Men's Participation in Reproductive Health

A Study of few Villages in Andhra Pradesh

(Sponsored by Achuta Menon Centre,
Sree Chitra Institute of Medical Sciences)

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Introduction

Defining Reproductive Health

The World Health Organization (WHO) defines reproductive health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (WHO, 1992-93). Reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice and the right of access to appropriate health care services.

Thus the definition of reproductive health is far broader 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 several ways, beyond the capability of health professionals. Reproductive morbidity, on the other hand, is more easily definable, more measurable, and more 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, does include the power to make personal decisions relating to health, including sexual behavior 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 ICPD program of Action not only endorsed this view of reproductive health but also helped operationalize what reproductive health care services should include, as follows: "Reproductive health care in the context of primary health care should, interalia, include: family-planning counseling, 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 the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counseling, as appropriate, on human sexuality, reproductive health and responsible parenthood" (WHO, 1994).

Men's Participation in Reproductive Health

The 1994 International Conference on Population and Development, held in Cairo reminded the world audience that good reproductive health is the right of all people, men and women alike, and that together they share responsibility for reproductive matters. By emphasizing gender the 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 in Cairo is that neither women nor men are likely to enjoy good productive health until couples are able to discuss sexual matters and make reproductive decisions together.

Couple Communication and Reproductive Health

When reproductive health decisions are taken jointly by both partners, these decisions are more likely to be implemented. Men become more supportive by helping their partners to receive reproductive health services when needed and by providing the resources needed to obtain these services.

Thus couple, or spousal, communication can be a crucial step toward increasing men's participation in reproductive health (Becker, S. 1998; Biddlecom, A.E, et. al. 1997; Lasee, A and Becker, S. 1997; Mahmood, N and Ringheim, K. 1997; Omondi-Odhiambo. 1997). Since men, as well as women, play key roles in reproductive health, communication is necessary for making responsible, healthy decisions.

Communication enables husbands and wives to know each other's attitudes toward family planning and contraceptive use. It allows them to voice their concerns about reproductive health issues, such as worries about undesired pregnancies or STD's. 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 (Blanc, A., et. al. 1996; De Silva, W. I. 1994; Fort, A. 1989).

A study conducted in Uttar Pradesh shows that wives basically agreed with the decisions taken by their husbands. Silent occurrences by women or lack of protest by them were interpreted as having arrived at a joint decision. Women almost never question the decision of their husbands, nor do they enter into any discussion with them (Khan M E and Patel B. C, 1996).

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 to have another child. Increased communication between partners improves understanding of each partner's reproductive preferences and decreases some of the consequences of poor communication, such as unintended pregnancy and a large family size.

A few studies (Becker 1996; Blanc 1996) have found that communication and open disagreement on sexual and reproductive matters between spouses were uncommon, and that men rarely discussed family planning and related issues with their wives. To a great extent, this prevents couples from acting on a commonly held preference. In the second All India survey by the Operations Research Group of Baroda (ORG), it was observed that two-thirds of the couples did not communicate with each other either on the number of children they should have or on the issue of family planning. Seventy percent of the couples in rural areas and 50 percent in urban areas did not discuss these issues. At the national level, in half the cases the husband took the

decision and in only one-third of the cases was the decision taken jointly (Khan and Prasad 1982:336).

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 impede such discussions (Meekers, D. and Oladosu, M. 1996). In many societies sex is taboo subject for men and women to discuss. Also, men and women are often afraid of rejection by a sex partner, especially at the beginning of a relationship. Consequently, they may not bring up uncomfortable issues, such as sexual history or use of contraception (Pliskin, K.L. 1997).

As with decision-making in general, women's inferior status and lack of power limit couple communication (Diaz, M. 1997; Salway, S. 1994; Worth, D. 1989). For many women traditional female gender roles mean they have little say in sexual matters and lack the status to influence their partner's behavior (Dixon-Muller, R. 1993; Fort, A. 1989; Van Der Straten, A., King, R., Grinstead, O., Serufilira, A., and Allen, S. 1995; Worth, D. 1989). Even when men and women discuss reproductive health issues, it is usually not on equal terms (De Schutter, M. 1998).

Traditional cultures often discourage married women from starting discussions about contraception. For their part, men may feel there is nothing to discuss or no need to take account of their wives' feelings and opinions. In countries such as India, Kenya, and Nigeria, traditional male dominance is a major obstacle to spousal communication about family planning (Evaluation Project. 1997; Isiugo-Abanihe, U. C. 1994; Omondi-Odhiambo. 1997). Also, a husband might consider his wife promiscuous or unfaithful if she tries to discuss contraception with him. (Fort, A. 1989). In some cultures it is easier for unmarried women and prostitutes to negotiate sexual activity with men, including condom use, than for married women to do so with their husbands (Ulin, P.R., Cayemittes, M., and Metellus, E. 1995).

Increasingly, health care providers and researchers are realizing that the most appropriate client for reproductive health information and services may be the couple rather than the individual (Becker, S. 1996; Becker, S. and Robinson, J. C. 1998;

Keller, S. 1996). For example, men who discuss family planning with their wives are more likely to use contraception and support their wives' use of contraception.

Men's Role in Family Planning

Data on men's attitudes toward family planning suggests that in many regions men view family planning favorably 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 child bearing (http://www: rho.org/htm/menrh_keyissues.htm).

A study of male involvement among five generations of a South Indian family found that men readily accepted condom use and vasectomy, even though they may not have liked some of the specific characteristics of the method. Karra, et al., (1997) examines male involvement in family planning practice and decision-making in one Indian family over five generations. Data were collected from 152 living family members; information about an additional 26 members who were deceased or unavailable for interview were 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). Particularly among older generations who had limited access to 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 in the family reported being motivated to use male methods by external factors such as desire for the improved economical status of a smaller family.

Men's traditional responsibility for providing their families' economic support is clearly a motivating factor for fertility regulation among male respondents of all age groups. Economic pressures forced men from land ownership to private and public sector employment, a trend initiated by the oldest generation and continued in the following two generations. Economic pressure, combined with the transition to new employment sectors, contributed significantly to men's desire for smaller families. Moreover, the move to public and private sector employment demanded that the men obtain higher education. Higher education was readily embraced by the men in this

family, because education (whether of the formal western or informal religious type) is traditionally valued among Brahmins as a means to increase income and accrue status. As a result, the men pursued education as a means of competing 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 in order to ensure college educations for their sons. As male education assumed greater importance for defining security and status, the desire to educate daughters in order 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 desired family size.

Effective use of a contraceptive method, and even satisfaction with the method chosen, is often influenced by men. A man's support often contributes to better use of female methods and, for many couples. One of the frequent reasons given by women for not beginning or continuing to use contraception is their partner's opposition. Men who are educated about reproductive health issues are more likely to support their partner's 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 had generated more open communication between spouses about family planning (Kak LP, Signer MB, 1993).

Family planning programmes traditionally have focused on women as the primary beneficiaries of services provision. Men have been considered "silent partners" (Forrest, quoted in Edwards, 1994), whereas research on contraceptive acceptance has concentrated on the methods' effects on women and factors affecting method choice (Cosminsky, 1982; Sargent, 1982). Further more, few studies examine the broader social, economic, and cultural forces affecting individual fertility-regulation decisions or the decision-making dynamics within couples (Browner, 1986; Handwerker, 1992; Stark, 1993; Tucker, 1986). Indeed, a 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 (Edwards, 1994). Moreover, a recent review of studies of couples' behaviour indicate that reproductive health interventions targeted at couples demonstrate greater impact than those aimed at a single sex (Becker, 1996).

Unfortunately, perspectives on male involvements are often rooted in negative assumptions. Programme planners view men as gatekeepers, potential obstructionist who, if involved in decision-making, 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 (Ezeh son, 1993, FPAI, 1985) and promote communication about contraception between spouses (Jolly, 1976).

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 number and timing of pregnancies.
- Encouraging women's to have adequate nutrition during pregnancy and providing the needed physical, financial, and emotional support to do so.
- 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 cutting.

Men who are involved in the health of their families also may enjoy better health and closer relationships with family members (www:rho.org/htm/menrh_keyissues.htm).

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 can attend to the health of their children. WHO estimates that 585,000 women die each year from complications of pregnancy, childbirth, and unsafe abortion, about one death every minute (World Health Organization (WHO), 1996; World Health

Organization (WHO), 1998). Nearly all of these deaths could be prevented. Pregnancy related complications cause one-quarter to one-half of deaths among women of reproductive age in developing countries. In some countries pregnancy related complications are the leading cause of death for reproductive age women (Fotney J.A, et. al. 1988; Royston E, and Armstrong S, 1989; World Health Organization (WHO), 1991). 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 (Fortney J.A, and Smith J.B, 1996).

Safe motherhood consists of ensuring good health for women and their babies during pregnancy, delivery, and in the postpartum period. Men play many key roles during women's pregnancy and delivery and after the baby is born. Their decisions and actions often make the difference between illness and health, life and death (American Association for World Health, 1998; Sherpa H, and Rai D, 1997; Thaddeus S, and Maine D, 1994).

Involving men in reproductive health has been found to have a positive impact on women and children's health in a number of ways, including improving MCH care. A study on the impact of providing antenatal education to prospective fathers in India found a significantly higher frequency of antenatal clinic visits and significantly lower perinatal mortality among the women whose husband received antenatal education (Bhalerao et al., 1984). Furthermore, men participating in antenatal education tend to know more about family planning methods and are more concerned about their partner's nutritional needs during pregnancy (Raju and Leonard, ed. 2000).

Good nutrition and plenty of rest also 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 (American Association for World Health, 1998; Sharma R, and Desai S, 1992; Sherpa H and Rai D, 1997; UNICEF, 1998; West K, 1998). Anemia, while not a direct cause of maternal deaths, is a factor in almost all such deaths. An anemic woman is five times more likely to die of pregnancy related causes than a woman who is not anemic (Viterif. E, 1994). Vitamin A is important to the health of both the mother and the

foetus (Sharma R, and Desai S, 1992; UNICEF, 1998). Women need to have enough vitamin A both to support the healthy development of their baby and to protect their own health, particularly their eyesight and 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 (UNICEF, 1998). 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 percent (West K, 1998).

In order 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, which contributed to an increase in women's attendance. Also, in the project area where husbands were contacted, women had a more in-depth understanding of antenatal services compared to women whose husbands had not been included in the programme. Although the exact role of husbands is not conclusive, qualitative research shows that the husbands in the project area held a more positive view of their potential roles to assist their wives during pregnancy. In an attempt to increase hospital referrals for high-risk pregnant women, the Society for Education Welfare and Action (SEWA-Rural) 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 level of awareness among family members. About 65 percent responded to suggestions for appropriate care as outlined in the postcards (SEWA-Rural Research Team, 1998).

Bhalerao, V. R. et al evaluated the role of involving prospective fathers in the care of pregnant women attending a clinic in Bombay, India. Beginning in October 1982, pregnant women attending the clinic were requested to ask their husbands to meet with the resident medical officer of the center. The out come of the maternal health care programme for the 270 women whose husbands are 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 center were educated individually and in groups about their role in nutrition and health of their wives during pregnancy and their responsibility is subsequent child rearing. The physiology of pregnancy, complications of pregnancy, and the possible ways and

means of preventing the complications were explained in detail. The husbands also were told to encourage their wives to attend the antenatal clinic of the center as often as possible. The difference between two groups was a significantly lower perinatal mortality in Group1. Further more, more women in Group1 accepted postpartum sterilization than women in Group 2. This effort confirms that the involvement of prospective fathers is possible and pays good dividends even in an uneducated and now socioeconomic community.

Arranging for skilled care during delivery

In developing countries the majority of women deliver their babies without skilled assistance, helped only by untrained traditional birth attendants or family members. A trained attendant present during childbirth can mean the difference between life and death. Men can help by arranging for a trained attendant to be available for the delivery and by paying for the services. They also can arrange ahead of time for transportation and can buy supplies, if necessary.

Helping after the baby is born

Most maternal deaths occur within three days after delivery, due to infection or hemorrhage. To prevent deaths, men can learn about potential postpartum complications and be ready to seek help if they occur. Men also can make sure that women get good nutrition. While they are breastfeeding, women continue to need extra vitamin A to ensure that they pass enough of the vitamin on to their infants.

During 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 contract. Finally, they can begin using contraception, either a temporary method to space the next birth or possibly a vasectomy if no more children are desired (AAWH, 1998; Sherpa H, and Rai D, 1997).

Men can join in post pregnancy family planning and care at several levels. At most basic level, 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 breast-feeding women since there methods do not affect breast milk.

Men's Involvement in Abortion Care

Post abortion counseling of men can help prevent repeat abortion by stressing the need for consistent use of reliable contraception to prevent unwanted pregnancy. 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 quarters of Turkish women who sought abortions were using withdrawal at the time of conception. In addition many couples do not realize the potential health risk of repeat abortions, which can impair fertility.

In Egypt, a recent population council study found that women who entered hospitals for treatment of incomplete abortions worried about being pressured by their husbands and families during their recovery (Huntington D, 1995). They especially feared castigation for not being able to carry a pregnancy to term. The women did not expect support from their spouses, but simply hoped they would not become a source of worry.

Men's Involvement in RTIs and STDs

In third world countries, most health care system attends only when they are the target of family planning programmes. Little attention has been given to the reproductive health of non-pregnant women. One reason for the relative neglect of gynecological care is a failure to appreciate the extent of unmet needs in rural areas (Bang, Bang et al, 1989).

In the overwhelming majority of cases, it is clear that the initiatives to include men were motivated by a concern about 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 ground realities within the context of women's health. For example, a number of NGOs found that sexually transmitted infections (STIs) could not be treated by simply providing physical access to women-friendly health care services. For women, a more crucial question was that of social access, which invariably included what men in their families had to say. As high as 50 percent 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 members did not allow them to attend the camp (Khan et al, 1998).

In the course of their intervention, Community Aid Sponsorship Programme in alliance with Foster Parents Plan International (CASP-PLAN) realized that many women with STIs attending their gynaecology clinic were not showing satisfactory improvement. A closer probe made it clear that these women required 'partner compliance', which was lacking. The women in their project areas often insisted that their husbands should also be contacted and sensitized to the fact that their behaviour has a bearing on the reproductive health of their women partners. A common refrain was: *"Aap hame to samjha dete ho, per hamare admi ko kaun samjayega"* (you make us understand everything, but who is going to make our men understand?) (Pal, 1998). Data collected by the Rural Women's Social Education Centre (RUWSEC) on reproductive health problems showed that a significant proportion of reproductive tract infections (RTIs) among women were a direct result of men's promiscuity (Subramanian, 1998).

The effect of men's attitudes and behaviours with respect to women's health is perhaps most evident in STD prevention and treatment. For prevention programmes to be effective, they need to educate and treat both partners. Increase condom use and changing high risk sexual behaviours are primary STD prevention strategies. Where condoms have been heavily promoted by social marketing campaigns, condom use has gone up markedly. Increasing condom use is a step toward changing men's behaviour in a way that directly affects their own health, as well as the health of their partners and wives. But surveys show that condom use is much higher out side of marriage than with spouses and wives with little power to negotiate condom use can be infected by husbands.

Abstinence, condom use, monogamy and other safer sex practices are some of the methods of preventing STDs often these safer sex practices assume a context of rationality and a concern for disease and pregnancy prevention, so that successful sexual negotiations result in safer sex practices. Sexual negotiation between sexual partners assumes that there must be a process of bargaining to reach an agreement for

the adoption of sexual behaviors, which are for whatever reason, unacceptable to one of the partners.

The Indian literature on sexual behavior and sexual negotiation, particularly with in marriage, is sparse. Mumbai has highest number of diagnosed HIV/AIDS cases in India (Survivelance for HIV infections/ AIDS cases in India, 1998) and heterosexual intercourse is though to be the primary mode of transmission. Studies on adult sexual behavior indicate that premarital and extramarital sex occurs across all social strata and with a range of partners (Nag M., 1995). Sexual violence and coercion have been found to be wide spread in marriage in rural India (Khan M. E, 1998), but information about the nature and extent of that coercion is absent.

A study in 1995 (George A, 1995) showed that the following all served to constrain women's ability to control their sexual and reproductive lives: women's 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 for women to influence sexual and contraceptive decision-making, limited knowledge of bodily process, limited discussion between married couples about sexual and reproductive concerns, and the threat and use of violence by husbands.

Research on sexuality, especially in the field of HIV/AIDS has highlighted the inadequacy of strategies that target only women. Because of unequal gender power relations, women are especially vulnerable but are unable to negotiate changes in sexual behavior to practice safe sex with out the co-operation of their sexual partners. Research on sexual negotiation strategies has dramatically under scored the need for involving men in programmes that aim at brining about changes in sexual behaviour for the prevention of infection. Changes in sexual behaviour are also needed for promoting contraception and addressing other reproductive health problems. There fore men's involvement as responsible sexual partners is essential to improving the reproductive and sexual health of women (Pachauri S, 1997).

In review of anthropological and socio-cultural studies on sexual behavior, networking and transmission of HIV, Dyson (1992) hypothesizes that the initiation of

sexual intercourse at an earlier age, higher capital frequency, and a greater number of partners are related to a decline in customary restraints on sexual behavior. Dyson suggests that change in the notions of what constitutes acceptable partners of a sexual behavior has resulted from a wider worldview, itself a result of migration, education, urbanization, mass media and increased economic autonomy for women.

Programmes to encourage men's participation in reproductive health face a major challenge in the area of safer 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 (Panos, 1998; 5). Married women are particularly at risk in some areas, such as Kigali in Rwanda, where a study indicated 20 percent of HIV positive women had only had one sexual partner, with 45 percent contracting the virus from their husband. (Forman, 1998; 31). 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 over come their behavioral barriers to negotiating condom use (Warner, 1999).

Sexual Communication between Couples

There seems little doubt that in many sector of Indian society (as in other cultures) a number of men assert their dominant roles in family life through insistence on their right to sexual intercourse, "on demand" regardless of the attitudes and responsiveness of their wives. In some of the studies, the impression is given 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 the relation to the use of condoms, as well as timing and situations when their husbands desire sexual satisfaction from them. On the other hand, the focus of attention on the negative side of sexual communications and wide prevalence of sexual violence and coercion with in family may be presenting a distorted picture. Further most of the findings are based on single-contact interviews that perhaps tends to project a negative 'I don't like- sex' attitudes and coercion by women. These responses may represent normative responses rather than actual behavior.

Some studies have even indicated that it would be a shameful act if women initiate or express their desire for sex (Khan et al, 1997 and Khan and Patel, 1996). As in the few other studies of sexual communication in the literature most of the initiating signals or messages that existed are non-verbal or indirect. Unlike the general belief that sexual interaction, in our conservative Indian society, is always initiated by the husbands; and women remained a passive partner during sexual intercourse a study shows women also indicate and communicate their desire for sex to their husbands. However we did find some women who directly speak to their husbands suggesting sexual desire.

Corresponding in depth studies on inter spouse communication and sexual interaction is virtually absent in India. Thus besides understanding the sexual behaviors of general population, it is important that we have clear data about husband-wife interactions, including sexual interactions, if we are to develop effective programmes for prevention of sexually transmitted infections and HIV/AIDS.

Women's Utilization of Health Services

Women's access to health care is a complex one, because it is both the outcome of women's status in society, including societies response to their health needs, and a determinant of women's 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 (Chatterjee, 1983). Interaction of these factors shows how they result 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 i.e. supply, use of health services occurs. Severely constrained permission and ability restrict demand by women for health services. Effective demand or use of health services is further reduced by the inadequate fit between needs and services available.

Khan et al., (1982) reported that in the U.P villages they studied, only in 9 percent of female illness was treatment sought from the near by PHC or Government health facility. The vast majority of women simply used traditional remedies.

Few women venture to health centers, clinics and hospitals that are the repositories of such information. Available data on the extent of utilization of health services definitely indicate differences between males and females. Despite higher morbidity among females, more treatment is sought for males, higher percentage of ailing men than women get treatment, and higher proportion of services are provided to men (Coyaji, 1980).

Despite higher morbidity and malnutrition among females, they receive less health care than males. Cause-specific mortality data reveal that female mortality from the common, major diseases is consistently higher than that of males. Although these diseases are easier to recognize and are diagnosed more frequently among females, they are also fatal more often among females because of failure to treat them.

Miller (1981) lists several studies of hospital admissions in different parts of the country, which demonstrated higher ratios of male to female admissions in hospitals in the North compared with the South, although boys were favored in all areas. This is explained by the cultural "belief" that scarce resources of time and money should not be spent on girls or women who must tolerate pain and suffering which are their lots.

Hospital and clinic attendance records invariably show a preponderance of males receiving treatment. The proportion of medical treatment provided to women is lower weather one considers outpatient attendance or indoor admissions. For example, in Safdarjung hospital, Delhi only 35 percent of admissions were female (Ghosh, 1985). Similarly, Khan et al., (1983) reported that a larger number of males were treated at the primary health centers in Uttar Pradesh, Gujarat and Rajasthan.

Low treatment rates exist despite the availability of free government health facilities in both rural and urban areas. Khan et al., (1982) found that in the Uttar Pradesh villages, treatment was sought from the near by primary health center (PHC) or government health facility, in only 9 percent of female illness. The vast majority of women simply used traditional remedies. 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 percent of patients had approached government facilities, the remainder seeking private allopathic or traditional care (Jesudason and

Chatterjee, 1979). Only one-third of the women respondents knew the location of nearest sub center and about 40 percent the location of the nearest PHC. Knowledge of the working timings of these facilities was even pourer. Only a quarter of the women had actually ever visited the local sub center and less than 20 percent the PHC itself. Nor do women attend sub centers or PHC's for antenatal care or for delivery (Jesudason and Chatterjee, 1979; Jeffery et al., 1984; Khan et al., 1982; 1983).

The latter group of researchers have reported that between 3 and 11 percent of pregnant women interviewed in Bihar, U.P and Rajasthan received MCH services such as antenatal check-ups, tetanus toxoid, iron fortification, birth attendance, or post-partum family planning counseling (Khan and Prasad, 1983b). In Kerala almost 40 percent of women received the first three of these services, but fewer obtained the last two. The best coverage rates were found in Gujarat where 35-43 percent of women received the various services.

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 reports proportions closer to 90-95 percent (Jeffery et al., 1984). Dyson and Moore (1983) have pointed to geographical differences in birth attendance by trained personnel, it is lowest in the North and Northwest, and highest in South. This pattern co-incidence with the status of women in the different regions and is inversely related to mortality.

A recent study by Ramalinga Swami (1987) in the Southern state of Andhra Pradesh found that only 2 percent of women in tribal villages and 24 percent in non-tribal villages were delivered by an Auxiliary Nurse Midwife (ANM) or at a hospital, and 16 percent and 62 percent respectively, received tetanus toxoid in the prenatal period. In contrast, over 95 percent of all women had been approached for family planning, and every one knew about 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 (e.g. for family planning), the services succeed in doing so.

Factors influencing the women's utilization 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 P (1975) found literacy an important variable to explain differences in mortality rates in all states. He examined over all death rates in terms of literacy, doctor, hospital and bed- population ratios, percapita expenditures on medical and health services. While literacy was the most important factor, the health service ratio's also had some explanatory power.

The influence of female education on health service utilization is also important in urban settings where health services are relatively accessible, as in Kerala. Khandekar (1974) found that with in middle and low-income groups in Bombay, education had an impact on the utilization of MCH services.

In most rural areas, one in three women lives more than five kilometers from the nearest health facility, and 80 percent of rural women live more than five kilometers form the nearest hospital. The scarcity of vehicles, especially in remote areas and poor road conditions can make it extremely difficult for women to reach near by facilities, walking is the primary mode of transportation, even for women in labour. In rural Tantamia 84 percent of women who have gave birth at home intended to deliver at a health facility, but did not due to distance and the lack of transportation.

In Zaria, Nigeria a study 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 fees are to affect their use of health services.

Many women describe providers in the formal health care system as unkind, rude, brusque, unsympathetic and uncaring. Where health workers are perceived to be hostile and unfriendly, many women rely instead on traditional healers or Traditional Birth Attendants (TBA's) for antenatal, delivery and postpartum care. This can lead to fatal delays in seeking adequate care for pregnancy-related complications. In Tanzamia, a study found that 21 percent of women delivered at home because at home because of the rudeness of the health staff- even thought they thought delivering

in a health facility was safer.

In Ghana, a study of women who died of pregnancy related complications found that 64 percent of the women had sought help from an herbalist, soothsayer or other traditional provider before going to a health facility. Families citied 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 a woman to a hospital (H. Odoi- Agyarka, N Dollimore, O.Owusu-Aygyei. 1993).

In many parts of the world, women's decision-making power is extremely limited, particularly in matters of reproduction and sexuality. Decisions about maternal care are often made by mother-in law, husband or other family members.

Men as Responsible Partners in Reproductive Health

Since gender inequalities favour men in patriarchal societies and sexual and reproductive health decisions are made by them, there is a growing realisation that unless men are reached, programme efforts will have 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 father. Given the situation, the present study intends to proceed with the following objectives.

Objectives of the Study:

The main objectives of the study are to

- Understand the influence of gender on reproductive health of women
- Investigate the role of men in promoting reproductive health of women
- The extent to which women utilize health services for improving one's own reproductive health.

Influence of Gender on Reproductive Health of Women

Understanding Gender

Gender refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values 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 (Health Canada, 2000b). All societies are divided along the "fault lines" of sex and gender (Papanek, 1984) 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 gender norms are culturally specific and thus vary tremendously around the world. Almost everywhere, however, men and women differ substantially from each other in power, status, and freedom. In virtually all societies men have more power than women have (Berer, M. 1996; Evaluation Project, 1997; Helzner, J. F. 1996; Moser, C. O. N. 1993; Riley, N. E. 1997).

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 (CEDPA, 1998; CEDPA, 1996; Hollerbach, P. 1980; Pfannenschmidt, S. et.al, 1997; Riley, N. E.1997). It also can 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 own lives and to use resources for their own 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 (Hollerbach, 1980; Riley, 1997). 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 (Evaluation Project, 1997; Ezeh, 1993; and Mbizvo, 1996).

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

Reproductive Health - 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 beyond reproductive age as well as within it. Reproductive health sets the ground for human sexuality, regardless of whether it leads to reproduction.

Gender differentials in 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 relationship can lead to early and excessive childbearing as well as exposure to STDs and violence. Women who lack decision-making power and control of 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 much 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 on women's health.

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

access to adequate health services. The young woman who dies in first childbirth at age 15 likely incurred obstructed labour or haemorrhage associated with malnutrition or chronic anemia. Chances are, she received less food and health care than her husband. Few child survival or maternal and child health programs even recognize such gender differentials as a problem, let alone seek to combat them. The older, higher parity woman who dies in childbirth not only accumulated the disadvantages from adolescence, but also may 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 (Greer 1987).

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

Gender and Contraception Acceptability

The gender differentials in knowledge and use may arise for a number of reasons. They may reflect actual differences in knowledge and use, or gender-related differences in the accuracy of reports (either deliberate or unintentional) or a mixture 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 recognize that the male partner may have the final say on method use 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 contraceptive 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 women. 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 clandestine use of contraception (Snow, R., et al. 1997). Women interviewed in a five-year women's studies project, carried out in eight countries by Family Health International, said that to attain their family planning objectives, they needed supportive partners, adequate information, unobtrusive methods and respectful services (Barnett, Barbara, and Jane Stein. 1998).

Most modern contraceptive 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 percent of married couples practicing contraception worldwide, less than one third rely 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 sterilization or IUDs (United Nations. 2000).

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 (Ezeh AC, 1995). One explanation may be that women are too shy or embarrassed to report 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 physically using the method. Although the DHS questionnaire is designed to avoid this misunderstanding, it may still happen in certain cases. On the other hand, it
could be that men are using withdrawal without the knowledge of their wives. 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 the perceptions of whether particular behaviour constitutes contraception or not. Men report higher periodic abstinence than women. One explanation for this is that men may interpret periodic abstinence after a birth, for example, as a means of avoiding another pregnancy while women primarily consider it to be for other reasons, e g. to ensure the health of the newborn. Equally, men and women may differentially 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 percent 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 percent (Ruttenberg N, Blanc A and Kapiga S, 1994).

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, although 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 other of the partners using contraception outside the marital union. Men are often assumed to use condoms for extra-marital 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 extra-marital partners. Men are generally older than the women they marry, e g. in Pakistan men are on average 6.7 years older than their spouses. 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 percent had used a condom, whereas of those men who had had sex with a non-spouse, 60 percent had used a condom.

Gender and Adolescent Pregnancy

One important development in adolescence is coming to terms with one's sexual identity. Recognizing one's sexuality has been viewed as a male sphere in the country. The media presents sex as hedonism with the exhortation that it is "dirty" and "immoral." The age of menarche has dropped due to improved nutrition. This indicates a lengthening of the reproductive span and earlier exposure to pregnancy. During this difficult period in life's transition, little attention has been given to the problem of malnutrition. Puberty means increased nutritional requirements, which are, recognized more for male adolescents, the potential work force. In the 1992 National Nutrition Survey, females aged 13 and above had higher rates of anemia and iodine deficiency than males. A mother with iodine deficiency runs higher risks 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 fetal loss among adolescents has been observed. Among those less than 20 years of age, 12.2 percent of the women reported some fetal loss (NSO 1993).

Adolescent contraceptive use remains low. The Philippine National Demographic Survey in 1993 revealed that the contraceptive prevalence rate for women 15-19 years of age was 1.3 percent (NSO 1993). Of women aged 15-19, 7 percent had begun childbearing, 5 percent were already mothers, and 1 percent was pregnant for the first time at the time of the survey. At exact age 18, 10.3 percent had begun childbearing; at age 19, nearly a fifth of the group (19 percent) 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 percent). 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 Philippine data showed that education tends to depress fertility in the earliest childbearing years. The percentage of childbearing was 15 percent among women with no education, compared to 2 percent 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 percent of the country's population was 15 to 19 years of age (NSO 1993).

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 modernization and urbanization, 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.

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 (Gage, 1995). Like a man's power, a 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 more say than their husbands about whether or not they will have more children. Among Yoruba women with few children, however, their husbands' fertility desires usually prevail (Bankole, 1995). However in order to attain the 'power' many women tend to take risk. It is not uncommon for women in Africa, when about to give birth, to bid their older children farewell.

Ninety-nine percent of the approximately 500,000 maternal deaths each year are in developing countries, where complications of pregnancy and childbirth take the life of about 1 out of every 48 women. In some settings; as many as 40 percent of women suffer from serious illness following a birth (Fortney and Smith. 1996).

Avoiding unwanted pregnancy through family planning and proper antenatal care reduces maternal mortality. Only 70 percent 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 the studies that had any information on women's utilisation of pregnancy and delivery care reveals an overwhelming evidence women distrusted or disliked hospital delivery and preferred natural childbirth, and believed that antenatal care was not necessary. A study from rural Rajasthan (Hitesh 1996) reports that a very large proportion of pregnant women referred to tertiary centres did not avail of the referral because of lack of money, transportation facilities or time, and 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 shows further that when relatives were able to provide social support in terms of taking over the woman's domestic responsibilities, there was an even higher likelihood of a pregnant woman availing of referral even among the better off. Very similar findings are reflected in another study, also from Rajasthan (Unnithan-Kumar 1999), which found that work and lack of social support impeded access to health services.

A study of women from a fishing community in southern Tamil Nadu (Ram 1994) examining why women did not use delivery services found that some of the reasons reported by the women included prolonged stay in hospital disrupting their gender-based domestic responsibilities, caste gap between provider and user, harsh treatment by delivery staff and unnecessary medical interventions. Studies examining the association of various socio-economic factors with utilisation of services indirectly through statistical analysis (as opposed to direct questioning) find that women using antenatal care were economically better-off than those not (Khandekar et al. 1993), had more years of education themselves as well as were married to men with more years of education (Khan et al. 1997), were non-working women and did not belong to the Scheduled Castes (Khandekar et al.1993). Interestingly, though, these associations are interpreted as implying the ignorance of women. The studies then argue for convincing and educating the illiterate women on the need for antenatal care and for trained attendance at birth, without probing further 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, that anyone who does not see this 'truth' has to be ignorant and uninformed and needs to be educated and made aware.

In terms of choice of provider for reproductive health care, a preference for traditional *dais* (traditional birth attendants or TBAs) for delivery care is indicated by many studies. The low cost of services appears to be an important consideration. In the only study that actually documents cost of care, from Vellore in Tamil Nadu (Sahachowdhury 1998), 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 the unwillingness to invest on childbirth, a reflection on the value placed on a life-and-death situation for women by their households and society at large. Cost was a consideration in choice of provider for induced abortion for one-third of the respondents, according to one study (Ganatra et al. 1998b). The same study also reported that women's heavy work load at home made them prefer abortion providers who did not insist on repeated visits or an overnight stay.

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 practice 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 women's. A mix of cultural norms, social expectations, and men's sex drive encourages men's risky sexual behavior (Berker, G. 1996; Center for Development And Population Activities, 1996; Danforth, N. 1998; Speidel, J. 1998). Some societies, as in Haiti and Thailand, accept that married men will have extramarital sex, either with girlfriends or prostitutes (Tangchonlatip, K., and Ford, N. 1993; Ulin, P. R., and Cayemittes, M., and Metellus, E. 1995). Similarly, in many Latin American and Caribbean cultures, the concept of *machismo* encourages

men to be promiscuous to prove their masculinity (Barker, G. 1996). Such male gender roles can contribute to their contracting STDs and passing them on to their wives or 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 more subtle in women. Even 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 health risks associated with it. Third, a power imbalance between the sexes favours men. Women frequently have little power over when, with whom, and under what conditions sexual relations occur. 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 stigmatized. 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, protection against transmission is ensured by preventing direct contact with semen, genital discharge, genital lesions, and infectious secretions (Cates and Stone 1992).

Gender Violence and Reproductive Health

Gender violence, until recently a marginal subject among themes related to health, has such a significant impact in women's health that it is responsible for one in every five potential years of healthy life lost (Heise L, 1994).

Contrary to common sense that imagines pregnancy as a sanctified state of peace and beatitude. Violence does not necessarily decrease during this period, tending in many cases to increase in intensity or frequency (Stewart DE, Cecutti A, 1993). The prevalence of violence during pregnancy tends to be higher than that found for

physical and sexual violence in the previous year among populations of non-pregnant women. This leads some authors to postulate that pregnancy could be considered as an increased risk factor for violence (Stark E, Flitcraft A, 1995).

Sexual violence leads to unwanted pregnancies not only in the context of rape by strangers but also in forced sexual intercourse within intimate relationships, and seems to have important consequences (Gielen C A et.al. 1994).

Studies suggest that the younger the women, the more vulnerable they are to violence during pregnancy, which affects 24 percent of all pregnant adolescent women (Parker B et. al. 1993). Unplanned pregnancies are also associated to violence. In a study conducted by Stewart and Cecutti (1993), 88 percent of the women who referred sexual abuse during the current pregnancy declared that it was not planned, whereas just 30 percent of the women who did not refer abuse had unplanned pregnancies. Younger women were also 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 particular lady to the abdomen (Stewart DE, Cecutti A, 1993). In a study with 203 pregnant women assisted for physical traumas, 31.5 percent of them were victims of intentional violence (Poole and Martin, 1996). The consequences of these traumas are several direct obstetric outcomes, which affect both mother and child's health.

In a study with 218 women that suffered domestic violence assisted at an emergency room, 5 percent of the women declared the abortion was due to violence, and. 16 percent declared they had attempted suicide previously (Berrios and Grady, 1991). These aggressions have also been held responsible for abruptio placentae, rupture of the uterus, liver or spleen, pelvic fractures, premature births, premature rupture of the membranes, fetal infection and fractures (Council on Scientific Affairs, 1992, http://www.nhvbc: com/nhwomen/fact3.htm).

Indirect repercussions on the health of the newly born are equally important. Low weight 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 (Campbell JC, 1995).

Gender roles can Harm Reproductive Health

The traditional gender roles can jeopardize the reproductive health of both women and men. Inequities in power often make women vulnerable to men's risky sexual behavior and irresponsible decisions. Because of their gender roles, many women around the world have trouble talking about sex or mentioning reproductive health concerns (Blanc, A. et.al. 1996; Glimore, S.et.al. 1995; Ulin, P.R., et.al.1995; Van Der Straten, et.al. 1995).

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 (Barnett, J. et.al. 1996; Dixon-Mueller, R. 1993). For women worldwide, the impact of gender inequality is apparent in many of their reproductive health problems (Alan Guttmacher Institute, 1998; Barnett and Stein, 1998; Hardon, A. 1995; Mbizvo and Bassett, 1996; Mccauley, A.P et.al. 1994; Salter et.al.1997; United Nations, 1995). Thus Gender has a powerful influence on reproductive decision-making and behavior (Blanc, A. et.al.1996; USAID 1997).

Gender is just one of many factors that influence couples and affects their reproductive decisions. Education level, family pressures, social expectations, socioeconomic status, exposure to mass media, personal experience, expectations for the future, and religion also shape such decisions (Beckman, L. 1983; Hollerbach, P. 1980). Consequently, no two couples' "decision-making environments" are identical (Hull, T. 1983). Some researchers have suggested that personal reproductive decisions result from many smaller, incremental decisions (Binyange, M, et.al. 1993; Mumford, S. 1983; Wilkinson, D, et.al. 1994). Other researchers suggest that in fertility decisions, social and cultural norms and expectations often prevail over individual preferences (Hull, T. 1983).

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, not by men alone (Grady, W. R et. al. 1996; Ogawa, N. et.al. 1993).

Study Design and Methodology

Historically Andhra Pradesh has been a diverse state in terms of socio-economic and demographic levels. Of the three main regions of Andhra Pradesh, Telangana is the most backward. Demographically coastal Andhra is close to the levels of Kerala, Telangana can be compared to the backward states of India. Rangareddy is one of the districts of Telangana region. Geographically Hyderabad, the capital of the state, is in the midst of Rangareddy district. The city of Hyderabad is recognized as one of the fastest growing cities in India not only in terms of population density but also in terms better infra-structural facilities such as health, accessibility, and communication facilities. Though Hyderabad is located in the center of the district, it seems the development has not percolated into the district. According to the latest census, the Rangareddy district is one of the backward districts in terms of developmental indicators. Due to the existing socio-economic situation of the district, a study in the rural areas of Rangareddy district is felt interesting.

Sampling Design

Sampling for the present study is done at two levels; sampling of the area and sampling of the couples. As mentioned above, the district of Rangareddy is choosen for the current study. With in the district there are a total of 29 primary health centres (PHC) in the rural areas. Of them 20 are known as round the clock women health centres (RCWHC) and 9 are ordinary primary health centres. RCWHC is an upgraded PHC and it is created with an intention to provide comprehensive reproductive health care, especially to make maternal health services available 24 hours of the day. The Government has made it mandatory to appoint at least one lady gynecologist at these centres, either on regular or contract basis. Structurally these centres are upgraded in terms of equipment, medicines and manpower. The current study is intended to focus on utilization of reproductive health services by women. Among various factors that determine the utilization of health services by women is the availability of health facilities. Therefore it is decided to select a few villages, which are covered under a RCWHC that have better health facilities. According to the state Government officials, the RCWHC located at Shamirpet has adequate health facilities and has been

identified as one of the best performing centers over years. Thus for the present study villages covered under Shamirpet RCWHC is selected as the study area.

Profile of the Health center

Shameerpet is acclaimed as one of the best Primary health centres in Andhra Pradesh. It is situated at a distance of 20 kms from Hyderabad. Shamirpet is one of the old PHCs of the state. In 1983-84 it was selected for up gradation and there after was one of the 'upgraded primary health centers' of the state. As part of the up gradation process a new building was built in 1984. In 1999 under the RCH programme the health center was converted as 'Round the clock women health center'. The center is well equipped with the necessary infrastructure both in terms of equipment and manpower. It has 30 beds for inpatients. All the equipment has been in condition and has been in use. The center has been receiving necessary medicines regularly. The center was chosen for various special programmes, both by the Government and the voluntary units. Frequently students of Gandhi medical college visit the center for training. The Shamirpet RCWHC covers a population of 96,109 as on April 2003. It has nine sub-centres and 30 villages under it. Of the total population 47 percent are main workers, 3 percent are marginal workers, and 51 percent are non-workers.

Selection of the villages

Shamirpet RCWHC has nine sub-centres and provides health services to a population of 30 villages. Random sampling technique is used to select the villages. First, selection of sub-centres was done. Out of the nine sub-centres, one-third of them, i.e. three centres are selected at random. The selected sub-centers are Shamirpet, Devaryamjal, and Aliabad. From each of the sub-centres, one village is selected at random. Thus the selected villages for the study are Shamirpet, Pothaipally, and Turkapally. According to the village administrative boundaries, there is one hamlet each attached to Pothaipally, and Turkapally. Yelgalguda is a hamlet of Pothaipally, and Turkapally Thanda is the hamlet of Turkapally.

Selection of the Couples

The main objective of the study is to see the influence of gender on reproductive health. Also literature suggests that traditional gender roles are starting to change. Thus, in order to examine the dynamics of the changed gender roles, a purposive

sampling technique is adopted for the study. The unit of the study is couples, i.e. wives in reproductive age group (13-49 years). Studies have shown that gender roles tend to diminish with lesser differences in spousal socio-economic and demographic characteristics. In Indian setting, 'duration of marriage of the couples' is assumed as an important variable in deciding power differences between the couples. Thus as a first step, house listing of all the couples by duration of marriage is carried out in the sampled villages. Subsequently all the couples are categorized on the basis of 'duration of marriage' at 5 year intervals. Broadly thus the couples are classified as (i) those married less than or equal to 5years ago; (ii) those married between 6 to 10 years ago; (iii) those married between 11 to 15 years ago; (iv) those married between 16 to 20 years ago; and (iv) those married between 21 to 25 years ago; and (iv) those married more than 25 years ago. In each of these categories randomly ten percent of couples are selected for the study, so that 10 percent of total couples in reproductive age group in all the study villages comprises the sample. Thus the selected number of couples for the study is 223. Table-3.1 gives the particulars of the selected couples by duration of marriage in each of the selected the village.

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 (Yrs)						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 Tanda	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

Tools of Data collection

A review of methodologies on male's 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 attempted to collect information using both structured schedules as well as by using qualitative techniques such as focus group discussions and in-depth interviews.

- *Focus Group Discussions* (FGDs) is carried at two different stages of work. The first round of FGDs is conducted with men and women to understand the 'power' relations with in the community in those villages. The information collected by these discussions not only helped in understanding the gender relations in the study areas but also helped in preparation of individual interview schedules. The FGDs also helped in building a rapport with the community. The second round of FGDs is conducted to a group of husbands and wives, separately, on their perceptions of reproductive illness and the need for a medical care.
- *Individual interviews* of couples are conducted separately for couples, both husbands and wives, with the help of interview schedule. This structured tool helped in bring out information on knowledge, access, and gender roles with respect to reproductive behaviour, health, morbidity and utilization of health services by women. The support wives expected and received from husbands is also collected.
- From the collected data, a few couples, either one or both of them, suffering from reproductive health are selected for in-depth interviews.

While designing the tools, care is taken to incorporate appropriate validity checks for editing the information at field level. Discussions with a programmer helped to modify the schedules suitable for entry checks. Similarly discussions with a statistician are made to check whether all the information can be pooled for appropriate analysis.

Preparatory Work Prior to Main Survey

A lot of preparatory work is done prior to the actual data collection. First, discussions are held with gynecologists to enable the researcher to familiarize with various components of reproductive morbidity and health. After the initial FGDs, the information collected helped in preparation of interview schedules. These schedules are initially developed in English. Then translated into Telugu and were again back

translated to check ambiguity in expression. Subsequently the questionnaires are pre-tested before finalizing and printing. Meanwhile permission was sought from the Directorate of Health and Family Welfare and district collector to seek cooperation at District level. The permission from them facilitated in obtaining permission from the District Medical and Health officer of Rangareddy district to collect relevant information from the selected RCWHC. Subsequently interactions with village heads, and popular persons of the village are made. This exercise helped in explaining the purpose of study and facilitated to conduct focus group discussions prior to the main survey.

Selection and Training of Field Staff

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

Operation of Fieldwork

Participatory Approach

Before starting the data collection activity as a preliminary exercise, village social maps are prepared with the help of some of local people and multipurpose health workers. First the maps were drawn on a mud floor. Sketches were drawn with identification of houses, and other land marks such as water tanks, school building, temples, any other religious places, health facilities, place of local quacks etc. These sketches are drawn with the help of coloured powders, different type of leaves, pebbles, wood pieces etc. There after a similar map was drawn on paper and asked the local persons to correct for any changes. This participatory technique enabled the field

staff in developing a lot of interaction with the local people, which subsequently helped in building a rapport. These social maps subsequently helped in door-to-door field survey.

Survey Method of Data Collection

The social maps helped the investigators to have clarity of universe, thus could move from one household to another without missing any household during the house listing exercise. From each of the household, particulars of the couples by duration of marriage are collected. This list formed as a universe to select the sample. Once the sample is identified, with the help of interview schedule, the couple, both wife and husband, are interviewed separately.

Qualitative Method of Data Collection

A few of the investigators are trained in the techniques of qualitative methods of data collection. The principal investigator with the support of these investigators conducted focus group discussions. The first round of FGDs are organised to understand the existing 'power' relations between men and women with in the community and the existing gender preferences. This type of information helped in designing the schedules. The second round of FGDs are organised for wives and husbands separately to understand their knowledge, attitude and obstacles in seeking health services. Gender dimensions and constraints in hindering utilization of health services are focused. Also from the couples's point of view, suggestive measures to improve couples reproductive health are noted down. In addition to the FGDs a few in-depth interviews of selected couples are done. Selection of the couples is based on the information collected through interview schedules. Couples, either wife or husband or both, suffering from any reproductive morbidity are selected at random for in-depth interviews.

Quality Checks of the Data

During the survey the field editors simultaneously edited the questionnaires. Care is taken regarding validation, mistakes and missing information. All the filled in questionnaires are once again edited at the office and open-ended questions are coded before the entry. The entered data is subsequently scrutinized and validation is done before the analysis.

Coverage of Women

Of the 223 total women identified for the survey, all were interviewed. None of the women refused to give information. A few women though initially refused, repeated assurance of the confidentiality of the information and interest showed by the investigators in clarifying all their doubts, resulted in complete coverage.

Ethical Concerns

Before proceeding with the survey the interviewers took informed consent from all respondents. Since a majority of them were either illiterates or had low literacy levels, their written consent was difficult to obtain. Therefore, their oral consent was considered adequate. The field team assured them about confidentiality of their responses and ensured that the information will be used only for research purpose. Also care is taken to see that no member was present other than respondent at the time of interview. Despite special efforts, if privacy is at stake, the interviewers are instructed to shift to the general topics from sensitive topics. After ensuring the privacy, a continuation of sensitive information is collected. Especially when young women are interviewed, if there is a chance for mother-in-law or other elder members of the family came and sat along with the respondent, then the interviewer tried to explain these members in detail about the purpose of the study and tried to see that the persons left the respondent alone. Since the study is based on personal information of the individuals, it was anticipated that there could be a refusal to answer along the mid way even after initially accepting for the interview they may be non-cooperative. One such experience faced by a lady investigator is as follows. A respondent at mid way of the interview was unwilling to give further information as she realized that the investigator is unmarried. The respondent questioned the validity to collect information by an unmarried investigator on reproductive behaviour. Then again, the respondent was made to realize that formal education attained by the investigator is adequate for her to discuss on the reproductive issues even though the investigator do not have a personal experience. Barring this incident there was no violent refusals. It took more than an hour for interview and in few cases repeated sittings on respondents' request was obliged. No amount was paid to the respondents, as the form of data collection did not disturb their daily economic activity. The constituted ethical committee for the project has approved the study.

Profile of the Study Area and Couples

The present chapter briefly describes about the study area and the couples. As mentioned in the previous chapter, for the present study three villages namely Shamirpet, Potaipally, and Turkapally are selected. Yeligalguda and Turkapally Thanda are the hamlets of Pathaipally and Turkapally respectively.

An Understanding of the Villages under study

Transportation to Villages

All the villages are well connected by roads and have both public as well as private transportation facilities. Transportation 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 Kms. from Hyderabad, the capital city of Andhra Pradesh.

Availability of Health Facilities

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

Basic Household Amenities

All the villages are connected with piped drinking water supply. However most of them have to get water from a public tap. Eighty percent of the households get water from a distance of 100 meters from their house, 14 percent has to go to a distance of nearly 200 meters, and 6 percent of the households have to go beyond 200 meters. More than half of the households (51.4 percent) do not have toilet facilities. Forty-six households have own toilet facility and the remaining use shared facility. Village wise analysis shows that all the houses in Turkapally Thanda and 83 percent of households in Yeligalguda have no toilet facility. Almost all the households use electricity as a source for lighting during nights.

Socio-Economic Characteristics of the Couples

Education

There are differences between the educational level of wives and husbands in the study villages. More than half of the wives (57 percent) are illiterates where as the corresponding percentage of the husbands is 28.7 (Table-4.1). Fifteen percent of the wives are educated up to primary and 28 percent have studied above primary level. Among husbands 26 percent of them are studied up to primary and 45 percent are educated above primary level.

Religion and Caste/Tribe

A majority of the couples in the study are followers of Hindu religion (91 percent), 6 percent of them are Muslims and a marginal percent of the couples are followers of Christianity (2.7 percent). Caste composition of the couples indicates that two-thirds of them are from backward castes (62.8 percent). Nearly one fifth of them are from Scheduled castes and 3.6 percent are from Scheduled tribes. Twelve percent of the total couples belong to forward castes.

Type of Family

Nearly three fourths of the total families are nuclear (72.6 percent), i.e., it consists of a husband and a wife with unmarried children, and the remaining are either extended or joint families (27.4 percent).

Work Status

More than half of the wives are working out side home either as daily wagers (30 percent), skilled workers (7.6 percent) or engaged in business (21 percent). Excepting one person in Turkapally village, all husbands under study are engaged in income generating activities. A majority of them are working for daily wages (39.5 percent). Followed by men engaged in skilled work (17 percent), clerical jobs (16.6 percent), cultivation (14.8 percent) and business (11.2 percent).

Demographic Characteristics of the Couples

Age distribution

Sixty percent of women are aged below 25 years of age; its corresponding percentage for men is 31 percent. Seventeen percent of the women, and 22 percent of men are in

the age group of 26 to 30 years. Nine percent of the women and 20 percent of the men are above 40 years of age.

Marriage particulars

Median age at marriage as well as cohabitation for women in all the villages is 16 years. Distribution of couples by duration of marriage reveals that 23 percent of the couples are married less than two years ago; 21 percent are married 3 to 5 years ago. Sixteen percent of the couples are married 21 years ago.

Parity

One fifth of the couples are still childless at the time of survey and another one-fifth of the couples have a single child. Twenty two percent of the couples have four or more children.

Table-4.1 Socio-Economic Characteristics of the Couples

Socio-economic Characteristics	Percentage of Couples			
	Shamirpet	Pothaipally	Turkapally	Total
Wife's education				
Illiterate	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				
Illiterate	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
Other 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				
Not working	48.2	34.2	34.2	41.3
Daily wage	27.7	36.8	30.1	30.0
Skilled worker	7.1	7.9	8.2	7.6
Business	17.0	21.1	27.4	21.1
Husband's work status				
Cultivation	14.3	10.5	17.8	14.8
Daily wage	41.1	44.7	34.2	39.5
Skilled worker	13.4	21.1	21.9	17.5
Business	8.9	10.5	15.1	11.2
Clerical	22.3	13.2	9.6	16.6
Not working	0.0	0.0	1.4	0.4
Total (Number)	**50.2 (112)**	**17.0 (38)**	**32.7 (73)**	**(100.0) 223**

Table-4.2 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)**

Media Exposure and Access to Reproductive Health Services

Utilization of reproductive health services is dependent in part on couples' exposure and awareness of available reproductive health services. Awareness levels of both the couples is felt essential to understand whether it has any impact on care seeking behaviour of women. This chapter discusses on survey findings on couples' exposure to messages related to some components of reproductive health such as family planning, pregnancy care, delivery care, care after child birth, AIDS, and other reproductive health problems. The couples are asked separately on whether they recalled hearing or seeing any of the message 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 is also collected.

Exposure to Various Components of Reproductive Health

There have been differences between couples' exposure to various aspects of reproductive health (Table-5.1). Comparatively more men (75.3 percent) have recalled hearing or seeing at least one message over past one month than the women (59.6 percent). Individually though more than half of the women and men are exposed to messages on aspects of reproductive health, only 35.4 percent of both the couples are exposed to at least one of the aspects of reproductive health. In the sampled villages 87 percent of the families either a husband or wife are exposed to messages related to reproductive health. Messages related to obstetric and gynecological aspects more women are exposed to media than men. Whereas men are more exposed to messages on family planning and AIDS.

Family Planning

Women who are exposed to message on family planning, 33 percent were exposed to the message about how to stop having further children, 27 percent were exposed on how to space between children, 23 percent exposed about postponement of first birth, and the remaining about how many children a couple should have. Where as among men 81 percent are exposed on how many number of children, and the remaining are exposed on how to stop having children.

Women in the age group of 26 to35 years (20 percent), educated above primary level (25.4 percent), relatively more from nuclear families (16 percent), with increase in duration of marriage and parity, and those relatively with high earnings are more exposed to family planning messages (Table 5.2). Similarly men educated above high school (68.4 percent) from nuclear families (26.5 percent) married less than five years ago (60 percent), and those working in non-agricultural activities are exposed to family planning messages (Table 5.3).

Pregnancy Care

Health care to be taken by a mother during pregnancy was the main message on which 63 percent of the women were exposed; where as 46 percent of men mentioned to have exposed on health of the foetus. Exposure to pregnancy care is observed more among women who are less than 25 years of age, younger the duration of marriage, those educated above primary level, and women of lesser parities. Unlike women, men exposed to pregnancy care are less. There has been a clear association with their socio-economic status and exposure to pregnancy care. More men between 20-30 years of age, married less than two years ago, with increase in educational level, working in tertiary sector, and those who have two or fewer children are more exposed to media on pregnancy care.

Delivery Care

On information related to delivery care, only one-fourth of the exposed women heard or seen a message about place of delivery; its corresponding percentage among men is 41 percent.

Women above 36 years of age are more exposed on delivery care. Apart from age, exposure to delivery care is also associated with women if they have studied above primary level, forward castes, women residing in nuclear families, with parity level of 2 or 3 and those from better earning families. Men aged between 21 to 30 years, educated above high school level, working in office jobs, with lesser duration of marriage and those from nuclear families are more exposed to messages related to delivery care.

After child birth

Messages related to care after childbirth drew maximum attention of women. However 65 percent of these women were actually exposed to the messages on child's vaccination. Only15 percent of women were exposed on postpartum care. Similarly more men exposed to messages related to vaccination of children.

Among those who are exposed, more women in the age group of 21-30 years, those educated above primary level (47 percent), those engaged in daily wages or skilled work, from backward castes (53 percent) and those married 3-5 years ago are exposed to media. Among men if they are aged between 21-40 years (75 percent), with increase in educational level, from nuclear families (17 percent), and those married less than 5 years ago (26 percent) are exposed to messages related to care after child birth.

AIDS

Government and non-governmental organizations have been taking a lot of interest in bringing awareness about AIDS. Despite all efforts only 25.6 percent of women, 71.7 percent of men are exposed to message on AIDS. A majority of the couples (90 percent) are exposed on messages related to prevention of AIDS and very few of them (less than 5 percent) were exposed to messages on spread of AIDS. Among women who are in the age group of 16 to 25 years (54 percent), educated (58 percent), and non-working women (54 percent) are exposed to messages on AIDS. Three-fourths of men aged between 21-40 years, those educated up to high school or above (94.7 percent), those working in nonagricultural activities, from backward castes and with lesser duration of marriage are exposed to messages on AIDS.

Other Reproductive Health Problems

Messages related to reproductive health problems, i.e. other than family planning, obstetric care and AIDS, very few women and men are exposed. Better-educated persons from high castes are more exposed to such messages than the remaining.

Types of Exposure

Type of media exposure differs from women and men in the study areas. Women are more exposed through interpersonal communication while more men are exposed through mass media. Fewer women are exposed by multiple sources than men. Again media of exposure among women differed with type of message. On issues related to pregnancy and childbirth or other reproductive health problems more than 80 percent of the exposed women have heard about it through interpersonal communication. Whereas messages on family planning and AIDS, mass media has been the main source for a majority of women, 66 percent and 94 percent respectively. In other words on issues, which are socially accepted for conversation women felt convenient to discuss and learn about it through interpersonal communication. Despite many decades of efforts still a conversation related to family planning is not a topic of acceptance. To converse on AIDS is further unapproved in a community, especially among women. Thus women largely rely on mass media as a major source of information. In case with men though mass media has been the chief source of information for all types of messages, yet more than half of them who have heard or seen were also exposed through interpersonal communication and group meetings. Men, as compared to women, have fewer inhibitions to know about the specified issues. With in the topics, men took less interest to be acquainted with messages related to pregnancy and childcare as many think it is an area mainly confined to women.

Access to Reproductive Health Services

Reproductive health of women is affected by social, psychic and economic costs of care. Access to services is in turn assessed in two ways, cognitive and physical. Cognitive access refers to couple's awareness about the availability of services. Physical accessibility refers to the physical distance and travel time to reach a facility. Reproductive health services are broadly categorized as services related to temporary methods of contraception, medical termination of pregnancy, permanent sterilization, pregnancy care, delivery care, postpartum care, gynaecological health problems, sexually transmitted diseases, and AIDS.

Cognitive access

Cognitive levels of men and women on components of health care are culturally controlled. Health care referring to obstetric and gynaecological health comparatively more women reported better knowledge than men. Services related to family planning, STDs and AIDS, more men reported better knowledge. Table-5.4 shows the cognitive knowledge levels on access to various components of reproductive health care. Every woman is aware of availability of pregnancy and delivery care. Almost every woman also knows facilities for postpartum care and other gynaecological health problems. Availability of sterilization facilities is known to 91 percent of women. On contrary only 19 percent of women are aware of availability of temporary methods of contraception. Services related to medical termination of pregnancy is known to 36 percent of women, and about STDs only 28 percent of women are aware of it. Very few women know about the availability of health care facilities for AIDS.

Cognitive levels of men on access of reproductive health services reveal that, a majority (96 percent) is aware of sterilization facilities. Knowledge about pregnancy and delivery care facilities is known to nearly three-fourths of men. Cognitive knowledge about temporary methods of contraception is known to two-thirds of men. Even though knowledge about STDs and AIDS is known to more men compared to women, barely one out of two men is aware of them.

Physical access

Cognitive levels of access to various components of reproductive health are similar to the physical access for both women and men. That is the couple that cognized about existence of health facilities for various components of reproductive health, are also certain about the location of the facilities (Table-5.5). Presence of round the clock health center (RCWHC) at Shamirpet is referred as the main source of access for reproductive health services by all the women and men, who have expressed awareness about physical access. While three fourths of the woman in the study areas knew that sterilization and obstetric health services are available at RCWHC, Shamirpet, interestingly less than one-tenth of the women knew it as a source for temporary contraceptives and AIDS. Only one-fifth of the women knew that services related to medical termination of pregnancy and STDs are available at RCWHC. The next most recognized place of health facility is private clinic/hospital by the women.

Unlike women, men did not refer RCWHC as the main source of health facility. A considerable percent of men recognized private clinic/hospitals as a source of health facility for most of the reproductive health care. For temporary methods men equally relied on medical shops. Interestingly men mentioned Anganwadi workers as source of supply for temporary methods while none of the women ever mentioned about them, despite the probability for more women to interact with them than men.

Table-5.1 Couples Exposed to Various Components of Reproductive Health Through Media

Components of Reproductive Health	Couples Exposed to Media			
	Women	Men	Both the couples	Either of the couples
Family Planning	13.5	23.3	4.0	32.7
Pregnancy Care	31.8	18.4	13.0	37.2
Delivery Care	17.0	10.3	4.5	22.9
After Child Birth	36.8	16.1	9.9	43.0
AIDS	25.6	71.7	20.6	76.7
Other Reproductive Health Problems	9.4	4.0	0.4	13.0
At least one of the components	59.6	75.3	35.4	87.0

Table-5.2 Women Exposed to Various Components of Reproductive Health Through Media by Background Characteristics

Socio-economic Characteristics	Components of Reproductive Health					
	Family Planning	Pregnancy Care	Delivery Care	After Child Birth	AIDS	Other Reproductive Health Problems
Current age						
<=15	0.0	16.7	0.0	0.0	33.3	0.0
16-20	12.7	40.8	16.9	38.0	1.4	12.7
21-25	15.8	35.1	21.1	45.6	29.8	8.8
26-30	20.5	23.1	15.4	41.0	28.2	5.1
31-35	20.0	6.7	0.0	6.7	33.3	6.7
36-40	6.7	26.7	20.0	40.0	20.0	13.3
40+	0.0	35.0	25.0	30.0	25.0	10.0
Education						
Illiterate	8.7	23.6	14.2	33.1	18.9	7.9
Up to primary	9.1	30.3	9.1	30.3	18.2	3.0
Above primary	25.4	49.2	27.0	47.6	42.9	15.9
Work status						
Not working	16.3	40.2	18.5	38.0	33.7	10.9
Daily wage	11.9	32.8	19.4	46.3	23.9	6.0
Skilled worker	5.9	11.8	0.0	47.1	11.8	0.0
Business	12.8	21.3	17.0	17.0	17.0	14.9
Caste/Tribe						
Scheduled caste	10.6	27.7	19.1	29.8	23.4	4.3
Scheduled tribe	14.3	32.9	15.0	36.4	24.3	10.7
Other backward caste	14.3	35.7	21.4	53.6	35.7	7.1
Others	12.5	25.0	25.0	25.0	25.0	25.0
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	27.9	9.8
Marriage Duration						
<=2	13.5	46.1	15.4	32.7	21.1	15.3
3-5	12.7	38.3	27.6	53.2	34.0	8.5
6-10	18.9	27.0	18.9	37.8	24.3	8.1
11-15	15.2	18.2	3.0	39.4	30.3	6.0
16-20	22.2	16.7	11.1	11.1	22.2	0.0
21+	2.8	27.7	23.3	30.5	19.4	11.1
Parity						
0	11.1	48.9	11.1	20.0	26.7	20.0
1	17.7	33.3	24.4	51.1	26.7	6.7
2	15.4	7.7	25.6	48.7	33.3	7.7
3	13.6	25.0	18.1	43.2	22.7	6.8
4+	10.0	20.0	8.0	24.0	20.0	6.0
Daily earning						
0	15.8	42.7	19.5	39.0	34.1	11.0
<=20	8.5	17.0	12.8	36.2	10.6	6.4
21-25	17.1	41.5	17.1	51.2	26.8	9.8
26-30	2.6	13.6	10.5	10.5	13.2	2.6
30+	33.3	40.0	33.3	53.3	53.3	26.6
Total (Number)	**13.5 (30)**	**31.8 (71)**	**17.0 (38)**	**36.8 (82)**	**25.6 (57)**	**9.4 (21)**

Table-5.3 Men Exposed to Various Components of Reproductive Health Through Media

Socio-economic Characteristics	Components of Reproductive Health					
	Family Planning	Pregnancy Care	Delivery Care	After Child Birth	AIDS	Other Reproductive Health Problems
Age						
<=20	0.0	0.0	0.0	0.0	50.0	0.0
21-30	30.5	26.3	14.4	22.9	79.7	5.9
31-40	18.6	13.6	8.5	15.3	72.9	1.7
40+	11.2	4.5	2.3	0.0	50.0	2.3
Education						
Illiterate	3.1	4.7	1.6	3.1	50.0	1.6
Up to primary	13.6	13.6	1.7	11.9	66.1	0.0
High school	35.8	27.2	19.8	25.9	87.7	7.4
Above high school	68.4	42.1	26.3	31.6	94.7	22.2
Work status						
Cultivation	21.2	6.1	3.0	15.2	63.6	3.0
Daily wage	10.2	12.5	3.4	12.5	55.7	0.0
Skilled worker	33.3	23.1	15.4	20.5	84.6	2.6
Business	16.0	12.0	12.0	16.0	88.0	4.0
Clerical	48.6	40.5	27.0	21.6	91.9	16.2
Not working	100.0	100.0	0.0	0.0	100.0	0.0
Caste/Tribe						
Scheduled caste	23.4	12.8	6.4	17.0	74.5	2.1
Scheduled tribe	18.6	19.3	10.0	15.0	68.6	4.3
Other backward caste	50.0	25.0	17.9	17.9	85.7	3.6
Others	12.5	12.5	12.5	25.0	62.5	12.5
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
Marriage Duration						
<=2	32.7	42.3	23.1	26.9	86.5	7.7
3-5	27.1	12.5	4.2	27.1	75.0	6.3
6-10	32.4	18.9	16.2	13.5	75.7	5.4
11-15	13.3	6.7	3.3	10.0	66.7	0.0
16-20	22.2	16.7	5.6	5.6	72.2	0.0
21+	5.3	2.6	2.6	0.0	47.4	0.0
Parity						
0	22.2	35.5	11.1	4.4	82.2	13.3
1	35.5	20.0	17.7	37.8	80.0	2.2
2	28.2	25.6	15.3	33.3	82.1	5.1
3	24.4	6.7	6.6	8.9	68.9	0.0
4+	8.7	33.3	2.0	0.0	8.2	0.0
Total	**23.3**	**18.4**	**10.3**	**16.1**	**71.7**	**4.0**
(Number)	**(52)**	**(41)**	**(23)**	**(36)**	**(160)**	**(9)**

Table-5.4 Cognitive Knowledge of Couples on Access to Various Components of Reproductive Health

Components of Reproductive Health	Percentage of couples			
	Women	Men	Either	Both
Temporary contraceptives	18.8	64.6	71.3	12.1
Medical termination of pregnancy	35.9		68.2	23.3
Sterilization	91.0	95.5	98.7	87.9
Pregnancy care	100.0	73.9	100.0	74.0
Delivery care	100.0	77.1	100.0	77.1
Postpartum care	99.1	58.7	100.0	57.8
Women's other health problems	96.9	51.6	98.7	49.8
STDs	28.3	50.2	62.8	15.7
AIDS	12.6	36.3	44.4	4.5
Total	**223**	**223**	**223**	**223**

Table-5.5 Knowledge of Couples on Physical Access to Various Aspects of Reproductive Health

Aspects of Reproductive Health	Percentage of couples	
	Women	Men
Temporary methods of contraception	**18.8**	**64.6**
• PHC/ Sub-centre /MPHA's	10.3	22.4
• Pvt. Clinic/Hospital	2.7	14.3
• Medical Shops / Depot Holder	5.8	23.3
• Anganwadi Workers	--	4.5
Medical termination of pregnancy	**35.9**	**55.6**
• PHC/MPHA's/ Sub-centre	20.2	30.0
• Pvt. Clinic/Hospital/Voluntary agency	14.8	24.2
• Govt. Medical college hospital	--	1.3
• Medical Shops	0.9	--
Sterilization	**91.0**	**95.5**
• PHC/ Sub-centre/ MPHA's	71.3	68.2
• Pvt. Clinic/Hospital/Voluntary agency	17.9	25.6
• Govt. Medical college hospital	1.8	1.8
Pregnancy care	**100.0**	**73.5**
• PHC/ Sub-centre/ MPHA's	73.1	47.5
• Pvt. Clinic/Hospital/Voluntary agency	25.6	24.2
• Govt. Medical college hospital	1.3	1.3
• Anganwadi Workers	--	0.4
Delivery care	**100.0**	**77.1**
• PHC/ Sub-centre/ MPHA's	72.6	51.1
• Pvt. Hospital/Voluntary agency	24.7	23.3
• Govt. Medical college hospital	1.3	1.8
• TBA's (Dai)	1.3	0.9
Postpartum care	**99.1**	**58.7**
• PHC/ Sub-centre/ MPHA's	73.5	34.5
• Pvt. Clinic/ Hospital/ Voluntary agency	23.8	22.4
• Govt. Medical college hospital	1.3	1.8
• TBA's (Dai)	0.4	--
Gynaecological health problems	**96.9**	**51.6**
• PHC/ Sub-centre/ MPHA's	66.4	25.6
• Pvt. Hospital/Voluntary agencies	30.0	24.7
• Govt Medical college hospital	0.4	1.3
STDs	**28.3**	**50.2**
• PHC/ Sub-centre/ MPHA's	22.9	25.6
• Pvt. Clinic/ Hospital/Voluntary agency	4.9	23.3
• Govt./ Medical college hospital	0.4	1.3
AIDS	**12.6**	**36.3**
• PHC	10.8	22.0
• Pvt. Clinic/Hospital	1.3	13.9
• Govt. Medical college hospital	0.4	0.4
Total	223	223

Contraceptive Health

Contraceptive behaviour of couples has a direct bearing on reproductive health of woman. Contraceptive behaviour in turn depends on various factors such as cognitive levels of the couples about pregnancy and planning of family. Thus present section first discusses about couples perspectives to wards family planning. Apart from individual planning, combined planning of the couples is likely to have a direct bearing on reproductive health of the couple. Thus the role of husband towards contraceptive health can be viewed in terms of husband and wife communication on related matters. Thus the present study also focuses on this aspect. Thereafter, extent of contraceptive usage between the couples, related morbidity and care seeking behaviour is covered in this chapter.

Psychological Perspectives of Couples on Family Planning

Individual cognitive levels on family planning are essential to understand couples reproductive behaviour. It also helps to recognize the extent of gender differences towards reproductive control. In the present study psychological perspectives of couples are analysed mainly from three broad points of view. Firstly the couples' perspectives are examined on locus control over pregnancy; secondly the couples' self-efficiency related to usage of contraception; lastly about the couples' perception related to pregnancy avoidance is discussed.

Locus of Control over Pregnancy

Table-6.1 gives details of the couples by locus of control over pregnancy. The couples are asked whether they agree or not to various traits of control over pregnancy. The responses are analysed in a scale of four i.e. strongly agree, agree, disagree, and strongly disagree. The findings indicate that nearly nine out of ten women and three out of four men have agreed that *'if one of the couple does not desire, they cannot have sex'*. Though the statement actually refers to both the couples, but both men and women seem to have associated it to a husband. That is, they opine that if husband does not desire, wife cannot have sex.

A majority of women (95 percent) and men (90 percent) have 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 couple perceive that woman's body is destined to become pregnant thus prevention of pregnancy is not in one's control. Nearly all the couples agree that a woman is synonymous to pregnancy. While acknowledging the association between woman and pregnancy, yet all these women also agree that *a couple can limit the number of children they* want. Whereas still one fourth of the men disagreed and three fourths of them agreed that a coupe can limit the number of children. Even though most of the women thought that a couple can limit the number of children they want, at the same time nine out of ten women think that '*luck plays a big part in determining whether a woman can keep from getting pregnant'*. Interestingly comparatively few men thought the role of luck than women. Despite women's reliance on luck, again women accept the role of individual behaviour. Nine out of ten women agreed that, '*if a couple is careful, an unwanted pregnancy will rarely happen*'. Eight of ten men agreed with it.

The opinion of women and men on locus of control over pregnancy though infers that women have been expressing contradictorily, it in turn indicate that a majority of women believe in having a control over pregnancy, provided they have a control on their bodies. The reactions of men on control over pregnancy is not so varied as that of women probably because men assume that woman's, may be wife's, body is in their control.

Self-efficiency Related to Usage of Contraception

Cognitive levels on self-efficiency on usage of contraception not only elicit individual capabilities but also reflect the gender differentials in a community. Self-efficiency is addressed to only those couples that were not using any method of contraception (Table-6.2). The responses of couples are categorized in a similar manner, as that of previous section on locus of control over pregnancy. Perceptions related to '*capability to obtain a method of family planning*' indicate that more than eighty percent of women do not cognize that they have a capacity where as 95 percent of men feel that they have the capability. One of the reasons for not in favour of a temporary method of contraception is reflected in couples' opinion that, nearly 90 percent of both the couples admitted that they find *great difficulty in always remembering to use*

contraception in order to avoid pregnancy. Though opinion on couples is similar with respect to memory, it differed in terms of coital behaviour. When asked on '*if I could not get contraception, I could still keep myself not contributing to pregnancy by refraining from sexual activity*', there has been vast differences in opinion between women and men. Nearly 80 percent of women felt that they could not refrain from sexual activity. In other words women do not have control on their bodies. Where as, opinion of men differed. Nearly half of the men felt that they could refrain from sexual activity. Similarly there is a difference in perceptions of women and men about *the capability to use a contraceptive method every time when they wanted to use.* Nearly 80 percent of women disagreed with the statement, i.e. they felt they do not have the capability where as 77 percent of men expressed that they have the capability to use contraception as and when they desired.

It is again convivial to know that more than half of the women (57 percent) disagreed to the statement on '*negotiating with spouse about the use of a method of family planning would be impossible for me*'. In other words, 57 percent of the women felt that they could negotiate with their husbands. Slightly more men (63 percent) felt that they could negotiate with their wives.

One way to maintain better reproductive health is to practice single-sexual partners and the capacity to impress upon the spouses to follow it. It also reflects the level of confidence one has upon other. Eighty two percent of women agreed to the statement that, '*I am capable of persuading my spouse from extramarital sexual contacts*'. Relatively few men (71 percent) felt that they can persuade their wives. More encouraging aspect in the context of reproductive health is that, nearly 95 percent of both the couples agreed that *they are capable of seeking treatment if they have any reproductive health problems.*

Information on self-efficiency brings out certain extreme perceptions of women. On one-hand women seems to have no capabilities to obtain a method and have denied the capability to use a method whenever they wanted, which indicates poor cognitive access to contraception as well as their inability to ascertain themselves. Their inability is again reiterated by not able to refrain from sex, if contraception is not available. In contrast women seems to have confidence in negotiating their husbands

about usage of a family planning method. Probably here women have indicated about terminal methods and not the temporary methods. In a society where by and large across all communities a small family size has been accepted, probably negotiating husbands in favour of terminal methods, especially tubectomy is not felt difficult by women. However to negotiate husband in favour of usage of temporary contraceptive methods is difficult because of the unequal power relations in the family.

Woman's self-efficiency in negotiating their husbands against extramarital sexual relations has to be understood with a caution. Is it really likely the women have the capability or is that women assume that they can restrain their husbands from extramarital sexual relations?

Value of Pregnancy Avoidance

Table 6.3 gives couples' perceptions on value of pregnancy avoidance. The couples are asked to reply how they value to each of the statements related to avoidance of pregnancy, i.e. whether they feel it important or not and how severely they feel about each of the statements. The responses are categorized as unimportant, mildly important, moderately important and very important. The opinion about pregnancy avoidance is asked to only those women who have not adopted permanent method of contraception.

Couples who are uncertain about future need of children are asked to react to the statement: '*how important it is to you to have no more children*'. Almost every woman mentioned that it is very important for her not to have any more children in future. Where as opinion of men differed. Fifty percent of men agreed with women, 33 percent moderately agreed to the statement, but 11 percent felt it is unimportant i.e. these 11 percent of men opine that to have children is necessary. Even though all women said that to have no more children is very important to them, yet not all could agree to the statement that, '*because I do not want to have more children, I make sure that I am protected from getting pregnant*'. Where as, men's opinion is by and large in coherence with previous opinion. This in turn reflects on the capabilities of the women to have a say or control over future pregnancies. Despite woman's unwillingness, they are not certain to take a decision in accordance to their will.

The couples intending to have more children were asked to mention their opinion on two aspects. First, couples were asked about, '*how important it is to delay the birth of your next child*' and secondly on '*because I want to delay having more children, I make sure that I am protected from getting pregnant'*. Eighty seven percent of women felt it is very important for them to delay the birth of next child, yet all could not protect themselves from getting pregnant. It indicates that all women are not capable of either obtaining a method of contraception, or persuade their husbands in favour of postponing pregnancy by protecting one self.

Husband and wife Communication

An understanding between husband and wife is necessary to avoid untimely as well as unnecessary pregnancies so that it may avoid deterioration of woman's health in general and reproductive health in particular. Table-6.4 gives details related to husband and wife communication among the study couples. The table draws attention on two aspects. Primarily, nearly six out of ten couples (57.8 percent) have ever discussed about issues related to fertility. Secondly, there are differences in reporting between women and men, especially on certain topics.

A further analysis of the couples who ever had a discussion indicate that, educated couples from forward castes, nuclear families, and those married 3 to 10 years ago with two children communicated on issues related to fertility among themselves (Table-6.5). In other words with increase in education levels, couples from better social status felt comfortable to communicate with each other. Extent of discussion on various topics related to reproduction varied. Table-6.4 shows that more couples reported to have had a discussion on 'total number of children required' (47.5 percent); 'whether to use a method or not' (46.2 percent); 'type of method' (47.1 percent); and 'who should use between the couples' (45.3 percent). Also the findings indicate that only a few couples discussed on whether to use a contraceptive method prior to first pregnancy (22.9 percent), and hardly any one discussed on postponement of a pregnancy or spacing between children. All this in turn reveals that the couples who ever initiated a discussion was more about usage of terminal methods rather than on temporary methods, i.e. those who have already attained the desired family size.

More women reported to have had a discussion between the spouses than the men. Differences in reporting varied by type of topics (Table-6.4). More women than men said that they had a discussion related to number of children the couple wanted; to use a contraceptive method or not; type of method to be used; and who should use. Where as relatively more men said that they had discussions on spacing and postponement of children. Differences in reporting are minimal only on two topics, i.e. whether they have ever discussed prior to first pregnancy or not, and whether to consult a medical person prior to use a method.

Current Use of Contraception

A little more than half of the couples (53.5 percent) are using contraception at the time of survey (Table-6.6). A majority of them are adopters of permanent methods of contraception, 92.4 percent are users of female sterilization and 0.8 percent (one person) is a user of male sterilization. Even though only a few couples (6.8 percent) used temporary methods of contraception, there is a difference in reporting between the couples. More men have reported about usage of condoms and periodic abstinence than women. The couples who were using temporary methods are married less than five years ago; living separately i.e. in nuclear families; educated i.e. husbands studied above high school level and wife educated above primary level; and are having one or no children.

The median age at sterilization for the women in the villages is 21 years. Table-6.7 gives details of the couples those have opted for a permanent sterilization. Nearly six out ten couples are illiterates. Relatively more workingwomen preferred to go for sterilization then non-working women. A higher percent of wives, whose husbands engaged in business, have gone for sterilization. Three out of four women are sterilized by the age of 30 years. Seven out of ten women went for sterilization by 10 years of completed married life and with two living children. Relatively a higher percent of couples living in nuclear families adopted sterilization than those living in joint families.

Situations leading to use of contraception

Table-6.8 gives various details pertaining to usage of contraception by the couples. Motivating persons behind the couples to use a method of contraception differs

between couples. Nearly half of the men were self-motivated to use a contraceptive method to limit the number of children. Comparatively fewer women (30 percent) were self-motivated than men. In other words women depended more on others rather than self for usage of contraception. This is more so if they have to use temporary methods of contraception. Only one-third of the couples together were motivated to use a method of contraception. Once motivated there is an improvement in making decisions by self among women (41 percent). Thus, either individually or in consultation with husband 71 percent of women could decide to use a contraceptive method. Corresponding percentage for men is 79 percent. The main reason to opt for a contraceptive method by the couples is to stop further pregnancies. Thus 97 percent of the total users of contraception are adopters of sterilization. One woman in the study villages opted to go for a hysterectomy instead of tubectomy due to prolonged menstruation. Interestingly three men expressed that their wives have opted for tubectomy to either postpone pregnancy or to have a gap between pregnancies. This in turn suggests lack of adequate knowledge on methods of contraception.

Contraceptive Morbidity and Utilization of Health Services

Out of total women who have used a method of contraception, 16.7 percent of women reported to have suffered from illness after its use. All of these women are users of terminal method, i.e. the women who underwent tubectomy. A further analysis of the woman suffering from contraceptive morbidity is carried out to understand the non-medical factors determining the morbidity. The findings of the logistic regression analysis reveals that (Table-6.9), 'marriage between non-relatives'; 'husband and wife communication'; 'type of family'; 'caste'; and 'having a health center in the village' are proved to be significant determinants of a woman suffering from contraceptive morbidity. In other words, if a woman is not related to her husband prior to marriage she is likely to suffer from 0.331 times more than those women who are related prior to marriage. Again if she is living in a joint family she is likely to suffer 0.111 times more than the women living in nuclear families. A workingwomen is more likely to suffer from contraceptive morbidity by 4.0756 times more than non-workingwomen. Women from scheduled castes or tribes are likely to suffer from contraceptive morbidity 3.739 times more than the women from other castes. Having a communication between husband and wife (0.070) showed a positive association with

contraceptive morbidity and similarly having a health center in a village (0.095) is positively associated with contraceptive morbidity.

These findings infer that those women living in joint families especially married to non-relative is likely to feel hesitant and probably may not be in a position to express the need to rest for self after a tubectomy. This is more likely in deprived communities where working outside home does not empower her position in the family rather becomes a requirement at the cost of health. Similarly the relationship between husband-wife communication and presence of the morbidity probably indicates differently that is, having morbidity might have helped the couple to communicate with each other. In a similar manner having a health center in the village might have encouraged the women to acknowledge the morbidity.

Among the women who have suffered from contraceptive morbidity, 76.3 percent sought treatment. A review of the women who have not sought treatment indicates that (Table 6.10), a majority of them are from non-nuclear families, either relatively younger aged women or those reaching to menopause, deprived communities (either belong to scheduled castes/ tribes or backward castes), and have never discussed with husbands about their problem. Relatively a higher percent of workingwomen did not seek treatment than non-working women. In other words it suggests that younger aged women living in non-nuclear families probably feel hesitant to seek treatment, as they have to take head of the household's permission. Women from deprived classes, those working for wages may be do not wish to forego their wages for a day or not in a position to spend money to seek treatment vis-à-vis other immediate priorities. Among those who have sought treatment, a majority of these women preferred private clinics or hospitals (64.3 percent) than from public health facility like the RCWHC (35.7 percent).

Future reproductive planning

Nearly half of the women (50.2 percent) are not the adopters of a permanent method of contraception in the study villages. A majority of these women are intending to have more children in future. After achieving the desired number of children, 89 percent of the women are interested in using any method of contraception. Of them

only half of them are clear about their future choice of method. These women prefer to go for a tubectomy, as they want to stop further pregnancies. Among the remaining, even though a few do want to have any more children yet are unsure about usage of contraception mainly because of uncertainty of their husband's decision.

Table 6.1 Percent 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.		
○ Strongly Agree	48.4	35.9
○ Agree	39.9	47.1
○ Disagree	7.6	15.7
○ 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		
○ Strongly Agree	21.5	17.9
○ Agree	72.2	73.1
○ Disagree	5.8	9.0
○ Strongly disagree	0.4	0.0
A couple can limit the number of children they have		
○ Strongly Agree	73.1	48.9
○ Agree	21.1	27.4
○ Disagree	5.4	23.3
○ Strongly disagree	0.4	0.0
Luck plays a big part in determining whether a woman can keep from getting pregnant.		
○ Strongly Agree	49.3	24.7
○ Agree	30.5	34.1
○ Disagree	17.5	38.1
○ Strongly disagree	2.7	3.1
If a couple is careful, an unwanted pregnancy will rarely happen		
○ Strongly Agree	62.3	18.8
○ Agree	31.4	58.3
○ Disagree	5.4	21.1
○ Strongly disagree	0.9	1.8
Total Couples	**223**	

Table 6.2 Percent of Couples by Self-efficiency related to Usage of Contraception

Aspects related Self-efficiency on usage of contraception	Women	Men
Capable of obtaining a method of family planning		
○ Strongly Agree	2.9	42.7
○ Agree	16.5	52.4
○ Disagree	35.0	3.9
○ Strongly disagree	45.6	1.0
I have great difficulty in always remembering to use contraception in order to avoid pregnancy		
○ Strongly Agree	40.8	23.3
○ Agree	47.6	65.0
○ Disagree	10.7	11.7
○ Strongly disagree	1.0	0.0
If I could not get contraception, I could still keep myself not contributing to pregnancy by refraining from sexual activity		
○ Strongly Agree	1.9	3.9
○ Agree	19.4	40.8
○ Disagree	63.1	52.4
○ Strongly disagree	15.5	2.9
I am capable of using contracceptive method every time when I need		
○ Strongly Agree	3.9	23.3
○ Agree	18.4	53.4
○ Disagree	39.8	22.3
○ Strongly disagree	37.9	1.0
Negotiating with my spouse about the use of a method of family planning would be impossible for me		
○ Strongly Agree	2.9	1.9
○ Agree	39.8	35.0
○ Disagree	31.1	48.5
○ Strongly disagree	26.2	14.6
I am capable of persuading my husband (restraining my self) from extra-marital sexual contacts		
○ Strongly Agree	21.1	9.9
○ Agree	61.4	61.4
○ Disagree	17.0	25.6
○ Strongly disagree	0.4	3.1
I am capable of seeking treatment if I have any reproductive health problems		
○ Strongly Agree	39.0	13.0
○ Agree	55.6	83.4
○ Disagree	4.9	3.6
○ Strongly disagree	0.4	0.0
Total Couples	**103 (46.2)**	

Table 6.3 Percent of couples by Value of Pregnancy Avoidance

Aspects related to Value of Pregnancy Avoidance	Women	Men
Extent of self importance to have no more children		
○ Unimportant	0.0	11.1
○ Mildly Important	0.0	0.0
○ Moderately Important	0.0	33.3
○ Very Important	100.0	55.6
Because I do not want to have more children, I make sure that I am protected from getting pregnant		
○ Unimportant	0.0	11.1
○ Mildly Important	12.5	0.0
○ Moderately Important	0.0	44.4
○ Very Important	87.5	44.4
Total couples Answered	8	
Extent of importance to delay the birth of your next child		
○ Unimportant	0.0	66.3
○ Mildly Important	12.5	12.9
○ Moderately Important	0.0	7.9
○ Very Important	87.5	12.9
Because I want to delay having more children, I make sure that I am protected from getting pregnant		
○ Unimportant	75.5	63.4
○ Mildly Important	11.8	15.8
○ Moderately Important	6.9	8.9
○ Very Important	5.9	11.9
Total Couples	101 (45.3)	

Table-6.4 Details of Husband and wife Communication with respect to Fertility and Contraception

Various aspects	Percent of Wives	Percent of Husbands
Total number of children required	47.5	37.7
Whether discussed prior to first pregnancy	22.9	21.1
Post pone children	2.7	4.0
Space between children	3.6	10.3
Whether to use a contraceptive method or not	46.2	22.9
Type of method	47.1	38.1
Who should use between the couple	45.3	36.8
Availability of a contraceptive method	38.1	35.4
Health problems as a consequence of contraceptive usage	17.9	10.8
To consult a medical person prior to use a method	8.1	8.5
Couples ever had a communication with each other	**57.8 (129)**	**55.6 (124)**
Total number of couples	223	

Table 6.5 Background Characteristics of the Couples who had Communicated with Each other on Aspects Related to Reproduction

Socio-economic Characteristics	Percent of women	Total Number	Percent of men	Total Number
Couples communication				
Education				
Illiterate	52.0	127	39.1	64
Up to primary	66.7	33	67.8	59
Above primary	65.1	63	***	***
High school	**	**	55.6	81
Above high school	**	**	73.7	19
Work status				
Not working	63.4	82	100.0	1
Daily wage	47.1	68	50.0	88
Skilled worker	65.4	26	48.7	39
Business	59.6	47	64.0	25
Clerical	**	**	64.9	37
Cultivation	**	**	60.6	33
Current age				
<=15	0.0	6	**	**
16-20	50.7	71	0.0	2
21-25	57.9	57	39.7	68
26-30	71.8	39	76.0	50
31-35	86.7	15	64.3	42
36-40	60.0	15	58.8	17
40+	50.0	20	50.0	44
Duration of marriage				
<=2	40.4	52	50.0	52
3-5	63.8	47	48.9	47
6-10	64.9	37	67.6	37
11-15	57.6	33	66.7	33
16-20	83.3	18	55.6	18
21+	55.6	36	50.0	36
Parity				
0	35.6	45	28.9	45
1	46.7	45	64.4	45
2	82.1	39	71.8	39
3	65.9	44	65.9	44
4+	62.0	50	52.0	50
Religion				
Hindu	58.1	203	55.2	203
Muslim	57.1	14	71.4	14
Christian	50.0	6	33.3	6
Caste/Tribe				
Scheduled caste	53.2	47	51.1	47
Scheduled tribe	37.5	8	25.0	8
Other backward caste	58.6	140	55.7	140
Others	67.9	28	71.4	28
Type of family				
Nuclear	61.7	162	58.6	162
Non nuclear	47.5	61	47.5	61

** No observations

*** Not Categorized

Table 6.6 Current Use of Contraceptives by Couples in the Villages

Type of Contraceptive method	Percentage According to wives	Percentage According to Husbands
Type of Method		
Permanent method		
- Female Sterilization	94.0	92.4
- Male Sterilization	0.9	0.8
Modern Temporary methods		
- IUD	1.7	1.7
- Oral Pills	0.9	0.8
- Condoms	1.7	2.5
Traditional methods		
- Periodic abstinence	0.9	1.7
Total Users	52.5 (117)	53.5 (119)
Total Couples	223	

Table 6.7 Background Characteristics of the Couples who have used a Permanent Method of Contraception

Socio-economic Characteristics	Percent of women	Total Number	Percent of men	Total Number
Individual characteristics				
Education				
Illiterate	61.4	127	70.3	64
Up to primary	45.5	33	52.5	59
Above primary	28.6	63	***	***
High school	**	**	38.3	81
Above high school	**	**	21.1	19
Work status				
Not working	37.0	92	0.0	1
Daily wage	56.7	67	50.0	88
Skilled worker	82.4	17	43.6	39
Business	53.2	47	60.0	25
Clerical	**	**	45.9	37
Cultivation	**	**	54.5	33
Current age				
<=15	0.0	6	**	**
16-20	12.7	71	0.0	2
21-25	49.1	57	11.8	68
26-30	76.9	39	44.0	50
31-35	100.0	15	69.0	42
36-40	86.7	15	88.2	17
40+	80.0	20	84.1	44
Common characteristics	**Percent of couples**		**Number of couples**	
Duration of marriage				
<=2	0.0		52	
3-5	21.3		47	
6-10	69.4		36	
11-15	84.8		33	
16-20	94.4		18	
21+	83.8		37	
Parity				
0	0.0		45	
1	4.4		45	
2	71.8		39	
3	82.2		45	
4+	89.8		49	
Religion				
Hindu	50.2		203	
Muslim	50.0		14	
Christian	33.3		6	
Caste/Tribe				
Scheduled caste	44.7		47	
Scheduled tribe	25.0		8	
Other backward caste	53.6		140	
Others	46.4		28	
Type of family				
Nuclear	51.9		162	
Non nuclear	44.3		61	
Had Communication				
Yes	59.7		124	
No	37.4		99	

** No observations

*** Not Categorized

Table-6.8 Particulars of Usage of Contraceptive Methods by Couples

Particulars	Usage of Contraceptives			
	Permanent Method		Temporary Method	
	Women	Men	Women	Men
Motivated by				
Self	30.6	50.5	0.0	75.0
Spouse	28.8	12.6	66.7	0.0
Both	30.6	30.6	33.3	12.5
Parent-In-laws	1.8	0.9	0.0	0.0
Others	8.1	5.4	0.0	12.5
Decided by				
Self	41.4	55.9	0.0	75.0
Spouse	28.8	10.8	66.7	0.0
Both	29.7	33.3	33.3	12.5
Reason to use a method				
Postpone pregnancy	0.0	0.9	50.0	50.0
Gap between pregnancies	0.0	1.8	50.0	37.5
Stop further pregnancies	99.1	97.3	0.0	0.0
Health concerns	0.9	0.0	0.0	12.5
Total Users by method	111 (49.8)		8 (3.6)	
Total contraceptive Users	119 (53.4)			

Table-6.9 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
Marriage Duration	.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 percent level.*
***Indicates significance at 0.1 percent level*

Table 6.10 Women suffering from Contraceptive Morbidity and Health Care Seeking Behaviour by Background Characteristics

Background Characteristics	Percent of women suffering from morbidity	
	Treatment sought	Did not seek treatment
Women's Age		
<=30	62.5	37.5
30-40	85.7	14.3
40+	75.0	25.0
Education		
Illiterate	73.3	26.7
Literate	75.0	25.0
Work status		
Working	69.2	30.8
Not working	83.3	16.7
Caste/Tribe		
Scheduled caste/Scheduled tribe	75.0	25.0
Backward castes	74.4	26.6
Type of family		
Nuclear	80.0	20.0
Non nuclear	50.0	50.0
Husband wife communication on Contraceptive morbidity		
Discussed	100.0	0.0
Not discussed	70.6	29.4
Availability of Health Center		
Available	71.4	25.0
Not available	75.0	28.6
Total	**73.6**	**26.3**

Fertility Behaviour and Obstetric Health

The present chapter discusses on couples' fertility behaviour and its impact on obstetric health of women. Primarily the chapter first focuses certain aspects related to marriage, because in the Indian context largely fertility occurs with in the union of marriage.

Particulars related to Marriage

Median age at marriage for the women in the sampled villages is 15 years and for men it is 21 years. An increase in age at marriage of women and men is only marginal over the years. Median age at marriage of the women currently aged between 20-25 years is 16 years and that of women who are currently aged between 40-49 years is 15 years. As against the practicing age at marriage, 89 percent of the women are aware that minimum legal age at marriage for girls in India is 18 years. More men (95 percent) are aware about girl's legal age at marriage. Knowledge about legal age at marriage of boys is relatively lesser among both women (78 percent) and men (88 percent). Parents wants their daughters to be married at an early age is mainly for the fear of rising dowry demands with time. Parents are not worried about the reparations of early age at marriage. Rather every one opines that a girl's happiness lies in her being married.

Consanguineous marriage is a practice in the villages under study. More than one-third of the couples (36.3 percent) are related to each other before their marriage. Many of them have married to their first cousins, and a few women were married to their maternal uncles. Parents play a major role in deciding the marriage of daughters. Before deciding the marriage, 10 percent of the women were not consulted by their parents. The remaining 90 percent of the women though were consulted by their parents before the marriage, but to seek their opinion was mere a formality. In a real sense girl's parents decide the marriage according to their choice and assume that they are making a best decision for the daughter and most of the daughters too opine the same.

Fertility Behaviour

Out of total 223 couples, 178 women (79.2 percent) had live birth at least once in life. The median age at first pregnancy for these women is 17 years and median age at last pregnancy for the sterilized women is 21 years. Median number of children ever born per woman is 3. The median number of children born to the women, who have married more than 16 years, is 4. Twenty percent of the women never had a live birth. Of them 11.7 percent never conceived where as 8.5 percent experienced pregnancy, but never had a live birth. All these women are below 30 years of age; 68.9 percent of them are aged between 16-20 years, 13 percent are below 16 years of the age the remaining are between 20-30 years of age.

Reporting on pregnancy particulars is given in Table-7.1. By and large men and women reported similarly on information related to successful out come of a pregnancy. That is information about number live births, number of currently surviving and non-surviving children, knowledge about date of last birth, and timing of last pregnancy. The differences in reporting between women and men were related to still birth, abortion, and current pregnancy. An analysis of in-depth interviews of the couples that reported differently reveals that, there was an occurrence of stillbirth and women did not want to acknowledge stillbirth while husbands did not mind giving the details of it. Women insisted the stillbirths as infant deaths. In the community it is considered that death of an infant could occur due to various 'external' reasons, whereas a stillbirth is associated to women. Probably women do not want to be held self-responsible and subject to criticism, thus may be trying to evade the truth of stillbirths. For the same reason less men knew about wife's abortions. The three women have not informed their husbands or parents-in-law about the abortions they had. Perhaps for this reason one woman did not disclose about her pregnancy to husband, as she wants to wait until certain period to confirm the continuity of pregnancy. The differences in reported by women and men also suggest the existing gendered attitude towards women. Woman's relative position in the family and immediate family is largely related to her reproductive capabilities. Thus the desire to conceive among women, especially soon after marriage, is very much apparent in the reply of women on timing of pregnancy. The women who were pregnant during the reference period were asked to express whether they wanted to be

pregnant at that time or not. Every woman replied the desire to be pregnant. Even though almost all of their husbands agreed, one person admitted that his wife had become pregnant accidentally. On contrary his wife wanted to be pregnant and bear a child to improve her relative position in the house. This particular woman wanted the child, as it was her first pregnancy.

Obstetric Health

The present section discusses about various aspects of obstetric health in terms of realization for the need for a care, the deciding persons in promotion of care, actual care taken by the women during three specific periods viz. antepartum, intrapartum, and postpartum. Also women's expectation of support from husband versus actual support received is analysed. Apart from the women who have experienced pregnancy recently, also opinion of the other women's expectation of care during specific periods of obstetric health is examined.

Characteristics of the Women

Of the total 223 couples identified for the study, ninety-four women (42.2 percent) had experienced pregnancy during the reference period of two years. Of them 7 women were pregnant more than once during the reference period. Table-7.2 gives socio-economic details of these women. A majority of the women (54.3 percent) are aged between 16-20 years and 35 percent are between 20-24 years of age. One fifth of the women are pregnant for the first time and another one fifth of the women are of parity two. Thirty eight percent of the women are of parity one and 4.3 percent of women are of parity four or more. Forty three percent of these women are illiterate and 38 percent of them are educated above primary level. Most of the women belong to deprived sections; 58 percent are from backward castes and 30 percent are from scheduled categories. Three fourths of them are living in nuclear families. Thirty-seven percent of the women are related to their husbands prior to marriage. More than half of the women (53 percent) are engaged in income generating activities.

Antepartum Period

The safe motherhood initiate proclaims that all pregnant women must receive basic, professional antenatal care (Harrison, 1990). 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 counseling 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 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 check-ups and other procedures to detect pregnancy complications (Ministry of Health and Family Welfare, 1997,1998b).

Details of Antenatal Care and Role of Husband

Results indicate a high rate of antenatal care utilization by women (96.8 percent) in the villages (Table 7.3). All of them had antenatal care from one or more qualified health personnel for care; 89 percent went to allopathic doctor, 27.5 percent to Multi-purpose health worker in the RCWHC and 2 percent to other health personnel. Either the elderly female family members or the husbands are the main persons advised the women to seek treatment. Actual decision to seek treatment is rested with husbands in more than half of the women (51.6 percent). The next main person involved in decision-making is the elderly female member of the family. Less than one-tenth of the woman could decide by herself on the need to take a treatment. It is interesting to know that; there has been an apparent difference in the place of antenatal care sought by women and the deciding person. When husband or elderly female member of the family decided about the need for antenatal care, the women sought antenatal care from private allopathic doctor or a Government maternity hospital. When women took a decision by her a majority went to the RCWHC or sub-centre.

Nine out of ten women, who had an antenatal care, were tested for risk pregnancy (Table-7.4). Relatively more women who have sought care from a private doctor were tested against risk pregnancy. Ninety-eight percent of the women were given IFA tablets, and 96 percent took TT injections. Nine out of ten women had weight and height measured, blood pressure was tested, their blood and urine was tested. A majority of the women received advise during antenatal care was related to food (98 percent); followed by advise on danger signs of pregnancy (65 percent).

Antepartum Morbidities and Treatment seeking Behaviour

Out of total women who have been pregnant during reference period, 47.8 percent suffered from antepartum morbidities. Table 7.5 gives details of women suffered from various morbidities during antepartum period. The table also provides information about awareness levels of husbands about different antepartum morbidities faced by their wives. The findings reveal that a majority of the husbands (64.4 percent) reported that they are not aware of the morbidities faced by their wives during recent pregnancy. Seven percent of the husbands mentioned that their wives never faced any morbidity, while the wives did suffer from illnesses.

Table 7.6 provides information about women suffered from antepartum morbidities vis-à-vis the role of husband on decision to seek antenatal care or not. For morbidities such as fits and bleeding during pregnancy all husbands perceived the necessity to seek treatment thus advised their wives to go for treatment. For other morbidities like fever for more than 3 days, severe vomiting, varicose veins more than half of the husbands decided in favour of seeking a treatment. For the remaining morbidities other members of the family, mostly the elderly women at home decided the need for seeking a treatment. Irrespective of the ailment, a majority of the women sought treatment from a qualified health professional, i.e. an allopathic doctor (Table 7.7).

Support of Men towards 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. Also an attempt is made to look at the disparities in expectation of wives, who were pregnant during the reference period, vis-à-vis the actual support extended by the husbands during pregnancy. Table 7.8 reveals that almost every woman, irrespective of their age or parity, expects their husbands to extend care. Especially expectations are high with respect to emotional support, health and nutritional care. On physical help like managing older children or assisting in household work less than three percent of women opine that there is no necessity for husbands to extend help. On the other hand, less than half of the men ever felt that they to extend support to wives during pregnancy. A majority of these men reported that they have to extend emotional support and the care towards wives' health by either taking the wife for antenatal checkup or by arranging someone to go

with wife for a checkup. Only one out ten men perceived their role in terms of physical help.

All the women who had been pregnant during the reference period opine that husbands should extend emotional support, health care and nutritional care (Table 7.9). On extending physical care two percent of women felt no necessity and the remaining 98 percent felt the need. Opinion of the husbands is far below than the expectations of wives. Nearly half the men feel that they have to talk affectionately when wife is pregnant and perceived their responsibility in providing necessary support to have antenatal care. Even though not many men opined their role as supporters to wife during pregnancy, more women felt or reported that their husband's did extend support related to health, nutrition and physical help. There has been a shortfall in opinion related to emotional support.

Intrapartum period

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

Place of Delivery

Once a woman is pregnant, the family plans about the place of delivery. It is assumed that if actual place of delivery is different to that of actual place of delivery, there is a probability of occurrence of an emergency, which might have forced for the change. The Table-10 shows that in the present study, a majority of the women had a delivery as per the plan. Less than two percent of deliveries though initially planned to have at an institution, private hospital. Around 8 percent of women though initially planned for a home delivery, however finally they had to go to an institute; 2.8 percent at RCWHC and 4.3 percent at private hospital; due to prolonged or difficult labour.

An analysis by place of delivery also reveals that nearly 75 percent of women delivered at an institution. Despite a high level utilization of health services during antepartum period, there is a decline in institutional health care for delivery in the villages. A separate analysis by place of delivery by background characteristics of women reveal that relatively more women who are educated, nonworking, from non-

deprived castes, lower parities, nuclear families had a delivery at institution than the other women (Table 7.11). Also the table reveals that when husband is the main decision maker regarding place of delivery, there are higher chances for women to have a delivery at institution. An analysis by logistic regression revels similarly (Table7.12). Among various socio-economic variables, women works status (0.302), type of family (0.190), having a vehicle in the house (5.958), and deciding person about place of delivery (4.725) came out as significant determinants of utilization of health facilities for delivery. That is if a woman is not working, from nuclear family, when husband is the deciding person and if household has a vehicle there are more chances for woman to have an institutional delivery.

Intrapartum Morbidity

Women suffered from morbidities during delivery are given in Table 7.13. Among the women who give birth to a child during the reference period, 39 percent have suffered from intrapartum morbidities. Of these women nearly 60 percent had to undergo caesarean section, 22 percent experienced labour for more than 18 hours, 15 percent suffered from excessive bleeding and in another 15 percent of cases child was not born five hours after the sac burst. One out of ten women were recorded with high Blood Pressure and the baby was in breech position. Despite such experiences by the wives, 74.3 percent of their husbands reported that their wives had no problems during delivery. Three percent of men admitted that they ignorant about wives' experiences of intrapartum morbidities. It is likely that because of the nature of these morbidities, excepting one woman all of them had an institutional delivery (Table 7.14). In other all these women were taken to a hospital having experienced problems at the time of delivery. The deciding person about the place of delivery in turn reiterates that in majority of the cases it is the elderly women who took a decision in favour of institution. Husbands' were involved in decision making on visible morbidities such as, long period of labour and if caesarean was required.

Support of Men towards Wives during Delivery: Expectation versus Reality

This section reveals the differences in opinion of women and men regarding the role of husbands towards wives during delivery. In addition an attempt is made to look at the disparities in expectation of wives, who were pregnant during the reference period, vis-à-vis the actual support extended by the husbands during delivery.

Findings reveal that 99 percent women of all ages expect their husbands to extend care (Table 7.16). Expectations are equal with respect to physical, health and financial care. On emotional support there is a marginal decline in expectation. On the other hand, three fourth of the men visualize their support only in terms of finances. Less than half of them thought they could support in calling a health personnel and even less than a quarter of men realized their responsibilities in terms of getting necessary medicines or arranging transportation. Least considered support by men is on emotional front.

Opinion of women who had been pregnant during the reference period and their husbands did not alter much to the opinion of over all women and men in the community regarding extension of support to wives during delivery (Table 7.17). Actual support extended by husbands, compared to the opinions expressed by them is shortfall on all aspects excepting the emotional support. In other words even though many men opined that their major role lies in extending financial support (75 percent) during delivery, actually much lesser percent did support financially (57 percent). This is probably because traditionally in few cultures for cost of first and at times the second delivery of a woman is borne by her parents rather than the husband. Similarly differences are noted with respect to emotional support. While many opine that it is least kind of support they should be extending to wife (11.8 percent), actually 23.5 percent of women felt that they have received the support emotionally from husbands. This needs to be interpreted with care. Probably though men do not realize, but do extend emotional support to wives in situations like this or these women are happy with the extent of emotional support they received from husbands while husbands themselves did not perceive it as a support.

Postpartum Period

Postpartum period is not officially defined, however it is supposed to be the period after the delivery of placenta to the following six weeks.

Postpartum Care

Table 7.18 provides details of knowledge and practices related to postpartum care. Knowledge levels of all the women related to postpartum care is mainly related to diet. Fifty nine percent of women opine that women should continue to take nutritious

diet, 48 percent believe in following certain restrictions in diet. Around 35 percent women believe that one should have adequate rest during postpartum period and should not indulge in heavy work. Very few women, 1.4 percent, thought that regular health checkups are essential.

Among the women who had been pregnant during the reference period, nearly 85 of the women resumed to household work two weeks after the delivery. An analysis of types of physical activity carried by these women included, cooking (83 percent), carrying older children (78 percent), lifting water, (52 percent), washing and rinsing of clothes (47.8 percent), bringing water from distance and lifting heavy items (4.3 percent each). Only 12 percent of them had a postpartum checkup. Most of them had postpartum check up from qualified health personnel and went for a checkup 20 days after the delivery. Table 7.19 shows that among the women who had a delivery during the reference period, higher aged women (2.120), and those working for wages (4.712), and if husbands are educated above primary level (2.521) have higher chances to go for postnatal health check up. This may be because, while a majority of the women and men do not realize the requirement for postnatal check up, with increase in husband's educational level, they are more likely to support women to have a health checkup. If women is relatively of older ages and working out side home, probably she has can perceive, express and may go for postpartum checkup.

Postpartum Morbidity

Out of total women who had a delivery during the reference period, 49 percent of them suffered from postpartum morbidities (Table 7.20). A majority of the women experienced pain in lower abdomen, 20 percent of them suffered from depression, 17 percent suffered from fever for more than 3 days and an equal percent of women experienced painful as well as burning urination, 14 percent of them had excessive bleeding. Husbands' knowledge about wives' postpartum morbidities is similarly poor as information about intrapartum morbidities. Only less than three percent of husbands at all knew about wives' illnesses during postpartum period.

Support of Men towards Wives After Delivery: Expectation versus Reality

This section reveals the opinion of women and men regarding the role of husbands towards wives during delivery. Like the opinion of wives during different obstetric

periods, almost every woman expects husband's support during postpartum period. Every one hopes that husbands should take care of their health by helping her to have regular checkups, provide physical help and see that wife do not get physically stained during the period. In addition women also want their husbands to be responsible fathers by managing older children during this phase and extend adequate emotional support to wives. On the other hand men seems to be not very sensitive towards women for a support during postpartum period. Only half the men felt the necessity to extend physical help and take care of health of wives' during the period. One third of the men perceived their role as fathers, and one-quarter of them felt the need to provide physical help.

Opinion of women who had been pregnant during the reference period and their husbands did not alter much to the opinion of over all women and men in the community regarding extension of support to wives after delivery (Table 7.22). The only difference is that 5.4 percent of overall men expressed no necessity to support wives after delivery whereas among recent fathers none expressed like wise.

Actual support extended by husbands, compared to the opinions expressed by them is shortfall in extending health support. Even though many men opined that their role lies in extending health support (45.7 percent) after delivery, actually much lesser percent did support (4.3 percent). This is because probably men opined extending health support refers to child rather than mother. There is an increase in the support extended by husbands in managing older children, by not allowing wife to strain, and providing emotional support to wife.

An understanding of Abortion and Health Care

Literally 'abortion' means 'premature delivery'. Abortion may take place due to unhealthy condition of the pregnant woman or due to unwanted pregnancies. In the present study perceptions of women and men about abortion and utilization of health facilities for it is examined. Table 7.22 provides opinion of women and men on various aspects related to abortion. As a first reaction, a majority of women and men in the villages under study consider that induced abortion is a non-appreciating decision. Among the couples, relatively more men (83 percent) are not in favour of abortion than women (62.8 percent). Though a majority is not in favour of induced

abortion, yet on health grounds 95 percent of women and 81 percent of men consider it as acceptable. Every alternate woman and one out of three men opine that a woman can abort to avoid further children. Nearly one third of the couples do agree that abortion can be done to space between children. To postpone first birth a majority of the couples, especially more women, are not in favour of induced abortion.

To have an abortion a majority of the couples (95 percent women; 81 percent men) opine it is necessary for wife to take husband's permission. More women (78.9 percent) opine that permission of parents-in-law is needed than the men (38.1 percent). Requirement of permission of woman's parents is considered low by both the couples. Though none of women felt the need to take permission from health personnel, but 21.5 percent men thought it was necessary. At the same time almost every woman and mea felt the need to take consult a doctor.

Every woman and 80 percent of men feel discussion between the couples prior to abortion is necessary. Every alternate woman opined that discussion should be focused on health consequences of women and on the necessity for abortion. One fifth of the women thought couple should discuss on place of abortion, future fertility, and social consequences. Men gave importance in the order of the need, place, financial and method of abortion.

At the time of abortion, more than 80 percent of couples felt the necessity of husband to be along with wife. The main reason, according to couples, for wanting to stay with wife is to give a written agreement at the hospital. Most of them opine that unless husband signs on the agreement forms a woman cannot have an abortion. The other reason for wanting husbands to be with wives at time of abortion is to provide financial support. Apart from husband, the other expected members to be accompanied with a woman for abortion are mother and mother-in-law. More women wanted mother-in-law to be with them because they opine that it helps them against future mistreatment.

Table 7.1 Difference of Information Reported by Couples on Fertility and Obstetric Information

Aspects related to Fertility and Obstetrics	Number of couples 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 still births	2	4
Whether had still births	2	4
Whether had abortion	18	15
Number of times wife had abortion	18	15
Out come of abortion	18	15
Currently pregnant	30	29
Month of pregnancy	30	29
Number of times conceived after Deepavali 2001	101	102
Outcome of the pregnancy occurred after Deepavali 2001	74	74
Timing of pregnancy: Wanted to be pregnant at that time	94	93

Table 7.2 Background Characteristics of Women who experienced Pregnancy During the Reference Period

Characteristics	Percent of Women
Women's age	
<=15	2.1
16-20	54.3
21-25	35.1
26-30	8.5
Parity	
0	21.3
1	38.3
2	20.2
3	16.0
4+	4.3
Women's education	
Illiterate	43.6
Up to primary	18.1
Above primary	38.3
Caste/Tribe	
Scheduled cast/ tribe	29.8
Other backward caste	58.5
Others	11.7
Type of family	
Nuclear	72.3
Non nuclear	27.7
Consanguineous	
Yes	37.2
No	62.8
Women's work status	
Not working	47.9
Working out side Home	52.1
Total Women	94

Table 7.3 Some Particulars of Antenatal Care Taken by Women

Particulars of Antenatal Care	Percent of Women
Location of ANC visits	
Round the Clock Women Health Centre	39.6
Govt.hospital	7.7
Pvt.hospital/doctor	76.9
Persons examined during gestation	
Allopathic Doctor	89.0
MPHA	26.6
Other health personnel	2.2
Persons advised woman for a check-up	
Husband	47.3
Mother/Mother-in-law	48.4
Self	3.3
Person Decided for a check-up	
Husband	51.6
Mother/Mother-in-law	39.6
Self	8.8
Opinion of Husbands on Antenatal Care	
ANC is necessary during Pregnancy	98.9
ANC is not necessary during Pregnancy	1.1
Husband accompanied to ANC	86.2
Reasons for not Accompanying wife for ANC	
- Female assistant desired by Women	58.8
- Men have to attend to work	42.2
Total Women who had ANC	(96.8) 91

Table 7.4 Components of Antenatal Care Received by Women

Quality particulars	Percent of women
Had TT injection	95.6
Had IFA tablets	97.8
Women 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 heart beat	52.7
Internal exam	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 Women	91

Table 7.5 Women Suffered from Various Morbidities during Antepartum Period and Knowledge of Husbands About it

Morbidities During Antepartum Period	Percent of Women Suffered	Percent of Husbands Aware
Swelling of hands & 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 >3days	15.6	2.2
High blood pressure	11.1	0.0
Severe vomiting whether treatment required	22.2	2.2
Diabetes	0.0	2.2
No movement of fetus	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 Women	47.8 (45)	

Table 7.6 Women suffered from Various Morbidities during Antepartum period And the Deciding Person on the need for Antenatal Care

Morbidities During Antepartum Period	Decision Made by (%)	
	Husband	Others
Swelling of hands & 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 >3days	57.1	42.9
High blood pressure	40.0	60.0
Severe vomiting whether treatment required	50.0	50.0
No movement of fetus	0.0	100.0
Bleeding	100.0	0.0
Total Women suffered from Antepartum Morbidities	**47.8 (45)**	

Table 7.7 Women Suffered from Various Morbidities during Antepartum period And Treatment Particulars

Morbidities During Antepartum Period	Person Consulted by women (%)	
	Allopathic Doctor	Health Assistant
Swelling of hands & feet	100.0	0.0
Blurred vision	100.0	0.0
Giddiness	100.0	0.0
Fits	100.0	0.0
Urinary problem	100.0	0.0
Varicose veins	50.0	50.0
Fever >3days	85.7	14.3
High blood pressure	100.0	0.0
Severe vomiting whether treatment required	100.0	0.0
No movement of fetus	100.0	0.0
Bleeding	100.0	0.0
Other Morbidities	80.0	20.0
Total Women with Antepartum Morbidities	47.8 (45)	

Table 7.8 Difference of Opinion between Women and Men related to Care to be extended by Husbands towards Wives during Pregnancy

Types of Care	Opinion of Husbands (%)	Opinion of Wives (%)
Emotional		
Talk affectionately	48.0	100.0
Express concern towards health	25.6	100.0
Health		
Take you to an antenatal check up	27.4	100.0
Arrange with someone to go to antenatal checkup	30.0	100.0
Arrange/Assist in transportation	7.6	99.5
Monitor on intake of medicines	13.0	98.0
Nutritional		
Get fruits/sweets for you	21.5	100.0
Take interest towards your diet	9.4	99.5
Physical		
Manage older children	13.5	98.0
Assist in household work	12.6	97.5
Total Couples	223	

Table 7.9 Opinion of Wives who have been recently Pregnant and their husbands Related to Care to be extended by Husbands during Pregnancy versus Actual Care received

Types of Care	Opinion of (%)		Actual care received by Wives (%)
	Wives	Husbands	
Emotional			
Talk affectionately	100.0	46.8	23.4
Express concern towards health	100.0	28.7	14.9
Health			
Take you to an antenatal check up	100.0	27.7	46.8
Arrange with someone to go to antenatal checkup	100.0	29.8	7.4
Arrange/Assist in transportation	98.9	4.3	6.4
Monitor on intake of medicines	100.0	12.8	24.5
Nutritional			
Get fruits/sweets for you	100.0	25.5	44.7
Take interest towards your diet	100.0	6.4	13.8
Physical			
Manage older children	97.9	11.7	8.5
Assist in household work	97.9	17.0	19.1
Total Couples	94		

Table 7.10 Planned Place of Delivery versus Actual Place of Delivery

Planned place of delivery	Actual place of delivery (Percent of Women)		
	RCWHC/ Govt. hospital	Private hospital	Home
PHC/Govt.hospital	20.3	0.0	0.0
Pvt.hospital/Doctor	1.4	46.4	1.4
Home	2.8	4.3	23.1

Table 7.11 Place of Delivery by Background Characteristics of Women

Characteristics	Percent of Women	
	Institution	Home
Women's age		
<=20	75.8	24.2
21-30	75.0	25.0
Women's education		
Illiterate	74.3	25.7
Up to primary	61.5	38.5
Above primary	85.7	14.3
Women's work status		
Not working	81.6	18.4
Working	67.7	32.3
Caste/Tribe		
Scheduled caste/tribe	70.8	29.2
Other backward caste	76.3	23.7
Others	85.7	14.3
Type of family		
Nuclear	71.2	28.8
Non nuclear	88.2	11.8
Parity		
1	77.4	22.6
2	77.8	22.2
3+	63.2	36.8
Consanguineous		
Yes	76.9	23.1
No	74.1	25.6
Decision Made By		
Husband	80.0	20.0
Father-in-law	100.0	0.0
Elderly female members	69	30.2
Total Women	69	

Table-7.12 Determinants of Use of Institutional Health Care for Delivery: Logit Analysis

Explanatory variables	Institutional Delivery		
	B	S.E.	Exp (B)
Women's Age	.194	.649	1.215
Women's Education	-.017	.454	.983
Women's work status **	-1.199	.709	.302
Men's education	-.053	.443	.948
Men's work status	-.147	.800	.864
Type of family **	-1.662	.965	.190
Parity	-.625	.487	.535
Caste	-.321	.720	.725
Having Vehicle **	1.784	.778	5.956
Deciding Person on place of delivery **	1.553	.930	4.725
Family Violence	.805	.703	2.236

***Indicates significance at 0.1 percent level*

Table 7.13 Women suffered from various morbidities during Delivery and Knowledge of Husbands About it

Morbidities During Intrapartum Period	Percent of Women Suffered	Percent of Husbands Aware
Labour more than 18 hours	22.2	7.2
Use of forceps	3.7	1.4
Excessive bleeding (More than 3 sarees stained)	14.8	0.0
Sac burst and even after 5 hours child was not born	14.8	7.2
Sac burst and the fluid was greenish colored	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 Couples' Knowledge	69	

Table 7.14 Women suffered from various Intrapartum morbidities by Place of Delivery

Morbidities During Intrapartum Period	Percent of Women Suffered by Place of Delivery	
	Home	Hospital
Labour more than 18 hours	0.0	100.0
Use of forceps	0.0	100.0
Excessive bleeding (More than 3 sarees stained)	25.0	75.0
Sac burst and even after 5 hours child was not born	0.0	100.0
Baby was in breech position/not in normal position	0.0	100.0
High BP	0.0	100.0
Caesarean	0.0	100.0
Other morbidities	0.0	100.0

Table 7.15 Women suffered from various Intrapartum morbidities by Person Decided on Place of Delivery

Morbidities During Intrapartum Period	Person decided on Place of Delivery	
	Husband/ Father-in-law	Elderly Women
Labour more than 18 hours	33.3	66.7
Use of forceps	0.0	100.0
Excessive bleeding (More than 3 sarees stained)	0.0	100.0
Sac burst and even after 5 hours child was not born	50.0	50.0
Baby was in breech position/not in normal position	0.0	100.0
High BP	0.0	100.0
Caesarean	43.8	56.3
Other Morbidities	100.0	0.0

Table 7.16 Difference of Opinion between Women and Men related to the Care to be extended by Husbands towards Wives during Delivery

Types of Care	Opinion of Husbands (%)	Opinion of Wives (%)
Call for an assistant/health personnel	40.6	99.5
Arrange transportation	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 couples	223	

Table 7.17 Expectation of Care during Delivery from Husbands by recently Pregnant Wives Versus Actual Care received by them

Types of Care	Expectation of Wives (%)	Actual Care Received (%)	
		According to Wives	According to Husbands
Call for an assistant/health personnel	97.1	5.9	39.7
Arrange transportation	95.6	17.6	25.0
Get necessary items/medicines	97.1	32.4	19.1
Financial help	97.1	57.5	75.0
Emotional support	94.2	23.5	11.8
Did not help at all	**	26.5	0.0
Not Necessary	2.9	2.9	0.0
Total Percent	69	69	69

** Not Applicable

Table 7.18 Details of Women who were Pregnant during Reference period and their Particulars about Postpartum Care

Particulars of Postpartum Care	Percent of Women
Knowledge about Postpartum Care	
Nutritional diet	59.4
Restricted diet	47.8
Adequate rest	34.8
Not to indulge in heavy work	36.2
Abstaining sex	5.8
Feeding practices	11.6
Regular health checkup	1.4
Had Postpartum Checkup	12.1
Place of Checkup	
RCWHC/SC	10.1
Govt. 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
Bring water from distance	4.3
Lifting heavy items	4.3
Total Women	**39.1 (27)**

Table-7.19 Determinants of Use of Institutional facilities for Postpartum Care: Logit analysis

Explanatory variables	Postpartum Care		
	B	S.E.	Exp (B)
Women's Age **	.751	.574	2.120
Women's Education	-.483	.452	.617
Women's work status **	1.550	.650	4.712
Men's education **	.925	.469	2.521
Men's work status	.013	.663	1.013
Type of family	-.547	.673	.579
Parity	.479	.444	1.614
Caste	.048	.645	1.049
Having Vehicle	-.828	.692	.437
Deciding Person on place of delivery	-.060	.724	.941
Family Violence	-.218	.612	.804
Postpartum morbidities	.644	.657	1.905

***Indicates significance at 0.1 percent level*

Table 7.20 Women suffered from various morbidities After Delivery and Knowledge of Husbands About it

Morbidities After delivery	Differences in Reporting about Postpartum morbidities (%)	
	Women	Men
Pus formation in tare	10.3	0.0
Fever >3 days	17.2	2.9
Pain in lower abdomen	69.0	1.4
Painful, burning feeling when urinating	17.2	0.0
Changes in mental make-up	10.3	0.0
Fits/convulsions	0.0	1.4
Discharge that smells	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 Couples	42.0 (29)	

Table 7.21 Difference of Reporting between Women and Men related to the Care to be extended by Husbands towards Wives After Delivery

Types of Care	Differences in Reporting about Intrapartum morbidities (%)	
	Husbands	Wives
Arrange/take you for a health checkup	45.5	100.0
Managing older children	36.5	98.6
Not allowing you to strain physically	28.4	100.0
Providing physical help	50.7	100.0
Extending emotional support	0.0	94.2
Any other	0.0	1.2
Not necessary	5.4	0.0
Total Couples	223	

Table 7.22 Expectation of Wives who have been recently Pregnant Versus Actual Care received from Husbands after Delivery

Types of Care	Expectation of Wives (%)	Actual Care received (%)	
		According to Wives	According to Husbands
Arrange/take you for a health checkup	100.0	4.3	45.7
Managing older children	98.6	34.8	24.3
Not allowing you to strain physically	100.0	44.9	35.7
Providing physical help	100.0	31.9	50.0
Extending emotional support	94.2	31.9	4.3
Any other	1.4	1.4	0.0
Total Couples	69		

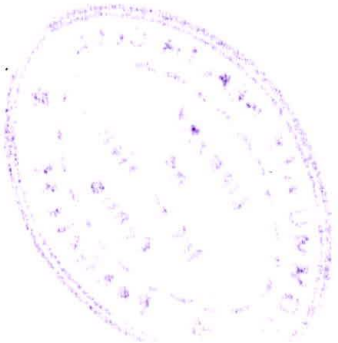

Table 7.23 Opinion of Women and Men about certain Aspects of Abortion

Various Aspects On Abortion	Opinion of Women (%)	Opinion of Men (%)
Can a Woman go for Abortion		
Agree	37.2	17.0
Disagree	62.8	83.0
Woman can go for Abortion for Reasons Like		
For Health of Woman	95.5	81.2
To Avoid further Children	53.4	32.7
To postpone first Birth	12.1	17.0
To Space between Children	30.0	28.7
For having Abortion Permission 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
Not necessary	0.0	0.4
Need to discuss between Couple prior to going for an Abortion		
Required	99.6	79.8
Not required	0.4	20.2
Couples' Need to Discuss on		
To decided 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
The need for Husband to be with woman at the time of Abortion		
Need to be	84.8	82.1
No need	15.2	17.9
Person required to Accompany Woman for Abortion		
Mother	72.2	69.5
Mother-in-law	52.5	28.3
Sister	4.5	0.9
Relatives	0.4	1.8

Sexual Practices and Reproductive Health of Women

Sexual health depends not only the practices, but also on individual attitude and knowledge. Sexual practices of men before and after marriage have important reproductive health implications, both for men themselves and for the wives. This chapter examines sexual practices of men vis-à-vis their sexual health. Besides the chapter focuses on reproductive health of women, and couples knowledge about it. In the end an effort is made to over view on household health expenditure.

Sexual practices of Men Before and After Marriage

In all the villages 28.7 percent of the total men had premarital sexual experience Table 8.1). Median age at first sexual contact of these men is 19 years. Some of them had premarital sexual contacts as early as at 16 years. After marriage extramarital sexual contacts have lessened among men (13 percent). Before marriage 11.7 percent had sexual relationship with multiple partners; after marriage it is declined to 2.8 percent. Prior to marriage, only 1.3 percent of men always used condoms, one out of four men (23.3 percent) before marriage never used condoms. This percentage is decreased after marriage is also may be because over men having extramarital relations decreased. Socio-economic background of men having extra-marital sexual relations reveal that, comparatively men in the age group of 31-40 years are more involved in relations than the younger or older men (Table 8.2). If men are married for than 10 years, showed interest to go to other women than the recently married men. Men with less educational levels; engaged in skilled work or business; from backward castes and from tribes; those had non-consanguineous marriage; and from non-nuclear families maintained extramarital sexual relations.

Sexually transmitted Diseases and Health Care Seeking behaviour

Men who had premarital sexual relations, 17.2 percent suffered from sexually transmitted diseases (Table 8.1). Many of them experienced difficulty in urination. Only 6.4 percent of men tried to seek treatment from allopathic doctor and the remaining tried self-treatment or never tried to seek treatment. After marriage 3 men out of 29 men, those ever maintained extramarital sexual relations, suffered from

STDs. Only one of them felt necessary to seek treatment from a doctor, while the remaining tried self-treatment.

Marital Sexual Behaviour and Attitude of Couples

Median age at first sexual intercourse for women is 16 years. Two women out of total 223 women had first coital relation at the age of 11 years. Sixty percent of women had first coital relation by 16 years of age. Ninety four percent of women had coital relations while they are still in adolescent age. Many of the women were ignorant or had partial knowledge about coitus. Having been exposed to coitus at an early age, 30 percent of the women felt scared; 7 percent of women never liked it. Forty seven percent of women felt shy about it and 31 percent women liked it.

There have been differences in reporting between women and men on information related to sexual practices of the couples. During four weeks prior to the survey, the couples were asked to mention certain details related to sexual practices. Out of total 223 couples, 222 couples stayed together. According to men 81 percent of them have coitus once per day, 16.6 percent reported that they have coitus twice per day, and 2.4 percent of the men said that they involve three in it three times a day. According to women 99.6 percent have sex once per day and a marginal percent of women admitted that they have coitus two times a day. A majority of the women opine that their duty is to oblige husbands' sexual desires. At the same time they consider that having coitus once in a day is an acceptable practice. Where as, men differ their opinion with women. Men think that there is no ideal number of times a couple should involve in coitus per day and also opine that a husband has every right on wife's body, thus wife should not deny husbands' sexual demands.

Sexual Behaviour of Men after Morbidity

Three men out 223 men suffered from STDs at the time of survey. Two of them discussed about illness with wives. They knew that their ill health may have an effect on women's gynaecological ill health, thus they started using condoms during coital relations with wife. One of them never discussed with wife, but has stopped coital relations with her. All three of them continued to have extramarital sexual relations.

The only precaution they felt necessary was to use condoms, thus all three men used condoms during relations with other women.

Beliefs of Couples about Sexually Transmitted Disease

A majority of women and men are not aware about STDs. When all the women are asked to express whether they are disagree or do not know about the statements related to STDs. The statements were:

- A person contacts gonorrhea only once, after that he or she becomes immune to the diseases
- Syphilis can be treated with penicillin and other antibiotics
- Venereal disease can be passed from a mother to her baby before or during birth
- Some people who have venereal diseases show no symptoms at all
- It is harmful for a man to have sex with another man.

The results show that for most of the beliefs about STDs considerable variations are noticed between men and women (Table 8.3). On 'venereal disease can be passed from a mother to her baby before or during birth', 85 percent of men and 35 percent of women agreed. For the remaining aspects a majority expressed ignorance. One out of four, both women and men, agreed that 'some people who have venereal diseases show no symptoms at all'. Relatively more women (13.9 percent) believed than men (9.4 percent) about the statement that 'it is harmful for a man to have sex with another man'. Hardly any woman believed about the statement 'a person contacts gonorrhea only once, after that he or she becomes immune to the diseases' and 'syphilis can be treated with penicillin and other antibiotics' where as 12 percent and 47 percent of men respectively believed on the statements.

Reproductive Health of Women

Women's reproductive health situation is analysed before and after the marriage. Out of the total women, 29.6 percent of them have suffered from menstrual related ill health. One out of women experienced abdominal pain, 9 percent had irregular periods. Less than one percent of women suffered from prolonged menstruation and vaginal discharge. Nearly half of the women felt the need to seek treatment. Forty percent of them went to an allopathic doctor.

One out of four women (24.7 percent) were suffering from reproductive tract infections at the time of survey (Table 8.4). Some of the mentioned illnesses by the women are, nearly six out of ten women reported pain at the mouth of vagina; three out of ten women expressed sever pain deep inside the vagina. Sixteen percent of women noticed abnormal vaginal discharge.

Women by their background characteristics reveal that (Table 8.5) relatively a higher percent of women aged between 31-35 years (40 percent); with parity three or more (59.3 percent); women belonged to Scheduled tribes (37.5 percent) and Backward castes (26.4 percent) suffered from reproductive tract infections. Marginally a higher percent of women who had consanguineous marriages (27.6 percent) and husbands' having extramarital sexual relations (27.9 percent) suffered from reproductive tract infections.

Generally in traditional societies it is believed that disclosing about reproductive tract infections, unlike maternal morbidities, among women is a matter of shame. However 53 percent of women in the villages did not hesitate to discuss their illness to husbands. 27 percent of women felt comfortable to share their problems with elderly women. The remaining women felt comfortable to discuss about illness with peer group women. For seeking health care however 64 percent of women felt it is necessary to inform husband and take his permission. Among the 55 women who suffered from one or the other reproductive tract infections, only 27 percent sought treatment. All these women either sought treatment from qualified health personnel, either doctors or health assistants; either at round the clock health center or at a private hospital.

Factors, which determine to seek health care for reproductive tract infections, is analysed by a logit model. Table 8.6 shows that if wife discusses about her reproductive tract infection with her husband, she has 33.903 chances more to seek treatment than those women who do not discuss with wives. Illiterate women (0.142) and those working or daily wages (2.388) have high probability to seek care in the villages under study. Women with fewer children have 0.294 chances more to seek health care than women with more children. Domestic violence at home is a

detrimental to women to seek health care. In the houses without family violence, women have 3.015 chances more to seek health care than the families, which has violence.

Medical and Health Expenditure

Expenditure towards Wives Health

In many communities it is believed 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 by spending towards medical and health aspects. Table 8.7 gives details of health expenditure incurred towards wives' obstetric and other reproductive health care. Out of total couples, 81.1 percent of husbands mentioned that their wives sought medical and health care during their last pregnancy. All of them said that wife had sought care during antenatal period, 68.4 percent during delivery, and 59.2 percent during postpartum period. Eighty nine percent of these husbands agreed that there was a need to spend money in cash or kind. Slightly a lesser percent of husbands did spend towards wives' obstetric care than the required because the remaining could not spend due to lack of adequate finances.

Out of total couples, 7.6 percent of husbands said that their wives required seeking reproductive health care, and in all cases husbands did spend towards them. Excepting for one woman, in all other cases husbands had to spend to spend money and for one woman she sought treatment from round the clock health centre.

Household Health Expenditure

Seventy percent of the total families had incurred medical expenditure during one year prior to the survey. One fifths of the husbands reported having spent some money on them selves, 69 spent money on the health care of wives, 49 percent on their children, 8.3 percent towards their parents and 1.9 percent for others. An analysis of expenditure in terms of rupees reveals that median amount of money spent by the households is Rs.2500. minimum amount spend by a household is Rs.100 and maximum amount spent is Rs.45000. Out of total household, 16.6 percent of the households had to take loan to meet the medical expenditure. Out of total amount taken on loan 64.9 percent of households had taken for the sake of wives, 35 percent

for health care of children, 22 percent for themselves and the rest for the remaining persons of the family.

Table 8.1 Sexual Behaviour and Health Seeking Behaviour of Men Before and After Marriage

Particulars of Sexual Activity and Health	Percent of Men	
	Prior to Marriage	After Marriage
Men ever had extramarital sexual contact	28.7	13.0
Median Age at first sexual contact	19 years	
Men having contacts with multiple women	11.7	2.8
Ever used Condoms during sexual contacts		
- Always	1.3	1.3
- Sometimes	4.0	4.0
- Never	23.3	7.6
Experienced any of the morbidities		
- Any discharge from your penis	0.4	0.4
- Any sore on your genital or anal area	0.9	0.0
- Difficulty urinating	4.5	0.4
- Pain with urination	0.9	0.0
- Very frequent urination	0.4	0.0
- Swelling of your testes or in groin area (penis)	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 Men who had contacts	**64**	**29**

Table 8.2 Socio-economic Characteristics of Men having Extra-marital Sexual Relationship

Socio-economic Characteristics	Extra-marital relationship of Men in Percent	
	Having	Not Having
Current age		
21-25	11.8	88.2
26-30	10.0	90.0
31-35	16.7	83.3
36-40	23.5	76.5
40+	11.4	88.6
Duration of marriage		
<=2	11.5	88.5
3-5	10.6	89.4
6-10	8.1	91.9
11-15	21.2	78.8
16-20	16.7	83.3
21+	13.9	86.1
Parity		
0	8.9	91.1
1	15.6	84.4
2	15.4	84.6
3	15.9	84.1
4+	10.0	90.0
Education		
Illiterate	10.9	89.1
Up to primary	16.9	83.1
High school	13.6	86.4
Above high school	5.3	94.7
Work status		
Daily wage	11.4	88.6
Skilled worker	17.9	82.1
Business	16.0	84.0
Clerical	10.8	89.2
Cultivation	12.1	87.9
Caste/Tribe		
Scheduled caste	8.5	91.5
Scheduled tribe	12.5	87.5
Other backward caste	15.7	84.3
Others	7.1	92.9
Consanguineous Marriage		
Yes	12.3	87.7
No	13.4	86.6
Type of family		
Nuclear	12.3	87.7
Non nuclear	14.8	85.2
Total	**29** (13.0)	**194** (87.0)

Table 8.3 Knowledge about Sexually Transmitted Diseases among Couples

Particulars of Knowledge	Percent of Men			Percent of Women		
	Agree	Do not agree	Do not Know	Agree	Do not agree	Do not Know
A person contacts gonorrhea only one, after that he or has 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 Couples	**223**					

Table 8.4 Details of women suffering from Reproductive Tract Infections

Details of Reproductive Tract Infections	Percent of Women suffered
Pain at the mouth of vagina	58.3
Pain inside the vagina	33.3
Abnormal vaginal discharge	16.1
Frequent urination or Pain during urination	7.2
Pain during / after intercourse	5.4
Itching/Irritation in vaginal area	4.0
Severe lower abdominal pain	2.2
Bad odour in vaginal area	1.8
Giddiness along with fever	0.9
Blood spots after intercourse	0.9
Total Women Suffered	24.7 (55)

Table 8.5 Socio-economic Characteristics of Women suffering from Reproductive Tract Infections

Socio-economic Characteristics	Percent of Women Suffered	
	Yes	No
Education		
Illiterate	25.2	74.8
Up to primary	21.2	78.8
Above primary	25.4	74.6
Work status		
Not working	22.0	78.0
Daily wage	30.9	69.1
Skilled worker	19.2	80.8
Business	23.4	76.6
Current age		
<=15	33.3	66.7
16-20	19.7	80.3
21-25	22.8	77.2
26-30	20.5	79.5
31-35	40.0	60.0
36-40	33.3	66.7
40+	35.0	65.0
Duration of marriage		
<=2	21.2	78.8
3-5	21.3	78.7
6-10	27.0	73.0
11-15	21.2	78.8
16-20	27.8	72.2
21+	21.8	66.7
Parity		
0	22.2	77.8
1	24.4	75.6
2	15.4	84.6
3	27.3	72.7
4+	32.0	68.0
Religion		
Hindu	26.1	73.9
Muslim	7.1	92.9
Christian	16.7	83.3
Caste/Tribe		
Scheduled caste	19.1	80.9
Scheduled tribe	37.5	62.5
Other backward caste	26.4	73.6
Others	21.4	78.6
Consanguineous marriage		
Yes	29.6	70.4
No	21.8	78.2
Type of family		
Nuclear	23.5	76.5
Non nuclear	27.9	72.1
Husband with Extramarital sexual relations		
Having	27.6	72.4
Not having	24.2	75.8
Total	**24.7**	**75.3**
	(55)	**(168)**

Table 8.6 Determinants of Health seeking Behaviour of women for Reproductive tract infections

Dependent variables	Reproductive Health Problems		
	B	S.E.	Exp (B)
'Life threatening'			
Women's Age	.261	.288	1.299
Women's Education **	.397	.245	1.487
Women's work status	.328	.362	1.388
Men's Age	.298	.260	1.348
Men's education **	-.578	.236	.561
Men's work status	-.452	.398	.636
Type of family	-.289	.377	.749
Marriage Duration	-.389	.317	.678
Parity	.061	.268	1.063
Consanguineous Marriage **	-.739	.365	.478
Caste	-1.58	.422	.854
Religion **	1.051	.807	.478
Having Property	-.217	.366	.805
Having Vehicle	-.296	.432	.744
Availability of Health Centre	-.201	.344	.818
Awareness of AIDS **	-.389	.412	.678
Awareness of Reproductive Health Problems	.566	.499	1.762

***Indicates significance at 0.1 percent level*

Table 8.7 According to Men Expenditure on Wife's Obstetric Health

Expenditure on Wife's Reproductive Health	Percent of Men
Wife sought treatment during	
- Pregnant	81.1
- Delivery	68.4
- Six weeks after birth	59.2
Needed to spend either in cash/kind for wife's obstetric Health	
- Needed	89.3
- Not needed	10.7
Unable to seek proper medical treatment due to lack of adequate finances for wife's obstetric health	
- Could not seek care	17.1
- Could seek care	82.3
- Do not Know	0.6
During last one year needed to spend for wife's reproductive health care	
- Needed	7.6
- Not needed	91.9
Women sought treatment	100.0

Table 8.8 Particulars of Health/Medical Expenditure of the Households in the Study Villages

Details of Medical Expenditure	Extent
Percent of Families incurred on Medical expenditure during 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 year in Rupees	
- Median amount spent	2500
- Minimum amount spent	100
- Maximum amount spent	40,000
Percent of families felt the expenditure incurred is beyond their family financial status	16.6
Total Families	**223**

Family Violence and Reproductive Health

Gender based violence occurs in all societies and is largely unpolished. Such violence occurs within the home or in wider community and it affects women and girls disproportionately. Family violence, which typically occurs when a man beats female partners, is the most prevalent form of gender-based violence. In the present study primarily cognitive levels of couples related to violence is examined; next the extent of violence among the couples is studied.

Cognitive levels of Women and Men About Family Violence

Women's behaviour is always at vigilance in a gendered based society. Especially in natal family she is expected to be at her best in manners. If woman deviates from expectations she is subjected not only to criticism, but also in certain situations it is approved that her family members can physically control her. 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. In the present section perceptions of men and women attitude towards expected behaviour as well as physical control of wife is examined.

To assess the cognitive levels of men and women, each of them are asked to agree or disagree to certain statements related to wife's behaviour and physical control. If they agree strongly, the responses are noted separately to understand the intensity of their attitude. Every woman agreed that wife should always show respect to elders particularly her in-laws in the family (Table 9.1). Though 94 percent men agreed similarly, the difference between women and men existed on levels; 89.2 percent of women strongly agreed, 38.6 percent of men agreed strongly. Similarly perceptions of women and men are asked about whether wife should show respect to her husband (Table 9.2). All women again agreed on this view as well. More men (96.4 percent) wanted wives to show respect towards husbands than towards elders/in-laws.

Ninety percent of women agreed that *wife should always follow instructions given to her, whether liked or not, by elders particularly her in-laws in the family* as well as towards *husband*. Seventy two percent of men agreed that wife should follow

instructions, yet slightly more than them (77 percent) wanted wife to follow the instructions of husband.

Unlike earlier opinions, fewer women (50 percent) agreed to the statement that *if necessary one should use force to make wife listen to all instructions of elders particularly her in-laws in the family* or her *husband.* Men as well agreed in less percent (31), yet again when referred to listening to instructions of husband a little higher percent of them (49) did not mind forcing wife.

If wife disobeys instructions of elders particularly her in-laws in the family, 99 percent of women appreciate persuasion would bring a change in wife, 19 percent of them do not mind verbal insults, 9 percent of women opine that physical beating is required, and 6.7 percent expressed that physical isolation will make a wife realize and would obey. Similar disobedience if showed towards husbands, opinion of women about persuasion and verbal insults has not differed. However there is a decline in percent of women supporting physical beating or physical isolation as measures to used to bring a change in wife. Even though by and large men opine that persuasion and verbal insults should be the measures to be taken, relatively more percent of men (12 percent) felt physically wife can be beaten to make her listen to the instructions of husbands.

Only four out of ten women opine that *there is no harm if wife sometimes disagrees with instructions given to her by elders particularly her in-laws in the family* or her *husband.* More men (74 percent) agreed than women to the statement. When the statement referred to husbands, the percentage of men agreeing has come down to 63.Moe than 95 percent of women opine that *no verbal insults and/or physical beating should be used against wife if she does not follow instructions given to her by elders particularly her in-laws in the family* or her *husband.* While women perceive like this, still four out of ten disagree with this attitude.

Thus, cognitive levels of women and men indicate evident gendered attitude towards women. While most of the women seem to follow polite manners of respecting elders, at the same time they are made to internalize to accept a subordinate position by accepting certain levels of measurements against wives to bring a 'desirable change'.

However given an option most of the women seems to have not in favour of physical control. On the other hand some men though seem to be liberal under various situations, yet when it is applicable to the behaviour of wife towards husband, there has been an expression of physical control. Again given an open choice, still four tenths of husbands could not really accept a complete lack of physical control of wife.

Reporting of Family Violence by Women and Men

Reporting on family violence is given in Table-9.3. There is a lot of variation between the information provided by women and men. The couples are asked to mention whether the women were physically hit, slapped, kicked or tried to hurt by their husbands. Twenty one percent of women agreed that there has been violence at home, where as more men (56 percent) reported the same. Similarly there have been differences in reporting by men and women about the number of times violence occurred at home. Women tried to report less number of times than men.

An analysis of reporting by types of violence reveals that, more women reported of various severities than men. More women (68.8 percent) reported of slapping/pushing than men (23.2 percent). Half of the women also mentioned that their husbands either punched or kicked where as less than one percent of men agreed about it. A few women (6.3 percent) have mentioned that their husbands have used a stick or weapon during violence, where none among men reported the same. A majority of men (89.6 percent) reported the violence was largely confined to shouting and yelling. Similarly a majority of women (81.3 percent) too agreed that shouting and yelling was part of violence but not always it was confined to it.

Reactions of wives after the violence show a distinctive difference in reporting between women and men. Every man mentioned that after the episode, his wife cried and did nothing. Though 75 percent of women did agree that they cried, only 27 percent have mentioned that they did nothing subsequent to the violence. Almost seventeen percent of women mentioned that they have shouted and yelled back at husbands during violence. Another four percent of women stated that they have stated that as a reciprocal reaction to violence, they have either hit or slapped their husbands.

Reporting about wives seeking help after violence was more by men (2.7 percent) than by women (1.3 percent). Though very few women sought medical help after violence, yet there are differences in reporting among women (0.9 percent) and men (0.4 percent).

Family Violence by Background Characteristics of Couples

Table 9.4 gives details of the couples' background characteristics. A higher percent of illiterate women (30.7 percent) reported of family violence than the educated women. Among men a decline in family violence is reported if he is educated above high school. Non-working women reported less in percent than the workingwomen. Among men skilled workers reported comparatively less violence than the men in other occupations. Among both women and men with increase in age, duration of marriage, and parity extent of violence is high. Religion wise analysis reveals that a higher percent of Hindu women reported violence, where as among men a higher percent of Muslims mentioned of occurrence of violence. Both women and men from deprived castes reported of violence than others. Relatively more women from nuclear families admitted of occurrence of violence, where as among men those living in joint families reported of violence.

Violence and Reproductive Health

Gender violence, until recently a marginal subject among themes relate 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 (Heise L, 1994). In the present study impact of violence on some of the reproductive aspects of women is analysed.

Existence of violence has a bearing on the reproductive health of women. Table 9.6 shows controlling all other variables, influence of domestic violence on certain aspects of reproductive health are analysed by a logit model. Results show that wives which living in a family, which has violence, has higher chances to suffer from contraceptive morbidity than the women who never faced family violence.

Occurrence of violence during pregnancy is the most tragic faces of gender violence, resulting in serious consequences for women's physical and mental health. In the

present study, five pregnant women (2.2 percent of total women) mentioned that their husbands behaved violently during the pregnancy. Six husbands (3.6 percent) agreed that their wives were pregnant when they violently misbehaved with them. Impact of violence on antepartum and intrapartum morbidities is found to be insignificant in the present study. However, impact of domestic violence on decision made by husband on place of delivery came out as a significant determinant. In other words in families which has no family violence, there is higher chances for husbands decide in favour of institutional delivery (0.404 times) for wives than the husbands from a family which has violence. Impact of violence resulted as a significant determinant of wife suffering from postpartum morbidities. In the villages, if there is no family violence women are 0.725 times less likely to suffer from postpartum morbidities than the women from family violence.

Both men and women were asked to report whether there is any violence existed related to couples' sexual behaviour. On matters related to sexual behaviour, fewer men reported about of presence of violence between the couple as compared to women. While 21.1 percent of women mentioned that their husbands had sex when they themselves were not interested, relatively less men (17 percent) did mention the same. Similarly more women (12.8 percent) than men (7.9 percent) reported that their husbands had forcible sex when they were not interested in it. Again violence showed a significant positive association with contraceptive Specifically in families where women experience violence due to her relative low position; she cannot assert herself for basic postoperative rest either after sterilization or after childbirth. In such situations women instead of recovering to normal health, by involving in all kinds of domestic work further likely to deteriorate their health condition. In such situations seeking of health care for themselves is meager.

Table 9.1 Cognitive levels of Men and Women on Physical control of Wife towards Elders/Parents-in-law

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 given to her, whether liked or not, 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
- Other	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 against wife even if she does not follow instructions given to her by 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 Couples	223	

Table 9.2 Cognitive levels of Men and Women on Physical control of Wife towards 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, whether she likes or not, by her husband		
- 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 listen to all 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 of her, the following measures should be taken		
- Verbal insults	16.6	44.4
- Physical isolation	4.5	3.6
- Physical beating	7.2	12.1
- Persuasion	97.8	91.0
- Other	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 against wife even if she 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 Couples	223	

Table 9.3 Differences in Reporting Information related to Family Violence

Particulars of Domestic Violence	As Reported By	
	Women	Men
Woman being ever physically hit, slapped, kicked or tried to hurt by her Husband	21.5	56.1
Types of Violence 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 last time		
- Yelled and shouted	16.7	0.4
- Hit and slapped	4.2	0.0
- Cried	75.0	100.0
- Did nothing	27.1	100.0
Wife sought Help from others	1.3	2.7
Was she required to seek Medical help after family violence	0.9	0.4
Total Number Women and Men	**48**	**125**

Table 9.4 Background Characteristics of Couples with Family Violence

Socio-economic Characteristics	Percent of women	Total Number	Percent of men	Total Number
Education				
Illiterate	30.7	127	54.7	64
Up to primary	15.2	33	67.8	59
Above primary	6.3	63	***	***
High school	***	***	54.3	81
Above high school	***	***	31.6	19
Work status				
Not working	17.1	82	**	1
Daily wage	23.5	68	59.1	88
Skilled worker	23.1	26	48.7	39
Business	25.5	47	52.0	25
Clerical	***	***	54.1	37
Cultivation	***	***	63.6	33
Current age				
<=15	0.0	6	***	***
16-20	9.9	71	**	2
21-25	24.6	57	47.1	68
26-30	23.1	39	40.0	50
31-35	26.7	15	69.0	42
36-40	40.0	15	64.7	17
40+	40.0	20	75.0	44
Duration of marriage				
<=2	5.8	52	38.5	52
3-5	17.0	47	42.6	47
6-10	24.3	37	62.2	37
11-15	27.3	33	63.6	33
16-20	16.7	18	83.3	18
21+	44.4	36	72.2	36
Parity				
0	13.3	45	33.3	45
1	4.4	45	44.4	45
2	17.9	39	64.1	39
3	29.5	44	65.9	44
4+	40.0	50	72.0	50
Religion				
Hindu	22.7	203	56.7	203
Muslim	7.1	14	64.3	14
Christian	16.7	6	16.7	6
Caste/Tribe				
Scheduled caste	19.1	47	59.6	47
Scheduled tribe	37.5	8	37.5	8
Other backward caste	25.0	140	60.0	140
Others	3.6	28	35.7	28
Type of family				
Nuclear	22.2	162	54.3	162
Non nuclear	19.7	61	60.7	61

** No observations
*** Not Categorized

Table 9.5 Differences in Reporting Information related to Violence and Reproductive Health

Violence Related to Reproductive Health	As Reported By	
	Women	Men
Women experienced violence While pregnant	10.4	6.4
Husband insisted on Wife for forcible sex	12.8	7.9
Husband had forcible sex with wife	21.1	17.0
Total Number Couples	223	

Table-9.6 Impact of Domestic Violence on Various Aspects of Reproductive Health

Various Aspects of Reproductive Health	B	S.E.	Exp (B)
- Contraceptive Morbidity **	1.609	0.251	4.999
- Decision by Husband 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*

Summary and Gender Inference

The new perspective looks at men as the potential partners in and advocates for good reproductive health rather than bystanders, barriers, or adversaries. In this context the study focuses on how men's participation promote women to utilize health services for improving one's own reproductive health. Reproductive health covers an array of issues, however the present study examines reproductive health of women from three approaches: contraceptive health, obstetric health, and reproductive tract health.

The study is part of the Ford grants project. It is sponsored by Achuta Menon Centre of Sree Chitra Tirunal Institute of Medical Sciences, Thiruvanantapuram.. The study is carried out in few villages of Rangareddy district of Andhra Pradesh. The current study is intended to focus on utilization of reproductive health services by women, therefore a few villages which are covered under Shamirpet Round the Clock Women Health Centre is considered as universe. Out of total nine sub-centres, three sub-centres are selected at random. From each of the sub-centres, one village is selected at random. For selection of the couples, 'duration of marriage' is assumed as an important variable in deciding power differences between the couples. Based on house listing exercise, all the categories of couples in the reproductive age group are grouped into five-year intervals, and then randomly ten percent of couples are selected for the study. Thus the selected number of couples for the study is 223.

Principal findings of the study broadly concentrate on couples' (i) exposure and access to reproductive health services, (ii) psychological perspectives on family planning, its use, contraceptive morbidity and utilization of services, (iii) fertility behaviour and obstetric health, (iv) sexual practices and reported sexual morbidity, and (v) family violence and reproductive health of women.

Exposure and access to reproductive health services

Exposure to reproductive health information is not uniform among couples in the villages covered under Round the clock Women Health Centre. In the present study more husbands (75 percent) are exposed to various components of reproductive health than the wives (59 percent). Though in 87 of the families at least one of the couples

are exposed to information, only 35.4 percent of both the couples are exposed. More wives are exposed to messages related to obstetric health, while husbands are more exposed to information related to AIDS. Wives received largely messages through interpersonal communication, where as husbands received the messages through media. It is interesting to note that despite huge expenditure on AIDS awareness program, spread of messages is not uniform between both sexes in a community.

Information based on focus group discussions of women and men reveals that, wives feel comfortable to discuss or make efforts to learn about obstetric care, as it is always considered as an area confined to women. Similarly it is not approved to discuss on contraception or AIDS or gynaecological health. It is because these are the subjects on whom if women discuss they are pointed as 'uncultured' or 'lacks women's modesty'. Thus many women themselves do not wish to take additional interest to know on aspects other than obstetric care. If women are genuinely interested to know on these aspects then they feel it is convenient to rely on media for such information. Even though most of the women do get exposed to mass media, especially television, they actually do not get exposed to reproductive health information. This is because women prefer to watch particular channels, which do not carry any of these messages. A couple of women did mention that they had an opportunity to watch billboards or wall posters informing about AIDS but they felt embarrassed to stand and read the complete message. Husbands on the other hand get exposed more through media find it interesting to know more about messages like AIDS. A majority did not take interest to learn about obstetric health, because they opine that it is not a subject related to men.

Similarly gender differences are reported on knowledge about cognitive as well as physical access to various reproductive health services. Every woman is aware of availability of obstetric care, gynaecological health problems and availability of sterilization facilities. On contrary only few women are aware of availability of temporary methods of contraception, medical termination of pregnancy, and about STDs. Cognitive levels of husbands on access of reproductive health services reveal that, 96 percent is aware of sterilization facilities. Knowledge about obstetric care is known to nearly three-fourths of husbands. Even though knowledge about temporary

methods of contraception, STDs and AIDS is known to more husbands compared to wives, only half of the husbands are aware of them.

Perspectives on family planning, its use, contraceptive morbidity and utilization of services

Psychological perspectives of couples are examined on locus of control over pregnancy, the couples' efficiency related to usage of contraception and pregnancy avoidance. Perceptions of wives and husbands differed on locus of control over pregnancy. Many women assume that they have no control on their body whereas men think they have a control on wives' body. Thus even though 94 percent of women think that if a couple is careful an unwanted pregnancy will rarely happens, yet they rely largely on luck. Whereas men rely less on luck, but they opine that women is meant to be pregnant and one fifth of husbands still believe that an unwanted pregnancy can happen.

Information on self-efficiency is addressed to only those who have not used any method of contraception. The results reveal that a majority of the wives expressed their inability to obtain and use a method of contraception as well as to refrain from sex unlike husbands. In other words these women find extremely difficult to cross the barrier of gender to obtain and use a temporary method. In addition they confessed the lack of self-control on their bodies. These perceptions of women are further reiterated by their opinions on value of pregnancy. A majority of the women agreed that they could convince their husbands on limiting the children but lack efficiency in postponing or spacing of pregnancy either by usage of contraception or by abstaining from sex.

Fifty eight percent of couples had a communication related to planning of their family. However there are differences in reporting between wives and husbands on certain topics. More couples had a discussion if they are from forward castes, nuclear families, and recently married. Though some of the socio-cultural aspects facilitated husband and wife communication, however initiation to the discussion was largely determined by the gendered behaviour. Perceptions of women and men related to discussion revealed that all women wanted to have a discussion and preferred men to

initiate a discussion because they are cautious of being named as promiscuous. Half of the men never felt necessary to discuss, but those who had a discussion never perceived that a woman could initiate.

A little more than half of the couples (53.5 percent) were using contraception at the time of survey; a majority of them are adopters of tubectomy. Even though only a few couples (6.8 percent) used temporary methods of contraception, there is a difference in reporting between the couples. More men reported about usage of condoms and periodic abstinence than women. The reason for using condoms by the couples is not for avoiding pregnancy; rather because the husbands were suffering from STDs. Probably for this reason the wives did not want to reveal. The cultural restrictions compel women not to disclose the illnesses related to STDs where as men are not so conditioned to conceal. Motivating person to use a method of contraception differs between couples. Women depended more on others rather than self for usage of contraception, thus women opine that with out husbands' approval they cannot use a method of contraception. This is more so if they have to use temporary methods of contraception.

Seventeen percent of contraceptive users reported to have suffered from illness after its adoption. All of these women are adopters of tubectomy. Generally tubal ligation need not result into any complications after surgery. However women living in joint families especially married to non-relative where women 's relative position is less is not likely to have adequate rest for self after a tubectomy. This is more likely in deprived communities where working outside home does not empower her position in the family rather becomes a requirement at the cost of health. Similarly the relationship between husband-wife communication and presence of the morbidity probably indicates differently that is, the couple might have had a communication to go for tubectomy. Thus the low gendered position as well as poor financial situation might have resulted in ill health after tubectomy for these women. There is strong notion with in the community among both men and women that, women's health would deteriorate after tubectomy. Yet all men as well as women want only wives to go for sterilization. While men perceive that women have to take the burden of ill health in the interest of family's financial situation vis-à-vis number of children;

women in addition to this opinion, also expressed that they feel secured against repeated pregnancies as many a time to become pregnant is beyond their control.

Three out of four women those suffered from contraceptive morbidity, have sought treatment. Non-seeking care by the remaining health care is influenced by both social and the relatively low position of woman in the family.

Fertility behaviour and obstetric health

Median age at marriage for the women and men in the sampled villages is 15 and 21 years respectively. Twenty one percent of women belong to zero parity. Median number of children ever born per woman is 3. Differentials in reporting about particulars related to fertility experiences of the couple reveals that there is a coherence between the couples with respect to living children, however variation is noted with number of stillbirth and abortions. Women's unsecured position in the family, perceived unsupportive behaviour of husbands compels them to hide the unsuccessful outcome of pregnancies.

Forty two percent of total women had experienced pregnancy during the reference period of two years. A high rate of antenatal care utilization by these women (96.8 percent) is reported in the villages. More than half of the husbands decide whether his wife should seek antenatal care or not and where she should go it. When husbands decided about the need for antenatal care, they want wives to go to a private allopathic doctor or a Government maternity hospital. When women decided on by themselves they went to the RCWHC. Though The RCWHC comprises of equally qualified medical personnel, when decision are made by men, women perceive in terms of physical, nutritional, and emotional; otherwise such a support is missed when decision are made by themselves. Antepartum morbidities were experienced by 47.8 percent of the women. Most of the husbands (64.4 percent) are not aware of the morbidities faced by their wives during recent pregnancy. When husbands' are not aware about the type of illness, health care seeking behaviour of wives during this period did not really influence, as women received support from other elder members of the family.

Seventy five percent of wives delivered at an institution. To decide in favour of institutional delivery is determined by husbands' initiation. At the same time other socio-economic conditions such as if women are living in nuclear families, with a better standards of living especially in terms of procession of vehicle helped women to seek institutional delivery in these villages. Awareness of husbands about intrapartum morbidities suffered by their wives is low. It is because, culturally most of the problems are never revealed to men excepting incase of a caesarean section.

After the delivery only 12 percent of them had a postpartum checkup. A majority of the women (85 percent) who had been pregnant resumed to domestic work two weeks after the delivery. Women opined that cooking is inevitable, however women from joint expected some kind of help from other family members but women from nuclear families perceived no alternative.

Expectations of women about husbands' support during three distinctive phases of obstetric period reveals that, all women opine husband should extend support to wives with respect to medical, health, nutritional as well as emotional. Relatively less percent of women expected physical help from husbands. Most of the husbands never realized the need to support wives during obstetric period.

Sexual practices and reported sexual morbidity

Premarital is higher than extramarital sexual activity among husbands; 28.7 percent reported premarital sexual contact and 13 percent after marriage. Median age at first sexual contact of these men is 19 years. Before marriage 11.7 percent had sexual relationship with multiple partners; after marriage it is declined to 2.8 percent. Prior to marriage only 1.3 percent of men always used condoms. Men who had premarital sexual relations, 17.2 percent suffered from STDs. Only 6.2 percent sought treatment.

Median age at first sexual intercourse for women is 16 years. Many of the women were ignorant or had partial knowledge about coitus before first sexual contact. There have been differences in reporting between women and men on information related to sexual practices of the couples. A majority of the women opine that their duty is to oblige husbands' sexual desires. At the same time they consider that having coitus once in a day is an acceptable practice. Where as, men differ their opinion with

women. Men think that there is no ideal number of times a couple should involve in coitus per day and also opine that a husband has every right on wife's body, thus wife should not deny husbands' sexual demands.

Sexual practices are very much constructed by gender. Unlike men, women opine certain restrictions are necessary in frequency of coitus. Women feel ashamed to declare if it is beyond the 'accepted frequency'. Again women are made to perceive that they have to oblige the 'needs' of husbands rather than self-physical need.

Regarding beliefs about STD risks and behaviour considerable variations are noticed between men and women. Eighty five percent of men and 35 percent of women agreed that 'venereal disease can be passed from a mother to her baby before or during birth'. A majority expressed ignorance for the remaining aspects; such as 'some people who have venereal diseases show no symptoms at all', 'it is harmful for a man to have sex with another man', 'a person contacts gonorrhea only once, after that he or she becomes immune to the diseases', and 'syphilis can be treated with penicillin and other antibiotics'.

Out of the total women, 29.6 percent of them have suffered from menstrual related ill health prior to marriage. One out of four wives (24.7 percent) were suffering from reproductive tract infections at the time of survey. Only one half of them discussed with husbands about illness. The remaining women felt comfortable to discuss about illness with women. Only 27 percent of these women sought treatment. For seeking health care however 64 percent of women felt it is necessary take husbands' permission. It is evident from findings that those women who could discuss with husbands had higher probability to seek treatment.

Husbands in this study are most willing to spend on health care of their wives, even though they did not have correct awareness of their wives health situation. More than four fifths of husbands spent towards wives' during pregnancy. Often husbands have spent more towards wives' health care than on any one else in the family.

Family violence and reproductive health of women

Husbands hold strong and appropriate behaviours of wives towards themselves and elders/in-laws. More than husbands, wives also opine such a feeling about their behaviour. Nearly nine out of ten both husbands and wives think that, a wife should show respect towards husbands and elders/in-laws. Two thirds think that they should follow instructions; nearly three fourths believe that wife should be perused to obey instructions. While no wife wants to be either verbally or physically beaten for not listening, one third of the husbands do not mind implementing these measures. More women prefer to have a free relation with husband, while more husbands expects wives to be more obedient and obliging towards them.

More than half of the husbands, and one fifth of the wives have reported physical violence towards wives. While a 89 percent of husbands reported of occurrence of shouting/yelling during differences of opinion, 68 percent of wives reported that slapping/pushing and half of them have mentioned punching/kicking was also experienced. Despite high level of family violence very few women sought help from others, because women do believe that to publicize family violence by themselves brings disrespect to women. A few women also had to seek medical help after family violence. Nearly ten percent of women experienced violence while they were pregnant. More women (21 percent) reported forcible sex than husbands (17 percent) with in marriage.

An impact of domestic violence on certain aspects of reproductive health care is observed in the study. Findings revealed that violence is negatively associated with contraceptive morbidity, home delivery and postpartum morbidity. In other words it suggests that when men involve in matters related to women's health, the chances of them to utilize better health services is likely to increase, especially in a gender based society.

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MEN'S PARTICIPATION IN REPRODUCTIVE HEALTH

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 people live in your household?			
5	How many women live in your household?			
6	How many married women live your house? (Included widowed, divorced, and separated)			
S. No	Name of the married women	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		

CENTER FOR ECONOMIC AND SOCIAL STUDIES
Nizamia Observatory Campus, Begumpet, Hyderabad - 500 016,
Andhra Pradesh.

MEN'S PARTICIPATION IN REPRODUCTIVF HEALTH

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		

CENTER FOR ECONOMIC AND SOCIAL STUDIES

Nizamia Observatory Campus, Begumpet, Hyderabad – 500 016,

Andhra Pradesh

Please name all the persons in your household

S.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	Yes No
	A cot.....	.....1.....2
	A pressure cooker.....	.....1.....2
	A clock or watch.....	.....1.....2
	An electric fan.....	.....1.....2
	A radio or transistor.....	.....1.....2
	A television.....	.....1.....2
	A bicycle.....	.....1.....2
	A moped, scooter or motorcycle...	.....1.....2
	A car.....	.....1.....2
	A bullock cart.....	.....1.....2
	A tractor.....	.....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

MEN'S PARTICIPATION IN REPRODUCTIVE HEALTH

WOMEN'S SCHEDULE

(Confidential for research purpose 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 **Centre for Economic and Social Studies**. We are conducting a survey on Men's Participation on Reproductive Health. We appreciate your participation in this survey. As per research ethics, your name and identity of your household and all other information will not be revealed to anybody.

We hope that you will participate in the survey since your views are important. Do you want to ask me any thing about the survey?

Respondent agrees for the interview. Respondent does not agree for the interview

---- 1 → **Q101.** ----.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	At what age you attained puberty?	In completed years ☐☐
105	How many years after puberty you were married?	In completed years ☐☐
106	Prior to marriage is your husband a relative?	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 you started living with your husband?	In completed years ☐☐
110	How many years have passed since you are 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 you have had?	Total births ☐☐ None.....00→Q120
115	How many are now surviving?	Total surviving ☐☐ None.....00
116	How many are now not surviving?	Total not surviving ☐☐ None.....00

117	How many years after your marriage you had 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.....97 Year ☐☐☐☐
120	Have you ever had a stillbirth?	Yes.....1 No.....2→Q122
121	How many times you ever had stillbirth?	Number of times ☐☐
122	Have you ever had an abortion?	Yes.....1 No.....2→Q125
123	How many times you ever had abortion?	Number of times ☐☐
124	Last time when you had an abortion, was it spontaneous or induced?	Spontaneous.....1 Induced.....2
125	Are you pregnant now?	Yes.....1 No.....2 DK.....7 Q127
126	How many months pregnant are you now?	Month ☐☐ DK month.....97
127	Have you ever attended school	Yes.....1→Q129 No.....2
128	Can you read and write?	Yes.....1 No.....2 Q130
129	How many years of schooling have you completed?	Years of schooling (completed years) ☐☐
130	Some women work, which helps them to earn some income. Do you do any of such activities?	Yes.....1 No.....2→Q132
131	What type of work do you do?	
132	During past one year did you do any such work?	Yes.....1 No.....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 you work?	Number of days ☐☐☐
136	How much do you earn per day?	In Rs. ☐☐ In kind.....95

SECTION: 2A MEDIA EXPOSURE

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

Sl.No.		Family Planning	Pregnancy Care	Delivery Care	After child birth	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 any 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 new born.............5 Do not recall........6	Need for postpartum care...................1 Vaccination of new born..........2 Health care of new borne..................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

Sl.No.		Family Planning	Pregnancy Care	Delivery Care	After child birth	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 health care 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 heath care 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 (mention each of it) was discussed?	Number of times ☐☐ None.....00	Number of times ☐☐ None.....00	Number of times ☐☐ None.....00	Number of times ☐☐ None.....00	Number of times ☐☐ None.....00	Number of times ☐☐ None.....00

207	When was the last contact made?	Days.....a ☐☐ Months.....b ☐☐ Do not remember.....97
208	With whom was your last contact made?	Govt. allopathic doctor.....11 Govt. ISM practitioner.....12 MPHA.....13 Male health worker.....14 Pvt. allopathic doctor.....15 Pvt. ISM practitioner.....16 Voluntary organization worker.....17 Industry/ESI clinic worker.....18 Anganwadi worker.....19 Village health guide.....20 Dai (TBA).....21 Medical shop.....22 General merchant/kirana shop.....23 Teachers/informal and formal leaders.....24 Others*(Speciy)*_____96
209	Where you satisfied with the information/services this person provided?	Yes.....1 No.....2→Q211
210	Reasons for satisfaction? ***Circle all responses mentioned***	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 Service site open.....m Others*(Speciy)*_____x →Q212
211	Reasons for dissatisfaction? ***Circle all responses mentioned***	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 Staff not available.....j Service site not open.....k Others*(Speciy)*_____x

SECTION: 2B INFORMATION ON ACCESS

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

S.No.		Oral contraceptives/ condoms/IUD	Medical termination of pregnancy (abortion)	Sterilization	Pregnancy care	Delivery care	Postpartum care	Women's other health problems	STDs	AIDs
		I	ii	iii	iv	v	vi	vii	viii	ix
212	Tell me all the places you know that provide (service)?									
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
PHC/Additional PHC..........................12
Sub-centre.......................................13
Pvt.hospital.....................................14
Voluntary agencies............................15
Industrial units/ESI clinics/hospitals......16
Allopathic doctors (p)........................17
ISM practitioners (p)..........................18
MPHAs...19
Anganwadi workers............................20
TBAs(Dais)......................................21
Medical shops...................................22
Pan shops..23
Depot holders...................................24
General/Kirana merchant shops 25
Camps..26
Others ________________ 96
(Specify)
DK...97
NA...98

S.No.		Oral contraceptives/ condoms/IUD	Medical termination of pregnancy (abortion)	Sterilization	Pregnancy care	Delivery care	Postpartum care	Women's other health problems	STDs	AIDs
		i	ii	iii	iv	v	vi	vii	viii	xi
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?	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this 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 discussed on number of children you should have?	Yes.....1 No.....2
302	Did you and your husband ever discussed on usage of a family planning method?	Yes.....1 No.....2
303	Did you and your husband discuss on the following aspects at any time?	Yes / No Postpone 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 sterilization.....11 Female sterilization.....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 sterilization?	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 sterilization?	Yes.....1 No.....2 DK.....7→Q309

308	Which health facility did you (your husband) visit?	Medical college hospital.....11 Govt.hospital.....12 PHC.....13 Sub-centre.....14 Pvt.hospital/clinic.....15 Voluntary agency/industry/ ESI hospital/clinic.....16 Govt.ISM hospital/clinic.....17 Pvt.ISM hospital/clinic.....18 Others_____96 *(Speciy)*
309	Has any one from health department visited you (your husband) after sterilization 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 Govt. hospital.....12 PHC/Sub-centre.....13 Govt.ISM hospital/clinic.....14 Pvt.hospital/clinic.....15 Pvt.ISM hospital/clinic.....16 Voluntary agency/industry/ ESI hospital/clinic.....17 MPHA.....18 Dai (TBA).....19 Medical shop.....20 kirana shop/Pan shop.....21 Others_____96 *(Speciy)*
312	At your last visit, did you receive any counseling 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 you have been using this 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 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 Govt.hospital.....12 PHC.....13 Sub-centre.....14 Pvt.hospital/clinic.....15 Voluntary agency/industry/ ESI hospital/clinic.....16 Govt.ISM hospital/clinic.....17 Pvt.ISM hospital/clinic.....18 Others_____96 *(Speciy)*
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 a 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 Cost too much.....27 Inconvenient to use.....28 Afraid of sterilization.....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 sterilization.....11 Female sterilization.....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 periods begins.....13 About two week after her periods 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 now 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 health 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 *Depavali* 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 *Depavali* 2003.

RECORD TWINS AND TRIPLETS ON SEPARATE LINES

Think back to your (last/previous) pregnancy before *Depavali* 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 pregnancy?	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				
	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 Yr", **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 some thing 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 Induce.....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 *DEPAVALI* 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 husband from sex.....13 Husband wanted a child.....14 In-laws wanted a child.....15 Others_____96 *(Specify)*
418	During this pregnancy, did you see? Any one for antenatal care? **If YES,** whom did you see? Any one 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's 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, have 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 have 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? ***Circle all responses mentioned***	Always felt well/Not necessary...a Don't know where to go /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/nurses not good....i Service not good/no medicine....j Family did not allow....k No one to care children....l Others _____ x ***(Specify)***

428	Did you have any of these illness or problems during last/current pregnancy?	Yes No
	Swelling of hands & 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 fetus	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?	Talk affectionately....a Express concern towards health...b Take you to an antenatal checkup.c Arrange with someone to go to antenatal checkup....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
	Circle all responses mentioned	
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-center.....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-center.....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?	Yes No
	Labour more than 18 hours.....	.....1.....2
	Use of forceps.....	.....1.....2
	Excessive bleeding (More than 3 sarees stained)	.....1.....2
	Sac burst and even after 5 hours child was not born.....	.....1.....2
	Sac burst and the fluid was greenish colored...	.....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
	High BP.....	.....1.....2
	Caesarean.....	.....1.....2
	Others_____ *(Specify)*	.....1.....2
437	In which way your husband extended help at the time of childbirth?	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
	Circle all responses mentioned	
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 done during first six weeks after childbirth?	Yes.....1 No.....2→Q442
440	With in 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: Pus formation in tare..... Fever >3 days..... Loss of consciousness for >15 minutes..... Pain in lower abdomen..... Painful, burning feeling when urinating..... Changes in mental make-up..... Fits/convulsions..... Discharge that smells..... Breast abscess..... Excess bleeding..... Depression..... Backache..... 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
443	In general, what type of care a woman is 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 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 with in six weeks after the childbirth? Carrying older children..... Rinsing clothes..... Bring water from distance..... Lifting heavy items.....	Yes No .....1.....2 .....1.....2 .....1.....2 .....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)*	.....1.....2
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.....1 No.....2
454	Did you seek health care after the (last) abortion?	Yes.....1 No.....2→Q456

455	Where did you go for the health care?	PHC.....11 Govt.hospital.....12 Pvt.hospital.....13 Pvt.clinic.....14 Dai.....15 RMP.....16 Traditional healers.....17 Others _____96 *(Specify)* →Q 457
456	Why did you not seek health care after the (last) abortion? *Circle all responses mentioned*	Did not want others to know....a Husband did not allow.....b Family did not allow.....c Service not good/no medicine...d Attitude of doctors/nurses not good.....e Don't know where to go.....f Not necessary.....g Too far away.....h No transportation.....i Cost too much.....j No time to go.....k Not open when I could go.....l No one to care children.....m Others _____x *(Specify)*
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 No .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....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 No .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....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.....	.....1.....2
	Piles.....	.....1.....2
	Any other_____	.....1.....2
	*(Specify)*_____	→Q467
460	At any time did you become pregnant prior to *Depavali* 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 & 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 fetus.....	.....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 on intake of medicines	1	2
	Manage older children	1	2
	Assist in household work	1	2
	Any other _____ *(Specify)*	1	2
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 sarees stained)	1	2
	Sac burst and even after 5 hours child was not born	1	2
	Sac burst and the fluid was greenish colored	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? Pus formation in tare..... Fever >3 days..... Loss of consciousness for >15 minutes Pain in lower abdomen..... Painful, burning feeling when urinating.... Changes in mental make-up..... Fits/convulsions..... Discharge that smells..... Breast abscess..... Excess bleeding..... Depression..... Backache..... 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
466	In your opinion should a husband support his wife after the childbirth in following ways? Arrange/take you for a health checkup..... Managing older children..... Not lifting you to strain physically..... Providing physical help..... Extending emotional support..... Any other _____ *(Specify)*	Yes No .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....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 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 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 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)***
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 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 vaginal discharge .....e 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→Q514
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 have the problem could you discuss about it to any one? ***Record all persons mentioned***	Husband.....a Mother/Mother-in-law.....b Elder female relatives.....c Neighbours.....d Others _____x *(Specify)*
517	In your opinion when a wife suffers from such problems, is it necessary for her to discuss about 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? ***Record all persons seen***	Allopathic doctor.....a ANM/LHV/midwife.....b Any other health personal.....c Dai.....d Other_____x *(Specify)*
520	Are you having menstruation regularly?	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 of 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 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.....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 getting pregnant.	Strongly agree.....1 Agree.....2 Disagree.....3 Strongly disagree.....4
609	If I could not get contraception, I could still keep myself from getting pregnant by refraining from sexual activity.	Strongly agree.....1 Agree.....2 Disagree.....3 Strongly disagree.....4
610	I am capable of using contraceptive method every time I need.	Strongly agree.....1 Agree.....2 Disagree.....3 Strongly disagree.....4

611	Negotiating with my husband about the use of a method of family planning would be impossible for me.	Strongly agree.....1 Agree.....2 Disagree.....3 Strongly disagree.....4
612	I am capable of persuading my husband not to have extra-marital sexual contacts.	Strongly agree.....1 Agree.....2 Disagree.....3 Strongly disagree.....4
613	I am capable of seeking treatment if I have 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 STERILIZED...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 → Q712 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 _____ *(Specify)*	.....1 / 2
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.....1 No.....2 Do not remember.....7
712	Did your husband ever have sex with you even if you were not willing?	Yes.....1 No.....2 Do not remember.....7 Q715
713	Did your husband ever physically forced you to have sex with you?	Yes.....1 No.....2 Do not remember.....7 Q715
714	How long ago was the last time this happened?	Month .....a ☐☐ Year... .....b ☐☐ Less than one month.....00

ATTITUDES TOWARDS PHYSICAL CONTROL OF WIFE

715	Wife should always show respect to elders particularly her in-laws in the family.	Strongly agree.....1 Agree.....2 Disagree.....3 Strongly disagree.....4 DK.....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.....1 Agree.....2 Disagree.....3 Strongly disagree.....4 DK.....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.....1 Agree.....2 Disagree.....3 Strongly disagree.....4 DK.....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 No .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....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.....1 Agree.....2 Disagree.....3 Strongly disagree.....4 DK.....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, the following measures should be taken. Verbal insults..... Physical isolation..... Physical beating..... Persuasion..... Other _____ *(Specify)* DK/can't say.....	Yes No .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....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 one's sexual behaviour is necessary for understanding their reproductive health. All that you tell me will be kept strictly confidential and combined with the information gathered from other women for use in health 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 you had 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 you had sex with your husband in the last four weeks?	Number of times ☐☐ None.....00
814	Usually how many times per day 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 No.....2 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? ***Record all persons seen***	Allopathic doctor.....a ISM doctor.....b Medical shop.....c Friends.....d Self treatment.....e Other _____x *(Specify)*
820	Did he ever discuss about 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)***. A person contacts gonorrhea only once, after that he or she becomes immune to the disease..... Syphilis can be treated with penicillin and other antibiotics..... Venereal diseases can be passed from a mother to her baby before or during birth.... Some people who have venereal diseases show no symptoms at all..... It is harmful for a man to have sex with another man.....	Yes No DK 1.....2.....7 1.....2.....7 1.....2.....7 1.....2.....7 1.....2.....7

THANK THE RESPONDENT FOR THE COOPERATION EXTENDED

MEN'S PARTICIPATION IN REPRODUCTIVE HEALTH

MEN'S SCHEDULE

(Confidential for research purpose 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 **Centre for Economic and Social Studies**. We are conducting a survey on Men's Participation on Reproductive Health. We appreciate your participation in this survey. As per research ethics, your name and identity of your household and all other information will not be revealed to anybody.

We hope that you will participate in the survey since your views are important. Do you want to ask me any thing about the survey?

Respondent agrees for the interview. ---- 1 → **Q101.**

Respondent does not agree for 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 she ever had stillbirth?	Number of times ☐☐
116	Did your wife ever have an abortion?	Yes.....1 No.....2→Q119

117	How many times she ever had abortion?	Number of times ☐☐ DK..... 97
118	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 pregnant is she?	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 some questions about media exposure you had for different reproductive health aspects

Sl.No.		Family Planning	Pregnancy Care	Delivery Care	After child birth	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 any 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 new born.............5 Do not recall........6	Need for postpartum care...................1 Vaccination of new born..........2 Health care of new borne..................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

Sl.No.		Family Planning	Pregnancy Care	Delivery Care	After child birth	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 health care 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 heath care 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 (mention each of it) was discussed?	Number of times ☐☐ None.....00	Number of times ☐☐ None.....00	Number of times ☐☐ None.....00	Number of times ☐☐ None.....00	Number of times ☐☐ None.....00	Number of times ☐☐ None.....00

207	When was the last contact made?	Days.....a ☐☐ Months.....b ☐☐ Do not remember.....97
208	With whom was your last contact made?	Govt. allopathic doctor.....11 Govt. ISM practitioner.....12 MPHA.....13 Male health worker.....14 Pvt. allopathic doctor.....15 Pvt. ISM practitioner.....16 Voluntary organization worker.....17 Industry/ESI clinic worker.....18 Anganwadi worker.....19 Village health guide.....20 Dai (TBA).....21 Medical shop.....22 General merchant/kirana shop.....23 Teachers/informal and formal leaders.....24 Others *(Speciy)*_____96
209	Where you satisfied with the information/services this person provided?	Yes.....1 No.....2→Q211
210	Reasons for satisfaction? ***Circle all responses mentioned***	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 Service site open.....m Others *(Specify)*_____x →Q212
211	Reasons for dissatisfaction? ***Circle all responses mentioned***	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 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 reproductive aspects

S.No.		Oral contraceptives/ condoms/IUD	Medical termination of pregnancy (abortion)	Sterilization	Pregnancy care	Delivery care	Postpartum care	Women's other health problems	STDs	AIDs
		i	ii	Iii	iv	v	vi	vii	viii	ix
212	Tell me all the places you know that provide (service)?									
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
PHC/Additional PHC........................12
Sub-centre...................................13
Pvt.hospital..................................14
Voluntary agencies.........................15
Industrial units/ESI clinics/hospitals......16
Allopathic doctors (p).......................17
ISM practitioners (p).......................18
MPHAs...19
Anganwadi workers..........................20
TBAs(Dais)...................................21
Medical shops...............................22
Pan shops....................................23
Depot holders...............................24
General/Kirana merchant shops 25
Camps..26
Others ________________ 96
(Specify)
DK..97
NA..98

S.No.		Oral contraceptives/ condoms/IUD	Medical termination of pregnancy (abortion)	Sterilization	Pregnancy care	Delivery care	Postpartum care	Women's other health problems	STDs	AIDs
		i	ii	iii	iv	v	vi	vii	viii	xi
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?	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this village	Kms. [ ][ ][ ] Code 998 if in this 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 wife ever discussed on number of children you should have?	Yes.....1 No.....2
302	Did you and your wife discussed on usage of a family planning method prior to first pregnancy?	Yes.....1 No.....2
303	Did you and your wife discuss on the following aspects at any time?	Yes / No Postpone 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 sterilization.....11 Female sterilization.....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 sterilization?	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 sterilization?	Yes.....1 No.....2 DK.....7 →Q309

308	Which health facility did you (your wife) visit?	Medical college hospital.....11 Govt.hospital.....12 PHC.....13 Sub-centre.....14 Pvt.hospital/clinic.....15 Voluntary agency/industry/ ESI hospital/clinic.....16 Govt.ISM hospital/clinic.....17 Pvt.ISM hospital/clinic.....18 Others_____96 *(Specify)*
309	Has any one from health department visited you (your wife) after sterilization 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 Govt. hospital.....12 PHC/Sub-centre.....13 Govt.ISM hospital/clinic.....14 Pvt.hospital/clinic.....15 Pvt.ISM hospital/clinic.....16 Voluntary agency/industry/ ESI hospital/clinic.....17 MPHA.....18 Dai (TBA).....19 Medical shop.....20 kirana shop/Pan shop.....21 Others_____96 *(Specify)*
312	At your last visit, did you receive any counseling 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 you have been using this 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.....11 Wife.....12 Both.....13 Parents.....14 Parents-in-law.....15 Other relatives.....16 Others_____96 *(Specify)*
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 not you opt for sterilization? instead of your wife?	
320	In general between the couple who do you think should go for sterilization? **WHY?**	→Q324
321	Did you any time use a family planning method?	Yes.....1 No.....2→Q323
322	Why are you not using it now?	→Q324
323	Why you never wanted to use a family planning method?	
324	Did your wife any time experience any health problems because of use of the family planning method?	Yes.....1 No.....2→Q328
325	Did she seek treatment for it?	Yes.....1 No.....2→Q328

326	Where did she seek treatment for it?	Medical college hospital.....11 Govt.hospital.....12 PHC.....13 Sub-centre.....14 Pvt.hospital/clinic.....15 Voluntary agency/industry/ ESI hospital/clinic.....16 Govt.ISM hospital/clinic.....17 Pvt.ISM hospital/clinic.....18 Others_____96 *(Speciy)*
327	Who assisted her to go for a treatment?	Self.....11 Both.....12 Parents.....13 Parents-in-law.....14 Other relatives.....15 Others _____96 *(Specify)*
328	**CHECK: Q305 if coded '12' skip to Q336 if coded '13' or '14' skip to Q334**	
329	What is a 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 Menopausal/ 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 Cost too much.....27 Inconvenient to use.....28 Afraid of sterilization.....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 sterilization.....11 Female sterilization.....12 IUD.....13 Oral pills.....14 Condoms.....15 Any other _____96 *(Specify)* Not sure/undecided.....97
333	When do you (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 periods begins.....13 About two week after her periods begins.....14 All times are the same, it makes no difference.....15 Other _____96 *(specify)* DK.....97

SECTION: 4 OBSTETRIC HEALTH

I would like to ask you now 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 health report without any personal identification. If the meaning of any question is unclear, please ask me.

401	Has your wife ever been pregnant since *Depavali* 2001?	Yes.....1 No.....2→Q433
402	How many times did she become pregnant since *Depavali* 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 have a baby 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 a child, how did this happen?	Accidental.....11 Did not know how to prevent.....12 Wife wanted a child.....13 Parents wanted a child.....14 Others_____96 *(Specify)*
407	During this pregnancy did your wife see any one for antenatal care? **If YES,** whom did she see? Any one else? ***Record all persons seen***	Allopathic doctor.....a MPHA(F).....b Any other health personal.....c Dai .....d Other _____x *(Specify)* No one.....f DK.....x
408	Is it essential for a wife to go for antenatal checkup? **If Yes,** Why do you think so? ***Circle all the responses mentioned***	Maintain good health.....a To have healthy baby.....b To avoided complications.....c Others_____x *(Specify)* Not necessary.....d
409	Did you go anytime with your wife for antenatal checkup?	Yes.....1→Q411 No.....2
410	Why you never went with her?	

411	Did your wife have any health complications during this pregnancy? **If YES,** specify **PROBE** ***Circle all the responses mentioned***	Swelling of hands & feet.....a Blurred vision.....b Giddiness.....c Fits.....d 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 fetus.....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 checkup.....c Arrange with someone to go to antenatal checkup.....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-center.....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? **If YES,** specify **PROBE** ***Circle all the responses mentioned***	Labour more than 18 hours.....a Use of forceps.....b Excessive bleeding (More than 3 sarees stained).....c Sac burst and even after 5 hours child was not born.....d Sac burst and the fluid was greenish colored.....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 done during 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 a woman is 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 sex.....e Feeding practices.....f Regular health checkup.....g Any other _____x *(Specify)*
421	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 checkup.....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 an abortion? **PROBE** ***Circle all the 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.....13 Parents-in-law.....14 Doctor/Nurse.....15 Informal health care providers.....16 Others_____96 *(Specify)*
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 health care after the abortion?	Yes.....1 No.....2→Q429
428	Where did she go for the health care?	PHC.....11 Govt.hospital.....12 Pvt.hospital.....13 Pvt.clinic.....14 Dai.....15 RMP.....16 Traditional healers.....17 Others _____96 *(Specify)* →Q430
429	Why did not she seek health care after the abortion? ***Circle all responses mentioned***	Did not want others to know.....a Family did not allow.....b Service not good/no medicine.....c Attitude of doctors/nurses not 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? ***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
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 checkup.....a Managing older children.....b Not allowing her to strain physically.....c Providing physical help.....d Extending emotional suppor....e Any other _____x *(Specify)*
432	After delivery/abortion did she experience any of these problems?	Yes No DK
	Feeling of heaviness in the abdomen or feeling of uterus coming down.....	.....1.....2.....7
	Experienced problem of passing of urine such as passing urine all the time or when coughing, sneezing.....	.....1.....2.....7
	Passing stools through the vaginal.....	.....1.....2.....7
	Piles..... Any other_____ *(Specify)*_____	.....1.....2.....7 →Q440
433	At any time did your wife become pregnant prior to *Depavali* 2001?	Yes.....1 No.....2→Q437

434	At any time during her previous pregnancies did she face any of the health problems? **If YES,** specify **PROBE** ***Circle all the responses mentioned***	Swelling of hands & feet.....a Blurred vision.....b Giddiness.....c Fits.....d 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 fetus.....o Bleeding.....p Others _____x *(Specify)* None.....q DK.....r
435	At any time during her previous deliveries, did she experience any of the 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 sarees stained).....c Sac burst and even after 5 hours child was not born.....d Sac burst and the fluid was greenish colored.....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 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 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
437	In your opinion when a wife is pregnant should a husband extend care/cooperation? **If YES,** which way? ***Circle all 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 checkup.....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)* 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 the childbirth? **If YES,** which way? ***Circle all responses mentioned***	Arrange/take her for a health checkup.....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 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 first child can a woman go for an abortion?	Yes.....1 No.....2
445	To 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 un willing 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 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 on 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 on your family's health needs. By health expenses, I mean payments for fees of 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 health care in the past one-year?	Total expenditure on health care 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 member 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 health care 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***	Amout Rs. ☐☐☐☐☐☐
509	**CHCEK: 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
Hospitalization 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 health care 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 health care of your wife during the last pregnancy?	Yes.....1 No.....2→Q518
516	Did you provide money or goods/services in 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.....1 No.....2 DK.....7
518	Has your wife needed any other health or medical care this past year for a gynecological or obstetric condition?	Yes.....1 No.....2 DK.....7 Q601▼
519	Has she been able to receive it?	Yes.....1 No.....2 DK.....7
520	Do you think you should provide money or goods/services in any kind for medical and health care of your wife for gynecological or obstetric problems?	Yes.....1 No.....2

611	My wife would have difficult time negotiating with me about the use of a 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 gynecological 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 STERILIZED.....skip to Q701**	
615	**CHECK: Q334 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: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 capable of using contraceptive method every time she needs to.	Strongly agree.....1 Agree.....2 Disagree.....3 Strongly disagree.....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 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?	Yes No
	Shouting/yelling.....	.....1.....2
	Slapping/pushing.....	.....1.....2
	Punching/kicking.....	.....1.....2
	Use of stick/weapon.....	.....1.....2
	Other *(Specify)*_____	.....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.....1 No.....2 DK.....7

712	Have you ever had sex with your wife even if she was not willing?	Yes.....1 No.....2 DK.....7 Q715
713	Have you ever physically forced your wife to have sex with you?	Yes.....1 No.....2 DK.....7 Q715
714	How long ago was the last time this happened?	Month .....a ☐☐ Year... .....b ☐☐ Less than one month.....00

ATTITUDES TOWARDS PHYSICAL CONTROL OF WIFE

715	Wife should always show respect to elders particularly her in-laws in the family?	Strongly agree.....1 Agree.....2 Disagree.....3 Strongly disagree.....4 DK.....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.....1 Agree.....2 Disagree.....3 Strongly disagree.....4 DK.....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.....1 Agree.....2 Disagree.....3 Strongly disagree.....4 DK.....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 No .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....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.....1 Agree.....2 Disagree.....3 Strongly disagree.....4 DK.....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. Verbal insults..... Physical isolation..... Physical beating..... Persuasion..... Other _____ *(Specify)* DK/can't say.....	Yes No .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....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 women before marriage?	Yes.....1 No.....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.....1 No.....2
804	Have you ever used condoms at the time of sexual intercourse with this woman/these woman?	Always.....1 Sometimes.....2 Never.....3
805	Before marriage have you ever had:	Yes / No
	Any discharge from your penis?.....	.....1 / 2
	Any sore on your genital or anal area?.....	.....1 / 2
	Positive syphilis blood test?.....	.....1 / 2
	Difficulty urinating?.....	.....1 / 2
	Pain with urination?.....	.....1 / 2
	Very frequent urination?.....	.....1 / 2
	Swelling of your testes or in your groin area (penis)?...	.....1 / 2
806	**CHECK: Q805 If 'YES' to any one ask Q807 to Q814 Q812**	**If 'NO' to all skip to**
807	How many months before your marriage did this happen?	Months ☐☐
808	Have you consult any one for treatment?	Yes.....1 Self treatment.....2→Q810 No.....3→Q811
809	Who did you consult for treatment? *Record all persons seen*	Allopathic doctor.....a ISM doctor.....b Medical shop.....c Friends.....d Self treatment.....e Other _____x *(Specify)*
810	At the time of your marriage, were you completely cured of this problem?	Yes.....1 No.....2
811	Have you ever discussed this problem with your wife?	Yes.....1 No.....2
812	After marriage, the first time you had intercourse with your wife, did you or your wife use a family planning method?	Yes.....1 No.....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 had 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 you had sex with your wife in the last four weeks?	Number of times ☐☐ None.....00
821	Usually how many times per day 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 women 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 No .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....2 .....1.....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 any one for treatment?	Yes.....1 Self treatment.....2 No.....3 → Q830
829	Whom did you consult for treatment? ***Record all persons seen***	Allopathic doctor.....a ISM doctor.....b Medical shop.....c Friends.....d Self treatment.....e Other_____x ***(specify)***
830	Have you ever discussed about this with your wife?	Yes.....1 No.....2
831	Since you had problems, did you stop having sex with your wife?	Stopped.....1 Less frequent.....2 No change.....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.....1 Less frequent.....2 No change.....3
833	Did you start using condoms?	Wife Other women Yes.....1.....2 No.....1.....2 Stopped sex...1.....2
834	Did you make any other changes in your habits ***(Specify)***? _____	Yes.....1 No.....2

835	Are you currently having	Yes No
	Any discharge from your penis?.....	.....1.....2
	Any sore on your genital or anal area?.....	.....1.....2
	Positive syphilis blood test?.....	.....1.....2
	Difficulty urinating?.....	.....1.....2
	Pain with urination?.....	.....1.....2
	Very frequent urination?.....	.....1.....2
	Swelling of your testes or in your groin area (penis)?....	.....1.....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 any one for treatment?	Yes.....1 Self treatment.....2 No.....3 → Q838
838	Whom did you consult for treatment? ***Record all persons seen***	Allopathic doctor.....a ISM doctor.....b Medical shop.....c Friends.....d Self treatment.....e Other_____x *(Specify)*
839	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 gonorrhea only one, after that he or has 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

Number of Sub-Centres and Villages Covered under the Round The Clock Women Health Centre – Total Universe and the sampled Villages

S.No.	Name of Sub-centres	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*** **Yelligalguda*** (Hamlet of Pothaipally)
5	Jaganguda	Jaganguda Sampanbole Laligadimalkpet
6	Lakshmapur	Lakshmapur Modichintalapally Narayanapur Potharam Lingapur
7	Aliyabad	Aliyabad Majidpur **Turukapally*** **Turukapally Thanda*** (Hamlet of Turkapally)
8	Uddamarri	Uddamarri Usharpally Adraspalli
9	Kesavapur	Kesavapur Ponnal Bommaraspet

* Sampled Villages