family members expected to accompany the woman were her mother and mother-in-law. More women wanted their mother-in-law to be with them because they felt it would safeguard them against future mistreatment.

7.8 Synopsis of findings and gender inferences

One-fifth of the total number of couples studied had parity zero. The median number of children born per couple was three. While reporting particulars of their fertility experiences, the partners agreed in terms of living children, but were mismatched in reporting the number of stillbirths and abortions. This was probably related to women's low position in the family.

Forty-two per cent of the women had experienced pregnancy during the reference period of two years. A high rate of utilisation of antenatal care by these women (96.8 per cent) was reported in the villages. More than half of the husbands decided whether their wives should seek antenatal care. When husbands took the decision, they took their wives to a private allopathic doctor or a government maternity hospital. When women decided by themselves they went to the RCWHC. Though the RCWHC personnel are equally qualified, when men decided on the need for antenatal care, the women reported better physical, nutritional, and emotional support. Such support was missed when they had to make the decision on their own.

If couples lived alone, the husbands realised their role in their wives' healthcare. If the men were from the forward castes and engaged in non-agricultural occupations, they had more exposure that allowed them to think in favour of women's health.

Antepartum morbidities were experienced by 47.8 per cent of the women. Most of the husbands (64.4 per cent) were unaware of the morbidities faced by their wives during a recent pregnancy. But that did not really affect the wives' access to healthcare because they received support from elders in the family.

Seventy-five per cent of the women gave birth at an institution. Their husbands determined this decision. At the same time, socio-economic factors such as whether the women were living in nuclear families, with better standards of living, especially in terms of possessing of a vehicle, played a role.

The husbands' awareness about the intrapartum morbidities suffered by their wives was low. This was because most of the problems, with the exception of a Caesarean section, were never revealed to them. After delivery, only 12 per cent of women had a postpartum check-up. A majority (85 per cent) resumed domestic work two weeks later. The women said cooking was inevitable. Women in joint families expected some help from other members, but those in nuclear families had no choice.

All the women felt that their husbands should extend medical, health, nutritional, and emotional support to them during the three distinctive phases of obstetric care. Relatively fewer women expected physical help from their husbands. But most of the husbands never realised the need to support their wives.

Chapter 8
Sexual practices and reproductive health of women

Sexual health depends not only on practices but also on individual attitudes and knowledge. The sexual practices of men before and after marriage have important implications for reproductive health, both for the men and for their wives. This chapter examines the sexual practices of men in terms of their sexual health. It also focuses on the reproductive health of women, and the knowledge of couples about reproductive health.

8.1 Sexual practices of men before and after marriage

In the villages under study, 28.7 per cent of men had premarital sexual experience (Table 8.1). Their median age at first sexual contact was 19 years. Some of them had premarital sexual contact as early as at 16 years. But extramarital sexual contact was low (13 per cent). Before marriage 11.7 per cent had sexual relations with multiple partners; after marriage this declined to 2.8 per cent. Prior to marriage, only 1.3 per cent of men used condoms during all sexual contact, while nearly one in four (23.3 per cent) never used condoms. The socio-economic background of men having extramarital sexual relations revealed no significant association (Table 15 in Annexure 2).

8.1.1 *Sexually transmitted diseases and healthcare-seeking behaviour*

Of the men who had premarital sexual relations, 17.2 per cent suffered from sexually transmitted diseases (Table 8.1). Many of them experienced difficulty in urination. Only 6.4 per cent tried to seek treatment from allopathic doctors. The rest tried self-treatment or just ignored the problem. After marriage, three out of the 29 men who had extramarital sexual relations suffered from STDs. Only one of them felt it necessary to seek treatment from a doctor. The other two tried self-treatment.

Table 8.1 Sexual behaviour and healthcare of men before and after marriage

Particulars of sexual activity and health	Percentage of men	
	Prior to marriage	After marriage
Ever had extramarital sexual contact	28.7	13.0
Median age at first sexual contact	19 years	
Had contacts with multiple women	11.7	2.8
Used condoms during sexual contact		
- Always	1.3	1.3
- Sometimes	4.0	4.0
- Never	23.3	7.6
Experienced any of these morbidities		
- Any discharge from the penis	0.4	0.4
- Any sore in the genital or anal area	0.9	0.0
- Difficulty in urination	4.5	0.4
- Pain during urination	0.9	0.0
- Very frequent urination	0.4	0.0
- Swelling of the testes or in the groin	0.0	0.4
Any one problem	4.9	0.4
Number of men	(11)	(3)
Sought treatment for the morbidities from		
- Allopathic doctor	54.5	33.3
- Self/Friends/Never sought treatment	45.5	66.7
Total number of men who had sexual contact	**64**	**29**

8.2 Marital sexual behaviour and attitude of couples

Two out of the total of 223 women in the study had their first coital relation at the age of 11. Ninety-four per cent had coital relations while still at an adolescent age. Many of the women were ignorant or only had partial knowledge about coitus. Having been exposed to it at an early age, 30 per cent of the women felt scared, seven per cent never liked it, 47 per cent felt shy about it, and 31 per cent liked it.

Reporting between women and men about information related to their sexual practices as couples was mismatched. They were asked certain details of these practices during the four weeks prior to the survey. Of the 223 couples, 222 lived together. According to the men, 81 per cent had coitus once a day, 16.6 per cent reported it twice a day, and 2.4 per cent said they had intercourse three times. But 99.6 per cent of women reported having sexual intercourse once a day. The rest said they had it twice.

A majority of the women felt it was their duty to fulfil their husbands' sexual desires. At the same time they felt that coitus once a day was acceptable. But the men felt there was no ideal number. They also felt that they had every right to their wives' bodies and the latter could not refuse their demands.

8.3 Sexual behaviour of men after morbidity

Three men out of the 223 were suffering from STDs at the time of the survey. Two of them discussed their illness with their wives. They knew that their ill-health could affect their wives' gynaecological health and started using condoms with them. The third man never discussed the issue with his wife. He simply stopped having coital relations with her. But all three continued to have extramarital sexual relations. The only precaution they thought necessary was to use condoms.

8.4 Beliefs of couples about STDs

A majority of women and men were not aware of STDs. All of them were asked whether they disagreed with or did not know about the following statements:

- A person contracts gonorrhoea only once. After that he or she becomes immune to it.
- Syphilis can be treated with penicillin and other antibiotics.
- Venereal disease can be passed from mother to child before or during birth.
- Some people who have venereal disease exhibit no symptoms.
- It is harmful for a man to have sex with another man.

Responses of the men and women (Table 8.2) varied considerably on one statement. Eighty five percent of men and 35 per cent of women agreed that "Venereal disease can be passed from mother to child before or during birth." A majority expressed ignorance about the other aspects. One out of four, both women and men, agreed that "Some people

Table 8.2 Awareness of couples about STDs

Particulars of knowledge	Percentage of men			Percentage of women		
	Agree	Don't agree	Don't know	Agree	Don't agree	Don't know
A person contacts gonorrhoea only once, and then becomes immune to the disease	12.1	17.9	70.0	0.9	0.4	98.7
Syphilis can be treated with penicillin and other antibiotics	47.1	10.3	42.6	0.9	2.2	96.9
Venereal diseases can be passed from a mother to her baby before or during birth	84.3	2.2	13.5	35.0	0.0	65.0
Some people who have venereal diseases show no symptoms at all	40.8	7.6	57.6	26.9	1.8	71.3
It is harmful for a man to have sex with another man	9.4	11.7	78.9	13.9	0.9	85.2
Total number of couples	**223**					

who have venereal disease exhibit no symptoms." More women (13.9 per cent) than men (9.4 per cent) believed that "It is harmful for a man to have sex with another man." Hardly any woman believed the statements, "A person contracts gonorrhoea only once, and then becomes immune to the disease," and " Syphilis can be treated with penicillin and other antibiotics." But 12 and 47 per cent of men believed the respective statements.

8.5 Reproductive health of women

The reproductive health situation of women before and after marriage was analysed. Of the total of 223 women, 29.6 per cent had suffered from menstruation-related ill-health. One per cent had experienced abdominal pain while nine per cent had irregular periods. Less than one per cent suffered from prolonged menstruation and vaginal discharge. Nearly half of the women felt the need to seek treatment. Forty per cent went to an allopathic doctor.

One out of four women (24.7 per cent) was suffering from some infection of the reproductive tract at the time of the survey (Table 8.3). Nearly six out of ten women reported pain at the mouth of the vagina, three out of ten had severe pain deep inside the vagina, and 16 per cent had noticed abnormal vaginal discharge.

When seen in terms of background characteristics, a higher percentage of women aged between 31 and 35 years (40 per cent), with parity three or more (59.3 per cent), belonging to the scheduled tribes (37.5 per cent) and backward castes (26.4 per cent) suffered from reproductive tract infections (Table 16 in Annexure 2). A marginally higher percentage of women in consanguineous marriages (27.6 per cent) or whose husbands were having extramarital sexual relations (27.9 per cent) also suffered from these infections.

In traditional societies it is generally believed that disclosing reproductive tract infections, unlike maternal morbidities, is a matter of shame for women. But 53 per cent of the women did not hesitate to discuss their illness with their husbands. Twenty-seven per cent felt more comfortable sharing their problems with elder women. The rest discussed them with their peer group.

However, 64 per cent of the women felt it necessary to inform their husbands and seek their permission for seeking healthcare. Among the 55 women who suffered from one or the other RTIs, only 27 per cent sought treatment. All of them sought treatment from qualified health personnel, either doctors or health assistants, at the round-the-clock women's health centre or a private hospital.

Factors determining the women's behaviour in seeking healthcare for their reproductive tract infections were analysed by a logit model. Table 8.4 shows that if a woman discussed her problem with her husband, she had a greater chance (33.903) of seeking treatment. Illiterate women (0.142) and those working for daily wages (2.388) had a high probability of seeking seek care. Women with fewer children had a greater chance (0.294) of seeking medical help. Domestic violence at home, however, was a detrimental factor. Women from homes without violence had better chances (3.015) of seeking healthcare.

Table 8.3 Details of women suffering from RTIs

Details of reproductive tract infections	Percentage of women
Pain at the mouth of the vagina	58.3
Pain inside the vagina	33.3
Abnormal vaginal discharge	16.1
Frequent urination or pain during urination	7.2
Pain during or after intercourse	5.4
Itching/Irritation in the vaginal area	4.0
Severe lower abdominal pain	2.2
Bad odour in the vaginal area	1.8
Giddiness along with fever	0.9
Blood spots after intercourse	0.9
Total number of women who had RTIs	**24.7% (55)**

Table 8.4 Determinants of healthcare-seeking behaviour of women for RTIs

Dependent variables	Reproductive health problems		
	B	SE	Exp (B)
Women's age*	0.871	0.587	2.388
Women's education*	-1.948	1.011	0.142
Women's work status	-0.560	0.795	0.571
Consanguineous marriage	0.037	0.769	1.038
Caste	0.272	0.850	1.312
Parity*	-1.225	0.552	0.294
Marriage duration	-0.046	0.617	0.955
Availability of health centre*	1.143	0.753	3.137
Awareness of AIDS	-0.724	0.748	0.485
Extramarital relationship	-1.068	1.262	0.344
H-W communication**	3.524	0.832	33.903
Family violence*	1.103	0.776	3.015
Frequency of coitus	-0.007	0.055	0.993
Personal hygiene	-0.909	1.017	0.403
Awareness of RH services	6.234	33.028	509.706

*Indicates significance at 0.1 per cent level

8.6 Medical and health expenditure

8.6.1 *Expenditure on wives' health*

Many communities believe that men should take care of household finances. One way of assessing men's ability to support their wives, children, and other family members is in terms of expenditure on medical aid and health. Table 8.5 gives details of the expenditure incurred on the women's obstetric and other reproductive healthcare. Of the total of 223 couples, 81.1 per cent of husbands said their wives had sought medical and healthcare during their last pregnancy. All of them said their wives had sought care during the antenatal period, 68.4 per cent during delivery, and 59.2 per cent in the postpartum period. Eighty-nine per cent of the men agreed with the need to spend money in cash or kind. But a lower percentage actually spent for their wives' obstetric care. The rest could not afford it.

Again, 7.6 per cent of husbands said their wives required reproductive healthcare, and in all but one case they did spend money for this. The solitary exception was a woman who sought treatment from the RCWHC.

Table 8.5 Expenditure on wife's obstetric health according to men

Expenditure on wife's reproductive health	Percentage of men
Wife sought treatment during	
-Pregnancy	81.1
-Delivery	68.4
-Six weeks after delivery	59.2
Needed to spend in cash/kind for wife's obstetric health	
-Yes	89.3
-No	10.7
Unable to seek proper medical care for wife's obstetric health owing to lack of adequate finances	
-Could not seek care	17.1
-Could seek care	82.3
-Do not know	0.6
Needed to spend for wife's reproductive healthcare during the past one year	
-Yes	7.6
-No	91.9
Women who sought treatment	100.0

8.6.2 *Household health expenditure*

Seventy per cent of the families had incurred some medical expenditure during a period of 12 months prior to the survey (Table 17 in Annexure 2). One-fifth of the husbands reported having spent some money on themselves, 69 per cent on the healthcare of their wives, 49 per cent on their children, 8.3 per cent on their parents, and 1.9 per cent on others. An analysis of expenditure in rupee terms revealed households spend a median amount of Rs. 2500. The minimum amount spent was Rs. 100 and the maximum was Rs. 45,000. Nearly 17 per cent of the households had to take loans to meet these expenses. Nearly two-thirds of the men took loans for the healthcare of their wives, 35 per cent for their children, 22 per cent for themselves, and the rest for other members of the family.

8.7 Synopsis of findings and gender inferences

The men had more premarital sexual contacts than extramarital relations. The median age at first sexual contact for the men was 19 years. Before marriage 11.7 per cent had sexual relations with multiple partners; after marriage this figure declined to 2.8 per cent. Prior to marriage only 1.3 per cent of men always used condoms. Even though many men were aware of the need to use condoms, they had incorrect knowledge. Most thought a condom was needed only if they visited a commercial sex worker. Of the men who had premarital sexual relations, 17.2 per cent suffered from STDs, but only 6.2 per cent sought treatment. Many of the women had their first sexual contact while in their early teens. They were ignorant of coitus or had only partial knowledge at the time.

Reporting of sexual practices by women and men differed. Clearly, sexual practices are constructed by gender. Women believed that certain restrictions were necessary in the frequency of coitus. They felt ashamed to talk if it was beyond the "accepted frequency." But they were made to believe that they had to oblige the "needs" of their husbands rather than their own. Similarly, the views of men and women varied considerably about the risk of STD, though the majority were ignorant about the subject.

Of the women surveyed, 29.6 per cent had suffered from menstruation-related ill-health before marriage and one out of four was suffering from RTIs at the time of the survey. Only half of them discussed the illness with their husbands and 27 per cent sought treatment. For seeking healthcare, 64 per cent felt it was necessary to seek their husbands' permission.

The husbands were willing to spend on the healthcare of their wives even though they often did not have correct awareness of the problems. More than four-fifths spent money on their wives during pregnancy. Often they spent more on their wives' healthcare than on anyone else in the family.

Chapter 9
Family violence and reproductive health

Gender-based violence occurs in all societies. Such violence occurs within the home or the wider community and affects women and girls disproportionately. Violence in the family, which typically occurs when a man beats his female partner, is the most prevalent form of gender-based violence. This study examined the cognitive levels of couples related to violence and the extent of violence among the couples.

9.1 Cognitive levels of women and men about family violence

A woman's behaviour is almost always under scrutiny in a gender-based society. She is especially expected to be on her best behaviour in her natal family. If she deviates from expectation she is not only subjected to criticism but also, in certain situations, control of her physically by family members is condoned. Hence a wife's relative position not only depends on her behaviour but also upon the cognitive levels of her immediate family members, especially husbands. This section examines the perceptions of men and women towards expected behaviour and physical control of wives.

Men and women were asked to agree or disagree with certain statements related to a wife's behaviour and physical control in order to assess their cognitive levels. If they agreed strongly, the responses were noted separately to understand the intensity of their attitude.

Every woman agreed that the wife should always show respect to elders, particularly her in-laws, in the family (Table 18 in Annexure 2). Although 94 per cent of men agreed with this, there was a difference in the levels; 89.2 per cent of women agreed strongly whereas only 38.6 per cent of men agreed strongly. Similarly, the women and men were asked whether the wife should show respect to her husband (Table 19 in Annexure 2). All the women agreed. More men (96.4 per cent) also wanted their wives to show them respect.

Ninety per cent of women agreed that the wife should always follow instructions given to her, whether she liked them or not, by elders, particularly her in-laws and husband. Seventy-two per cent of men agreed with this, but a slightly higher number (77 per cent) wanted her to follow the husband's instructions.

Fewer women (50 per cent) agreed with the statement that if necessary one should use force to make the wife follow all the instructions of elders, particularly her in-laws and husband. A lesser number of men agreed with this statement (31 per cent), but a bigger number (49 per cent) did not mind using force when it involved the husband's instructions.

Ninety nine per cent of women said persuasion should be used to change her attitude if the wife disobeys the instructions of elders, particularly her in-laws; 19 per cent did not mind verbal insults, nine per cent felt that a beating may be required, and 6.7 per cent said physical isolation would work. If similar disobedience were shown towards the husband, the opinion of women regarding persuasion and verbal insults did not change. But the numbers supporting a beating or isolation declined. Men also felt that persuasion or verbal insults should be used, but relatively more men (12 per cent) felt that the wife could be beaten.

Only four out of ten women felt that there was no harm if the wife sometimes disagreed with the instructions of her elders, particularly the in-laws or husband. More men agreed with this statement. But when the statement referred to the husband's instructions, the percentage of men agreeing fell to 63 per cent. More than 95 per cent of women felt that no verbal insults and/or physical beating should be used against the wife if she did not follow instructions given to her by elders, particularly her in-laws or husband.

Gender bias is thus evident in the cognitive levels of women and men. While most of the women agreed with the need to be polite and respect their elders, they were also made to internalise a subordinate position by accepting certain measures against them to bring about a "desirable change." Given an option most women were not in favour of

physical control. On the other hand some men, though seemingly liberal in other situations, were in favour of physical control over the wife's behaviour with regard to her husband. Given an open choice, four-tenths of husbands could not accept a complete lack of physical control over their wives.

9.2 Reporting of family violence by women and men

The information provided by women and men varied a lot (Table 9.1). The couples were asked whether the women were hit, slapped, kicked, or otherwise subjected to physical violence by their husbands. Twenty-one per cent of women said there had been violence in the home, but more men (56 per cent) reported the same. Similarly, there were differences in reporting the number of times violence occurred in the home. Women tended to report a smaller number.

but none of the men reported this. A majority of men (89.6 per cent) claimed the violence was largely confined to yelling. A majority of women (81.3 per cent) too agreed that yelling was part of violence, but said it did not always remain confined to yelling. Reactions to the violence showed another distinctive difference in reporting between women and men. Every man said that after the episode his wife cried and did nothing. Though 75 per cent of the women agreed that they cried, only 27 per cent said they did nothing else. Almost 17 per cent said they shouted back at their husbands. Another four per cent said they hit back.

More men (2.7 per cent) than women (1.3 per cent) reported that their wives sought help after the violence. Although very few women sought medical help, even in this there were differences between women (0.9 per cent) and men (0.4 per cent).

Table 9.1 Mismatch in information reported by couples on family violence

Particulars of domestic violence	As reported by:	
	Women	Men
Woman was ever hit, slapped, kicked, or otherwise hurt physically by her husband	21.5	56.1
Type of violence that occurred		
- Shouting/yelling	81.3	89.6
- Slapping/pushing	68.8	23.2
- Punching/kicking	50.0	0.8
- Use of stick/weapon	6.3	0.0
Reactions of wife after she was hit the last time		
- Yelled and shouted back	16.7	0.4
- Hit back at husband	4.2	0.0
- Cried	75.0	100.0
- Did nothing	27.1	100.0
Wife sought help from others	1.3	2.7
Required to seek medical help	0.9	0.4
Total number of women and men	**48**	**125**

An analysis by types of violence revealed that more women reported various severities than men. More women (68.8 per cent) reported slapping/pushing than men (23.2 per cent). Half of the women also mentioned that their husbands either punched or kicked them whereas less than one per cent of men agreed with this. A few women (6.3 per cent) said their husbands had used a stick or other weapon,

9.3 Family violence by background characteristics of couples

Table 20 in Annexure 2 gives details of the couples' background characteristics. More illiterate women (30.7 per cent) reported family violence than educated women. Family violence declined if the husband was educated beyond the high-school level. Non-working women reported less violence than

working women. Skilled male workers reported comparatively less violence than men in other occupations. With an increase in their age as well as the duration of marriage and parity, according to the reporting of both men and women, the extent of violence increased. A religion-wise analysis shows that a higher percentage of Hindu women reported violence, whereas a higher percentage of Muslim men reported it. Both women and men from the deprived castes reported more violence than the others. Relatively more women from nuclear families admitted to the occurrence of violence, whereas men living in joint families reported it more.

The impact of violence on antepartum and intrapartum morbidities was found to be insignificant in the study. But domestic violence emerged as a significant factor in the husband's decision on place of delivery. In families where there was no violence, the chances of the husband deciding in favour of institutional delivery were greater. But violence was a significant factor in the woman suffering from postpartum morbidities. Women from families in which there was no violence were less likely to suffer from these morbidities.

Both men and women were asked to report any violence in their sexual behaviour. Fewer men than women reported violence. While 21.1 per cent of the women said their husbands forced them to have sex when they were not in the mood, 17 per cent of the men admitted to this. Similarly more women (12.8 per cent) than men (7.9 per cent) reported that their husbands insisted on sex against their wishes.

Table 9.2 Differences in reporting violence related to reproductive health

Violence related to reproductive health	As reported by:	
	Women	Men
Women experienced violence while pregnant	10.4	6.4
Husband insisted on sex with wife	12.8	7.9
Husband had forcible sex with wife	21.1	17.0
Total number of couples	**223**	

9.4 Violence and reproductive health

Gender violence, until recently a marginal subject in themes related to health, has such a significant impact on women's health that it is responsible for one in every five potential years of healthy life lost. [107]. This study analysed the impact of violence on some aspects of women's reproductive health. Table 9.3 analyses the influence of domestic violence using a logit model after controlling all other variables. It shows that women living in families in which there is violence have a greater chance of suffering from contraceptive morbidity.

Violence had a significant association with contraception. In families where the women experienced violence, they could not assert their need for basic post-operative rest after sterilisation or childbirth and had to get involved in all kinds of domestic work, ruining their health instead of recovering it.

Table 9.3 Impact of domestic violence on various aspects of reproductive health

Aspects of reproductive health	B	SE	Exp (B)
- Contraceptive morbidity **	1.609	0.251	4.999
- Husband's decision on place of delivery *	-0.907	0.551	0.404
- Postpartum morbidities *	-0.322	0.244	0.725

**Indicates significance at 0.001 percent level, *Indicates significance at 0.1 percent level

Violence during pregnancy is one of the most tragic faces of gender violence, which results in serious consequences for women's physical and mental health. In the present study, five women (2.2 per cent of the total) reported violence by their husbands during pregnancy. Six husbands (3.6 per cent) admitted to violence during their wives' pregnancy.

9.5 Synopsis of findings and gender inferences

Husbands held strong views about the "appropriate" behaviour of wives towards them and elders/in-laws. More than husbands, wives also had

such feelings about their behaviour. Nearly nine out of ten husbands and wives thought that a woman should show respect towards her husband and elders/ in-laws. Two-thirds thought that they should follow instructions; nearly three-fourths believed that the wife should be persuaded to obey instructions. While no wife wanted to be verbally or physically abused for not listening, one-third of husbands did not mind using these measures. More women preferred to have a free relationship with their husbands, while more husbands expected their wives to be obedient and obliging.

More than half of the husbands, and a fifth of the wives, reported physical violence towards women. Eighty-nine per cent of husbands reported shouting/yelling, whereas 68 per cent of wives reported slapping/shoving and about half reported experiencing punching/kicking. Despite the high level of family violence, very few women sought help from others, because they believed that publicising family violence brought them disrespect. A few women had to seek medical help after the violence. Nearly 10 per cent experienced violence while they were pregnant. More women (21 per cent) reported forcible sex than husbands (17 per cent) within marriage.

The impact of domestic violence on certain aspects of reproductive healthcare was also observed in the study. Findings revealed that violence was significantly associated with contraceptive morbidity, home delivery, and postpartum morbidity. In other words, the study suggests that when men are involved in matters related to women's health, the chances of women getting to use better health services increase.

Chapter 10
Policy implications based on the study

The villages under study were linked to one of the best round-the-clock women's health centres, but only one-third of the couples were exposed to at least one message related to reproductive health. More strikingly, 13 per cent had never been exposed to such messages.

Despite efforts to promote client-oriented contraceptives, the shift was not evident. More messages related to temporary methods need to reach recently married couples. Many women get married at an early age, mainly as a result of social problems like dowry and gendered attitudes. This needs to be handled at a broader level. It is difficult to control early marriages. But efforts can be made to delay early pregnancy by giving information about its health aspects and providing adequate knowledge of temporary methods of contraception.

Most of the women were not aware of the different methods of contraception when they are actually needed – prior to the first pregnancy. Some women, even though aware of the existence of such methods, were unable to obtain and use them without the consent of their husbands. Since most of the women get married at a very young age, providing the right information to them is essential.

The attitude of the male health workers needs to change. The shift from a target-based to a target-free approach has not changed their attitude. In an informal discussion, the health staff admitted that it is more convenient to motivate women get sterilised once the desired family size has been attained. As it is, the gender restrictions on women ensure that they cannot procure temporary methods despite their desire to postpone pregnancy.

Communication between couples showed a positive association with the use of contraception and with increasing the utilisation of healthcare for contraceptive morbidity. Clearly, more efforts are needed to educate the men when they are young.

There was a positive association between the participation of husbands and the obstetric healthcare that their wives received. Men were inclined to accompany their wives for antenatal check-ups at private clinics rather than at the RCWHC. One of the main reasons for this unwillingness to go to the RCWHC was lack of "space" for men. Men were embarrassed and found it inconvenient to be with their wives in the RCWHC for two main reasons. First, they were conscious of being sniggered at by the people around. Second, whenever they took an interest in the details of their wives' ill-health, the health workers were reluctant to brief them and advised them to send along a female elder from the family.

This gender bias on the part of the health staff needs to be curbed. In fact, they should be encouraging the women to come with their husbands for antenatal services. This not only makes husbands aware of the situation and ensures better care of the pregnant women's health, but also encourages them to go for institutional delivery. It also helps to prepare the couples to delay their next pregnancy.

Similarly, during delivery husbands need to be educated about their wives' health status. Findings revealed a positive association between husbands' initiation and institutional delivery. Apart from this, it also makes men realise the importance of support in the postpartum period. Many of the men were not reluctant to extend support; they were just ignorant about their role.

Although the men are aware of AIDS, they are not clear about the need to use condoms in premarital and extramarital sexual encounters. Despite the massive effort by the government to spread awareness about AIDS, the information is not clear to many young men. Since initiation into premarital sex starts at age of 19 or less, targeting adolescent boys is extremely essential.

Healthcare for STDs is not utilised largely because of ignorance about the availability of services. Information about the availability of these health services needs to be spread in the community. Efforts by a few men to prevent the spread of STDs to their wives by using condoms should be appreciated.

Domestic violence is a social problem. The attitude of not only men but also the women needs to change to combat this problem. The gender attitude of women encourages them to tolerate violence. Recently the local authorities have initiated action against domestic violence. Such measures should be encouraged. Even if they do not change the attitude of men, they may help in lowering the levels of violence.

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Annexure 1

Case studies

A total of 25 in-depth interviews were carried out for the study. A few representative case studies are presented in brief in this annexure. Case studies with similar expressions have been avoided. The interviews covered reproductive health, utilisation of health services, and men's role from a gender perspective.

Case 1

Wife's particulars

Name:	X1
Age:	25 years
Occupation:	Daily wager
Health problem:	She is suffering from white discharge. Her first pregnancy resulted in spontaneous abortion. The third pregnancy ended as a stillbirth.

Husband's particulars

Name:	Y1
Age:	35 years
Occupation:	Daily wager
Health problem:	Prior to marriage he experienced difficulty in urination.
Religion:	Hindu
Caste:	Kummari (BC)
Children:	Daughters – 2; Son – 1
Family type:	Extended. His widowed mother lives with them.
Marriage:	Consanguineous

Contraception and pregnancy care

X1 got married at the age of 12. After she attained puberty her parents thought it better to get her married because of the existing demand for dowry. She was ignorant about temporary contraceptive methods prior to marriage. The couple never discussed the timing or number of children they should have.

A few months after marriage she became pregnant. She had uterine bleeding in the third month of pregnancy. Her husband took her to the PHC, where the doctor confirmed it as a spontaneous abortion. After a few months she became pregnant again and gave birth to a daughter. She was taken to the Gandhi Hospital (a tertiary level hospital) for antenatal check-ups and delivery. After two years she delivered another daughter. This time too she was taken to the Gandhi Hospital for antenatal check-ups and delivery.

During both pregnancies her mother assisted her to the hospital. During delivery, her father made the necessary arrangements. X1 once again became pregnant. This time her natal family was expected to provide healthcare. Her mother-in-law and husband were disappointed at not having a son. She was asked to go to the PHC for antenatal care. A *dai* was called for the delivery. When the *dai* could not handle the case, she advised Y1 to take his wife to a doctor. X1 was taken to a PHC, where she underwent a Caesarean section and delivered a stillborn child. After a year she was pregnant for the fifth time. This time she was again taken to Gandhi Hospital for antenatal care and for delivery. She gave birth to a boy. Both the husband and mother-in-law were happy. X1 wanted to go for sterilisation. Her husband was unwilling; he wanted another son. So with the consent of her mother-in-law she underwent a tubectomy.

Gynaecological health

X1 has been suffering from white discharge for the past few months. She did not tell Y1 or her mother-in-law. She once went to the PHC and sought treatment. The medicines prescribed did not help and she did not go again for treatment because she could not afford to spend time at the cost of her work and household responsibilities. She felt women are destined to suffer.

Sexual behaviour and health

Y1 had premarital as well as extramarital sexual experiences. He believes a man can have sex outside marriage for a change. He had sex with multiple partners, prostitutes as well as female relatives. Y1 was aware of condoms. He always used condoms to protect himself against AIDS. Earlier he

had suffered from a urinary infection and sought treatment from a qualified allopathic doctor.

Case 2

Wife's particulars

Name: X2
Age: 23 years
Occupation: Teacher in a school
Health problem: Her first pregnancy resulted in spontaneous abortion; during the second pregnancy she suffered from a few mild as well as serious morbidities; the third pregnancy ended in an induced abortion.

Husband's particulars

Name: Y2
Age: 32 years
Occupation: Supervisor in a spinning mill
Religion: Hindu
Caste: Yadava (BC)
Children: Daughters – 1
Family type: Nuclear
Marriage: Non-consanguineous

Contraception and pregnancy care

X2 got married at the age of 18. Before marriage she was ignorant about temporary contraceptive methods. Y2 was aware of condoms and permanent family planning methods. Prior to the first pregnancy the couple discussed the number of children they should have and the contraceptive methods to be used. Y2 was away from his wife for one year after marriage due to his job. After one year X2 conceived but the first pregnancy ended in a spontaneous abortion in the third month. She did not reveal this to anyone in her family nor consult anyone for treatment for fear of being blamed by members of her natal family.

For a year she did not conceive again. She was subjected to criticism and abuse. Y2 took her to a private hospital and sought treatment for conception. She subsequently became pregnant for the second time. During pregnancy Y2 took her for antenatal check-ups and provided necessary financial support. He also assisted her in household work. X2 suffered from a few mild as well as serious morbidities such as severe vomiting, fever for more than three days, and swelling of the hands and feet. She gave birth to a daughter at a private hospital.

After the child's birth X2 and Y2 followed periodic abstinence. X2 then got pregnant for a third time. This pregnancy ended in induced abortion with Y2's support. According toY2 the foetus was malformed. Y2 repeatedly expressed the need for a male child for the family lineage. But after the abortion, on a nurse's advice the couple has been using condoms. They want to have a male child after which X2 wants to go for sterilisation.

Sexual behaviour and health

Y2 had sexual experiences with multiple partners before as well as after marriage. He thinks that for a change a man can have sex outside marriage. Whenever he has money he goes to prostitutes. He uses condoms to protect himself against HIV/AIDS. He does not mind forcing his wife when he does not have money to go to prostitutes. X2 is unaware of her husband's extramarital sexual contacts. Y2 knows that his extramarital sexual contacts may have an effect on his wife's gynaecological health.

Case 3

Wife's particulars

Name: X3
Age: 28 years
Occupation: Housewife
Health problem: Suffering from white discharge.

Husband's particulars

Name: Y3
Age: 31 years
Occupation: Cook in a motel
Health problem: He has been experiencing discharge from the penis since five months.
Religion: Hindu
Caste: Mala (SC)
Children: Sons – 2
Family type: Extended; his widowed mother lives with them.
Marriage: Non-consanguineous

Contraception and pregnancy care

X3 got married at the age of 23. Before marriage, neither she nor her husband was aware of temporary methods of contraception. They never discussed the number of children they should have before the first pregnancy. A year after marriage X3 became pregnant and gave birth to a son. She went to Gandhi Hospital for her antenatal check-ups and delivery. After one year she gave birth to another son. This time too she was taken to Gandhi Hospital for antenatal check-ups and delivery. During both pregnancies her husband assisted her to hospital for the regular antenatal check-ups. Both of them feel that a wife needs to take her husband's permission to seek healthcare because the husband is the one who arranges for the money. X3's mother-in-law wanted another grandchild, and so X3 is pregnant again. Her husband accompanies her to the Gandhi Hospital or PHC for antenatal check-ups. After this delivery the couple plans to go for female sterilisation.

Gynaecological health

X3 has been suffering from white discharge from the past few months. She discussed it with her husband and on his advice went to a private hospital for treatment. The initial treatment did not help. She is not interested in going again to the doctor because of the cost. She now thinks there is no need to seek treatment for the condition.

Sexual behaviour and health

Y3 has never had any premarital or extramarital relationships. He is aware of HIV/AIDS. He understands the need to use condoms for protect from AIDS and STDs. He is aware that the premarital and extramarital relations of a man can affect his wife's gynaecological health. Y3 has a discharge from the penis that started five months after marriage. He discussed it with his wife and sought treatment from a local RMP and ISM doctor. His problem persists. Y3 does not mind forcing his wife to have sex. He has never felt it necessary to give importance to her feelings.

Case 4

Wife's particulars

Name: X4
Age: 42 years
Occupation: Unskilled worker
Health problem: She is suffering from a "urinary problem" and sometimes white discharge as well as lower abdominal pain after her last delivery.

Husband's particulars

Name: Y4
Age: 59 years
Occupation: Agricultural labour
Religion: Hindu
Caste: Vaddara (BC)
Children: Daughters – 3; Sons – 3
Family type: Nuclear
Marriage: Consanguineous

Contraception and pregnancy care

At the age of 16 years X4 got married. Before marriage neither of the couple was aware of contraceptive methods. They never discussed the number of children they should have. After one year of marriage X4 gave birth to a child. She was pregnant six times. She never had antenatal check-ups during any of the pregnancies. Each time she was delivered at home with the assistance of a *dai*. On a nurse's advice, she finally underwent sterilisation at the Shamirpet PHC. Since her last delivery she has been suffering from "lower abdominal pain."

Gynaecological health

For a few months X4 has been suffering from a "urinary problem" and, occasionally, excessive white discharge. She sought treatment for the urinary problem from the RCWHC. But the medicines prescribed did not result in any improvement. She never consulted anyone to seek treatment for the white discharge. X4 discussed the problems with her husband, but he did not take them seriously saying she always had these problems. According to X4, a woman must take her husband's permission to seek treatment at a hospital because he is the one who arranges for the money. She thinks that without the husband's permission a wife can't do anything.

Sexual behaviour and health

Y4 has extramarital relationships with multiple partners. He thinks that for a change or whenever his wife does not cooperate, a man can have sex outside marriage. Although Y4 is aware of HIV/AIDS and understands the need to use condoms when one has sexual intercourse with multiple partners, he has never followed this practice. He simply assumes that he will not be affected. So far he has not suffered from any STDs. X4 is ignorant about HIV/AIDS.

Case 5

Wife's particulars

Name:	X5
Age:	19 years
Occupation:	Cultivation
Health problem:	She had a spontaneous abortion and underwent abdominal surgery for an abscess. She has suffered from severe abdominal pain during her menstrual periods as well as irregular and prolonged menstruation. She has been suffering from white discharge and urinary problems.

Husband's particulars

Name:	Y5
Age:	25 years
Occupation:	Cultivation
Religion:	Hindu
Caste:	Muttaraj (BC)
Children:	None
Family type:	Extended; his parents, married brother, his wife and their daughter live with them.
Marriage:	Consanguineous

Contraception and pregnancy care

X5 got married at the age of 15. The couple never discussed the timing and number of children they should have or the use of methods of family planning. Before marriage neither the wife nor husband was aware of methods of contraception. Now they are aware. Three years after marriage X5 conceived for the first time. She had antenatal check-ups at the RCWHC. The pregnancy ended in a spontaneous abortion in the fourth month. During pregnancy X5 experienced "giddiness" and "severe vomiting." After the abortion she did not consult any doctor, nor did she conceive again. For the past few months the couple has been taking treatment for infertility from a private hospital. Meanwhile X5 had an abscess and had to undergo abdominal surgery. X5 married her own cousin and her aunt/mother-in-law has been a support and has been reassuring her about fertility.

Gynaecological health

X5 has been suffering from severe abdominal pain during her periods. She often has irregular menstrual periods and experiences prolonged bleeding. She also suffers from white discharge and urinary problems. She discussed her problems with her husband and mother-in-law and went to the RCWHC for treatment, but the initial dosage did not result in any improvement. X5 believes that due to heat in the body one gets urinary problems, and so saw no point in taking further treatment. Rather the couple feels that abstaining from coitus on days of excessive white discharge is the best solution.

Sexual behaviour and health

Y5 is aware that extramarital relations can lead to different diseases like HIV/AIDS/syphilis/gonorrhoea. He is also aware that the husband's sexual habits can affect the wife's gynaecological health.

Case 6

Wife's particulars

Name:	X6
Age:	33 years
Occupation:	Daily wager
Health problem:	After her first delivery she suffered from convulsions. For the past four months she has been experiencing shorter menstrual cycles, that is, once in every 20 days, and occasional white discharge.

Husband's particulars

Name:	Y6
Age:	47 years
Occupation:	Cleaner and lorry maintenance.
Religion:	Hindu
Caste:	Madiga (SC)
Children:	Daughters – 1; Sons – 2
Family type:	Nuclear
Marriage:	Non-consanguineous

Contraception and pregnancy care

X6 got married at the age of 14. The couple is ignorant about temporary methods of contraception. Prior to the first pregnancy they never discussed the number of children they wanted. X6's natal members were extremely keen for a male child in her first pregnancy. X6 had antenatal check-ups at the RCWHC. Her mother accompanied her for all check-ups. She was taken to a military hospital for delivery. Soon after the delivery she had convulsions and the doctors advised that she be taken to Gandhi Hospital. She was treated at Gandhi Hospital and cured. Y6 often used to beat his wife on the head, even when she was pregnant.

After three years X6 became pregnant for the second time. This time too her mother took her for regular antenatal check-ups. This time she gave birth to a girl. X6 wanted to go for sterilisation at this stage, but her mother-in-law wanted another grandson. So X6 became pregnant again. This time too she had antenatal check-ups. Her mother-in-law accompanied her for the check-ups. But she gave birth at home with the assistance of a *dai*. The baby was a boy. All the natal family members were happy and X6 underwent sterilisation.

Gynaecological health

For the past four months X6 has been having her menstrual cycle at an interval of 20 days. When she shared this problem with her husband, he taunted her and asked her to go to Mediciti Hospital, which provides free healthcare for women. At times she also has a white discharge. So she went to the RCWHC without informing any of her family members. She says her husband never understands her problems and only mocks her. Y6, however, also says he always takes an interest in her health and even accompanied her to the health centre a few times.

Family violence

Y6 has a habit of hitting X6 on her head. X6 feels that due to this she is suffering chronic headaches and pain in the neck. She also believes that these repeated beatings during her first pregnancy gave her the convulsions.

Sexual behaviour and health

Y6 has had premarital and extramarital relationships. He believes that sexual experience before marriage is necessary for every man. Apart from his wife, he has maintained sexual relations with another woman with whom he was in contact prior to marriage. Since he does not have other sexual contacts, he thinks there is no need to use a condom. He is aware of HIV/AIDS and its effect on his wife's gynaecological health. Aware of her husband's extramarital relations, X6 is not keen on sexual intercourse with him. This is the main reason for their difference of opinion. Y6 beats her and forces her into coitus because he thinks he has a right over her body.

Case 7

Wife's particulars

Name:	X7
Age:	35 years
Occupation:	Unskilled labour
Health problem:	During pregnancy she experienced aching hands and legs and blurred vision. After delivery she suffered from lower abdominal pain and a prolapsed uterus. She now has thick white discharge with a severe smell, genital itching and severe abdominal pain.

Husband's particulars

Name:	Y7
Age:	42 years
Occupation:	Cultivation
Religion:	Hindu
Caste:	Mudiraj (BC)
Children:	Daughters – 2; Sons – 2
Family type:	Nuclear
Marriage:	Non-consanguineous

Contraception and pregnancy care

X7 got married at the age of 13. Prior to marriage both she and her husband were ignorant of temporary methods of contraception. They also never discussed the number of children they wanted to have. Within one year of marriage she gave birth to their first child. X7 was pregnant four times. At times she went to the health centre for antenatal check-ups. Her husband remained unaware of these checkups. Her first three deliveries took place at home with the assistance of a *dai* and an ANM. For the fourth delivery she was taken to a primary health

centre because the baby was too large. During pregnancy she suffered from aching hands and legs and blurred vision. After delivery she suffered from lower abdominal pain and a prolapsed uterus. After delivery, as part of the cultural practice, toddy was poured at the mouth of the birth canal. X7 underwent tubectomy on the advice of an ANM.

Gynaecological health

X7 has been suffering from thick white discharge with a bad smell. She is also suffering from stomach pain and itching. But she has never discussed these problems with her husband because she thinks he is not sensitive towards her health. Her daughters advised her to seek treatment at the RCWHC. She went there a few times but her condition did not improve.

Sexual behaviour and health

Y7 has had premarital and extramarital sexual relationships. He thinks that sexual experience is necessary before marriage. He also thinks that if the wife does not cooperate, a man can have extramarital sexual relationships. He knows that if a man has sex with commercial sex workers, then he may contract STDs. From television advertisements, wall posters, and other media, he is aware of HIV/AIDS. So he insists on the use of condoms. But X7 is unaware of HIV/AIDS. Sexual coercion exists between the couple; Y7 pressurises his wife against her will.

Case 8

Wife's particulars

Name: X8
Age: 22 years
Occupation: Community health worker in a private hospital
Health problem: Before marriage she suffered from irregular periods. After delivery she suffered from over-bleeding and backache. Currently she suffers from pain during intercourse.

Husband's particulars

Name: Y8
Age: 26 years
Occupation: Tractor driver (own)
Religion: Hindu
Caste: Yadava (BC)
Children: Daughter – 1
Family type: Nuclear
Marriage: Consanguineous

Contraception and pregnancy care

X8 got married at the age of 16. She was aware of contraceptive methods at the time of her marriage. Y8 was ignorant about temporary contraceptive methods, but was aware of permanent contraceptive methods. They never discussed the number of children they wanted to have. They followed periodic abstinence for one year. After that, X8 became pregnant. During pregnancy her husband took her to Mediciti Hospital for regular antenatal check-ups. In the same hospital X8 gave birth to a girl. After delivery she suffered from over-bleeding and backache. The couple again followed periodic abstinence for nine months thereafter. In the quest for a male child, they have decided to try once again before going for female sterilisation.

Gynaecological health

X8 had irregular periods before marriage. She did not consult anyone and the problem resolved itself before marriage. X8 has also been suffering from pain inside the vagina during intercourse. She discussed the problem with her husband who advised her to seek treatment. But she did not consult anyone for treatment. Currently she is cured of the problem. According to the couple, the husband's permission is necessary for the wife to seek treatment because he has to accompany her and also arrange for the money.

Sexual behaviour and health

Y8 has had premarital and extramarital sexual experiences. He thinks that sexual experience is necessary before marriage, and that it gives a thrill. He had premarital and extramarital relationships with only one woman. He is aware of HIV/AIDS and the effect it can have on his wife's health. He believes a man must use condoms to protect himself. X8 believes that HIV/AIDS will attack through a man's illegal contacts, contaminated blood, and by sharing shaving razors. He sometimes convinces his wife to take part in sex though she is not interested. X8 is unaware about her husband's extramarital sexual

contacts. He thinks that even if she were aware, she would never question him directly.

Case 9

Wife's particulars

Name: X9
Age: 23 years
Occupation: Unskilled labour
Health problem: During pregnancy she suffered from giddiness. Currently she suffers from white discharge and lower abdominal pain.

Husband's particulars

Name: Y9
Age: 30 years
Occupation: Unskilled labour
Health problem: Before marriage, he had fluid discharge from the penis and a urinary problem.
Religion: Hindu
Caste: Vaddera (BC)
Children: Daughters – 2
Family type: Extended; his parents live with them.
Marriage: Non-consanguineous

Contraception and pregnancy care

X9 got married at the age of 12. Both husband and wife were ignorant of temporary contraception. They never discussed the timing or number of children. Two years after marriage X9 gave birth to a boy with her mother-in-law and a *dai* for assistance. The baby died immediately after birth. During pregnancy she suffered from giddiness. X9 has had four pregnancies, giving birth to three daughters and one son, but losing the son and one daughter. During all her deliveries a *dai* helped. Due to financial problems X9 did not go for regular antenatal check-ups, though she sometimes went to the Shamirpet PHC. On her mother-in-law's advice, she underwent tubectomy two years ago.

Gynaecological health

X9 has been suffering from white discharge and lower abdominal pain. She discussed her problem with her husband who advised her to seek treatment. But she did not consult anyone because of financial problems.

Sexual behaviour and health

Y9 has never had any premarital or extramarital relations. Before marriage he suffered from fluid discharge from the penis and pain during urination. He sought treatment from an allopathic doctor and was cured. He sometimes forces his wife to have sexual intercourse. He believes a man should use condoms to protect himself from AIDS.

Annexure 2

Tables 1 to 20

Table 1: Demographic characteristics of the couples

Demographic characteristics	Percentage of couples			
	Shamirpet	Pothaipally	Turkapally	Total
Current age of wife				
<=15	0.0	5.3	5.5	2.7
16-20	34.8	34.2	26.0	31.8
21-25	27.7	21.1	24.7	25.6
26-30	17.0	15.8	17.8	17.0
31-35	8.0	2.6	8.2	7.2
36-40	6.3	10.5	5.5	6.7
40+	6.3	10.5	12.3	9.0
Current age of husband				
<=25	28.6	34.2	34.2	31.4
26-30	24.1	23.7	19.2	22.4
31-35	21.4	15.8	16.4	18.8
36-40	7.1	5.3	9.6	7.6
40+	18.8	21.1	20.5	19.7
Duration of marriage				
<=2	22.3	23.7	24.7	23.3
3-5	23.2	23.7	16.4	21.1
6-10	16.1	13.2	17.8	16.1
11-15	16.1	13.2	13.7	14.8
16-20	8.0	5.3	9.6	8.1
21+	14.3	21.1	17.8	16.6
Parity				
0	20.5	18.4	20.5	20.2
1	20.5	21.1	19.2	20.2
2	17.9	21.1	15.1	17.5
3	19.6	15.8	21.9	19.7
4+	21.4	23.7	23.3	22.4
Total (Number)	**50.2 (112)**	**17.0 (38)**	**32.7 (73)**	**100.0 (223)**

Table 2: Women exposed to reproductive health messages, by background characteristics

Background characteristics of women	Percentage of women exposed to messages about:					
	Family planning	Pregnancy care	Delivery care	After child birth	AIDS	Other problems
Current age						
<=20	11.7	39.0	15.6	35.1	20.8	11.7
21-30	17.7	30.2	18.8	43.8	29.2	7.3
30+	8.0	24.0	16.0	26.0	26.0	10.0
Chi-square	2.976	3.333	0.352	4.602	1.586	0.994
Sig.	0.226	0.189	0.839	0.1	0.452	0.608
Education						
Non-literate	8.7	23.6	14.2	33.1	18.9	7.9
Literate	19.8	42.7	20.8	41.7	34.4	11.5
Chi-square	5.817	9.177	1.715	1.737	6.883	0.823
Sig.	0.018	0.004	0.129	0.12	0.013	0.248
Work status						
Household work	15.9	42.7	19.5	39.0	34.1	11.0
Working for wages	12.1	25.5	15.6	35.5	20.6	8.5
Chi-square	0.642	7.028	0.561	0.283	5.024	0.369
Sig.	0.272	.006	0.284	0.348	0.38	0.351
Caste/tribe						
SC/ST/BC	13.3	31.3	16.4	34.4	24.1	9.7
Others	14.3	35.7	21.4	53.6	35.7	7.1
Chi-square	0.019	0.222	0.436	3.887	1.735	0.194
Sig.	0.541	0.393	0.334	0.041	0.139	0.492
Type of family						
Nuclear	16.0	31.5	18.5	37.7	24.7	9.3
Non-nuclear	6.6	32.8	13.1	34.4	29.8	9.8
Chi-square	3.429	0.035	0.915	0.199	0.235	0.017
Sig.	0.046	0.486	0.227	0.388	0.373	0.537
Duration of marriage						
<=5	13.1	42.4	21.2	42.4	27.3	12.1
6-15	17.1	22.9	11.4	38.6	27.1	7.1
16+	9.3	24.1	16.7	24.1	20.4	7.4
Chi-square	1.643	9.214	2.784	5.203	1.009	1.529
Sig.	0.440	.010	0.249	0.074	0.604	0.466
Parity						
0	11.1	48.9	11.1	20.0	26.7	20.0
1-2	16.7	33.3	25.0	50.0	29.8	701
3+	11.7	22.3	12.8	33.0	21.3	604
Chi-square	1.205	10.022	6.099	12.348	1.715	7.432
Sig.	0.548	0.007	0.047	0.002	0.424	0.024
Total (number)	**13.5 (30)**	**31.8 (71)**	**17.0 (38)**	**36.8 (82)**	**25.6 (57)**	**9.4 (21)**

Table 3: Men exposed to reproductive health messages, by background characteristics

Background characteristics of Men	Percentage of men exposed to messages about:					
	Family planning	Pregnancy care	Delivery care	After child birth	AIDS	Other problems
Age						
<=30	30.0	25.8	14.2	22.5	79.2	79.2
30+	15.5	9.7	5.8	8.7	63.1	63.1
Chi-square	6.487	10.075	4.169	7.754	7.053	7.053
Sig.	0.008	0.001	0.033	0.004	0.006	0.006
Education						
Non-literate	3.1	4.7	1.6	3.1	50.0	1.6
Literate	31.4	23.9	13.8	21.4	80.0	5.0
Chi-square	20.470	11.224	7.432	11.238	20.946	1.418
Sig.	0.000	0.000	0.003	0.000	0.000	0.214
Work status						
Agricultural work	13.9	11.5	3.3	13.1	58.2	0.8
Non-agricultural work	34.7	26.7	18.8	19.8	88.1	7.9
Chi-square	13.266	8.572	14.413	1.825	24.407	7.194
Sig.	0.000	0.003	0.000	0.12	0.000	0.008
Caste/tribe						
SC/ST/BC	19.5	17.4	9.2	15.9	69.7	4.1
Others	50.0	25.0	17.9	17.9	85.7	3.6
Chi-square	12.749	0.934	1.970	0.069	3.081	0.018
Sig.	0.001	0.234	0.142	0.485	0.58	0.685
Type of family						
Nuclear	26.5	17.9	11.7	17.3	70.4	3.1
Non-nuclear	14.8	19.7	6.6	13.1	75.4	6.6
Chi-square	3.444	0.093	1.281	0.569	0.555	1.378
Sig.	0.043	0.449	0.190	0.297	.0284	0.208
Duration of marriage						
<=5	30.3	29.3	16.2	30.3	79.8	7.1
6-15	22.9	12.9	8.6	8.6	72.9	2.9
16+	11.1	5.6	1.9	0.0	55.6	0.0
Chi-square	7.210	15.199	8.070	28.023	10.193	4.876
Sig.	0.027	0.00	0.018	0.000	0.006	0.087
Parity						
0	20.0	35.6	11.1	4.4	80.0	13.3
1-2	32.1	22.6	16.7	35.7	81.0	3.6
3+	23.3	6.4	4.3	4.3	59.6	0.0
Chi-square	6.020	18.869	7.426	38.129	11.895	14.044
Sig.	0.049	0.000	0.024	0.000	0.003	0.001
Total (number)	**23.3 (52)**	**18.4 (41)**	**10.3 (23)**	**16.1 (36)**	**71.7 (160)**	**4.0 (9)**

Table 4: Background characteristics of the couples who communicated with each other on aspects related to reproduction

Socio-economic characteristics	Women who communicated with husbands			Men who communicated with wives		
	Percent	Number	X^2& Sig	Percent	Number	X^2& Sig
Education						
Illiterate	52.0	127	4.182	39.1	24	9.951
Literate	65.6	96	0.041	62.3	159	0.002
Work status						
Household work	63.4	82	1.648	**	**	0.591
Working for wages	54.6	141	0.199	**	**	0.442
Agricultural work	**	**		53.3	122	
Non-agricultural work	**	**		58.4	101	
Age at survey						
< =20	46.8	77	5.939			0.218
21-30	63.5	96	0.051	54.2*	120*	0.641
30+	64.0	50		57.3	103	
Duration of marriage						
< =5	51.5	99	3.071	49.5	99	5.580
6-15	61.4	70	0.215	67.1	70	0.061
16+	64.8	50		51.9	54	
Parity						
0	35.6	45	11.499	28.9	45	17.496
1-2	63.1	84	0.003	66.7	84	0.000
3+	63.8	94		58.5	94	
Caste/tribe						
SC/ST/BC	56.4	195	1.648	53.3	195	3.248
Others	67.9	28	0.199	71.4	28	0.072
Type of Family						
Nuclear	61.7	162	3.658	58.6	162	2.212
Non-nuclear	47.5	61	0.056	47.5	61	0.137

* < =30 ** Not categorised

Table 5: Background characteristics of the couples who have used a permanent method of contraception

Socio-economic characteristics	Women who communicated with husbands			Men who communicated with wives		
	Percent	Number	X^2& Sig	Percent	Number	X^2& Sig
Education						
Illiterate	61.4	127	15.993	70.3	64	15.143
Literate	34.4	96	0.000	41.5	159	0.000
Work status						
Household work	36.6	82	9.062	**	**	0.117
Working for wages	57.4	141	0.003	**	**	0.732
Agricultural work	**	**		50.8	122	
Non-agricultural work	**	**		48.5	101	
Age at survey						
< =20	11.7	77	78.252	**	**	63.793
21-30	60.4	96	0.000	25.0*	120*	0.000
30+	88.0	50		78.6	103	
Common characteristics	**Percentage of couple**		**Number**		**X^2& Sig**	
Duration of marriage						
< =5	10.1		99		1132.296	
6-15	77.1		70		0.000	
16+	87.0		54			
Parity						
1-2	35.7		84		101.046	
3+	86.2		94		0.000	
Religion						
Hindu	50.2		203		0.667	
Muslim	50.0		14		0.716	
Christian	33.3		6			
Caste/tribe						
SC/ST/BC	50.3		195		0.144	
Others	46.4		28		0.705	
Type of family						
Nuclear	51.9		162		1.021	
Non-nuclear	44.3		61		0.312	
Had communication						
Yes	59.7		124		10.954	
No	37.4		99		0.001	

* < =30 ** Not categorised

Table 6: Background characteristics of women who experienced pregnancy during the reference period

Characteristics	Percentage of women	X^2& Sig
Women's age		
< =20	56.4	58.922
21-30	43.6	0.000
Parity		
0	21.3	37.393
1-2	58.5	0.000
3+	20.2	
Women's education		
Illiterate	43.6	11.784
Literate	56.4	0.001
Caste/tribe		
SC/ST/BC	88.3	0.108
Others	11.7	0.743
Type of family		
Nuclear	72.3	0.008
Non-nuclear	27.7	0.930
Consanguineous		
Yes	37.2	0.058
No	62.8	0.809
Women's work status		
Household work	47.9	8.613
Working for wages	52.1	0.003
Total number of women	**94**	

Table 7: Particulars of antenatal care taken by women

Particulars of antenatal care	Percentage of women
Location of ANC visits	
Round-the-clock women's health centre	39.6
Government hospital	7.7
Private hospital/doctor	76.9
Person who examined during gestation	
Allopathic doctor	89.0
MPHA	26.6
Other health personnel	2.2
Person who advised woman to go for check-up	
Husband	47.3
Mother/mother-in-law	48.4
Self	3.3
Person who decided on the check-up	
Husband	51.6
Mother/mother-in-law	39.6
Self	8.8
Opinion of husband on antenatal care	
ANC is necessary during pregnancy	98.9
ANC is not necessary during pregnancy	1.1
Husband accompanied woman to ANC	86.2
Reason for not accompanying wife for ANC	
- Woman desired female assistant	58.8
- Had to attend to work	42.2
Total women who had ANC	**(96.8) 91**

Table 8: Components of antenatal care received by women

Quality particulars	Percentage of women
Had TT injection	95.6
Had IFA tablets	97.8
Tested for risk pregnancy	91.2
Tests conducted	
Weight measured	96.7
Height measured	87.9
Blood pressure checked	91.2
Blood test	91.2
Urine test	92.3
Abdomen measured with tape	56.0
Listened to baby's heartbeat	52.7
Internal examination	68.1
X-ray taken	44.0
Scanned/seen baby on TV screen	52.7
Amniocentesis	11.0
Advised on	
Diet	97.8
Danger signs of pregnancy	64.8
Delivery care	31.9
Newborn care	27.5
Family planning	18.7
Total number of women	**91**

Table 9: Place of delivery by background characteristics of women

Characteristics	Percentage of women		X^2& Sig
	Institution	Home	
Women's age			
< =20	75.8	24.2	0.005
21-30	75.0	25.0	0.942
Women's education			
Illiterate	74.3	25.7	0.044
Literate	76.5	23.5	0.833
Women's work status			
Not working	79.3	20.7	0.420
Working	72.5	27.5	0.517
Caste/tribe			
SC/ST/BC	74.2	25.8	0.450
Others	85.7	14.3	0.503
Type of family			
Nuclear	71.2	28.8	2.013
Non-nuclear	88.2	11.8	0.156
Parity			
0	100.0	0.0	0.946
1-2	22.4	22.4	0.623
3+	31.6	31.6	
Consanguineous			
Yes	76.9	23.1	0.055
No	74.4	25.6	0.815
Decision made by			
Husband	80.0	20.0	0.326
Others	73.5	26.5	0.568
Total number of women	**69**		

Table 10: Intrapartum morbidities suffered by women and knowledge of husbands about them

Morbidities during intrapartum period	Percentage who suffered	Percentage of aware husbands
Labour for more than 18 hours	22.2	7.2
Use of forceps	3.7	1.4
Excessive bleeding (more than three saris stained)	14.8	0.0
Sac burst and even after five hours child was not born	14.8	7.2
Sac burst and the fluid was greenish	0.0	1.4
Baby was in breech position/not in normal position	11.1	1.4
High BP	11.1	0.0
Caesarean	59.3	0.0
Other morbidities	3.7	0.0
None	0.0	76.8
Do not know	0.0	4.3
Total number of couples	**69**	

Table 11: Intrapartum morbidities suffered by women and person who decided on place of delivery

Morbidities during intrapartum period	Person who decided on place of delivery	
	Husband/ father-in-law	Elder women
Labour for more than 18 hours	33.3	66.7
Use of forceps	0.0	100.0
Excessive bleeding (more than three saris stained)		
Sac burst and even after five hours child was not born	0.0	100.0
Baby was in breech position/not in normal position	50.0	50.0
High BP	0.0	100.0
Caesarean	0.0	100.0
Other morbidities	43.8	56.3
	100.0	0.0

Table 12: Details of women who were pregnant during reference period and particulars about their postpartum care

Particulars of postpartum care	Percentage of women
Knowledge of postpartum care	
Nutritional diet	59.4
Restricted diet	47.8
Adequate rest	34.8
Not to indulge in heavy work	36.2
Abstention from sex	5.8
Feeding practices	11.6
Regular health check-up	1.4
Had postpartum check up	12.1
Place of check up	
RCWHC/Sub-centre	10.1
Government hospital	4.3
Private clinic/hospital	21.7
Other places	2.9
Type of physical work done	
Cooking	83.0
Carrying older children	78.3
Lifting water	52.0
Rinsing clothes	47.8
Bringing water from a distance	4.3
Lifting heavy objects	4.3
Total number of women	**39.1 (27)**

Table 13: Determinants of use of institutional facilities for postpartum care: logit analysis

Explanatory variables	Postpartum care		
	B	SE	Exp (B)
Women's age **	0.751	0.574	2.120
Women's education	-0.483	0.452	0.617
Women's work status **	1.550	0.650	4.712
Men's education **	0.925	0.469	2.521
Men's work status	0.013	0.663	1.013
Type of family	-0.547	0.673	0.579
Parity	0.479	0.444	1.614
Caste	0.048	0.645	1.049
Possession of vehicle	-0.828	0.692	0.437
Person deciding place of delivery	-0.060	0.724	0.941
Violence in the family	-0.218	0.612	0.804
Postpartum morbidities	0.644	0.657	1.905

**Indicates significance at 0.1 per cent level

Table 14: Opinion of women and men about certain aspects of abortion

Various aspects of abortion	Opinion of women (%)	Opinion of men (%)
Can a woman go for an abortion?		
Agree	37.2	17.0
Disagree	62.8	83.0
Woman can go for abortion for:		
Her health	95.5	81.2
Contraception	53.4	32.7
Postponing the first birth	12.1	17.0
Spacing her children	30.0	28.7
Permission is required from:		
Husband	94.6	84.8
Parents-in-law	78.9	38.1
Parents	15.2	8.1
Others	0.9	0.0
Health personnel	0.0	21.5
No one	0.0	0.4
Couple need to discuss before going for abortion:		
Agree	99.6	79.8
Disagree	0.4	20.2
Couples need to discuss:		
To decide on abortion	42.2	68.1
Place of abortion	26.0	52.7
Method of abortion	8.1	24.6
Health consequences	52.0	10.1
Future fertility	20.6	7.2
Social consequences	22.9	3.9
Ethical consequences	10.3	2.4
Financial aspects	14.3	30.0
Husband must be with wife at the time of abortion:		
Agree	84.8	82.1
Disagree	15.2	17.9
Other person required to accompany woman:		
Mother	72.2	69.5
Mother-in-law	52.5	28.3
Sister	4.5	0.9
Relatives	0.4	1.8

Table 15: Socio-economic characteristics of men having extramarital sexual relationships

Socio-economic characteristics	Extramarital relationship of men (in percentage)		
	Having	Not having	X^2& Sig
Current age			
< =30	10.8	89.2	1.083
30+	15.5	84.5	0.298
Duration of marriage			
< =5	11.1	88.9	0.572
6-15	14.3	85.7	0.751
16+	14.8	85.2	
Parity			
0	8.9	91.1	1.132
1-2	15.5	84.5	0.568
3+	12.8	87.2	
Education			
Illiterate	10.9	89.1	0.339
Literate	13.8	86.2	0.560
Work status			
Agricultural work	11.5	88.5	0.557
Non-agricultural work	14.9	85.1	0.456
Caste/tribe			
SC/ST/BC	13.8	86.2	0.972
Others	7.1	92.9	0.324
Consanguineous marriage			
Yes	12.3	87.7	0.049
No	13.4	86.6	0.825
Type of family			
Nuclear	12.3	87.7	0.227
Non-nuclear	14.8	85.2	0.634
Total	**29 (13.0)**	**194 (87.0)**	

Table 16: Socio-economic characteristics of women suffering from RTIs

Socio-economic characteristics	Extramarital relationship of men (in percentage)		
	Yes	No	X^2& Sig
Education			
Illiterate	25.2	74.8	0.045
Literate	24.0	76.0	0.832
Work status			
Not working	22.0	78.0	0.514
Working	26.2	73.8	0.474
Current age			
< =20	20.8	79.2	4.485
21-30	21.9	78.1	0.106
31+	36.0	64.0	
Duration of marriage			
< =5	21.2	78.8	1.991
6-15	24.3	75.7	0.370
16+	31.5	68.5	
Parity			
0	22.2	77.8	2.358
1-2	20.2	79.8	0.308
3+	29.8	70.2	
Religion			
Hindu	26.1	73.9	2.748
Muslim	7.1	92.9	0.253
Christian	16.7	83.3	
Caste/tribe			
SC/ST/BC	25.1	74.9	0.180
Others	21.4	78.6	0.671
Consanguineous marriage			
Yes	29.6	70.4	1.688
No	21.8	78.2	0.194
Type of family			
Nuclear	23.5	76.5	0.464
Non-nuclear	27.9	72.1	0.496
Husband has extramarital sexual relations			
Yes	20.3	79.7	1.029
No	26.6	73.4	0.310
Total	**24.7% (55)**	**75.3%(168)**	

Table 17: Particulars of health/medical expenditure of the households in the study villages

Details of medical expenditure	Extent
Percentage of families that incurred medical expenditure during the past one year	70.0
Persons on whom expenditure was incurred	
- Self	20.5
- Wife	69.2
- Children	49.4
- Parents	8.3
- Others	1.9
Total expenditure incurred per annum in rupees	
- Median amount spent	2500
- Minimum amount spent	100
- Maximum amount spent	45000
Percentage of families that felt the expenditure incurred was beyond their financial status	16.6
Total number of families	**223**

Table 18: Cognitive levels of men and women on physical control of the wife's behaviour towards elders husband

Aspects of physical control of wife	Cognitive levels of:	
	Women	Men
Wife should always show respect to her husband		
- Strongly agree	94.6	78.0
- Agree	5.4	18.4
- Disagree	0.0	3.6
Wife should always follow instructions given to her by her husband, whether she likes them or not		
- Strongly agree	15.7	34.5
- Agree	74.0	42.6
- Disagree	9.9	21.1
- Strongly disagree	0.4	1.8
If necessary wife should be forced to obey instructions given to her by her husband		
- Strongly agree	3.1	10.8
- Agree	47.5	38.1
- Disagree	39.0	43.0
- Strongly disagree	10.3	7.6
- Do not know	0.0	0.4
If wife disobeys instructions, the following measures may be adopted		
- Verbal insults	16.6	44.4
- Physical isolation	4.5	3.6
- Physical beating	7.2	12.1
- Persuasion	97.8	91.0
- Others	0.0	0.4
There is no harm if wife sometimes disobeys instructions given by her husband		
- Strongly agree	3.2	3.1
- Agree	40.1	58.7
- Disagree	32.8	33.6
- Strongly disagree	24.8	4.5
No verbal insults and/or physical beating should be used even if wife does not follow instructions given by her husband		
- Strongly agree	54.5	4.9
- Agree	43.2	46.6
- Disagree	1.4	39.9
- Strongly disagree	0.9	8.5
Total number of couples	**223**	

Table 19: Cognitive levels of men and women on physical control of wife's behaviour towards elders

Aspects of physical control of wife	Cognitive levels of:	
	Women	Men
Wife should always show respect to elders, particularly her in-laws in the family		
- Strongly agree	89.2	38.6
- Agree	10.8	55.6
- Disagree	0.0	4.9
- Do not know	0.0	0.9
Wife should always follow instructions, whether liked or not, given by elders, particularly her in-laws in the family		
- Strongly agree	20.2	17.9
- Agree	70.4	54.3
- Disagree	8.1	23.8
- Strongly disagree	1.3	3.1
- Do not know	0.0	0.9
If necessary one should use force to make wife listen to all instructions of elders, particularly her in-laws in the family		
- Strongly agree	7.6	6.3
- Agree	43.0	24.7
- Disagree	39.5	60.5
- Strongly disagree	9.9	7.2
- Do not know	0.0	1.3
If wife disobeys instructions of elders, particularly her in-laws in the family, the following measures should be used		
- Verbal insults	19.3	33.2
- Physical isolation	6.7	2.7
- Physical beating	9.0	8.5
- Persuasion	99.1	82.5
- Others	0.0	0.9
There is no harm if wife sometimes disagrees with instructions given to her by elders, particularly her in-laws in the family		
- Strongly agree	6.7	5.9
- Agree	33.2	68.2
- Disagree	40.4	25.1
- Strongly disagree	19.7	0.4
- Do not know	0.0	0.4
No verbal insults and/or physical beating should be used even if wife does not follow instructions of elders, particularly her in-laws in the family		
- Strongly agree	48.4	6.7
- Agree	47.5	54.3
- Disagree	3.1	35.9
- Strongly disagree	0.9	1.8
- Do not know	0.0	1.3
Total number of couples	**223**	

Table 20: Background characteristics of couples with family violence

Socio-economic characteristics	Women			Men		
	Percent	Total	X^2& Sig	Percent	Total	X^2& Sig
Education						
Illiterate	30.7	127	14.731	54.7	64	0.500
Literate	9.4	96	0.001	56.6	159	0.779
Work status						
Not working	17.1	82	2.835	**	**	2.584
Working	24.1	141	0.242	**	**	0.275
Agricultural	**	**		59.8	122	
Non-agricultural	**	**		51.5	101	
Current age						
< =20	9.1	77	15.370			19.023
21-30	24.0	96	0.004	43.3*	120*	0.000
30+	36.0	50		70.9	103	
Duration of marriage						
< =5	11.1	99	14.370	40.4	99	22.451
6-15	25.7	70	0.006	62.9	70	0.000
16+	35.2	54		75.9	54	
Parity						
0	13.3	45	18.500	33.3	45	18.266
1-2	10.7	84	0.001	53.6	84	0.001
3+	35.1	94		69.1	94	
Religion						
Hindu	22.7	203	2.216	56.7	203	4.344
Muslim	7.1	14	0.696	64.3	14	0.361
Christian	16.7	6		16.7	6	
Caste/tribe						
SC/ST/BC	24.1	195	6.549	59.0	195	5.688
Others	3.6	28	0.038	35.7	28	0.058
Type of family						
Nuclear	22.2	162	0.663	54.3	162	1.027
Non-nuclear	19.7	61	0.718	60.7	61	0.598

*< =30 ** Not Categorised

Annexure 3

HOUSELISTING FORM

(Confidential. For research purposes only)

1	Name of the village			
2	Household number			
3	Name of the head of the household			
4	How many persons live in the house**?**			
5	How many women live in the house?			
6	How many married women live in the house (included widowed, divorced, and separated women)?			
	Name of the married woman	Age *(completed years)*	Marital status 1. Currently married 2. Widowed 3. Separated/divorced 4. Never married	Duration of marriage (Ask only currently married women) *(completed years*
7	8	9	10	11
i			1 2 3 4	
ii			1 2 3 4	
iii			1 2 3 4	
iv			1 2 3 4	
v			1 2 3 4	
12	Total number of married women			
13	Total number of women selected			

House listing result

Completed in

One visit..... 1

Two visits..... 2

More than two visits..... 3

	Date	Name
Investigator		
Supervisor		

Annexure 4

HOUSEHOLD SCHEDULE

(Confidential. For research purposes only)

IDENTIFICATION

1	Name of the village
2	Household number
3	Name of the head of the household

INTERVIEWER'S VISIT AND RESULT

Interviewer's name	**Interview result**	**Interview date**
	Completed..... 1 No competent respondent at home..... 2 Household absent..... 3 Postponed..... 4 Refused..... 5 Others_____ 6 ***(Specify)***	

CHECK

4	Total members in the household	☐☐
5	Total number of eligible women selected	☐☐

VERIFIED BY

	Date	**Name**
Supervisor		
Field Editor		
Office Editor		

Please name all the persons in your household

Sl.No.	Name of the household member	Relationship to head of the household	Whether resident or visitor R-1 V-2	Sex M-1 F –2	Age in completed years	Marital status
1	2	3	4	5	6	7
1			1 2	1 2		1 2 3 4
2			1 2	1 2		1 2 3 4
3			1 2	1 2		1 2 3 4
4			1 2	1 2		1 2 3 4
5			1 2	1 2		1 2 3 4
6			1 2	1 2		1 2 3 4
7			1 2	1 2		1 2 3 4
8			1 2	1 2		1 2 3 4
9			1 2	1 2		1 2 3 4
10			1 2	1 2		1 2 3 4
11			1 2	1 2		1 2 3 4
12			1 2	1 2		1 2 3 4
13			1 2	1 2		1 2 3 4
14			1 2	1 2		1 2 3 4
15			1 2	1 2		1 2 3 4

Code: Q3

1 Head
2 Wife or Husband
3 Son or Daughter
4 Son-in-law or Daughter-in-law
5 Grandchild
6 Parent
7 Parent-in-law
8 Brother or Sister
9 Brother-in-law or Sister-in-law
10 Niece or Nephew
11 Other relative
12 Not related

Code: Q6

00 Age less than one year
95 Age 95 years or more

Code: Q7

1 Currently married
2 Widowed
3 Separated/Divorced
4 Never married

8	What is the highest level of education any of your household members has?	☐☐
9	What is the main source of drinking water for members of your household?	Piped water Piped into residence/yard plot……. 11→Q11 Public tap…….. 12 Ground water Hand pump in residence/yard/plot…….. 21→Q11 Public hand pump…….. 22 Well water Well in yard/plot…….. 31→Q11 Public well…….. 32 Surface water Pond…….. 43 Rain water…….. 51 Tanker/truck…….. 52 Others_____ 96 ***(Specify)***
10	How long you have to go to get the water?	Kms. ☐☐ ☐☐☐
11	What do you do to purify drinking water? *(Probe: Record all mentioned)*	Strain by cloth…….. a Water filter…….. b Boiling…….. c Electric purifier (Acquaguard)…….. d Nothing …….. e Others _____ x (***Specify***)
12	What kind of toilet facility does your household have?	**Flush toilet** Own flush toilet…….. 11 Shared flush toilet…….. 12 Public flush toilet…….. 13 **Pit toilet/latrine** Own pit toilet/latrine…….. 21 Shared pit toilet/latrine…….. 22 Public pit toilet/latrine…….. 23 No facility/bush/field…….. 31 Others _____ 96 (Specify)
13	What is the main source of lighting for your household?	Electricity…….. 1 Kerosene…….. 2 Gas…….. 3 Oil…….. 4 Others_____ 6 (***Specify***)

14	How many rooms are there in your household?	☐☐
15	Do you have a separate room which is used as kitchen?	Yes..... 1 No..... 2
16	What type of fuel you use for cooking /heating?	Wood..... a Crop residues..... b Dung cakes..... c Coal/coke/lignite..... d Charcoal..... e Kerosene..... f Electricity..... g Liquid petroleum gas..... h Bio-gas..... i Others_____ x (***Specify***)
17	Type of house *(Observe and record)*	Hut..... 1 Kutcha ..... 2 Pucca..... 3
18	Does your household own any of the following A cot..... A pressure cooker..... A clock or watch..... An electric fan..... A radio or transistor..... A television..... A bicycle..... A moped, scooter or motorcycle... A car..... A bullock cart..... A tractor.....	.....Yes..... No .....1..... 2 .....1..... 2 .....1..... 2 .....1..... 2 .....1..... 2 .....1..... 2 .....1..... 2 .....1..... 2 .....1..... 2 .....1..... 2 .....1..... 2
19	Does this household own any agricultural land?	Yes..... 1 No..... 2→Q21
20	Do you get income from agricultural land?	Yes..... 1 No..... 2
21	Does this household own any livestock?	Yes..... 1 No..... 2
22	What is the religion of the head of the household?	Hindu..... 1 Muslim..... 2 Christian..... 3 Others_____ 6 (***Specify***)
23	What community does the household belongs to?	Scheduled caste..... 1 Backward caste..... 2 General caste..... 3 Scheduled tribe..... 4 Not applicable..... 8

Annexure 5

WOMEN'S SCHEDULE

(Confidential. For research purposes only)

IDENTIFICATION

1	Name of the village	
2	Household number	
3	Name of the head of the household	
4	Woman's name and line number	

INTERVIEWER'S VISITS AND RESULT

Interviewer's name	Interview result	Interview date
	Completed..... 1 Respondent absent..... 2 Postponed..... 3 Refused..... 4 Others _____ 5 ***(Specify)***	

VERIFIED BY

	Name	Date
Supervisor		
Field Editor		
Office Editor		

INFORMED CONSENT

Namaskaram. My name is _____. I am from the **Centre for Economic and Social Studies**. We are conducting a survey on Men's Participation in Reproductive Health. We appreciate your participation in this survey. As per research ethics, your name, the identity of your household, and any other information that you provide will not be revealed to anybody.

We hope that you will participate in the survey, as your views are important. Do you want to ask me anything about the survey?

Respondent agrees to the interview —— 1 → **Q101.**

Respondent does not agree to the interview —— 2 → **END**

Centre for Economic and Social Studies

Nizamia Observatory Campus, Begumpet, Hyderabad 500 016, Andhra Pradesh.

SECTION 1: BACKGROUND CHARACTERISTICS

101	What is your current marital status?	Currently married..... 1 Widowed..... 2 Separated/divorced..... 3 Never married..... 4 END	
102	What is your date of birth?	Month DK month..... 97 Year DK year..... 97	☐☐ ☐☐☐☐
103	What is your current age?	In completed years	☐☐
104	At what age did you attain puberty?	In completed years	☐☐
105	How many years after puberty were you married?	In completed years	☐☐
106	Prior to marriage was your husband related to you?	Yes..... 1 No..... 2	
107	Who was mainly responsible for settling your marriage ?	Self..... 1 Parents..... 2 Relatives..... 3 Others_____ 6 **(Specify)**	
108	Was your consent taken prior to settling your marriage?	Yes..... 1 No..... 2 Not necessary..... 3	
109	How many years after marriage did you start living with your husband?	In completed years	☐☐
110	How many years have passed since you got married?	In completed years	☐☐
111	What is the minimum legal age at marriage for a boy in India?	Age	☐☐
112	What is the minimum legal age at marriage for a girl in India?	Age	☐☐
113	Have you ever become pregnant?	Yes..... 1 No..... 2→Q125	
114	How many live births have you had?	Total births None.....00→Q120	☐☐
115	How many children are now surviving?	Total surviving None.....00	☐☐
116	How many children are now not surviving?	Total not surviving None.....00	☐☐
117	How many years after your marriage did you have your first child?	In completed years	☐☐
118	What is the present age of your first child?	In completed years	☐☐

119	When was your last child born?	Month DK month…… Year	□□ 97 □□□□
120	Have you ever had a stillbirth?	Yes…… No……	1 2→Q122
121	How many times have you had stillbirths?	Number of times	□□
122	Have you ever had an abortion?	Yes…… No……	1 2→Q125
123	How many times have you had abortions?	Number of times	□□
124	The last time you had an abortion, was it spontaneous or induced?	Spontaneous…… Induced……	1 2
125	Are you pregnant now?	Yes…… No…… DK……	1 2 7 Q127
126	How many months pregnant are you now?	Month DK month……	□□ 97
127	Have you ever attended school?	Yes…… No……	1→Q129 2
128	Can you read and write?	Yes…… No……	1 2 Q130
129	How many years of schooling have you completed?	Years of schooling (years completed)	□□
130	Some women work, which helps them to earn anincome. Do you do any such activities?	Yes…… No……	1 2→Q132
131	What type of work do you do?		
132	During the past year did you do any such work?	Yes…… No……	1 2→Q134
133	What type of work did you do?		
134	**Check: Q130 and Q132, if 'Yes' in any one of them, ask Q135 or skip to Q201**		
135	How many days in a year do you work?	Number of days	□□□
136	How much do you earn in a day?	In Rs. In kind……	□□ 95

SECTION 2A: MEDIA EXPOSURE

Now I would like to ask you some questions about the media exposure you have had for different aspects of reproductive health

S. No		Family planning	Pregnancy care	Delivery care	Postpartum care	AIDS	Other reproductive health problems
		i	ii	iii	iv	v	vi
201	Have you heard or seen any message in the last one month?	Yes……….1 No……….2→Q204	Yes……….1 No……….2→Q204	Yes……….1 No……….2→Q204	Yes……….1 No……….2→Q204	Yes……….1 No……….2→Q204	Yes……….1 No……….2→Q204
202	Where did you see or hear this message? *Circle all responses mentioned*	Interpersonal visit…a **Group Meeting** Youth club……….b Orientation training camps….c **Mass Media** Radio……………. d Television………. e Cinema/film…….. f Print material……g Hoarding/wall painting………….h Others________ i ***(Specify)***	Interpersonal visit… a **Group Meeting** Youth club……….b Orientation training camps….c **Mass Media** Radio……………. d Television………. e Cinema/film…….. f Print material……g Hoarding/wall painting………….h Others________ i ***(Specify)***	Interpersonal visit… a **Group Meeting** Youth club……….b Orientation training camps….c **Mass Media** Radio……………. d Television………. e Cinema/film…….. f Print material……g Hoarding/wall painting………….h Others________ i ***(Specify)***	Interpersonal visit… a **Group Meeting** Youth club……….b Orientation training camps….c **Mass Media** Radio……………. d Television………. e Cinema/film…….. f Print material……g Hoarding/wall painting………….h Others________ i ***(Specify)***	Interpersonal visit… a **Group Meeting** Youth club……….b Orientation training camps….c **Mass Media** Radio……………. d Television………. e Cinema/film…….. f Print material……g Hoarding/wall painting………….h Others________ i ***(Specify)***	Interpersonal visit… a **Group Meeting** Youth club……….b Orientation training camps….c **Mass Media** Radio……………. d Television………. e Cinema/film…….. f Print material……g Hoarding/wall painting………….h Others________ i ***(Specify)***
203	What was the message mostly about?	How many children to have…………. 1 To stop having children…………. 2 To space children…………. 3 To postpone first birth……….. 4 Do not recall…….5	How many children to have…………. 1 Health of foetus…………… 2 Health of mother…. 3 Vaccination of women…………..4 Do not recall………… 5	Place of delivery……….. 1 How many children to have…… 2 Health of new born….. 3 Health of mother……… 4 Vaccination of newborn……… 5 Do not recall…. 6	Need for postpartum care……… 1 Vaccination of newborn……. 2 Health care of newborn…….. 3 Health of the mother……….. 4 Breastfeeding…. 5 Do not recall….. 6	Prevention…… 1 Curative facility.. 2 Social acceptance……. 3 Spread of disease…….. 4 Do not recall….. 5	Prevention…… 1 Curative facility.. 2 Social acceptance……. 3 Spread of disease…….. 4 Do not recall….. 5

S. No		Family planning	Pregnancy care	Delivery care	Postpartum care	AIDS	Other reproductive health problems
		i	ii	iii	iv	v	vi
204	How many contacts have you had in the last six months with any female healthcare provider (from both government and private sectors)?	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00
205	How many contacts have you had in the last six months with any male healthcare provider (from both government and private sectors)? **Check: Responses to Q204 and Q205. If no contacts made, skip to Q212**	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00
206	In how many of those total contacts was (mention each subject) discussed?	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00

207	When was the last contact made?	Days……	a ☐☐
		Months……	b ☐☐
		Do not remember……	97
208	With whom was your last contact?	Government allopathic doctor…	11
		Government ISM practitioner…	12
		MPHA……	13
		Male health worker……	14
		Private allopathic doctor……	15
		Private ISM practitioner……	16
		Voluntary organisation worker…	17
		Industry/ESI clinic worker……	18
		Aanganwadi worker……	19
		Village health guide……	20
		Dai (TBA)……	21
		Medical shop……	22
		General merchant/*kirana* shop…	23
		Teachers/informal and formal leaders……	24
		Others***(Specify)***_____	96
209	Were you satisfied with the information/ services this person provided?	Yes	1
		No	2→Q211
210	Reasons for satisfaction?	Complete information given……	a
		No physical complication……	b
		Services available when needed…	c
		Side effects attended to……	d
		Supplies available……	f
		Inexpensive……	g
		Convenient to reach……	h
		Attended promptly……	i
		Courteous staff……	j
		Staff available……	k
		Female health staff available…	l
	Circle all responses mentioned	Service site open……	m
		Others***(Specify)***_____	x
			→Q212
211	Reasons for dissatisfaction?	Inadequate information……	a
		Physical complication at the time of service……	b
		Was asked to come another time…	c
		Side effects not attended to……	d
		Supplies not available……	e
		Expensive……	f
		Too far……	g
		Too much time spent……	h
		Staff was discourteous……	i
	Circle all responses mentioned	Staff not available……	j
		Service site not open……	k
		Others***(Specify)***_____	x

SECTION 2B: INFORMATION ON ACCESS

I would like to ask some questions about where information and services can be obtained for different aspects of reproductive health

S.No		Oral contraceptives/ condoms/IUD	Medical termination of pregnancy (abortion)	Sterilisation	Pregnancy care	Delivery care	Postpartum care	Other health problems of women	STDs	AIDS
		i	ii	iii	iv	v	vi	vii	viii	ix
212	Tell me all the places you know that provide **(services)?**									
Check:		- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned →	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned
213	What is the nearest source for the (service)?									

Codes for Q212 & Q213

Govt/Medical college hospital…………	11	ISM practitioners (p)……………..	18	Depot holders……………………..	24
PHC/Additional PHC…………………	12	MPHAs……………………………	19	General/*kirana* merchant shops …..	25
Sub-centre…………………………….	13	Aanganwadi workers…………….	20	Camps…………………………….	26
Private hospital………………………..	14	TBAs (*Dais*)……………………….	21	Others______________________	96
Voluntary agencies…………………….	15	Medical shops…………………….	22	***(Specify)***	
Industrial units/ESI clinics/hospitals…...	16	Pan shops…. …………………….	23	DK……………………………….	97
Allopathic doctors (p)…………………	17			NA……………………………….	98

S.No		Oral contraceptives/ condoms/IUD	Medical termination of pregnancy (abortion)	Sterilisation	Pregnancy care	Delivery care	Postpartum care	Other health problems of women	STDs	AIDS
		i	ii	iii	iv	v	vi	vii	viii	ix
214	Where is the source located?	Village….. 1 Name of the village ________ Town/City… 2 Name of the town ________	Village….. 1 Name of the village ________ Town/City… 2 Name of the town ________	Village….. 1 Name of the village ________ Town/City… 2 Name of the town ________	Village….. 1 Name of the village ________ Town/City… 2 Name of the town ________	Village….. 1 Name of the village ________ Town/City… 2 Name of the town ________	Village….. 1 Name of the village ________ Town/City… 2 Name of the town ________	Village….. 1 Name of the village ________ Town/City… 2 Name of the town ________	Village….. 1 Name of the village ________ Town/City… 2 Name of the town ________	Village….. 1 Name of the village ________ Town/City… 2 Name of the town ________
215	How far is this place from where you live?	Km ☐☐☐☐ Code 998 if in same village	Km ☐☐☐☐ Code 998 if in same village	Km ☐☐☐☐ Code 998 if in same village	Km ☐☐☐☐ Code 998 if in same village	Km ☐☐☐☐ Code 998 if in same village	Km ☐☐☐☐ Code 998 if in same village	Km ☐☐☐☐ Code 998 if in same village	Km ☐☐☐☐ Code 998 if in same village	Km ☐☐☐☐ Code 998 if in same village
216	How long (in minutes) does it take to reach this source?	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐

SECTION 3: CURRENT AND FUTURE USE OF FAMILY PLANNING

301	Prior to first pregnancy did you and your husband ever discuss the number of children you should have?	Yes..... 1 No..... 2
302	Did you and your husband ever discuss the use of a family planning method?	Yes..... 1 No..... 2
303	Did you and your husband discuss the following aspects at any time?	Yes / No Postponing children..... 1 / 2 Gap between children..... 1 / 2 Number of children..... 1 / 2 What FP method to use..... 1 / 2 Who should use..... 1 / 2 Source of FP method..... 1 / 2 Side effects of FP method..... 1 / 2 To seek health advice prior to use of FP method..... 1 / 2
304	Are you or your husband currently using a family planning method?	Yes..... 1 No..... 2→Q324
305	What method are you or your husband using?	Male sterilisation..... 11 Female sterilisation..... 12 IUD..... 13 Oral pills..... 14 Condoms..... 15 → Q310 Periodic abstinence. ..... 16 Withdrawal..... 17 Any other ..... 96 *(Specify)* → Q314
306	How long ago were you (your husband) operated for sterilisation?	Months..... a ☐☐ Years..... b ☐☐ Less than one month..... 00 DK..... 97
307	Have you (your husband) visited any of the health facilities for follow-up services after sterilisation?	Yes..... 1 No..... 2 DK..... 7 → Q309
308	Which health facility did you (your husband) visit?	Medical college hospital..... 11 Government hospital..... 12 PHC..... 13 Sub-centre..... 14 Private hospital/clinic..... 15 Voluntary agency/industry/ ESI hospital/clinic..... 16 Government ISM hospital/clinic.... 17 Private ISM hospital/clinic..... 18 Others_____ 96 *(Specify)*

309	Has anyone from the health department visited you (your husband) after sterilisation for follow-up services?	Yes..... 1 No..... 2 DK..... 7 → Q315
310	For how long have you (your husband) been using the method continuously?	Months..... a ☐☐ Years..... b ☐☐ Less than one month..... 00 DK..... 97
311	From where do you (your husband) usually obtain FP services?	Medical college hospital..... 11 Government hospital..... 12 PHC/Sub-centre..... 13 Government ISM hospital/clinic... 14 Private hospital/clinic..... 15 Private ISM hospital/clinic..... 16 Voluntary agency/industry/ ESI hospital/clinic..... 17 MPHA..... 18 *Dai (*TBA)..... 19 Medical shop..... 20 *Kirana* shop/*paan* shop..... 21 Others_____ 96 ***(Specify)***
312	On your last visit, did you receive any counselling about different FP methods?	Yes..... 1 No..... 2
313	Has any health worker visited you for follow-up services or supplies?	Yes..... 1 No..... 2 → Q315
314	For how long have you been using the method continuously?	Months..... a ☐☐ Years..... b ☐☐ Less than one month..... 00 DK..... 97
315	What is the main reason for using the family planning method?	Postpone pregnancy..... 11 Gap between pregnancies..... 12 Stop further pregnancies..... 13 Health concerns..... 14 Others_____ 96 ***(Specify)***
316	Who mainly motivated you (your husband) to use the family planning method?	Self..... 11 Husband..... 12 Both..... 13 Parents..... 14 Parents-in-law..... 15 Other relatives..... 16 Others_____ 96 ***(Specify)***

317	Who decided about the usage of this particular method?	Self..... 11 Husband..... 12 Both..... 13 Parents..... 14 Parents-in-law..... 15 Other relatives..... 16 Others_____ 96 ***(Specify)***
318	**Check: Q305 if coded '11' skip to Q331 if coded '15' skip to Q329**	
319	Did you at any time experience any health problems because of use of a family planning method?	Yes..... 1 No..... 2→Q323
320	Did you seek treatment for it?	Yes..... 1 No..... 2→Q323
321	Where did you seek treatment for it?	Medical college hospital..... 11 Government hospital..... 12 PHC..... 13 Sub-centre..... 14 Private hospital/clinic..... 15 Voluntary agency/industry/ ESI hospital/clinic..... 16 Government ISM hospital/clinic.... 17 Private ISM hospital/clinic..... 18 Others_____ 96 ***(Specify)***
322	Who assisted you to go for a treatment?	Self..... 11 Husband..... 12 Both..... 13 Parents..... 14 Parents-in-law..... 15 Other relatives..... 16 Others_____ 96 ***(Specify)***
323	**Check: Q305 if coded '12' skip to Q331 if coded '13' or '14' skip to Q329**	
324	What is the main reason you are not using it to delay or avoid pregnancy?	Husband away..... 11 **Fertility-related reasons** Not having sex..... 12 Infrequent sex..... 13 Menopausal/had hysterectomy... 14→Q331 Sub-fecund/In-fecund..... 15 Postpartum/breastfeeding..... 16 Wants more children..... 17 **Opposition to use** Opposed to FP..... 18 Husband opposed..... 19 Other people opposed..... 20 Against religion..... 21 **Lack of knowledge** Knows no method ..... 22 Knows no source..... 23

		Method-related reasons Health concerns..... 24 Worry about side effects..... 25 Hard-to-get method..... 26 Costs too much..... 27 Inconvenient to use..... 28 Afraid of sterilisation..... 29 Don't like existing methods..... 30 Others _____ 96 ***(Specify)***
325	Do you plan to use any family planning method in future?	Yes..... 1 No..... 2→Q329
326	Why do you want to use a family planning method?	Postpone pregnancy..... 11 Gap between pregnancies..... 12 Stop further pregnancies..... 13 Health concerns..... 14 Others_____ 96 ***(Specify)***
327	What methods will you or your husband use?	Male sterilisation..... 11 Female sterilisation..... 12 IUD..... 13 Oral pills..... 14 Condoms..... 15 Any other _____ 96 ***(Specify)*** Not sure/undecided..... 97
328	When do you or your husband plan to begin using it?	Months..... a ☐☐ Years..... b ☐☐ Less than one month..... 00 Undecided..... 97
329	How many more children would you like to have?	Number of additional children ☐☐ None..... 00→Q331 Undecided..... 97
330	When would you like to have the next child?	After months ☐☐ Undecided..... 97
331	During a woman's monthly menstrual cycle, that is, from the beginning of one period to the beginning of the next, when would you say a woman is most likely to become pregnant if she has intercourse?	Right before her period..... 11 During her period..... 12 About one week after her period begins..... 13 About two weeks after her period begins..... 14 All times are the same, it makes no difference..... 15 Others_____ 96 ***(Specify)*** DK..... 97

SECTION 4: OBSTETRIC HEALTH

I would like to ask you some questions about your health. All that you tell me will be kept strictly confidential and combined with the information gathered from other women for use in the report without any personal identification. If the meaning of any question is unclear, please ask me.

400	**Check Q113: If Yes, ask if she ever been pregnant since Diwali 2001**	Yes..... 1 No..... 2→Q460

I would like to ask you about your pregnancies in the past two years, whether the child was born alive, born dead, or the pregnancy was lost before full-term, that is, as a miscarriage or an abortion. I would like to start with your latest pregnancy before Diwali 2003.

Record twins and triplets on separate lines

Think back to your (last/previous) pregnancy before Diwali 2003.

401	402	403	404	405	406	407	408	409
S. No.	What was your age at that (last/ previous) pregnancy?	Was that a single or multiple pregnancies?	Was the baby born alive, born dead, or lost before full term, that is, as a miscarriage or an abortion?	Did that baby cry, move, or breath when it was born?	What name was given to that child?	Is/was (name) a boy or a girl?	In what month and year was (name) born? **Probe:** What is his/her birthday?	Is (name) still alive?
1	Age ☐☐ (completed years)	Single.... 1 Multiple.. 2 DK..... 7	Born alive... 1 → Q406 Born dead.... 2 Lost before full term..... 3 → Q412	Yes.. 1 No... 2 → Q412	_____ Name	Boy..1 Girl...2	Month ☐☐ Year ☐☐	Yes. 1 No. 2 → Q411
2	Age ☐☐ (completed years)	Single.... 1 Multiple.. 2 DK..... 7	Born alive... 1 → Q406 Born dead.... 2 Lost before full term..... 3 → Q412	Yes.. 1 No... 2 → Q412	_____ Name	Boy..1 Girl...2	Month ☐☐ Year ☐☐	Yes. 1 No. 2 → Q411
3	Age ☐☐ (completed years)	Single.... 1 Multiple.. 2 DK..... 7	Born alive... 1 → Q406 Born dead.... 2 Lost before full term..... 3 → Q412	Yes.. 1 No... 2 → Q412	_____ Name	Boy..1 Girl...2	Month ☐☐ Year ☐☐	Yes. 1 No. 2 → Q411

Record twins and triplets on separate lines

410		411	412	413	414	415
If born alive				Born dead	If born dead or lost before full term	If lost before full term
Still alive		Now dead				
If alive: How old was (name) at his/her last birthday? **Record in years.**		**If dead:** How old was he/she when he/she died? If "1 Year," **Probe:** How many months old was (name)? **Record days if less than month, months if less than two years, otherwise record only in completed years.**	How many months did the pregnancy last? **Record in completed months.**	Was that baby a boy or a girl?	In what month and year did this pregnancy end?	Did this pregnancy end by itself or did you or someone else do something to end it?
1	Age in years ☐ →Q412	Need a prefix (1 to 3) in front of box Days..... 1 ☐☐ Months.. 2 ☐☐ Years..... 3 ☐☐	Month ☐ **If live birth go to next pregnancy or skip to Q 416**	Boy.....1 Girl.....2 DK.....7	Month ☐ Year ☐	Spontaneous.1 Induced.....2 **(Go to next pregnancy or if no more skip to Q416)**
2	Age in years ☐ →Q412	Need a prefix (1 to 3) in front of box Days..... 1 ☐☐ Months.. 2 ☐☐ Years..... 3 ☐☐	Month ☐ **If live birth go to next pregnancy or skip to Q 416**	Boy.....1 Girl.....2 DK.....7	Month ☐ Year ☐	Spontaneous.1 Induced.....2 **(Go to next pregnancy or if no more skip to Q416)**
3	Age in years ☐ →Q412	Need a prefix (1 to 3) in front of box Days..... 1 ☐☐ Months.. 2 ☐☐ Years..... 3 ☐☐	Month ☐ **If live birth go to next pregnancy or skip to Q 416**	Boy.....1 Girl.....2 DK.....7	Month ☐ Year ☐	Spontaneous.1 Induced.....2 **(Go to next pregnancy or if no more skip to Q416)**

Check: Q401 for last pregnancy prior to Diwali 2003 i.e. written in the first row.
I would like to ask you some further questions about the last pregnancy you had.

416	When you learned of this pregnancy, did you want to become pregnant then, did you want to wait until later, or did you want no (more) children at all?	Then..... 1→Q418 Later..... 2 No more..... 3
417	When you later/no more wanted to become pregnant, how did this happen?	Accidental..... 11 Did not know how to prevent..... 12 Could not oppose sex with husband ..... 13 Husband wanted a child..... 14 In-laws wanted a child..... 15 Others_____ 96 ***(Specify)***
418	During this pregnancy, did you see anyone for antenatal care? If yes, whom did you see? Anyone else? *Record all persons seen*	Allopathic doctor..... a MPHA(F)..... b Any other health personal..... c *Dai* ..... d Others _____ x ***(Specify)*** No one..... f→Q427
419	Did you see a doctor, nurse or midwife for an antenatal check up during the last month of this pregnancy?	Yes..... 1 No..... 2
420	Who advised you to show yourself for an antenatal check-up?	Husband..... 11 Mother/mother-in-law..... 12 Relative..... 13 Neighbour..... 14 *Dai*..... 15 Nurse/doctor..... 16 Self..... 17 Others_____ 96 ***(Specify)***
421	Who decided about whether you should go for an antenatal check up or not?	Husband..... 11 Mother/mother-in-law..... 12 Relative..... 13 Neighbour..... 14 *Dai*..... 15 Nurse/doctor..... 16 Self..... 17 Others_____ 96 ***(Specify)***
422	Where did you go for the antenatal check-ups? *Circle all responses mentioned*	PHC/Sub-centre..... a Govt. hospital..... b Pvt. hospital..... c Pvt. doctor/clinic..... d RMP/compounder..... e *Dai*..... f Others_____ x ***(Specify)***

423	Did you have the following performed at least once during any of your antenatal check-ups during this pregnancy?	Yes	No
	Weight measured……	1	2
	Height measured……	1	2
	Blood pressure checked……	1	2
	Blood test……	1	2
	Urine test……	1	2
	Abdomen measured with tape……	1	2
	Listened to baby' heartbeat……	1	2
	Internal exam……	1	2
	X-ray taken……	1	2
	Scanned/seen baby on a TV screen ……	1	2
	Amniocentesis……	1	2
424	Did you receive advice on any of the following during at least one of your antenatal check-ups for this pregnancy?	Yes	No
	Diet……	1	2
	Danger signs of pregnancy……	1	2
	Delivery care……	1	2
	Newborn care……	1	2
	Family planning……	1	2
425	When you were pregnant, were you given an injection in the arm to prevent you and the baby from getting tetanus?	Yes……	1
		No……	2
		DK……	7
426	When you were pregnant were you given any iron folic tablets or syrup?	Yes……	1
		No……	2 → Q428
427	What is the main reason you did not receive an antenatal check-up?	Always felt well/Not necessary…	a
		Don't know where togo / where it is……	b
		Not customary…… …	c
		Too far away……	d
		No transportation……	e
		Cost too much……	f
		No time to go……	g
		Not open when I could go……	h
		Attitude of doctors/nursesnot good……	i
		Service not good/no medicine……	j
		Family did not allow……	k
	Circle all responses mentioned	No one to care children……	l
		Others _____ ***(Specify)***	x
428	Did you have any of these illness or problems during last/current pregnancy?	Yes	No
	Swelling of hands and feet……	1	2
	Blurred vision……	1	2
	Giddiness……	1	2
	Fits……	1	2
	Urinary problem……	1	2
	Varicose veins……	1	2

	Fever >3days.....	1	2
	High blood pressure.....	1	2
	Severe vomiting whether treatment required.....	1	2
	Tuberculosis.....	1	2
	Malaria.....	1	2
	Heart disease.....	1	2
	Diabetes.....	1	2
	No movement of foetus.....	1	2
	Bleeding.....	1	2
	Others _____ ***(Specify)***	1	2
429	What type of care and cooperation did your husband extend to you when you were pregnant? *Circle all responses mentioned*	Talk affectionately..... a Express concern towards health... b Take you to an antenatal checkup..... c Arrange with someone to go to antenatal check up..... d Arrange/assist in transportation... e Get fruits/sweets for you..... f Take interest towards your diet... g Monitor on intake of medicines... h Manage older children..... i Assist in household work..... j Any other_____ x ***(Specify)*** Not necessary..... k	
430	In your opinion when a wife is pregnant should a husband extend the following care/cooperation?	Yes	No
	Talk affectionately.....	1	2
	Express concern towards health.....	1	2
	Take her to an antenatal checkup.....	1	2
	Arrange with someone to go to antenatal checkup.....	1	2
	Arrange/assist in transportation.....	1	2
	Get fruits/sweets for her.....	1	2
	Take interest towards her diet.....	1	2
	Monitor on intake of medicines.....	1	2
	Manage older children.....	1	2
	Assist in household work.....	1	2
	Any other ***(Specify)***_____	1	2
431	**Check: Q404 if coded 1 or 2 then ask Q432 or skip to Q448**		
432	Where did you originally plan to have your delivery?	PHC/Sub-centre..... 11 Govt. hospital..... 12 Private hospital..... 13 Home..... 14 Home of birth attendant..... 15 Others _____ 96 ***(Specify)***	

433	Where did you finally have your delivery?	PHC/Sub-centre..... 11 Govt. hospital..... 12 Private hospital..... 13 Parent's home..... 14 Natal home..... 15 Home of birth attendant..... 16 Others _____ 96 ***(Specify)***
434	Who attended you at the time of delivery?	No one..... 11 Relative..... 12 Untrained *dai*..... 13 Trained *dai*..... 14 MPHA (F)..... ..... 15 Doctor..... 16 Nurse..... 17 Others _____ 96 ***(Specify)***
435	Who was the person most responsible for having the delivery at (Q433)?	Husband..... 11 Mother/mother-in-law..... 12 Father/father-in-law..... 13 Elder female relatives..... 14 Neighbours..... 15 Others_____ 96 ***(Specify)***
436	Did you experience any of the following at the time of delivery? Labour more than 18 hours..... Use of forceps..... Excessive bleeding (More than 3 saris stained)..... Sac burst and even after 5 hours child was not born..... Sac burst and the fluid was greenish coloured..... Fainted during labour..... Fits or convulsions..... Baby was in breech position/not in normal position..... Placenta was down..... Twins/multiple births..... High BP..... Caesarean..... Others_____ ***(Specify)***	Yes / No 1 / 2 1 / 2 1 / 2 1 / 2 1 / 2 1 / 2 1 / 2 1 / 2 1 / 2 1 / 2 1 / 2 1 / 2 1 / 2
437	In which way did your husband extend help at the time of childbirth? *Circle all responses mentioned*	Called for an assistant/health personnel..... a Arranged transportation..... b Getting necessary items/ medicines..... c Financial help..... d Emotional support..... e Did not help at all..... f Any other_____ x ***(Specify)*** Not necessary..... g

438	In your opinion at the time of a wife's delivery should a husband extend the following help?	Yes / No Calling persons to assist her..... 1 2 Arranging transportation..... 1 2 Bringing necessary items/medicines..... 1 2 Financial help..... 1 2 Emotional help..... 1 2 Husband has no role to play..... 1 2 Any other ***(Specify)***_____ 1 2
439	Did you have a health check up done during first six weeks after childbirth?	Yes..... 1 No..... 2→Q442
440	Within how many days after childbirth did you have a check up?	Days ☐☐
441	Where did you go for a health check up? *Record all persons seen*	PHC/sub-centre..... a Govt. hospital..... b Pvt. hospital..... c Pvt. doctor/clinic..... d RMP/compounder..... e *Dai*..... f Traditional healers..... g Others_____ x ***(Specify)***
442	Did you face any of these problems/ illnesses during first two months after the delivery:	Yes / No Pus formation in tare..... 1 2 Fever >3 days..... 1 2 Loss of consciousness for >15 minutes..... 1 2 Pain in lower abdomen..... 1 2 Painful, burning feeling when urinating.... 1 2 Changes in mental make-up..... 1 2 Fits/convulsions..... 1 2 Discharge that smells..... 1 2 Breast abscess..... 1 2 Excess bleeding..... 1 2 Depression..... 1 2 Backache..... 1 2 Others _____ 1 2 ***(Specify)***
443	In general, what type of care is a woman supposed to take after childbirth? *Circle all responses mentioned*	Nutritional diet..... a Restricted diet..... b Adequate rest..... c Not to indulge in heavy work..... d Abstaining from sex ..... e Feeding practices..... f Regular health checkup..... g Any other _____ x ***(Specify)***
444	How many days after childbirth did you start doing household work?	Days ☐☐☐

445	Did you do any of the following within six weeks after the childbirth?	Yes / No Carrying older children..... 1 / 2 Rinsing clothes..... 1 / 2 Bring water from distance..... 1 / 2 Lifting heavy items..... 1 / 2
446	What kind of assistance did your husband provide to you after the childbirth? *Circle all responses mentioned*	Arrange/take you for a health checkup..... a Managing older children..... b Not allowing you to strain physically..... c Providing physical help..... d Extending emotional support..... e Any other _____ f ***(Specify)***
447	In your opinion should a husband support his wife after the childbirth in following ways?	Yes / No Arrange/take her for a health checkup..... 1 / 2 Managing older children..... 1 / 2 Not allowing her to lift objects..... 1 / 2 Providing physical help..... 1 / 2 Extending emotional support..... 1 / 2 Any other_____ ***(Specify)***
448	**Check: Q404 if she had abortion, go to Q449 or skip to Q457**	
449	**Check: Q415 if she had induced abortion, ask Q450 or skip to Q454**	
450	What circumstances led you to have the (last) abortion? *Probe/Circle all responses mentioned*	Advised by doctor..... a Postpone/space/limit children..... b In-laws wanted it..... c Husband wanted it..... d After sex determination test..... e Any other_____ x ***(Specify)***
451	Who mainly decided for the (last) abortion?	Self..... 11 Husband..... 12 Parents-in-law..... 13 Parents..... 14 Doctor/nurse..... 15 Informal health care providers.... 16 Others_____ 96 ***(Specify)***
452	Where did you have the (last) abortion?	PHC..... 11 Govt. hospital ..... 12 Pvt. hospital... ..... 13 *Dai*..... 14 RMP..... 15 Pharmacy..... 16 Others_____ 96 ***(Specify)***

453	Was your husband willing for the (last) abortion?	Yes…….. No……	1 2
454	Did you seek healthcare after the (last) abortion?	Yes…….. No……	1 2→Q456
455	Where did you go for the healthcare?	PHC…….. Govt. hospital …….. Pvt. Hospital …….. Pvt. Clinic …….. *Dai*…….. RMP…….. Traditional healers…….. Others _____ ***(Specify)***	11 12 13 14 15 16 17 96 →Q 457
456	Why did you not seek healthcare after the (last) abortion? *Circle all responses mentioned*	Did not want others to know…. Husband did not allow…….. Family did not allow…….. Service not good/no medicine… Attitude of doctors/nursesnot good…….. Don't know where to go…….. Not necessary…….. Too far away…….. No transportation…….. Cost too much…….. No time to go…….. Not open when I could go…….. No one to care children…….. Others _____ ***(Specify)***	a b c d e f g h i j k l m x
457	In your opinion at the time of a wife's delivery should a husband extend the following help? Calling persons to assist her…….. Arranging transportation…….. Bringing necessary items/medicines…….. Financial help…….. Emotional help…….. Husband has no role to play…….. Any other_____ ***(Specify)***	Yes 1 1 1 1 1 1 1	No 2 2 2 2 2 2 2
458	In your opinion should a husband support his wife after the childbirth in following ways? Arrange/take her for a health checkup…… Managing older children…….. Not allowing her to lift objects…….. Providing physical help…….. Extending emotional support…….. Any other_____ ***(Specify)***	Yes 1 1 1 1 1 1	No 2 2 2 2 2 2

459	After delivery/abortion did you experience any of these problems?	Yes	No
	Feeling of heaviness in the abdomen or feeling of uterus coming down……	1	2
	Experienced problem of passing of urine such as passing urine all the time or when coughing, sneezing……	1	2
	Passing stools through the vaginal opening……	1	2
	Piles……	1	2
	Any other_____	1	2
	(Specify)_____		→Q467
460	At any time did you become pregnant prior to Diwali 2001?	Yes……	1
		No……	2→Q467
461	At any time during your previous pregnancies did you face any of the following health problems?	Yes	No
	Swelling of hands and feet……	1	2
	Blurred vision……	1	2
	Giddiness……	1	2
	Fits……	1	2
	Urinary problem……	1	2
	Varicose veins……	1	2
	Fever >3days……	1	2
	High blood pressure…… ……	1	2
	Severe vomiting whether treatment required……	1	2
	Tuberculosis……	1	2
	Malaria……	1	2
	Heart disease……	1	2
	Diabetes……	1	2
	No movement of foetus……	1	2
	Bleeding……	1	2
	Others_____	1	2
	(Specify)		
462	In your opinion when a wife is pregnant should a husband extend the following care/cooperation?	Yes	No
	Talk affectionately……	1	2
	Express concern towards health……	1	2
	Take her to an antenatal checkup……	1	2
	Arrange with someone to go to antenatal checkup……	1	2
	Arrange/assist in transportation……	1	2
	Get fruits/sweets for her……	1	2
	Take interest towards her diet……	1	2
	Monitor intake of medicines……	1	2
	Manage older children……	1	2
	Assist in household work……	1	2
	Any other _____	1	2
	(Specify)		

463	At any time during your previous deliveries, did you experience any of the following?	Yes	No
	Labour more than 18 hours.....	1	2
	Use of forceps.....	1	2
	Excessive bleeding (More than 3 saris stained).....	1	2
	Sac burst and even after 5 hours child was not born.....	1	2
	Sac burst and the fluid was greenish coloured.....	1	2
	Fainted during labour.....	1	2
	Fits or convulsions.....	1	2
	Baby was in breech position/not in normal position.....	1	2
	Placenta was down.....	1	2
	Twins/multiple births.....	1	2
464	In your opinion at the time of wife's delivery should a husband extend the following help?	Yes	No
	Calling persons to assist her.....	1	2
	Arranging transportation.....	1	2
	Bringing necessary items/medicines.....	1	2
	Financial help.....	1	2
	Emotional help.....	1	2
	Husband has no role to play.....	1	2
	Any other _____ ***(Specify)***	1	2
465	Did you face any of these problems/ illnesses during first two months after any of the deliveries?	Yes	No
	Pus formation in tare.....	1	2
	Fever >3 days.....	1	2
	Loss of consciousness for >15 minutes	1	2
	Pain in lower abdomen.....	1	2
	Painful, burning feeling when urinating....	1	2
	Changes in mental make-up.....	1	2
	Fits/convulsions.....	1	2
	Discharge that smells.....	1	2
	Breast abscess.....	1	2
	Excess bleeding.....	1	2
	Depression.....	1	2
	Backache.....	1	2
	Others _____ ***(Specify)***	1	2
466	In your opinion should a husband support his wife after the childbirth in following ways?	Yes	No
	Arrange/take you for a health checkup.....	1	2
	Managing older children.....	1	2
	Not lifting you to strain physically.....	1	2
	Providing physical help.....	1	2
	Extending emotional support.....	1	2
	Any other _____ ***(Specify)***	1	2

Now, I would like to ask some general questions which are not related to you		
467	In your opinion can a woman go for an abortion?	Yes..... 1 No..... 2
468	For reasons related to a woman's health, can she go for an abortion?	Yes..... 1 No..... 2
469	To stop further children, can a woman go for an abortion?	Yes..... 1 No..... 2
470	To postpone first child can a woman go for an abortion?	Yes..... 1 No..... 2
471	To have space between children can a woman go for an abortion?	Yes..... 1 No..... 2
472	If a woman wants to go for an abortion, is she required to seek permission? If yes, from whom? *Circle all responses mentioned*	Husband..... a In-laws..... b Parents..... c Health personnel..... d Others _____ x ***(Specify)*** Not necessary..... e
473	Should husband and wife discuss prior to taking a decision related to abortion?	Yes..... 1 No..... 2→Q475
474	On what aspect should they discuss prior to abortion? *Circle all responses mentioned*	To decide on abortion ..... a Place of abortion..... b Method of abortion..... c Health consequences..... d Future fertility..... e Social consequences..... f Ethical consequences..... g Financial aspects..... h Any other_____ x ***(Specify)***
475	If husband is un willing for abortion, do you think a woman should go ahead? *Probe* *Due to health or other genuine reasons*	Yes..... 1 No..... 2
476	Who should accompany a woman while going for an abortion? *Probe/Record all persons mentioned*	Husband..... a Mother..... b Mother-in-law..... c Sister..... d Relatives..... e Others _____ x ***(Specify)***
477	Do you think is it essential for a husband to be present when a woman undergoes abortion?	Yes..... 1 No..... 2
478	Why do you think so?	
479	Is it necessary to seek health personnel's advice prior to deciding on to have an abortion?	Yes..... 1 No..... 2

SECTION 5: REPRODUCTIVE KNOWLEDGE AND HEALTH

I would like to ask you some questions about reproduction and pregnancy

501	Since puberty and until marriage did you face any kind of problems related to menstruation vaginal discharge? *Circle all responses mentioned*	Irregular periods..... a Prolonged menstruation..... b Abdominal pain..... c Nausea..... d Any other_____ x ***(Specify)*** No problem..... f→Q504
502	Whom did you consult? *Record all persons seen*	Allopathic doctor..... a MPHA..... b Any other health personal..... c *Dai*..... d Others_____ x ***(Specify)*** None..... ..... f
503	Were you cured of these problems?	Yes..... 1 No..... 2
504	Even though most pregnancies are normal, some women do experience complications, which can lead to sickness and even death, if untreated. Can you tell me some of the symptoms a woman can experience during pregnancy and childbirth, which should be viewed as a warning that such problems might occur? *Probe /Circle all responses mentioned*	Vaginal bleeding during pregnancy..... a High fever..... b Abdominal pain..... c Swelling of hands and face..... d Prolonged labour for more than 12 hours..... e Convulsions..... f Other _____ x ***(Specify)*** DK..... g
505	During the past three months, have you had a problem with an abnormal vaginal discharge?	Yes..... 1 No..... 2
506	Have you had any itching or irritation in your vaginal area with this discharge?	Yes..... 1 No..... 2
507	Have you noticed a bad odour in your vaginal area with this discharge?	Yes..... 1 No..... 2
508	In the past three months, did you have any severe lower abdominal pain with the discharge, not related with menstruation?	Yes..... 1 No..... 2
509	Did you have fever along with the discharge?	Yes..... 1 No..... 2
510	Did you have giddiness along with discharge?	Yes..... 1 No..... 2
511	During the past three months have you had a problem with pain or burning while urinating, or have you had more frequent or difficult urination?	Yes..... 1 No..... 2

512	Another problem some women have is feeling pain in their abdomen or vagina during intercourse. Do you often experience this kind of pain?	Yes.....1 No.....2→514	
513	Where did you experience this pain?	Yes	No
	Mouth of birth canal.....	1	2
	Interior of birth canal.....	1	2
514	Do you ever see blood after having sex, at times when you are not menstruating?	Yes.....	1
		No.....	2
515	**Check: Q505 to 514 if 'Yes' to any of the questions ask Q516 or skip to Q520**		
516	When you had the problem could you discuss it with anyone?	Husband.....	a
		Mother/mother-in-law.....	b
		Elder female relatives.....	c
		Neighbours.....	d
	Record all persons mentioned	Others _____	x
		(Specify)	
517	In your opinion when a wife suffers from such problems, is it necessary for her to discuss it with her husband?	Yes.....	1
		No.....	2
518	Have you seen anyone for advice or treatment to help you with these problem(s)?	Yes.....	1
		No.....	2→Q520
519	Whom did you see?	Allopathic doctor.....	a
		ANM/LHV/midwife.....	b
		Any other health personal.....	c
		Dai.....	d
	Record all persons seen	Other_____	x
		(Specify)	
520	Do you have regular menstruation?	Yes.....	1
		Menopause.....	2
		Hysterectomy.....	3
			Q522 ↓
521	Did you notice any of the following related to menstruation in your case?	Yes	No
	Cycle occurs in less than 21 days	1	2
	Cycle occurs in more than 40 days	1	2
	Volume of menstruation is heavy	1	2
	Duration is more than 7 days	1	2
	Spotting between the cycle	1	2
522	Did you ever notice a prolapsed uterus?	Yes.....	1
		No.....	2
523	**Check: Q520 if coded '2' or '3' ask Q524 or skip to Q526**		
524	Did you experience health problems after menopause/hysterectomy?	Yes.....	1
		No.....	2→Q526
525	What type of problems did you face?		
526	How many times in a week do you take a bath?	At least once a day.....	1
		Twice a day.....	2
		Alternate days.....	3
		Twice or less a week.....	4

SECTION 6: PSYCHOLOGICAL BEHAVIOUR

Now I am going to mention few statements. Please tell me if you strongly agree, agree, disagree or strongly disagree with the following statements.

A: LOCUS OF CONTROL

601	If one of the couple does not desire, they cannot have sex.	Strongly agree…… Agree…… Disagree…… Strongly disagree……	1 2 3 4
602	Most often it is not possible to prevent a pregnancy. If a woman is meant to be pregnant, she will be pregnant	Strongly agree…… Agree…… Disagree…… Strongly disagree……	1 2 3 4
603	A couple can limit the number of children they have	Strongly agree…… Agree…… Disagree…… Strongly disagree……	1 2 3 4
604	Luck plays a big part in determining whether a woman can keep from getting pregnant.	Strongly agree…… Agree…… Disagree…… Strongly disagree……	1 2 3 4
605	If a couple is careful, an unwanted pregnancy will rarely happen.	Strongly agree…… Agree…… Disagree…… Strongly disagree……	1 2 3 4

B: SELF-EFFICACY

606	**Ask only those not currently using contraceptives. Check: Q304 if 'Yes' skip to Q612**		
607	I am capable of obtaining a method of family planning	Strongly agree…… Agree…… Disagree…… Strongly disagree……	1 2 3 4
608	I would have great difficulty always remembering to use contraception in order to avoid getting pregnant.	Strongly agree…… Agree…… Disagree…… Strongly disagree……	1 2 3 4
609	If I could not get contraception, I could still keep myself from getting pregnant by refraining from sexual activity.	Strongly agree…… Agree…… Disagree…… Strongly disagree……	1 2 3 4
610	I am capable of using a contraceptive method every time I need.	Strongly agree…… Agree…… Disagree…… Strongly disagree……	1 2 3 4
611	Negotiating with my husband about the use of a method of family planning would be impossible for me.	Strongly agree…… Agree…… Disagree…… Strongly disagree……	1 2 3 4
612	I am capable of persuading my husband not to have extra-marital sexual contacts.	Strongly agree…… Agree…… Disagree…… Strongly disagree……	1 2 3 4
613	I am capable of seeking treatment if I have any gynaecological health problems	Strongly agree…… Agree…… Disagree…… Strongly disagree……	1 2 3 4

C: VALUE OF PREGNANCY AVOIDANCE

Now I am going to ask few questions. Please tell me how important you feel towards each of these questions. That is whether you feel very important, moderately important, mildly important or unimportant.

614	**Check: Q305 if sterilised...skip to Q701**	
615	**Check: Q329 if woman wants one or more children, skip to Q618**	
616	How important is it to you to have no more children?	Unimportant..... 1 Mildly important..... 2 Moderately important..... 3 Very important..... 4
617	Tell me how you respond to this statement: Because I do not want to have more children, I make sure that I am protected from getting pregnant.	Unimportant..... 1 Mildly important..... 2 Moderately important..... 3 Very important..... 4 →Q701
618	How important is it to you to delay the birth of your next child?	Unimportant..... 1 Mildly important..... 2 Moderately important..... 3 Very important..... 4
619	Tell me how you respond to this statement: Because I want to delay having more children, I make sure that I am protected from getting pregnant.	Unimportant..... 1 Mildly important..... 2 Moderately important..... 3 Very important..... 4

SECTION 7: FAMILY VIOLENCE

701	Thinking back to your childhood or adolescence, did you at any time see or hear your father physically beat or mistreat your mother?	Yes..... 1 No..... 2 No response..... 3 DK/do not remember..... 7
702	Did you at any time see your mother physically beat or mistreat your father?	Yes..... 1 No..... 2 No response..... 3 DK/do not remember..... 7
703	Were you ever physically hit, slapped, kicked or tried to hurt by your husband?	Yes..... 1 No..... 2 No response..... 3 DK/do not remember..... 7 → Q712
704	How many times did your husband behave this way with you?	Number of times ☐☐
705	How long ago was the first time your husband behaved this way with (physically hit/harmed) you? **Check: Q704 if number of times is <1...skip to Q707**	Month ..... a ☐☐ Year... ..... b ☐☐ Less than one month..... 00
706	How long ago was the last time your husband behaved this way with (physically hit/harmed) you?	Month ..... a ☐☐ Year... ..... b ☐☐ Less than one month..... 00
707	Did any of the following happen during the latest incident?	Yes / No Shouting/yelling..... 1 2 Slapping/pushing..... 1 2 Punching/kicking..... 1 2 Use of stick/weapon..... 1 2 Other _____ 1 2 ***(Specify)***
708	Were you pregnant at that time?	Was pregnant..... 1 Was not pregnant..... 2 DK..... 7
709	At the time of the last physical fight, how did you react? *Circle all responses mentioned*	Yelled and shouted..... a Hit and slapped..... b Cried..... c Ran away from house..... d Did nothing..... e Other _____ x ***(Specify)***
710	Did you seek help or support from any one after that?	Yes..... 1 No..... 2 Do not remember..... 7

711	Was it necessary for you to seek medical care afterwards?	Yes…… No…… Do not remember……	1 2 7
712	Did your husband ever have sex with you even if you were not willing?	Yes…… No…… Do not remember……	1 2 7 Q715
713	Did your husband ever physically force you to have sex ?	Yes…… No…… Do not remember……	1 2 7 Q715
714	How long ago was the last time this happened?	Month …… Year… …… Less than one month……	a ☐☐ b ☐☐ 00

ATTITUDES TOWARDS PHYSICAL CONTROL OF WIFE

715	Wife should always show respect to elders, particularly her in-laws in the family.	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7
716	Wife should always follow instructions given to her, whether liked or not, by elders, particularly her in-laws in the family	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7
717	If necessary one should use force to make wife listen to all instructions of elders, particularly her in-laws in the family.	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7
718	If wife disobeys instructions of elders, particularly her in-laws in the family, the following measures should be used. Verbal insults…… Physical isolation…… Physical beating…… Persuasion…… Other _____ ***(Specify)*** DK/can't say……	Yes 1 1 1 1 1 1	No 2 2 2 2 2 2
719	There is no harm if wife sometimes disagrees with instructions given to her by elders, particularly her in-laws in the family.	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7

720	No verbal insults and/or physical beating should be used against wife even if she does not follow instructions given to her by elders, particularly her in-laws in the family	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7
721	Wife should always show respect to her husband.	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7
722	Wife should always follow instructions given to her, whether she likes or not, by her husband.	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7
723	If necessary wife should be forced to listen to all instructions given to her by her husband.	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7
724	If wife disobeys instructions, the following measures should be taken. Verbal insults…… Physical isolation…… Physical beating…… Persuasion…… Other _____ ***(Specify)*** DK/can't say……	 Yes 1 1 1 1 1 1	 No 2 2 2 2 2 2
725	There is no harm if wife sometimes disobeys instructions given by her husband.	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7
726	No verbal insults and/or physical beating should be used against wife even if she does not follow instructions given by her husband.	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7

SECTION 8: SEXUAL ACTIVITY

Information about sexual behaviour is necessary for understanding reproductive health. All that you tell me will be kept strictly confidential and combined with the information gathered from other women for use in the report without any personal identification. In this section of the interview, I would like to talk with you about your sexual experiences.

801	How old were you at the time of your first sexual contact?	In completed years	☐☐
802	Were you aware about it before you actually participated in it?	Yes..... 1 No..... 2	
803	How did you feel about it when you first had an experience? ***Circle all responses mentioned***	Liked ..... a Disliked..... b Felt shy..... c Felt scared ..... d Other _____ x ***(Specify)***	
804	After marriage, the first time you had intercourse, did you or your husband use a family planning method?	Yes..... 1 No..... 2→Q806	
805	Did you and your husband ever talk about the risk of having an unwanted pregnancy?	Yes..... 1 No..... 2	
806	During your married life did you become pregnant at a time when you were not ready for it?	Yes..... 1 No..... 2 No child..... 7 Q808 ↓	
807	How many times did this happen?	Number of times	☐☐
808	How often have you had sex with your husband during menstrual period?	Never..... 1 Rarely..... 2 Some times..... 3 Frequently..... 4 Always..... 5	
809	**Check: Q114, Q120, Q122 if she ever gave birth or had abortion, ask Q810 or skip to Q811**		
810	How many days after (last) delivery/ abortion have you participated in coitus?	Number of days	☐☐
811	Did your husband stay with you in the last four weeks?	Yes..... 1 No..... 2→Q814	
812	For how many days did your husband stay with you in the last four weeks?	Number of days	☐☐
813	How many times did you have sex with your husband in the last four weeks?	Number of times None.....00	☐☐ ☐☐
814	Usually how many times per day do you have sex with your husband?	Number of times	☐☐

815	How long ago did you and your husband last have intercourse?	Days ……	a ☐☐
		Months……	b ☐☐
		Years ……	c ☐☐
816	Does your husband go to other women for sex?	Yes……	1
		Yes……	1
		DK……	7
817	Does your husband have any sexual health problems?	Yes……	1
		No……	2→Q822
818	Did he ever consult any one for treatment?	Yes……	1
		Self-treatment……	2
		No……	3
		DK……	7
			Q820
819	Whom did he consult for treatment?	Allopathic doctor……	a
		ISM doctor……	b
		Medical shop……	c
		Friends……	d
		Self-treatment……	e
	Record all persons seen	Other _____	x
		(Specify)	
820	Did he ever discuss this with you?	Yes……	1
		No……	2
821	Since he had problems, did he stop having sex with you?	Stopped……	1
		Less frequent……	2
		No change……	3
		Regularly uses condom……	4

822	I will now read you some statements about venereal diseases and sex behaviour. Please tell me if you agree or disagree with each of the statements ***(Do not probe)***.	Yes	No	DK
	A person contacts gonorrhoea only once, after that he or she becomes immune to the disease……	1	2	7
	Syphilis can be treated with penicillin and other antibiotics……	1	2	7
	Venereal diseases can be passed from a mother to her baby before or during birth..	1	2	7
	Some people who have venereal diseases show no symptoms at all……	1	2	7
	It is harmful for a man to have sex with another man……	1	2	7

THANK THE RESPONDENT FOR THE COOPERATION EXTENDED

Annexure 6

MEN'S SCHEDULE

(Confidential. For research purposes only)

IDENTIFICATION

1	Name of the village	
2	Household number	
3	Name of the head of the household	

INTERVIEWER'S VISITS AND RESULT

Interviewer's name	Interview result	Interview date
	Completed..... 1 Respondent absent..... 2 Postponed..... 3 Refused..... 4 Others _____ 5 ***(Specify)***	

VERIFIED BY

	Name	Date
Supervisor		
Field Editor		
Office Editor		

INFORMED CONSENT

Namaskaram. My name is _____. I am from the **Centre for Economic and Social Studies**. We are conducting a survey on Men's Participation in Reproductive Health. We appreciate your participation in this survey. As per research ethics, your name, the identity of your household, and any other information that you provide will not be revealed to anybody.

We hope that you will participate in the survey, as your views are important. Do you want to ask me anything about the survey?

Respondent agrees to the interview —— 1 → **Q101.**

Respondent does not agree to the interview —— 2 → **END**

Centre for Economic and Social Studies

Nizamia Observatory Campus, Begumpet, Hyderabad 500 016, Andhra Pradesh.

SECTION 1: BACKGROUND CHARACTERISTICS

101	What is your current marital status?	Currently married..... 1 Widowed..... 2 Separated/divorced..... 3 Never married..... 4 → END
102	What is your birth date?	Month ☐☐ DK month..... 97 Year ☐☐☐☐ DK year..... 97
103	What is your current age?	In completed years ☐☐
104	Are you married once or more than once?	Once..... 1 More than once..... 2
105	How old were you at the time of your (current)marriage?	In completed years ☐☐
106	How old were you when you started living with your wife?	In completed years ☐☐
107	How many years have passed since you are married?	In completed years ☐☐
108	What is the minimum legal age at marriage for a boy in India?	Age ☐☐
109	What is the minimum legal age at marriage for a girl in India?	Age ☐☐
110	How many children (live births) have you had with your (present) wife?	Total births ☐☐ None..... 00→Q114
111	How many are now surviving?	Total surviving ☐☐ None..... 00
112	How many are now not surviving?	Total not surviving ☐☐ None..... 00
113	When was your last child born?	Month ☐☐ DK month..... 97 Year ☐☐☐☐
114	Did your wife ever have a stillbirth?	Yes..... 1 No..... 2→Q116
115	How many times did she ever have stillbirth?	Number of times ☐☐

116	Did your wife ever have an abortion?	Yes..... 1 No..... 2→Q119
117	How many times did she ever have an abortion?	Number of times ☐☐ DK..... 97
118	The last time when she had an abortion, was it spontaneous or induced?	Spontaneous..... 1 Induced..... 2
119	Is your wife pregnant now?	Yes..... 1 No..... 2 DK..... 7 Q121
120	How many months is she pregnant?	Month ☐☐ DK month..... 97
121	Have you ever attended school?	Yes.....1→Q123 No.....2
122	Can you read and write?	Yes..... 1 No..... 2 Q124
123	How many years of schooling have you completed?	Years of schooling (completed years) ☐☐
124	What kind of work do you do most of the time?	

SECTION 2A: MEDIA EXPOSURE

Now I would like to ask you some questions about the media exposure you have had for different aspects of reproductive health

S. No		Family planning	Pregnancy care	Delivery care	Postpartum care	AIDS	Other reproductive health problems
		i	ii	iii	iv	v	vi
201	Have you heard or seen any message in the last one month?	Yes……….1 No……….2→Q204	Yes……….1 No……….2→Q204	Yes……….1 No……….2→Q204	Yes……….1 No……….2→Q204	Yes……….1 No……….2→Q204	Yes……….1 No……….2→Q204
202	Where did you see or hear this message about it in the last one month? ***Circle all responses mentioned***	Interpersonal visit… a **Group Meeting** Youth club……….b Orientation training camps….c **Mass Media** Radio……………. d Television………. e Cinema/film……..f Print material……g Hoarding/wall painting………….h Others________ i ***(Specify)***	Interpersonal visit… a **Group Meeting** Youth club……….b Orientation training camps….c **Mass Media** Radio……………. d Television………. e Cinema/film……..f Print material……g Hoarding/wall painting………….h Others________ i ***(Specify)***	Interpersonal visit… a **Group Meeting** Youth club……….b Orientation training camps….c **Mass Media** Radio……………. d Television………. e Cinema/film……..f Print material……g Hoarding/wall painting………….h Others________ i ***(Specify)***	Interpersonal visit… a **Group Meeting** Youth club……….b Orientation training camps….c **Mass Media** Radio……………. d Television………. e Cinema/film……..f Print material……g Hoarding/wall painting………….h Others________ i ***(Specify)***	Interpersonal visit… a **Group Meeting** Youth club……….b Orientation training camps….c **Mass Media** Radio……………. d Television………. e Cinema/film……..f Print material……g Hoarding/wall painting………….h Others________ i ***(Specify)***	Interpersonal visit… a **Group Meeting** Youth club……….b Orientation training camps….c **Mass Media** Radio……………. d Television………. e Cinema/film……..f Print material……g Hoarding/wall painting………….h Others________ i ***(Specify)***
203	What was the message mostly about?	How many children to have…………. 1 To stop having children…………. 2 To space children…………. 3 To postpone first birth……….. 4 Do not recall…….5	How many children to have…………. 1 Health of foetus…………… 2 Health of mother…. 3 Vaccination of women…………..4 Do not recall…….5	Place of delivery……….. 1 How many children to have…… 2 Health of new born….. 3 Health of mother……… 4 Vaccination of newborn……… 5 Do not recall…. 6	Need for postpartum care………. 1 Vaccination of newborn……. 2 Health care of newborn…….. 3 Health of the mother……….. 4 Breastfeeding…. 5 Do not recall….. 6	Prevention…… 1 Curative facility.. 2 Social acceptance……. 3 Spread of disease…….. 4 Do not recall….. 5	Prevention…… 1 Curative facility.. 2 Social acceptance……. 3 Spread of disease…….. 4 Do not recall….. 5

S. No		Family planning	Pregnancy care	Delivery care	Postpartum care	AIDS	Other reproductive health problems
		i	ii	iii	iv	v	vi
204	How many contacts have you had in the last six months with any female healthcare provider (from both government and private sectors)?	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00
205	How many contacts have you had in the last six months with any male healthcare provider (from both government and private sectors)? **Check: Responses to Q204 and Q205. If no contacts made, skip to Q212**	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00
206	In how many of those total contacts was (mention each subject) discussed?	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00	Number of contacts ☐☐ If none..... 00

207	When was the last contact made?	Days……	a ☐☐
		Months……	b ☐☐
		Do not remember……	97
208	With whom was your last contact?	Government allopathic doctor…	11
		Government ISM practitioner…	12
		MPHA……	13
		Male health worker……	14
		Private allopathic doctor……	15
		Private ISM practitioner……	16
		Voluntary organisation worker…	17
		Industry/ESI clinic worker……	18
		Aanganwadi worker……	19
		Village health guide……	20
		Dai (TBA)……	21
		Medical shop……	22
		General merchant/*kirana* shop…	23
		Teachers/informal and formal leaders……	24
		Others***(Specify)***_____	96
209	Were you satisfied with the information/ services this person provided?	Yes	1
		No	2→Q211
210	Reasons for satisfaction?	Complete information given……	a
		No physical complication……	b
		Services available when needed…	c
		Side effects attended to……	d
		Supplies available……	f
		Inexpensive……	g
		Convenient to reach……	h
		Attended promptly……	i
		Courteous staff……	j
		Staff available……	k
		Female health staff available…	l
	Circle all responses mentioned	Service site open……	m
		Others***(Specify)***_____	x
			→Q212
211	Reasons for dissatisfaction?	Inadequate information……	a
		Physical complication at the time of service……	b
		Was asked to come another time…	c
		Side effects not attended to……	d
		Supplies not available……	e
		Expensive……	f
		Too far……	g
		Too much time spent……	h
		Staff was discourteous……	i
	Circle all responses mentioned	Staff not available……	j
		Service site not open……	k
		Others***(Specify)***_____	x

SECTION 2B: INFORMATION ON ACCESS

I would like to ask some questions about where information and services can be obtained for different aspects of reproductive health

S.No		Oral contraceptives/ condoms/IUD	Medical termination of pregnancy (abortion)	Sterilisation	Pregnancy care	Delivery care	Postpartum care	Other health problems of women	STDs	AIDS
		i	ii	iii	iv	v	vi	vii	viii	ix
212	Tell me all the places you know that provide **(services)?**									
Check:		- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned →	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned	- If no source mentioned → - If one source mentioned → Q214 - If more than one source mentioned
213	What is the nearest source for the (service)?									

Codes for Q212 & Q213

Govt/Medical college hospital............	11	ISM practitioners (p).................	18	Depot holders..........................	24
PHC/Additional PHC......................	12	MPHAs.................................	19	General/*kirana* merchant shops	25
Sub-centre..................................	13	Aanganwadi workers.................	20	Camps..................................	26
Private hospital............................	14	TBAs (*Dais*)...........................	21	Others_______________	96
Voluntary agencies........................	15	Medical shops..........................	22	***(Specify)***	
Industrial units/ESI clinics/hospitals.....	16	Pan shops....	23	DK....................................	97
Allopathic doctors (p)......................	17			NA....................................	98

S.No		Oral contraceptives/ condoms/IUD	Medical termination of pregnancy (abortion)	Sterilisation	Pregnancy care	Delivery care	Postpartum care	Other health problems of women	STDs	AIDS
		i	ii	iii	iv	v	vi	vii	viii	ix
214	Where is the source located?	Village….. 1 Name of the village ______ Town/City… 2 Name of the town ______	Village….. 1 Name of the village ______ Town/City… 2 Name of the town ______	Village….. 1 Name of the village ______ Town/City… 2 Name of the town ______	Village….. 1 Name of the village ______ Town/City… 2 Name of the town ______	Village….. 1 Name of the village ______ Town/City… 2 Name of the town ______	Village….. 1 Name of the village ______ Town/City… 2 Name of the town ______	Village….. 1 Name of the village ______ Town/City… 2 Name of the town ______	Village….. 1 Name of the village ______ Town/City… 2 Name of the town ______	Village….. 1 Name of the village ______ Town/City… 2 Name of the town ______
215	How far is this place from where you live?	Km [ ][ ][ ][ ] Code 998 if in same village	Km [ ][ ][ ][ ] Code 998 if in same village	Km [ ][ ][ ][ ] Code 998 if in same village	Km [ ][ ][ ][ ] Code 998 if in same village	Km [ ][ ][ ][ ] Code 998 if in same village	Km [ ][ ][ ][ ] Code 998 if in same village	Km [ ][ ][ ][ ] Code 998 if in same village	Km [ ][ ][ ][ ] Code 998 if in same village	Km [ ][ ][ ][ ] Code 998 if in same village
216	How long (in minutes) does it take to reach this source?	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]	[ ][ ][ ][ ]

SECTION 3: CURRENT AND FUTURE USE OF FAMILY PLANNING

301	Prior to first pregnancy did you and your husband ever discuss the number of children you should have?	Yes..... 1 No..... 2
302	Did you and your wife discuss usage of a family planning method prior to first pregnancy?	Yes..... 1 No..... 2
303	Did you and your wife discuss the following aspects at any time?	Yes / No
	Postponing children.....	1 / 2
	Gap between children.....	1 / 2
	Number of children.....	1 / 2
	What FP method to use.....	1 / 2
	Who should use.....	1 / 2
	Source of FP method.....	1 / 2
	Side effects of FP method.....	1 / 2
	To seek health advice prior to use of FP method.....	1 / 2
304	Are you or your wife currently using a family planning method?	Yes..... 1 No..... 2→Q329
305	What method are you or your wife using?	Male sterilisation..... 11 Female sterilisation..... 12 IUD..... 13 Oral pills..... 14 Condoms..... 15 → Q310 Periodic abstinence. ..... 16 Withdrawal..... 17 Any other ..... 96 ***(Specify)*** → Q314
306	How long ago were you (your wife) operated for sterilisation?	Months..... a ☐☐ Years..... b ☐☐ Less than one month..... 00 DK..... 97
307	Have you (your wife) visited any of the health facilities for follow-up services after sterilisation?	Yes..... 1 No..... 2 DK..... 7 → Q309
308	Which health facility did you (your wife) visit?	Medical college hospital..... 11 Government hospital..... 12 PHC..... 13 Sub-centre..... 14 Private hospital/clinic..... 15 Voluntary agency/industry/ ESI hospital/clinic..... 16 Government ISM hospital/clinic.... 17 Private ISM hospital/clinic..... 18 Others_____ 96 ***(Specify)***

309	Has anyone from the health department visited you (your wife) after sterilisation for follow-up services?	Yes..... 1 No..... 2 DK..... 7 → Q315
310	For how long have you (your wife) been using the method continuously?	Months..... a ☐☐ Years..... b ☐☐ Less than one month..... 00 DK..... 97
311	From where do you (your wife) usually obtain FP services?	Medical college hospital..... 11 Government hospital..... 12 PHC/Sub-centre..... 13 Government ISM hospital/clinic... 14 Private hospital/clinic..... 15 Private ISM hospital/clinic..... 16 Voluntary agency/industry/ ESI hospital/clinic..... 17 MPHA..... 18 *Dai (*TBA)..... 19 Medical shop..... 20 *Kirana* shop/*paan* shop..... 21 Others_____ 96 ***(Specify)***
312	On your last visit, did you receive any counselling about different FP methods?	Yes..... 1 No..... 2
313	Has any health worker visited you for follow-up services or supplies?	Yes..... 1 No..... 2 → Q315
314	For how long have you been using the method continuously?	Months..... a ☐☐ Years..... b ☐☐ Less than one month..... 00 DK..... 97→Q334
315	What is the main reason for using the family planning method?	Postpone pregnancy..... 11 Gap between pregnancies..... 12 Stop further pregnancies..... 13 Health concerns..... 14 Others_____ 96 ***(Specify)***
316	Who mainly motivated you (your wife) to use the family planning method?	Self..... 11 wife..... 12 Both..... 13 Parents..... 14 Parents-in-law..... 15 Other relatives..... 16 Others_____ 96 ***(Specify)***

317	Who decided about the usage of this particular method?	Self…… wife…… Both…… Parents…… Parents-in-law…… Other relatives…… Others_____ ***(Specify)***	11 12 13 14 15 16 96
318	**Check: Q305 if coded '11' skip to Q336, if coded '13' or '14' skip to Q321, if coded '15' skip to Q334**		
319	Why did you not opt for sterilisation instead of your wife?		
320	In general between the couple who do you think should go for sterilisation?Why?		→Q324
321	Did you at any time use a family planning method?	Yes…… No……	1 2→Q323
322	Why are you not using it now?		→Q324
323	Why did you never want to use a family planning method?		
324	Did your wife at any time experience any health problems because of use of the family planning method?	Yes…… No……	1 2→Q328
325	Did she seek treatment for it?	Yes…… No……	1 2→Q328
326	Where did you seek treatment for it?	Medical college hospital…… Government hospital…… PHC…… Sub-centre…… Private hospital/clinic…… Voluntary agency/industry/ ESI hospital/clinic…… Government ISM hospital/clinic…. Private ISM hospital/clinic…… Others_____ ***(Specify)***	11 12 13 14 15 16 17 18 96
327	Who assisted her to go for a treatment?	Self…… Both…… Parents…… Parents-in-law…… Other relatives…… Others_____ ***(Specify)***	11 12 13 14 15 96
328	**Check: Q305 if coded '12' skip to Q336 if coded '13' or '14' skip to Q334**		

329	What is the main reason you or your wife are not using it to delay or avoid pregnancy?	Wife away..... 11 **Fertility-related reasons** Not having sex..... 12 Infrequent sex..... 13 Wife attained menopause/ had hysterectomy... 14→Q336 Sub-fecund/in-fecund..... 15 Postpartum/breastfeeding..... 16 Wants more children..... 17 **Opposition to use** Opposed to FP..... 18 Wife opposed..... 19 Other people opposed..... 20 Against religion..... 21 **Lack of knowledge** Knows no method ..... 22 Knows no source..... 23 **Method-related reasons** Health concerns..... 24 Worry about side effects..... 25 Hard-to-get method..... 26 Costs too much..... 27 Inconvenient to use..... 28 Afraid of sterilisation..... 29 Don't like existing methods..... 30 Others _____ 96 ***(Specify)***
330	Do you or your wife plan to use any family planning method in future?	Yes..... 1 No..... 2→Q334
331	Why do you want to use a family planning method?	Postpone pregnancy..... 11 Gap between pregnancies..... 12 Stop further pregnancies..... 13 Health concerns..... 14 Others_____ 96 ***(Specify)***
332	What methods will you or your wife use?	Male sterilisation..... 11 Female sterilisation..... 12 IUD..... 13 Oral pills..... 14 Condoms..... 15 Any other _____ 96 ***(Specify)*** Not sure/undecided..... 97
333	When do you or your wife plan to begin using it?	Months..... a ☐☐ Years..... b ☐☐ Less than one month..... 00 Undecided..... 97

334	How many more children would you like to have?	Number of additional children ☐☐ None..... 00→Q336 Undecided..... 97
335	When would you like to have the next child?	After months ☐☐ Undecided..... 97
336	During a woman's monthly menstrual cycle, that is, from the beginning of one period to the beginning of the next, when would you say a woman is most likely to become pregnant if she has intercourse?	Right before her period..... 11 During her period..... 12 About one week after her period begins..... 13 About two weeks after her period begins..... 14 All times are the same, it makes no difference..... 15 Others_____ 96 ***(Specify)*** DK..... 97

SECTION 4: OBSTETRIC HEALTH

I would like to ask you some questions about your wife's health. All that you tell me will be kept strictly confidential and combined with the information gathered from other women for use in the report without any personal identification. If the meaning of any question is unclear, please ask me.

401	Has your wife ever been pregnant since Diwali 2001?	Yes……1 No……2→Q433
402	How many times did she become pregnant since Diwali 2001?	Number of times ☐
	Now I would like to ask you some questions related to her last pregnancy	
403	What was the out come of the pregnancy?	Live birth…… 1 Stillbirth…… 2 Spontaneous abortion…… 3 Induced abortion…… 4 Q405
404	How old was the child at his/her last birthday?	In completed years ☐
405	When you learned of this pregnancy, did you want to become pregnant then, did you want to wait until later, or did you want no (more) children at all?	Then…… 1→Q407 Later…… 2 No more…… 3 Never thought about it…… 4→Q407
406	When you later/no more wanted to become pregnant, how did this happen?	Accidental…… 11 Did not know how to prevent…… 12 Wife want a child …… 13 Parents wanted a child…… 14 Others_____ 96 ***(Specify)***
407	During this pregnancy, did your wife see anyone for antenatal care? **If yes,** whom did she see? Anyone else? *Record all persons seen*	Allopathic doctor…… a MPHA(F)…… b Any other health personal…… c *Dai …… ……* d Others _____ x ***(Specify)*** No one…… f→Q427
408	Is it essential for a wife to go for antenatal check up? **If yes,** Why do you think so? *Circle all the responses mentioned*	Maintain good health…… a To have healthy baby…… b To avoid complications…… c Others_____ x ***(Specify)*** Not necessary…… d
409	Did you go anytime with your wife for antenatal check up?	Yes……1→Q411 No……2
410	Why did you never go with her?	
411	Did your wife have any health complications during this pregnancy?	Swelling of hands and feet …… a Blurred vision…… b Giddiness…… c Fits…… d

	If yes, specify *Probe/Circle all the responses mentioned*	Urinary problem..... f Varicose veins..... g Fever >3days..... h High blood pressure..... i Severe vomiting whether treatment required..... j Tuberculosis..... k Malaria..... l Heart disease..... m Diabetes..... n No movement of foetus..... o Bleeding..... p Others _____ x ***(Specify)*** None..... q DK..... r
412	In your opinion when a wife is pregnant, in which way should a husband help her? *Circle all the responses mentioned*	Talk affectionately..... a Express concern towards health... b Take her to an antenatal check up..... c Arrange with someone to go to antenatal check up ..... d Arrange/Assist in transportation... e Get fruits/sweets for her..... f Take interest towards her diet..... g Monitor on intake of medicines... h Manage older children..... i Assist in household work..... j Any other_____ x ***(Specify)***
413	**Check: Q403 if coded '1' or '2' ask Q414, or skip to Q422**	
414	Where did your wife have the delivery?	PHC/Sub-centre..... 11 Govt. hospital ..... 12 Private hospital..... 13 Parent's home..... 14 Natal home..... 15 Home of birth attendant..... 16 Others _____ 96 ***(Specify)***
415	Who was the person most responsible for having delivery at (Q414)?	Self..... 11 Mother/mother-in-law..... 12 Father/father-in-law..... 13 Elder female relatives..... 14 Neighbours..... 15 Others_____ 96 ***(Specify)*** DK..... 97
416	Did your wife experience any health problems at the time of delivery?	Labour more than 18 hours..... a Use of forceps..... b Excessive bleeding (more than 3 saris stained)..... c

	If yes, specify *Probe/Circle all the responses mentioned*	Sac burst and even after 5 hourschild was not born..... d Sac burst and the fluid was greenish coloured..... e Fainted during labour..... f Fits or convulsions..... g Baby was in breech position/ not in normal position..... h Placenta was down..... i Twins/multiple births..... j Any other_____ x ***(Specify)*** None..... k DK..... l
417	In your opinion at the time of a wife's delivery in which way should a husband help her? *Circle all the responses mentioned*	Call for an assistant/ health personnel..... a Arrange transportation..... b Getting necessary items/ medicines..... c Financial help..... d Emotional support..... e Any other_____ x ***(Specify)*** Not necessary..... f
418	Did she have a health check up during the first six weeks after childbirth?	Yes..... 1 No..... 2
419	After the delivery did your wife experience any health problems? **If yes,** specify *Probe/Circle all the responses mentioned*	Pus formation in tare..... a Fever >3 days..... b Loss of consciousness for >15 minutes..... c Pain in lower abdomen..... d Painful, burning feeling when urinating..... e Changes in mental make-up..... f Fits/convulsions..... g Discharge that smells..... h Breast abscess..... i Excess bleeding..... j Depression..... k Backache..... l Others _____ x ***(Specify)*** None..... m DK..... n
420	In general, what type of care is a woman supposed to take after childbirth? *Circle all the responses mentioned*	Nutritional diet..... a Restricted diet..... b Adequate rest..... c Not to indulge in heavy work.... d Abstaining from sex ..... e Feeding practices..... f Regular health check up ..... g Any other _____ x ***(Specify)***

421	In your opinion during the first two months after a wife's delivery, in which way should a husband help her? *Circle all the responses mentioned*	Arrange/take her for a health check up..... a Managing older children..... b Not allowing her to strain physically..... c Providing physical help..... d Extending emotional support..... e Any other _____ x ***(Specify)***
422	**Check: Q403 if coded '4' ask Q423 if coded '3' ask Q427 if coded '1' or '2' skip to Q432**	
423	What circumstances led your wife to have abortion? *Probe/Circle all responses mentioned*	Advised by doctor..... a Postpone/space/limit children..... b Parents wanted it..... c Wife wanted it..... d After sex determination test..... e Any other_____ x ***(Specify)***
424	Who mainly decided for an abortion?	Self..... 11 Wife..... 12 Parents-in-law..... 13 Parents..... 14 Doctor/nurse..... 15 Informal health care providers.... 16 Others_____ 96
425	Where did your wife have the abortion?	PHC..... 11 Govt. hospital ..... 12 Pvt. hospital... ..... 13 *Dai*..... 14 RMP..... 15 Pharmacy..... 16 Others_____ 96 ***(Specify)***
426	Was your wife willing for the abortion?	Yes..... 1 No..... 2
427	Did she seek healthcare after the abortion?	Yes..... 1 No..... 2→Q429
428	Where did she go for the healthcare?	PHC..... 11 Govt. hospital ..... 12 Pvt. Hospital ..... 13 Pvt. Clinic ..... 14 *Dai*..... 15 RMP..... 16 Traditional healers..... 17 Others _____ 96 ***(Specify)*** →Q 430
429	Why did she not seek healthcare after the abortion?	Did not want others to know.... a Family did not allow..... b Service not good/no medicine... c

	Circle all responses mentioned	Attitude of doctors/nursesnot good…… d Don't know where to go…… e Not necessary…… f Too far away…… g No transportation…… h Cost too much…… i No time to go…… j Not open when I could go…… k No one to care children…… l Others _____ x ***(Specify)***
430	In your opinion at the time of a wife's delivery in which way should a husband help her?	Calling for an assistant/health personnel…… a Arranging transportation…… b Bringing necessary items/ medicines…… c Financial help…… d Emotional help…… e Any other_____ x ***(Specify)*** Not necessary…… f
431	In your opinion during first two months after a wife's delivery, in which way should a husband help her? ***Circle all the responses mentioned***	Arrange/take her for a health check up…… a Managing older children…… b Not allowing her to strain physically…… c Providing physical help…… d Extending emotional support… e Any other _____x ***(Specify)***
432	After delivery/abortion did she experience any of these problems? Feeling of heaviness in the abdomen or feeling of uterus coming down…… Experienced problem of passing of urine such as passing urine all the time or when coughing, sneezing…… Passing stools through the vaginal opening…… Piles…… Any other_____ ***(Specify)***_____	Yes / No / DK 1 2 7 1 2 7 1 2 7 1 2 7 →Q440
433	At any time did your wife become pregnant prior to Diwali 2001?	Yes…… 1 No…… 2→Q437
434	At any time during her previous pregnancies did she face any health problems?	Swelling of hands an feet…… a Blurred vision…… b Giddiness…… c Fits…… d Urinary problem…… f Varicose veins…… g

	If Yes, specify *Probe/Circle all the responses mentioned*	Fever >3days..... h High blood pressure..... i Severe vomiting whether treatment required..... j Tuberculosis..... k Malaria..... l Heart disease..... m Diabetes..... n No movement of foetus..... o Bleeding..... p Others _____ x ***(Specify)***None..... q DK..... r
435	At any time during her previous deliveries, did she experience any health problems? **If yes,** specify *Probe/Circle all the responses mentioned*	Labour more than 18 hours..... a Use of forceps..... b Excessive bleeding (more than 3 saris stained)..... c Sac burst and even after 5 hours child was not born..... d Sac burst and the fluid was greenish coloured..... e Fainted during labour..... f Fits or convulsions..... g Baby was in breech position/ not in normal position..... h Placenta was down..... i Twins/multiple births..... j Others _____ x ***(Specify)*** None..... q DK..... r
436	Did she face any of the problems/illnesses during the first two months after any of the deliveries? **If yes,** specify *Probe/Circle all the responses mentioned*	Pus formation in tare..... a Fever >3 days..... b Loss of consciousnessfor >15 minutes..... c Pain in lower abdomen..... d Painful, burning feeling when urinating..... e Changes in mental make-up..... f Fits/convulsions..... g Discharge that smells..... h Breast abscess..... i Excess bleeding..... j Depression..... k Backache..... l Others _____ x ***(Specify)*** None..... m DK..... n
437	In your opinion when a wife is pregnant should a husband extend care/ cooperation?	Talk affectionately..... a Express concern towards health... b Take her to an antenatal check up.c Arrange with someone to go to antenatal check up ..... d

	If yes, which way? *Circle all responses mentioned*	Arrange/assist in transportation....e Get fruits/sweets for her..... f Take interest towards her diet... g Monitor intake of medicines..... h Manage older children..... i Assist in household work..... j Any other_____ x ***(Specify)*** Not necessary..... k
438	In your opinion at the time of wife's delivery should a husband extend help? **If yes,** which way? *Circle all responses mentioned*	Called for an assistant/health personnel..... a Arranged transportation..... b Getting necessary items/ medicines..... c Financial help..... d Emotional support..... e Any other_____ x ***(Specify)*** Not necessary..... f
439	In your opinion should a husband support his wife after childbirth? **If yes,** which way? *Circle all responses mentioned*	Arrange/take her for a health check up..... a Managing older children..... b Not allowing her to strain physically..... c Providing physical help..... d Extending emotional support..... e Any other _____x ***(Specify)*** Not necessary.....f
440	Even though most pregnancies are normal, some women do experience complications, which can lead to sickness and even death, if untreated. Can you tell me some of the symptoms a woman can experience during pregnancy and childbirth, which should be viewed as a warning that such problems might occur? Any others? *Circle all responses mentioned*	Vaginal bleeding during Pregnancy..... a High fever..... b Abdominal pain..... c Swelling of hands and face..... d Prolonged labour for more than 12 hours..... e Convulsions..... f DK..... g Other _____ x ***(Specify)***
	Now, I would like to ask some general questions which are not related to your family	
441	In your opinion can a woman go for an abortion?	Yes..... 1 No..... 2
442	For reasons related to a woman's health, can she go for an abortion?	Yes..... 1 No..... 2
443	To stop further children, can a woman go for an abortion?	Yes..... 1 No..... 2
444	To postpone the first child can a woman go for an abortion?	Yes..... 1 No..... 2

445	To have space between children can a woman go for an abortion?	Yes..... 1 No..... 2
446	If a woman wants to go for an abortion, is she required to seek permission? **If yes,** from whom? *Record all persons mentioned*	Husband..... a In-laws..... b Parents..... c Health personnel..... d Others _____ x ***(Specify)*** Not necessary..... e
447	Should husband and wife discuss prior to taking a decision related to abortion?	Yes..... 1 No..... 2→Q449
448	On what aspect should they discuss prior to abortion? *Circle all responses mentioned*	To decided on abortion..... a Place of abortion..... b Method of abortion..... c Health consequences..... d Future fertility..... e Social consequences..... f Ethical consequences..... g Financial aspects..... h Any other_____ x ***(Specify)***
449	If husband is unwilling for abortion, do you think a woman should go ahead? *Probe:* *Due to health or other genuine reasons*	Yes..... 1 No..... 2
450	Who should accompany a woman while going for an abortion? *Probe/Record all persons mentioned*	Husband..... a Mother..... b Mother-in-law..... c Sister..... d Relatives..... e Others _____ x ***(Specify)***
451	Do you think is it essential for a husband to be present when a woman undergoes an abortion?	Yes..... 1 No..... 2
452	Why do you think so?	
453	Is it necessary to seek health personnel's advice prior to deciding to have an abortion?	Yes..... 1 No..... 2

SECTION 5: EXPENDITURE AND SUPPORT FOR FAMILY HEALTH CARE

I would like to ask you some questions about your expenditure of your family's health needs. By health expenses, I mean payment of fees to medical and health provider (in all systems of medicine), and for medicines and drugs. Payments can be monetary or in-kind exchange of goods or services.

501	Did you spend anything for health/ medical care in the past one year?	Yes…… 1 No…… 2→Q505
502	Did you spend anything for health/ medical care of the following family members in the past one year? Self…… Wife…… Children…… Parents…… Others_____ ***(Specify)*** *Circle all responses mentioned*	Yes / No 1 / 2 1 / 2 1 / 2 1 / 2 1 / 2
503	How much in total did you spend for medical healthcare in the past one-year?	Total expenditure on healthcare Rs. ☐☐☐☐☐☐☐
504	How much of the total amount did you spend on health or medical care for yourself and your family members? *Interviewer: Be sure total amount reported in Q503 is same as Q504*	Self…… a Rs. ☐☐☐☐☐☐ Wife…… b Rs. ☐☐☐☐☐☐ Children…… c Rs. ☐☐☐☐☐☐ Parents…… d Rs. ☐☐☐☐☐☐ Others_____ x Rs. ☐☐☐☐☐☐ ***(Specify)***
505	Did any of your family members including yourself require more money for health and medical care in the last one year than you could afford to spend?	Yes…… 1 No…… 2→Q509
506	Which family members needed additional health and medical care expenses beyond what you could spend? *Circle all responses mentioned*	Self…… a Wife…… b Children…… c Parents…… d Others_____ x ***(Specify)***
507	Have you borrowed any amount from others to meet your own or family members' medical and healthcare expenses? *If all answers are "no" skip to Q509*	Yes / No Self 1 / 2 Wife 1 / 2 Children 1 / 2 Parents 1 / 2 Others 1 / 2 ***(Specify)***

508	How much money did you borrow for medical and health care expenses? *Check: Whether this amount was included in total amount mentioned for Q503 and correct if necessary*	Amount Rs. ☐☐☐☐☐☐
509	**Check: Q501……. If "yes"… ask Q510 or skip to Q511**	
510	How much of each type of health expense went for care for the following family members? ***(Record the amount in rupees in each cell)*** ***Check: Responses to Q502 & Q504***	

Various items	Self	Wife	Children	Parents	Other Relatives
Hospitalisation expenses					
Doctor's fees					
Medicine/drugs					
Laboratory tests					
Other expenses					
Total amount					

511	**Check: Q110 if has children…….skip to Q514** **Check: Q304 if "yes" skip to Q514**	
512	Do you have any reason to believe that your wife has any problem bearing children (infertility problem)?	Yes…….. 1 No…….. 2 DK…….. 7
513	Do you have any reason to believe that you yourself have infertility problem?	Yes…….. 1 No…….. 2 DK…….. 7 → Q518
	I would like to ask you some questions about your wife's needs for health and medical care at the time your last child was born.	
514	Did your wife receive any medical and healthcare while she was pregnant/during delivery/in the 6 weeks after birth?	Yes No DK While pregnant….. 1…. 2… 7 During delivery….. 1…. 2… 7 In 6 weeks after birth…….. 1…. 2…… 7
515	Do you think you should provide money or goods/services in any kind for medical and healthcare of your wife during the last pregnancy?	Yes…….. 1 No…….. 2→Q518
516	Did you provide money or goods/services n any kind for medical and health care of your wife during the last pregnancy?	Yes No DK While pregnant….. 1…. 2… 7 During delivery….. 1…. 2… 7 In 6 weeks after birth…….. 1…. 2…… 7

517	Did your wife need any health or medical care for the last live birth that she could not receive due to its expenses?	Yes…… No…… DK……	1 2 7
518	Has your wife needed any other health or medical care this past year for a gynaecological or obstetric condition?	Yes…… No…… DK……	1 2 7 Q601 ↓
519	Has she been able to receive it?	Yes…… No…… DK……	1 2 7
520	Do you think you should provide money or goods/services in any kind for medical and health care of your wife for gynaecological or obstetric problems?	Yes…… No……	1 2

SECTION 6: PSYCHOLOGICAL BEHAVIOUR

Now I am going to mention few statements. Please tell me if you strongly agree, agree, disagree or strongly disagree with the following statements.

A: LOCUS OF CONTROL

601	If one of the couple does not desire, they cannot have sex.	Strongly agree.....	1
		Agree.....	2
		Disagree.....	3
		Strongly disagree.....	4
602	Most often it is not possible to prevent a pregnancy. If a woman is meant to be pregnant, she will be pregnant	Strongly agree.....	1
		Agree.....	2
		Disagree.....	3
		Strongly disagree.....	4
603	A couple can limit the number of children they have	Strongly agree.....	1
		Agree.....	2
		Disagree.....	3
		Strongly disagree.....	4
604	Luck plays a big part in determining whether a woman can keep from getting pregnant.	Strongly agree.....	1
		Agree.....	2
		Disagree.....	3
		Strongly disagree.....	4
605	If a couple is careful, an unwanted pregnancy will rarely happen.	Strongly agree.....	1
		Agree.....	2
		Disagree.....	3
		Strongly disagree.....	4

B: SELF-EFFICACY

606	**Ask only those not currently using contraceptives. Check: Q304 if 'Yes' skip to Q612**		
607	I am capable of obtaining a method of family planning	Strongly agree.....	1
		Agree.....	2
		Disagree.....	3
		Strongly disagree.....	4
608	I would have great difficulty always remembering to use contraception in order to avoid my wife getting pregnant.	Strongly agree.....	1
		Agree.....	2
		Disagree.....	3
		Strongly disagree.....	4
609	If my self or my wife could not get contraception, I could still keep her from getting pregnant by refraining from sexual activity with her	Strongly agree.....	1
		Agree.....	2
		Disagree.....	3
		Strongly disagree.....	4
610	My wife is I am capable of using a contraceptive method every time she needs to.	Strongly agree.....	1
		Agree.....	2
		Disagree.....	3
		Strongly disagree.....	4
611	My wife would have a difficult time negotiating with me about the use of method of family planning	Strongly agree.....	1
		Agree.....	2
		Disagree.....	3
		Strongly disagree.....	4
612	My wife is capable of persuading me to not to have extra-marital sexual contacts.	Strongly agree.....	1
		Agree.....	2
		Disagree.....	3
		Strongly disagree.....	4
613	My wife is capable of seeking treatment if she has any gynaecological health problems	Strongly agree.....	1
		Agree.....	2
		Disagree.....	3
		Strongly disagree.....	4

C: VALUE OF PREGNANCY AVOIDANCE

Now I am going to ask few questions. Please tell me how important you feel towards each of these questions. That is whether you feel very important, moderately important, mildly important or unimportant.

614	**Check: Q305 if sterilised...skip to Q701**	
615	**Check: Q329 if man wants one or more children, skip to Q618**	
616	How important is it to you to have no more children?	Unimportant..... 1 Mildly important..... 2 Moderately important..... 3 Very important..... 4
617	Tell me how you respond to this statement: Because I do not want to have more children, I make sure that my wife is protected from getting pregnant.	Unimportant..... 1 Mildly important..... 2 Moderately important..... 3 Very important..... 4 →Q701
618	How important is it to you to delay the birth of your next child?	Unimportant..... 1 Mildly important..... 2 Moderately important..... 3 Very important..... 4
619	Tell me how you respond to this statement: Because I want to delay having more children, I make sure that I am or my wife is protected from getting pregnant.	Unimportant..... 1 Mildly important..... 2 Moderately important..... 3 Very important..... 4

SECTION 7: FAMILY VIOLENCE

701	Thinking back to your childhood or adolescence, did you at any time see or hear your father physically beat or mistreat your mother?	Yes..... 1 No..... 2 No response..... 3 DK/do not remember..... 7
702	Did you at any time see your mother physically beat or mistreat your father?	Yes..... 1 No..... 2 No response..... 3 DK/do not remember..... 7
703	Have you ever physically hit, slapped, kicked or tried to hurt by your wife?	Yes..... 1 No..... 2 No response..... 3 DK/do not remember..... 7 Q712
704	How many times did you behave this way with your wife?	Number of times ☐☐
705	How long ago was the first time you behaved this way with (physically hit/harmed) your wife? **Check: Q704 if number of times is <1...skip to Q707**	Month ..... a ☐☐ Year... ..... b ☐☐ Less than one month..... 00
706	How long ago was the last time you behaved this way with (physically hit/harmed) your wife?	Month ..... a ☐☐ Year... ..... b ☐☐ Less than one month..... 00
707	Did any of the following happen during the latest incident? Shouting/yelling..... Slapping/pushing..... Punching/kicking..... Use of stick/weapon..... Other _____ ***(Specify)***	Yes / No 1 2 1 2 1 2 1 2 1 2
708	Was your wife pregnant at that time?	Was pregnant..... 1 Was not pregnant..... 2 DK..... 7
709	At the time of the last physical fight, how did your wife react? *Circle all responses mentioned*	Yelled and shouted..... a Hit and slapped..... b Cried..... c Ran away from house..... d Did nothing..... e Other _____ x ***(Specify)***
710	Did your wife seek help or support from any one after that?	Yes..... 1 No..... 2 DK..... 7

711	Was it necessary for your wife to seek medical care afterwards?	Yes…… No…… DK……	1 2 7
712	Have you ever had sex with your wife even if she was not willing?	Yes…… No…… DK…… Q715	1 2 7
713	Did you ever physically force your wife to have sex with you?	Yes…… No…… DK…… Q715	1 2 7
714	How long ago was the last time this happened?	Month …… Year… …… Less than one month……	a b 00

ATTITUDES TOWARDS PHYSICAL CONTROL OF WIFE

715	Wife should always show respect to elders, particularly her in-laws in the family.	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7
716	Wife should always follow instructions given to her, whether liked or not, by elders, particularly her in-laws in the family	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7
717	If necessary one should use force to make wife listen to all instructions of elders, particularly her in-laws in the family.	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7
718	If wife disobeys instructions of elders, particularly her in-laws in the family, the following measures should be used. Verbal insults…… Physical isolation…… Physical beating…… Persuasion…… Other _____ ***(Specify)*** DK/can't say……	Yes 1 1 1 1 1 1	No 2 2 2 2 2 2
719	There is no harm if wife sometimes disagrees with instructions given to her by elders, particularly her in-laws in the family.	Strongly agree…… Agree…… Disagree…… Strongly disagree…… DK……	1 2 3 4 7

720	No verbal insults and/or physical beating should be used against wife even if she does not follow instructions given to her by elders, particularly her in-laws in the family	Strongly agree…….	1
		Agree……	2
		Disagree……	3
		Strongly disagree……	4
		DK……	7
721	Wife should always show respect to her husband.	Strongly agree…….	1
		Agree……	2
		Disagree……	3
		Strongly disagree……	4
		DK……	7
722	Wife should always follow instructions given to her, whether she likes or not, by her husband.	Strongly agree…….	1
		Agree……	2
		Disagree……	3
		Strongly disagree……	4
		DK……	7
723	If necessary wife should be forced to listen to all instructions given to her by her husband.	Strongly agree…….	1
		Agree……	2
		Disagree……	3
		Strongly disagree……	4
		DK……	7
724	If wife disobeys instructions of her husband, the following measures should be taken.	Yes	No
	Verbal insults……	1	2
	Physical isolation……	1	2
	Physical beating……	1	2
	Persuasion……	1	2
	Other _____ ***(Specify)***	1	2
	DK/can't say……	1	2
725	There is no harm if wife sometimes disobeys instructions given by her husband.	Strongly agree…….	1
		Agree……	2
		Disagree……	3
		Strongly disagree……	4
		DK……	7
726	No verbal insults and/or physical beating should be used against wife even if she does not follow instructions given by her husband.	Strongly agree…….	1
		Agree……	2
		Disagree……	3
		Strongly disagree……	4
		DK……	7

SECTION 8: SEXUAL ACTIVITY

Information about men's sexual behaviour is necessary for understanding their reproductive health and that of their female partners. In this section of the interview, I would like to talk with you about your sexual experiences.

801	Have you ever had any sexual contact with any woman before marriage?	Yes…… No……	1 2→Q805
802	How old were you at the time of your first sexual contact with these women?	Age in years	☐☐
803	Have you had sexual contact with more than one woman before marriage?	Yes…… No……	1 2
804	Have you ever used condoms at the time of sexual intercourse with this woman/ these woman?	Always…… Sometimes…… Never……	1 2 3
805	Before marriage have you ever had: Any discharge from your penis?…… Any sore on your genital or anal area?…… Positive syphilis blood test?…… Difficulty urinating?…… Pain with urination?…… Very frequent urination?…… Swelling of your testes or in your groin area (penis)?	Yes 1 1 1 1 1 1 1	No 2 2 2 2 2 2 2
806	**Check: Q805 If "yes" to any one ask Q807 to Q814**		**If "no" to all skip to Q812**
807	How many months before your marriage did this happen?	Months	☐☐
808	Have you consulted any one for treatment?	Yes…… Self-reatment…… No……	1 2→Q810 3→Q811
809	Who did you consult for treatment? *Record all persons seen*	Allopathic doctor…… ISM doctor…… Medical shop…… Friends…… Self-treatment…… Other _____ ***(Specify)***	a b c d e x
810	At the time of your marriage, were you completely cured of this problem?	Yes…… No……	1 2
811	Have you ever discussed this problem with your wife?	Yes…… No……	1 2
812	After marriage, the first time you had intercourse with your wife, did you or your wife use a family planning method?	Yes…… No……	1 2→Q814

813	What is the method?	Condoms..... 1 Oral pills..... 2 Other_____ 6 ***(Specify)***
814	Did you and your wife ever talk about the risk of having an unwanted pregnancy?	Yes..... 1 No..... 2
815	During your married life has your wife become pregnant at a time when you were not ready for it?	Yes..... 1 No..... 2 No child..... 3 Q817 ↓
816	How many times did this happen?	Number of times ☐☐
817	How often have you had sex with your wife during her menstrual period?	Never..... 1 Rarely..... 2 Some times..... 3 Frequently..... 4 Always..... 5
818	Did your wife stay with you in the last four weeks?	Yes..... 1 No..... 2→Q821
819	For how many days did your wife stay with you in the last four weeks?	Number of days ☐☐
820	How many times have you had sex with your wife in the last four weeks?	Number of times ☐☐ None..... 00
821	Usually how many times per day do you have sex with your wife?	Number of times ☐☐
822	How long ago did you and your wife last have intercourse?	Days ..... a ☐☐ Months ..... b ☐☐ Years ..... c ☐☐
823	Have you had sex with any woman other than your wife since you were married?	Yes..... 1 No..... 2→Q826
824	How many women?	Number of women ☐☐
825	Have you ever used condoms at the time of intercourse with this woman/ these woman?	Always..... 1 Some times..... 2 Never..... 3

826	After marriage have you ever had: Any discharge from your penis?..... Any sore on your genital or anal area?..... Positive syphilis blood test?..... Difficulty urinating?..... Pain with urination?..... Very frequent urination?..... Swelling of your testes or in your groin area (penis)?.....	Yes 1 1 1 1 1 1 1	No 2 2 2 2 2 2 2
827	**Check: Q826 If "yes" to any one ask Q828 to Q834**		**If "no" to all skip to Q835**
828	Have you ever consulted anyone for treatment?	Yes..... Self-treatment..... No.....	1 2 3 Q830
829	Whom did you consult for treatment? *Record all persons seen*	Allopathic doctor..... ISM doctor..... Medical shop..... Friends..... Self-treatment..... Other _____ ***(Specify)***	a b c d e x
820	Did you ever discussed about this with your wife?	Yes..... No.....	1 2
821	Since you had problems, did you stop having sex with your wife?	Stopped..... Less frequent..... No change.....	1 2 3
832	**Check: Q823 if the answer is "yes".... ask this question otherwise skip to Q833** Since you had problems, did you stop having sex with other women?	Stopped..... Less frequent..... No change.....	1 2 3
833	Did you start using condoms?	Yes..... No..... Stopped sex...	Wife 1..... 1..... 1.....	Other women 2 2 2
834	Did you make any other changes in your habits ***(Specify)***?_____	Yes..... No.....	1 2
835	Are you currently having: Any discharge from your penis?..... Any sore on your genital or anal area?..... Positive syphilis blood test?..... Difficulty urinating?..... Pain with urination?..... Very frequent urination?..... Swelling of your testes or in your groin area (penis)?.....	Yes 1 1 1 1 1 1 1	No 2 2 2 2 2 2 2

836	**Check: Q835 If "yes" to any one ask Q837 to Q838**			**If "no" to all skip to Q839**
837	Have you ever consulted anyone for treatment?	Yes…… Self-treatment…… No……		1 2 3 Q838 ↓
838	Whom did you consult for treatment? *Record all persons seen*	Allopathic doctor…… ISM doctor…… Medical shop…… Friends…… Self-treatment…… Other _____ ***(Specify)***		a b c d e x
839	I will now read you some statements about venereal diseases and sexual behaviour. Please tell me if you agree or disagree with each of the statements *(Do not probe).*	Yes	No	DK
	A person contacts gonorrhoea only one, after that he or becomes immune to the disease……	1	2	7
	Syphilis can be treated with penicillin and other antibiotics……	1	2	7
	Venereal diseases can be passed from a mother to her baby before or during birth..	1	2	7
	Some people who have venereal diseases show no symptoms at all……	1	2	7
	It is harmful for a man to have sex with another man……	1	2	7
THANK THE RESPONDENT FOR THE COOPERATION EXTENDED				

Annexure 7

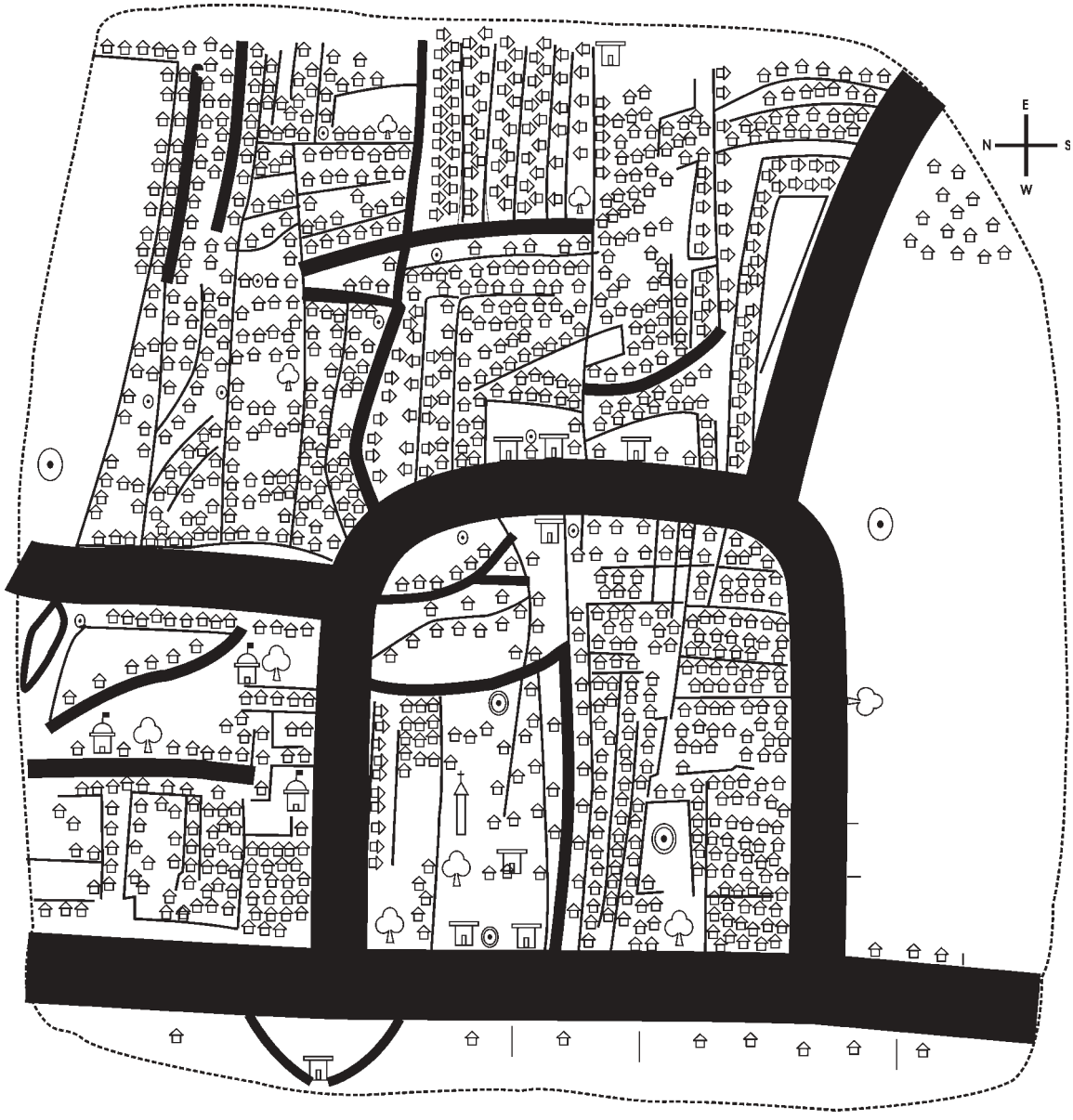
Coverage of selected areas, maps, and list of project personnel

Number of sub-centres and villages covered by the round-the-clock women's health centre: Total universe and the sampled villages

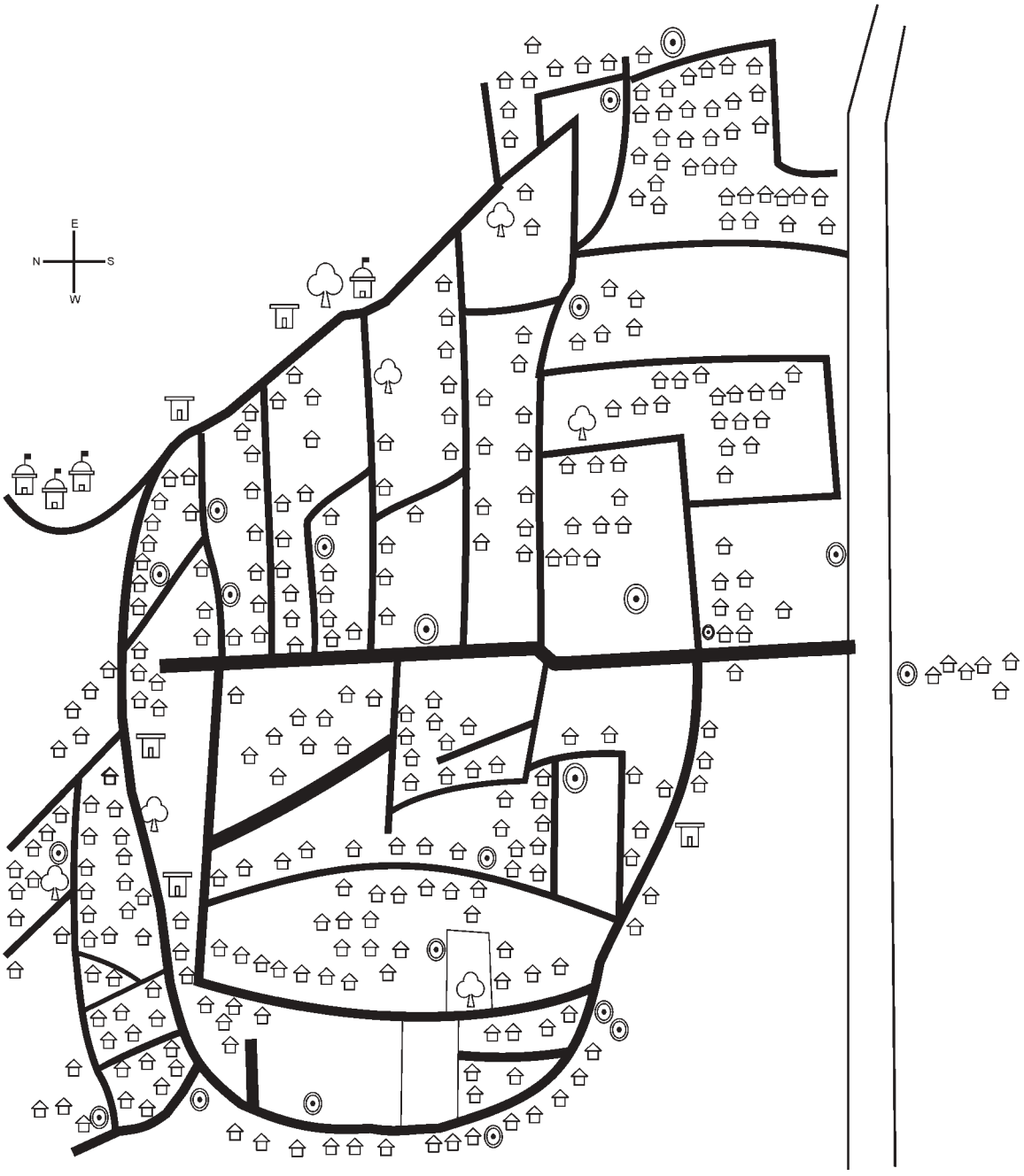
S No	Name of Sub-centre	Name of the village with hamlets
1	Shamirpet	**Shamirpet village*** Babaguda Upparapally
2	Thumukunta	Thumukunta village Mandaipally Anthaipally Singaipally Hakeempet
3	Kesavaram	Kesavaram Koltur Anantaram Nagisettipally
4	Devaryamjal	Devaryamjal Pothaipally* Yeligalguda*(hamlet of Pothaipally)
5	Jaganguda	Jaganguda Sampanbole Laligadimalkpet
6	Lakshmapur	Lakshmapur Modichintalapally Narayanapur PotharamLingapur
7	Aliyabad	Aliyabad Majidpur Turkapally* Turkapally Thanda* (hamlet of Turkapally)
8	Uddamarri	Uddamarri Usharpally Adraspalli
9	Kesavapur	Kesavapur Ponnal Bommaraspet

** Sampled villages*

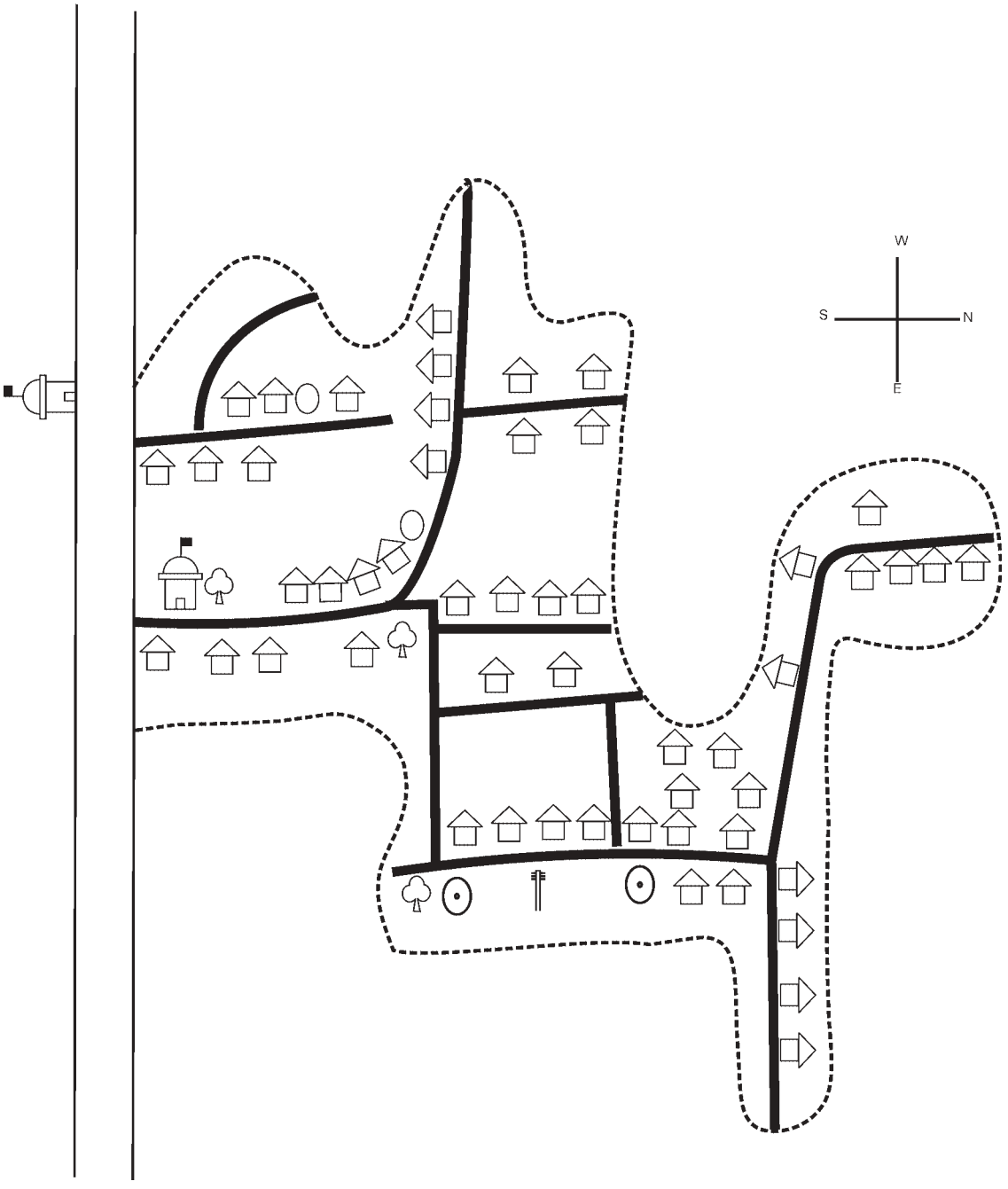
Map of Shamirpet village



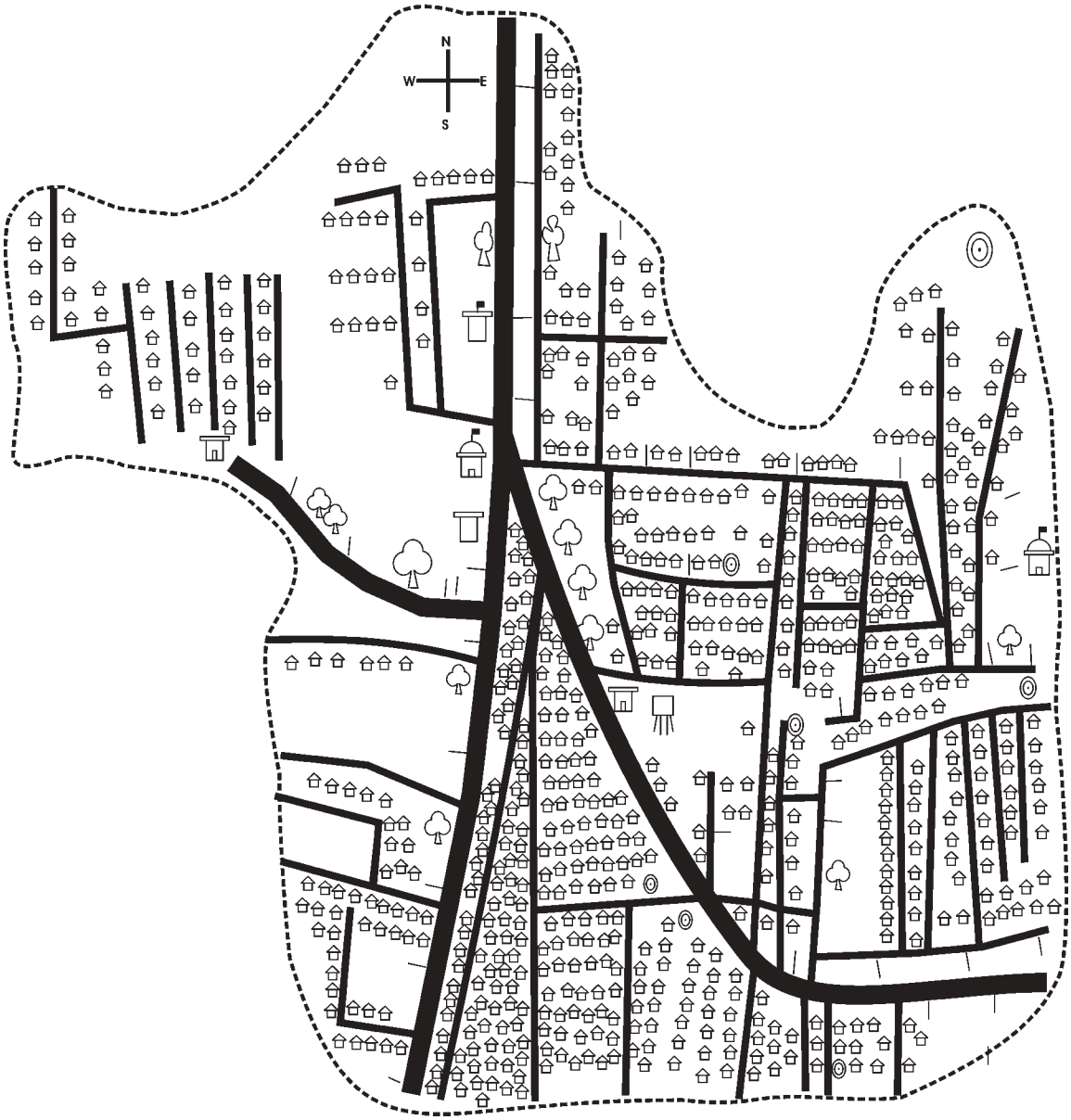
Map of Pothaipally village



Map of Yeligalguda village



Map of Turkapally and Turkapally Thanda



List of Project Personnel

PRINCIPAL INVESTIGATOR

G Rama Padma

RESEARCH ASSISTANT

K Panchakshari

PROGRAMMING ASSISTANT

K Anitha Kumari

P Pavan Kumar

FIELD INVESTIGATORS

P Kavitha

G Krishnasree

Shailaja

PNV Subba Rao

B Pradeep Reddy

AV Rao

M Suresh

List of studies completed under the initiative:

1. Gender, caste, class and health care access: Experiences of rural households in Koppal district, Karnataka
   Aditi Iyer

2. Correlates of high-risk sexual behaviour among never-married male industrial workers in Tirupur
   N Audinarayana

3. Involuntary childlessness among the middle class in Vadodara city
   Bhamini Mehta, Shagufa Kapadia, Debjani Chakraborty

4. Attitudes of adolescent students in Thiruvananthapuram towards gender, sexuality, sexual and reproductive health and rights.
   Philip Mathew KM

5. Men's participation in reproductive health:A study of some villages in Andhra Pradesh
   G Rama Padma

6. The interface between mental health and reproductive health of women among the urban poor in Delhi
   Ranendra Kumar Das and Veena Das

7. The interrelationship between gender and malaria among the rural poor in Jharkhand
   Sama

8. Middle class sexuality: Construction of women's sexual desire in the 1990s and early 21st century Mumbai
   Shilpa Phadke

9. Delay in seeking care and health outcomes for young abortion seekers
   Sowmini CV

10. Interface of heart disease and reproductive health: An exploratory study of gender dimensions
    R Sukanya, S Sivasankaran

11. Negotiating reproductive health needs in a conflict situation in the Kashmir Valley
    Zamrooda Khanday