MALE'S INVOLVEMENT IN FAMILY PLANNING IN RURAL DARRANG DISTRICT OF ASSAM.

U G C

MINOR RESEARCH PROJECT

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Submitted by

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Executive summary

Reproductive health of women covers an array of issues: pregnancy, pre-natal care, post-natal care, reproductive tract-related health, obstetric health, family planning such as contraceptive usage, contraceptive morbidities, spacing between two births, limiting the size of the family etc. Thus family planning, as one of the major issues of reproductive health of women is directly or indirectly related with other issues of women's reproductive health. In the context of new perspective, men have been looked upon as potential partners in reproductive health. The present study, thus, made an attempt to focus on how men's participation enhances women's accessibility to family planning methods for improving their contraceptive and reproductive health. Men's participation in the present study is examined in terms of spousal communication and decision making on family planning, contraceptive usage and awareness about the contraceptive morbidity and extending support to such morbidity care.

The study carried out in the rural areas of Darrang district of Assam. A stratified random sampling technique has been applied. A sample of 567 men with their wives (within the age group of 14-49 years) having at least one living child were selected. The study shows that 37 percent

of the couples were exposed to the massage related to family planning and reproductive health while one fourth of the couples reported neither of them was exposed to any such massage. Prescribed gender role restricted women's access to contraceptive. Compared to women men were more exposed to information related to family planning. However, educated couples were observed to have come out of all the barriers of gender norms in acquiring knowledge.

The participation of men in women's reproductive health was also examined by taking into account of their perception about the control over pregnancy. Men's perception about control over pregnancy was again compared with that of the women to analyze the influence of prevailing gender role in this regard. Many women reported that they assumed, they did not have any control over their body whereas men thought that they had control over their wives' bodies. Women were not efficient enough to obtain the temporary methods to avoid multiple pregnancies. Bu they were confident of using permanent methods and most of them wanted to opt for permanent method for avoiding multiple pregnancies. But men did not perceive the matters in the same manner.

More than half of the couples reported that they had discussion related to the planning of their families. Generally men initiated the discussion. Women hesitated to initiate the discussion because they were cautious of being called as promiscuous.

A little more than one fourth of the couples opted for Tubectomy. More men reported the usage of condom and traditional methods like withdrawal and periodic abstinence while, more women (one fifth of sterilized women) reported suffering from contraceptive morbidity like post operation (female sterilization) illness. It is the gender role within the family in general, economic hardship in particular restricted women to take adequate rest and care after the operation. Majority of them did not consult for or seek for medical treatment for post operation morbidities.

Lower age at marriage has been considered as one of the major causes of poor reproductive health of women. Early marriage and early pregnancy resulted in higher proportion of abortions in some rural areas of Darrang district. Illiteracy along with social beliefs at community level and prevailing gender role had shaped the women to believe that they were meant to give birth to children after marriage. Men also believed that women were meant to get pregnant. This had restricted women to get adequate health care during and post pregnancy period. Mere promoting the use of contraception amongst those couples through programme incentives could only help in approaching near to the target but not in raising the awareness and knowledge of family planning.

Chapter-1

Introduction

1.1 A Historical Perspective

Male involvement in women's reproductive health and family planning has been felt to be the most urgent in the reproductive policy formulation and programme implementation after the International Conference on Population and development, held in Cairo, 1994. Prior to the Cairo Conference, 1994, family planning policies remained women centric and hence excluded male's involvement. As a result, most of the demographic studies on family planning and reproductive health forwarded a partial analysis of contraceptive use and the issue like male's involvement in the policy formulation and programme implementation remained out of focus. Consequently, a setback in the process of achieving the policy objective and targets has been observed.

The 1994 Cairo Conference reminded the world that the reproductive health issue of women includes a number of issues relating to pregnancy

along with family planning which ultimately refers to the right of all people, men, women alike and also the responsibilities that they share for reproductive matter. Hence, realizing the gender-prescribed role of men and women play in society, the Conference focused on the urgency of inclusion of men in the policy and programme for exercising their responsibility for reproductive matters. It is also felt that a consensus is to be built amongst couples that for a good reproductive health a good congenial atmosphere for the discussion of sexual matters and making reproductive decisions together are important. To be more specific, men's involvement and participation in women's reproductive health was considered to be the pre requisite condition for promoting gender equality, fulfilling various reproductive responsibilities and henceforth good reproductive health. Thus, after the Conference at Cairo, 1994, world has observed a conceptual shift in policy and programme of reproductive matters.

The approaches of different programmes and policies to involve males into reproductive health during the post 1994, Cairo International Conference can be traced as follows (**Table- 1.1**).

Table-1.1.

Approaches to Involve Men in Sexual and Reproductive Health and Programme Implication

Approach	Purpose and Assumption	Programmatic Implication
….Prior to 1994 Cairo International Conference on Population and Development……		
Traditional Family Planning for Women	Increase contraceptive use and reduce fertility	Contraceptive delivery to women, in the context of maternity and child health, men absent
……Post 1994 Cairo International Conference on Population and Development……		
Men as clients	Address men's reproductive health needs	Extension of same range of reproductive health services to men as to women. Employment of male health workers.
Men as partner	Men have the central role to play in supporting women's reproductive health.	Training men (husbands) how to support women in various issues of reproductive health i.e., pre and post delivery issues, and also benefits of family planning for women's health.
Men, the agents of positive change	Full participation and cooperation of men - reduces gender inequality and improves men's and women's health	Paradigm shift took place in policy and programme formulation.Programmes are structured and services are delivered. Progrmmes activities covered a wider range

Adapted from "Male involvement in Family Planning and Reproductive health in Rural Central India" Arubdhti Char, 2011.

1.2 Evolution of Family Planning Policy in India

During the last three decades, in India family planning and the contraceptive use pattern have undergone a major change. In early 60's and late 70's males were the main acceptors of family planning (vasectomy and condom) and their proportion was more than 50 per cent to the total family planning acceptors. However, during the emergency period under the Congress rule at the centre, the programme through camp based male sterilization (vasectomy) to fulfill the demographic target, received a major setback. It raised several issues of human right violation. Later, the programme approach was made target free by including the development and welfare issues in the policy frame work. But with the introduction of new technology like mini-lap and laparoscopic sterilization the programme, gradually shifted towards women.

Following the ICPD Programme Action, 1994, India has also made a shift in the National Population Policy documents. Several new policies were formulated and several were revised to include this big shift. As a result, the reproductive health agenda is based on a broader spectrum. Some of the specific policies implied male's involvement in sexual and reproductive health programmes are briefly explained below (**Table-1.2 A& 1.2B**).

Table-1.2A

A shift in Conceptualization of NPP in India: from Population to Development

1946	Bhore committee Report: concept of primary health centre to provide comprehensive health services in the rural area.
1952	Family Planning Programme was launched and primary health care centers were established in rural areas.
1976	Formulation of the statements of National Population Policy.
1977	Policy statement on Family Welfare Programme
1983	Formation of a separate National Population Policy was emphasized. Need for adopting small family norm through voluntary efforts and moving towards the goal of population stabilization was emphasized.
1991	The National Development Council (NDC) appointed a Committee on Population that proposed the formulation of a National Policy to take a long term holistic view of development, population growth and environmental protection and to suggest policies and guidelines for formulation of programmes and monitoring mechanism with short, medium and long term perspective goals'.
1993	A draft of a National Population Policy was prepared for discussion in the Cabinet and then in the Parliament.
1994	Report on the draft of National Population Policy by the expert group.
2000	The National Population Policy was finalized

Source: National Population Policy, 2000

Table-1.2A shows the long journey of National Population Policy in India from family planning to family welfare and then to development.

Table-1.2B

Policy Guidelines of India's Sexual and Reproductive Health Programme

National Population Policy 2000	• Care taken for implementation of the policy programme • Seek to address the unmet need for contraception and health System • Seek to provide integrated service delivery for basic reproductive and child care • Seek to address gender issues impinging on women's health • Seek to provide quality health care through interaction between providers and client. • Seek to organize gender sensitization training for stakeholders • Encouraged male's involvement in reproductive health • Seek to facilitate women's and men's involvement in monitoring • reproductive and child health through client feedback (National Population Policy 2000)
National Youth Policy (2003)	• Multi sectoral approach to youth, emphasis given on education (including education on population and family life), health (accessibility to health services) etc.
National AIDS Control Programme and Policy (NACP-III) 2006	• The policy emphasizes the importance of inter-sectoral coordination. It recognized that the AIDs/HIV must be seen not only as the public health issue but also as a problem of development.
The tenth five year plan (2002-2005)	• For the first time during the period of 10^{th} five year plan some programmes were directed to involve males in the reproductive health and Planned Parenthood.
The eleventh five year plan (2008-20012	• Encouraged men to take the reproductive responsibilities in contraception. • Imparted knowledge to both men and women to bring about gender • balance and empower women too in reproductive and sexual health.

Source: National Population Policy, 2000

Despite the paradigm shift in the policy and programme formulation, contraceptive practice has remained women centric. Tubectomy has been observed to dominate the scenario of family planning in India (**Table-1.3**). Attempts are being made by the Government to popularize vasectomy but it has failed to regain its popularity.

The state of Assam is found to be no exception to this trend. The proportional use of Tubectomy to total use of contraception is found to be considerably high in the North Eastern states including Assam while, the percentage use of vasectomy is found to be very negligible. **Darrang** district being identified as one of the Minority concentrated districts in Assam (Base Line Survey of Minority concentrated districts, OKDI, Guwahati, Assam) shows higher percentage of Tubectomy acceptors. **District Family Welfare Bureau, 2007-08 shows that more than 99 percent of the total sterilization in Darrang district constitutes female sterilization (Tubectomy). Data at the PHC block level during 2011-12 to 2015-16 show poor percentages of NSV acceptors. Various measures for promoting male sterilization, such as, provisions for incentives to the beneficiaries and motivators (NSV) by the Government are made. But the achievement in this regard has been**

negligible. The block level report also shows that the proportions of NSV acceptors vary by religion.

Hence, it is urgently felt that to promote the men's involvement in family formation it is essential to understand their attitude towards family planning and the extent they feel their responsibility towards women's reproductive health. In other words, attempts should be to make the men responsible and also gender sensitive to meet their reproductive goal. Thus, the present research work makes an attempt to explore the factors which influence the men's attitude and preference for contraception for enhancing male's responsibility in family planning in Darrang district of Assam, so that a better reproductive health for the couples can be expected.

1.3 Background of the Present Study

Darrang district is typical rural in character but close to the metro city, Guwahati. The district is typically characterized with high fertility rates, (Census of India 2011), reliance on female sterilization and this was the primary consideration while selecting the study areas.

According to the 2011 census Darrang district has a population of 908,090 roughly equal to the nation of Fiji or the US state of

Delaware. This gives it a ranking of 463rd in India (out of a total of 640). The district has a population density of 491 inhabitants per square kilometer (1,270 /sq mi). Its population growth rate over the decade 2001-2011 was 19.51 percent. Darrang has a sex ratio of 923 females for every 1000 males, and a literacy rate of 64.55 percent. Majority of the total population (57.74 percent) are Hindus, while Muslims constitutes 35.54 percent, and Christians constitutes 1.75 percent (Census 2011).

Since inception of family planning programme in Darrang district, the record of year wise Family Welfare performance (Office of Chief Medical and Health Office, Darrang, 2007-08), shows a rapid fall in the proportional share of male sterilization to the total sterilization just after the emergency period. Out of 4402 total sterilization 3899 (i.e., 88.6 percent) was the total male sterilization in 1975-76. In 1976-77, out of 11102 total sterilizations 9667 (i.e., 87.1 percent) was male sterilization. Thereafter, the share of male sterilization has been found to decrease while the share of female sterilization has been observed to increase. **Since 1992 the share of male sterilization to total sterilization in the district has dropped to zero level. A steady increase in the use of other methods**

Table-1:3

Year-wise Family Welfare Performance Report in Darrang District since Inception.

Year	Sterilization			Loop /IUD/ Cut(T)			Condom Pcs	O.P cycles	MTP
	Vas	Tub	Total	Loop	Cut(T)	Total	Total pcs	Total cycles	Number
1975-76	3899 (88.6)	583 (11.4)	**4402 (100.0)**	747 (100.0)	-	**747 (100.0)**	12144	-	-
1980-81	109 (16.3)	559 83.7)	**668 (100.0)**	281 (100.0)	-	**281 (100.0)**	47025	175	-
1985-86	152 (2.5)	5914 (97.5)	**6066 (100.0)**	-	852 (100.0)	**852 (100.0)**	85422	2684	-
1990-91	41 (1.1)	3673 (98.9)	**3714 (100.0)**	-	1378 (100.0)	**1378 (100.0)**	202224	7499	-
1991-92	87 (2.5)	3362 (97.4)	**3362 (100.0)**	-	881 (100.0)	**881 (100.0)**	196101	2982	-
1992-93	-	579 (100.0)	**579 (100.0)**	-	1268 (100.0)	**1268 (100.0**	170234	220	-
200506	-	499 (100.0)	**499 (100.0)**	-	1564 (100.0)	**1564 (100.0)**	12782	5124	5229
2006-07	-	190 (100.0)	**190 (100.0)**	-	1062 (100.)	**1062 (100.0)**	29549	14102	5888
2007-08 up to Jan/08	**-**	**1067 (100.0)**	**1067 (100.0)**	**-**	**1070 (100.0)**	**1070 (100.0)**	**33626**	**20605**	**5188**
April 2015-March 2016	**13 (1.09)**	**1179 (98.9)**	**1192 (100.0)**	**NA**	**2726**	**-**	**-**	**-**	**-**

Source: District Family Welfare Bureau, Darrang District, 2008.

(female contraceptives) like Loop/IUD/Cut-t, oral pill and the proportion of women opted for MTP (from 2000-01) have been found to increase (Table-1.3). Increase in Medical Termination of Pregnancy

as reported by the District Family Welfare Bureau 2007-08, may be viewed as an increase in induced abortion stem from poor contraceptive or reproductive health associated with unwanted pregnancy.

Table-1.4

The Usage of Family Planning : Darrang
(Currently married women, age 15-49 years)

	NFHS- 4 (2015-16)	DLHS 3 (2007-08)	NFHS- 3 (2005-06)	DLHS-2 (2002-04)
Currently using any method	65.7	62.0	56.5	66.0
Currently using any modern method	44.4	44.4	27.0	36.4
Female sterilization	2.7	10.4	13.0	17.4
Male sterilization	0.0	0.0	0.2	0.2
IUD	2.1	1.1	1.3	1.8
Pill	36.0	24.1	10.3	11.8
Condom	3.3	1.3	2.4	0.9

Source: Reports, NFHS III and DLHS II

An improvement in the CPR in Darrang district during the survey periods of **NFHS -3 and 4** and **DLHS -2 and 3** is observed (**Table-1.4)**. Though a declining trend in the proportional use of female sterilization to the total use of contraception has been observed, at the same time the proportional

use of reversible female contraceptive (oral contraceptive pill) has been found to increase rapidly.

Table-1.5

Family Planning Performance by Some Selected District, Assam, 2015-16

District	Family planning performance – April to March			
	Male sterilization	Female sterilization	IUCD Insertion	Post partum IUCD
Assam	**4154**	**44171**	**86311**	**25558**
Darrang	31	1179	2726	934
Cachar	133	3168	2425	897
Dibrugahr	197	4588	3471	2529
Kamrup	924	4636	7480	4992

Source: NRHM, 2015-16

Table-1.5 shows that the proportional use of male contraceptive to total use of contraception at the state and district levels is considerably low. The use contraception in terms of IUDC and post partum insertion has increased.

1.4 Objective of the Study:

Keeping in view of the above background, the present research work intends to study the following objectives to understand the knowledge, attitude and belief and practices of male towards reproduction and family planning. More specifically the study is to address the following objectives-

1. To study how men in rural Darrang conceptualize and perceive family planning, paying special attention to male knowledge, perceptions, decision making and reliance on female sterilization.
2. To study intra-family relationships and communication, and their influence on choice of contraceptive method and timing of use.
3. To examine the extent, accessibility of reproductive health information and services, motivation and prevalence of village level health workers' interaction with men concerning reproductive health issues in Darrang district of Assam.

1.5 Review of Literature

1.5.1 Husband - Wife Communication and Contraceptive Health

The chances of implementation of decision reproductive health including choice of contraception are likely to be more when such decisions are taken jointly by the husband and wife. Moreover, men become comparatively cooperative and supportive to their partners to receive proper reproductive care services in time and in planning the size of the family. Thus spousal communication can be the critical step to promote gender equality in family planning and women's reproductive health (Backer S, and Rbinson JC, 1998; Biddlecom AE, Csterline JB, 1997; and Lasse A, Becker S, 1997). Communication enables the husband and wife to understand each other and know each other's attitude towards family planning and the use of contraception. It also enables the husband to take the responsibilities for their sexual and reproductive behavior including contraceptive health and their social and family roles (Bernstein and Hansen, 2006; Helzner, 1996; Helzner, 1966b).

In general, most of the couples in India and most of the south Asian countries, rarely discuss sexual matter and so fertility and family planning. Many studies have shown that spousal communication generally begins

after the birth of the one and two child (Blanc A, Wolff, Gage A. et al, 1996; De Silva WI, 1994; Fort A, 1994). A study in the state of Uttar Pradesh, India showed that women basically agree with the decisions taken by their husbands. Women never oppose the decisions of their husbands. They remain silent in decision making matters. In most of the cases silence concurrence or lack of protest by women is interpreted as having arrived at the joint decision (Kan ME, Patel BC, 1996).

Many studies show that poor communication amongst the couples gives rise to misunderstanding amongst the couples about the reproductive preferences. This gives rise to the problem of unintended pregnancy. It is found that some women become pregnant only because that they believe that their husband want more children. But in many cases it is not true. Surveys in several developing countries show that only a slightly more men than women prefer another child. However, increased communication amongst the partners helps to remove this misunderstanding such unintended pregnancy and large family. Communication also encourages couples to act on a common preference.

A few studies have shown that men rarely discuss with their wives on the issues of reproductive matters and contraception and chances of

disagreement between the spouses on such issues are uncommon (Becker S, 1996; Blank AK, 1996). The second round all-India Survey by the Operations Research Group of Boroda observed that two third of couples never discussed the issues related to reproductive decisions such as the number of children that they should have or family planning. Seventy percent couples in the rural areas and fifty percent in the urban areas never discussed the issues. At national level in fifty percent cases husbands took the decision while, one third of the couples took such decision jointly (Khan ME, Prasad CVS, 1982).

1.5.2 Men's Role in Family Planning and Reproductive Health

In the patriarchal culture predominantly prevalent in many parts of India, husbands enjoy the authority to make legitimate decisions on behalf of wives including reproductive health and use of contraceptive (Baliah et al., 1996; Edmeades et al., 2011; Karra et al., 1997; Sharma, 2002). But in most of the cases poor knowledge and attitude amongst the men towards the family planning and contraception has posed a barrier for women to seek care for reproductive health problems. Many empirical studies on men's attitude towards family planning have shown that men favours family planning and can have a strong influence on the use of

contraception. A study in Kenya suggests that the use of contraception is likely to go up by two to three times more when husbands rather than wives decide to limit the size of family (Padma. R. G, 2005).

Men's support is also often found to boost up the use of contraception in a better way. One most frequent reasons of not initiating or continuing the use of contraception is the oppositions from husbands. However, men who are educated about reproductive health are likely to support their partners' decision and thus help the women receiving the reproductive health care. Thus, men's involvement in family planning can be viewed as a means to attain the goal of good reproductive health. A project in rural Mali worked on the goal by using men in promoting family planning in local community. Feedback given by the women in Mali that male workers had changed their husband's attitudes towards family planning and generated more open communication about it between spouses (Kak L.P and Singer M.B, 1997).

Family planning programmes have been women centric and women have been the prime beneficiaries of the services provided. Men in this regard have been the 'silent partners' (Edwards SR, 1994). Most of the studies have focused on the factor affecting choice of methods on women and acceptance of contraceptives (Cosminsky S,1982 and Sargent C, 1982).

In India, the decade after the ICPD, 1994, resolution a number of studies in the area of male's involvement in family planning have emerged (Balaria et al.1999; Bloom et al. 2000; Chandhick et al. 2003; Chankappa et al. 2010; Das and Ray 2007, Gupta et al 2002; Kanitkar and Kulkarni 2002; Kerra et al 1997, Kan and Patel 1997). Few studies have examined the socio-economic and cultural factors affecting individual decisions to regulate fertility or various dimensions of reproductive decisions makings (Browner C. 1986; Handwerker P, 1992; and Tucker GM, 1986). Consideration of potential of men involving in family planning and contraceptive decision making is a recent concern. Especially after the emergence of HIV/AIDS, this issue gained importance and several studies focused on the prevention of transmission of HIV and the use of condom.(Basu at al.2004; Panda et al. 2000; Battala 2001; Bryan at al. 2001; Dhanu and Neogi 2004; NACO 2006;Reed 2001; Thomas et al. 2004).

1.5.3 Service Provider's Attitudes and Perceptions towards Male's Involvement

Unfortunately, in a society like India where there exists several social restrictive norms, men and women both are observed to be guided with many misconceptions and myths about sex. Perspectives on male's involvement in family planning are often rooted in negative assumptions.

Programme planners and workers view men as the gatekeepers and obstructionists to the regulation of fertility by women. In such a case involvement of men in family planning is assumed to defeat the whole effort to achieve the reproductive goal. But a review of recent studies have shown that family planning when aimed at both the men and women appears to be most successful in promoting communication between spouses rather than when it is aimed at one sex.(Mahmood N, Ringheim K Knowledge, 1997; Ezeh AC, 1993; Jolly KG, 1976). Several studies highlighting on the potential benefit of interaction with male clients revealed the fact that service providers need to be culturally sensitized to gender roles and ensure that involving men would in fact encourage joint responsibility, thus improving men's and women's reproductive health (Ringheim 2002; Gupta et al, 2002). Service providers often observed to have a bias against the male client and (Ringheim, 1999). As a result the male clients are less informed about the male contraceptives and hence feel uncomfortable to opt for vasectomy (Peit et al. 19999). Misconception appears regarding vasectomy that it causes impotence and weaknesses while, in fact it is comparatively less expensive and safer than female sterilization (Peit et al. 1999). An apprehension associated with the male contraceptives especially, vasectomy stem from the operation of camp based vasectomy during emergency period in seventies is the violation of

privacy and confidentiality (AVSC,1997). However, another study (Kim, 2001) showed that the counseling of both couple for family planning by the programme workers results in better communication amongst the couples and this encourages males to take the responsibilities for women ‘s reproductive health (Kim, 2001). Another study in western India shows that young couples are generally eager to acquire knowledge about family planning and reproductive health. But the health workers with their preconceived notion, do not like to discuss such matters. Specialized training for the health worker is required before they can address sexuality and gender equiality (Raju and Leonard, 2000b).

1.5.4 Dependency on Female Sterilization

NFHS-3 report has shown that almost one third of Indian women opt for female sterilization want to stop child bearings. The preference for female sterilization is also found to be highly influenced by the socio-economic and demographic factors. Women from poor rural backgrounds do not have the access to information and hence they do not have the choice (Pradhan and Ram 2009). Several studies have shown that women belonging from higher income group or higher class generally opt for reversible methods or spacing methods while women from lower income

group or lower class rely on female sterilization (Basu 2005, Rele el al. 1989).

Programme that promotes female sterilization ignoring vasectomy is a clear case of gender discrimination and violation of reproductive right (Chankapa 2010; Gupta et al 2002; Jeffrey ana Jeffrey 1994; Pradhan and Ram 2009). Several studies again found that family planning programmes generally become effective and successful only when men participate actively in it. This is possible only when men sincerely concern themselves with the health and wellbeing of their wives and family (Gupta et l. 2002; Jeffrey and Jeffrey et al. 1989; Kan and Patel 1997, Moore 1999, Ram Murthy and Dharma Rao 2003). Some studies however showed that uneducated and rural women found the reversible method cumbersome and hence undesirable. They strongly believe that modern reversible methods like spacing and vasectomy cause high physical and social risks (Hall et al. 2008). Other study also reveal that the decision regarding female sterilization is highly influenced by a number of factors such as preference for son combined with a small family norm (Edmeades al. 2001).

1.5.5 Intra Family Communication on Family Planning and Contraception.

Studies have revealed that healthy inter spousal interaction is the key factor to fostering shared decision making and responsibilities of family planning and reproductive health matters (Salway 1994; Santhya and Dasvarma 2002). Worldwide Demographic and Health Surveys Report shows that in many countries in Asia and sub-Saharan Africa communication between spouse about family planning is poor (DHS 2005; IIPS 2005-06). However, in Indian context where extended kinship and lineage structure of family have a strong social roots, decision making about contraceptive use and family planning goes beyond spouse (Barnet 1998; Hall et al. 2008;Orsin et al. 2002). This is particularly true and vivid in rural India. Several studies have suggested that extended family members and others have a strong influence on the sexual and reproductive health of the young couples (Barnett and Stein 1998; Boule and Valente 2005; Kadir et al. 2003). Qualitative studies (Jeffrey et al. 1998; Patel 1994) have revealed that reproductive choice of Indian women is influenced by the family interactions, particularly by mother-in-law. Studies on health and family planning issues in developing countries (Libbus and Kridli 1997; Mahmood and Ringheim 1993) are mainly from

gender perspective. Such studies showed that it is the husbands who take a leading role in family decision making.

Several studies (Saini et al. 2006; Orsin et al. 2002; Panchauri 2011) in North India have revealed that mother-in-law plays an important role in the family and the family gives her the authority to take health care and decisions for the daughter-in-law during the post – partum care. Thus mother in law influences decisions of the made by the young couples and daughter-in-law regarding adoption of modern contraceptive methods and family planning (Shing and Bhattacharya 2004). Another study showed that in a micro family set up the probability of taking and sharing decisions about family planning by spouse is generally higher (Agha 2010; Hall et al. 2008 Nag and Duza 1988). Other studies showed that husbands and mother-in –law have the power to influence women's lives.(Qurub 1995; Rutenberg and Watkins 1996). The status and power of the young daughter-in–law is associated with her capacity to produce offspring, preferably sons (Amritage 1993). Conversely, another study in Bangladesh showed that as the education of mother-in –law and father-in-law increases, they become more and more supportive of family planning (Bhuyan 1991).

There are altogether eight chapters including the present introductory one as mentioned below.

Chapter- 1	**Introduction**
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Chapter- 4	**Exposure and access to family planning**
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Chapter- 6	**Contraceptive health**
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Chapter-2

Design and Methodology

2.1 Introduction

The district is situated in the central part of Assam and on the northern bank of the mighty river Brahmaputra. On the North, the district is bound by the Udalguri district, the state of Arunachal Pradesh and Bhutan. On the East, there exists Sonitpur District and on the West, it is the Kamrup District.

The Darang district situated at the distance of 86 kilo metre away from Guwahati, the capital of the state of Assam, is basically rural in character. It has total population of 928500 as against the state's total of 3,12,05,576. Urban population of the district constitutes 55494 (6 percent) while rural population constitutes 873006 (94 percent) (Census, 2011). The density of population is 491 per sq. km, which is higher than the state average 397 per sq.km. The sex ratio of the district is 923 as against the state average 958. Out of total population in Darrang District, 35.3 percent (327322) are Hindus while, 64.3 percent are Muslims.

The literacy rate of the district (55.44 percent) is well below the state level (i.e. 63.82 percent) (Census, 2011). The occupational pattern of the people in the district is mainly agriculture. Women's participation in agriculture is comparatively less than the male counter parts. The total number of main workers in the district is high. The district accounts for comparatively a larger proportions of female marginal workers (Census 2011). Despite the improvement in the CPR, (couple protection rate) the district has recorded a considerably higher TFR (total fertility rate). According to Census 2011, the district accounts for a high infant mortality rate (73 per thousand live births) and MMR (325 per 100,000 live births). The use of female contraceptive is found to be higher than the state and national levels. The district is found to have a striking feature of registering lesser and lesser of no of vasectomy during the last several decades. The district is also observed to be lagging behind in terms of development indices such as, transportation, communication, and health facilities. The situation is more vivid in the rural areas of the district. Due to this existing socio-economic situation, a study in the rural area of Darang district is considered as being useful and interesting.

2.2 Details of The Sample Coverage:

The sampling of the study was done in two stages: first sampling of the area and second sampling of the male respondents who

are currently married (with wives in the reproductive age group of 15–49 years) having at least one living child.

In Darrang district of Assam there are four PHC Blocks namely, Spajhar, Jaljali, Patharighat and Kharupetia in the rural area and one Urban Health Centre at Mangaldai (district head quarter). There are 145 Family welfare sub-centres in the four PHC blocks of the district.

In selecting the study area we used multi stage sampling method. First, all the four PHC blocks namely Spajhar, Jaljali, Patharighat and Kharupetia PHC Blocks in the rural area were selected purposively. Second, one PHC was selected purposively from each block. The PHCs are Hazarikapara PHC from Sipajhar block, Jaljali PHC from JalJali block, Patharighat PHC from Patharighat block and Kunwaripukhuri PHC from Kharupetia block. Finally, two villages were selected randomly from each selected PHC.

To cover the urban health centre at Mangaldai, two villages were selected under Mangaldai Tehsil area. The names of the selected villages are:

1) Kacharipara village and Hazarikapara village from Sipajhar PHC Block
2) Patharighat village and Pipirakuchi village from Patharighat PHC Block

3) Gariapara village and and Jhargaon village from Jajali PHC Block

4) Kuwari pukhuri village and golandi village from Kharupetia PHC Block

5) Mangaldai Gaon and Tangabari village under Mangaldai Tehsil.

The current study has made an attempt to focus on the reproductive and contraceptive usage of the couples with especial attention to male's participation in family planning. Among the various factors that determine this was the availability of health service facilities. Hence, it was decided to select few villages where services of PHCs are frequently available.

Kharupetia PHC Block

The Kharupetia health centre is one of the oldest PHCs in the Darrang district. It is just 4-5 kilometers away from the Karupetia town. The centre has mainly 45 Sub-centre, of which 38 Sub-centers are under additional CM&HO (FW) and 7 Sub-centres are under Joint Director of Health Office. The centres are providing pre-natal and post partum services regularly to the women who had institutional deliveries. The PHC has regularly organized yearly 1-2 camps for vasectomy and Tubectomy. Two villages selected from Kharupetia PHC are namely, Kuwari Pukhuri and Golandi.

The block constitutes nearly half of the total population of the four PHC blocks in the district.

Jajali PHC Block

Jajali PHC Block which comes under the Pachim Manaldai development block has mainly 53 Sub-centres. 49 of them are the Sub-centres under additional CM&HO (FW) and 3 Sub-centres are under Joint Director of Health Office. The PHC has been conducting camps for female as well as male sterilization regularly since the year 2010-11. From the year 2010-11 to the year 2015-16 the centre has conducted 764 NSV and 1919 female sterilization. The Jaljai PHC has witnessed increasing Institutional deliveries during the periods. The centre also provides pre-natal and post partum care to the pregnant women and mothers of the new born babies.

Patharighat PHC Block

Patharighat PHC Block which falls under Shipajhar development block has mainly 35 Sub-centres, of which 28 Sub-centres additional CM&HO (FW) and 7 Sub-centres under Joint Director of Health Office. The Patharighat PHC at block level provides prenatal and post partum cares to pregnant women and mothers to the new born babies. The centre has been partly successful in promoting the institutional deliveries amongst the

pregnant women. The Pathatrighat PHC holds camp for both of NSV and Tubectomy or Laparoscopy at least one to two in a year. However, the response of the people towards NSV is still very poor. During the last year period total number of NSV at block PHC level was only two while the number of female sterilization was 147.

Sipajhar PHC Block

Sipajhar PHC Block mainly has all total of 31 Sub-centers. 30 of them are under Additional CM&HO (FW) and 1 under Joint Director of Health Service. It is considered as the best performing PHC in the district.

Mangaldai urban health centre

Mangaldai urban health centre is attached to the Mangaldai Civil hospital. It is the only **urban health centre** in the Darrang district. It provides health services not only to the urban people but also to the people from nearby villages. With the better and improved modern facilities of health care Mangaldai Civil Hospital covers almost all the people from nearby villages.

2.3 Selection of Respondents

The present study mainly intends to examine the men's participation in family planning in determining the women's reproductive health and

contraceptive health. A stratified random sampling was adopted to examine the dynamics of gender role in the present social set up of rural Darrang district of Assam. Though initially the unit of the study was the currently married man, finally it was decided to include the responses of the wives (15-49 years of age group) with at least one living child. This was done in order to examine gender gap in the attitude and the usage of family planning and reproductive intension of the couples.

Table- 2.1

Distribution of Total Sample Size: PHC Blocks and Village

PHC Block	Village	No of currently married men with their wives (14-49 years of age) by duration of marriage				Total
		<= 5 years	6 - 10 years	11 - 15 years	15 years & above	
Sipajhar	Hazarikapara	16	18	14	11	**59**
	Narikali	17	17	15	10	**59**
Patharighat	Piparakuchi	15	14	16	10	**55**
	Patharighat	16	15	16	09	**56**
Jaljali	Jalajali	17	16	15	10	**58**
	Goriapara	18	17	14	09	**58**
kharupetia	Golandi	15	15	15	09	**54**
	kuwaripukhuri	16	16	16	07	**55**
Mangaldai	Mangaldai	16	17	15	08	**56**
	Tangaari	17	16	16	08	**57**
	Total	**163**	**161**	**152**	**91**	**567**

Source: Sample of the present study

In the Indian social set up marriage duration is considered to be an important factor in determining the power difference within the couples.

Hence, in the first step, all the couples were house listed by the duration of marriage in the sampled villages.

In the second step couples were categorised on the basis of five-year interval duration. The categorisation was done as: 1) all those married for five years or below five years, 2) all those married between 6-10 years, 3) all those married between 11-15 years, and 4) all those married more than 15 years. This is presented in the **Table- 2** above.

Nearly 10 to 15 percent of couples from each of these categories were selected for the study to have a proper representation of all the couples from reproductive age group from the villages under study. The selected number of couples for the current study was 567. **Table-2.1** provides the particulars of the sample.

2.4 Tools of Data Collection

A well prepared questionnaire was prepared to collect the information. Except this a qualitative technique such as focused group discussion and in-depth interviews were also carried out before the finalization of the questionnaire.

✓ Two Focused group discussion (FGD) was also carried out at two different stages. First, discussion was carried out with husbands and wives. The information collected through this discussion had not only helped in understanding the gender relation in the society but also in the preparation of individual questionnaire. Such FGD also helped in building a rapport with the community. Second round of FGD was conducted with the group of husbands and wives separately on some issues like their perceptions about the usage of contraception and reproductive health and contraceptive morbidities and the need for medical care etc.

✓ Individual interviews were conducted separately for both husbands and wives with the help of a well structured questionnaire. It helped in collection of information about the knowledge, access, and gender roles with respect to reproductive behaviour, health, morbidity and utilization of health services by women.

2.5 Preparatory Work Prior to Main Survey

A lot of preparatory work was done prior to actual data collection. Discussion was carried out with the Doctors at PHCs on various topics

related to women's reproductive health. This information helped in preparing the pre scheduled questionnaire.

2.6 Selection of the field stuff

Post graduate or graduate persons from social science preferably from the local area were recruited for the work to collect information on the basis of questionnaire. Mock interviews and several discussions were organized to impart the knowledge of conducting a field survey.

2.7 Quality checks of the data

Care was taken regarding validation and mistakes and misinformation. This was done by setting the questions for checking and cross checking the answers.

2.8 Coverage of couples

Repeated assurance about the maintenance of confidentiality was given to the couples. Any confusion on the part of the respondents was cleared to get the accurate responses. Thus 567 couples were interviewed.

Chapter- 3
Profiles of the Couples and Study Area

Since the present work is all about the male's participation in family planning in the rural areas of the Darrang district of Assam, for the field study, all total ten villages were selected. Out of the ten villages, eight villages from four PHC blocks (i.e., two villages from each PHC block namely, Sipajhar, Jaljali, Patharighat and Kharupetia), and two villages from the Mangaldai tehsil were selected at random. The village profiles of ten selected villages are discussed below.

3.1 An Overview of the Villages:

3.1.1 Profile of the Villages

Kuwari Pukhuri Village and Golandi Village under Kharupetia PHC Block

Kuwari Pukhuri Village under the Kharupetia PHC block is inhabited by Muslim population. Total population of the village is 2994 (M=1558 and F=1436). The sex ratio of the village is not favourable to females. The literacy rate of males 58 percent while

for females, it is only 39 percent. Thus there exists a wide gap of literacy between males and females in the village.

Golandi village has 3977 population and cent percent of the population are Muslims. The sex ratio of Golandi village shows female population has outnumbered the male population (F=2023 and M=1954). There are two LP school, one M.E. school, one Senior Madrassa school and one High Secondary school and one Arabic Collage. But, there exists a wide gender gap in literacy rate (M= 52% and F=36%). The main occupation of the people in the village is farming and majority of female population are engaged in house-hold activities.

Hazarikapara Village and Narikali Village Under Sipajhar PHC Block

Hzarikapara village has 2769 population (Census, 2011). The sex ratio of the village is 979 higher than the state average (979). The sex ratio of children below the age of 6 years is 979 which again higher than the state average (958). The literacy rate of the village is found to be 94.7 percent (M=97percent) and F=93 percent) which is above the state average (72.19). the total worker of the village is 1038 (=806 and F=502. The percentage of marginal worker is 415 (M=89; F=326).

Narikali village is located in Sipajhar Tehsil of Darrang district in Assam, India. It is situated 23km away from district headquarter Mangaldai. Sipajhar is the sub-district headquarter of Narikali village. The total geographical area of village is 282.07 hectares. Narikali has a total population of 1,412 peoples. There are about 308 houses in Narikali village. Total population of the village is 1412 and total male population is 715 while female population is 697.

Patharighat village and Pipirakuchi village under Patharighat PHC Block

Patharighat village, according to the Census 2011 has 694 population and a total of 159 househokd. The sex ratio of the village population is. The village being situated at Sipajhar administrative block is 7 kilometers away from Shipajhar.

Pipirakuchi village has a population of 1,135 and 270 hose holds. Total male population of the village is 576 and the female population is 559. The connectivity of the village is good. Public bus and private bus services are the main means of communication in the village.

Jhargaon and Goriapara villages under Jaljali PHC block

Jaljali village is only 3 kilo meters away from District Head quarter Mangaldai. Village has one M.E school and one high school. **The**

Goriapara village is inhabited by 1535 people.

Tengabari and Mangaldai villages under Mangaldai Tehsil

Tengabari village is located in Mangaldoi Tehsil of Darrang district in Assam, India. It is situated 1km away from sub-district headquarter Mangaldoi and 1km away from district headquarter Mangaldoi. The total geographical area of village is 44.32 hectares. The total population of the village is 760 peoples. There are about 185 houses in the village. Total population of the village is 760 while, male population is 377 and female population is 383. The village shows a favourable sex ratio for females i.e., 103f female per 100 males.

Mangaldai Gaon is located in Mangaldoi Tehsil of Darrang district in Assam, India. It is situated 1km away from district headquarter Mangaldoi. The total geographical area of village is 83.76 hectares. Mangaldai Gaon has a total population of 2,879 peoples of which 1497 are males and 1382 are females (Census, 2011). There are

about 659 houses in Mangaldai Gaon. Mangaldoi is nearest town to Mangaldai Gaon. The village has a well developed bus transportation system.

3.2.A Socio-economic Characteristics of the Couple

Age:

Altogether 567 currently married women were interviewed. The average age of the male respondents (husbands) are found to be 31 years (31.3). Gender differential is also found with respect to the age. The mean age of females is estimated at 27 years (26.5). Proportion of women below the age group of 15 years (below the legal age at marriage) was found 2 percent. More than two fifth (47 percent) of the women belonged to the age group of less than 25 years while the corresponding percentage for men was only 10 percent. In upper age group the proportion of women became less while the proportion of men was found to be comparatively larger (**Table-3.1**).

Education

There were differences in the educational status of the wives and husbands in the villages under study. One fifth of women were illiterate as against this one tenth of men was found to be illiterate. Nearly 55 percent

Table-3.1
Socio-economic Characteristics of the Couples

Age Group(in years)	Husbands (%)	Wives (%)
<= 15	---	10 (1.8)
20-24	52 (9.17)	229 (40.4)
25-29	103 (18.2)	199 (35.1)
30-34	291 (51.3)	99 (17.5)
35-39	106 (18.7)	21 (3.7)
40+	15 (2.7)	9 (1.6)
Mean Age	**31.3 years**	**26.5 years**
Educational status		
Illiterate	64 (11.3)	110 (19.4)
Primary School	85 (15.0)	139 (24.5)
Middle School	207 (36.5)	186 (32.8)
High School	161 (28.4)	115 (20.3)
Graduate & above	50 (8.8)	17 (5.4)
Occupational status		
Service	8.2	5.6
Business	8.8	---
Daily wage earner	15.0	10.2
Cultivators	56.7	----
Housewives	----	85.2
Unemployed	11.3	----
Community		
SC	(29.1)	
General Caste Hindu	(49.2)	
Muslims	(22.7)	
Monthly family Income		
Less than Rs 3000	(32.3)	
Rs 3001-5000	(34.2)	
Rs 5001-8000	(21.9)	
Rs 8001-10000	(9.0)	
Rs 10000+	(2.6)	
Type of Family		
Joint	244 (43.1)	
Nu clear	323 (56.9)	
Number of Children		
One	119 (21.0)	
Two	231 (40.7)	
Three	157 (27.7)	
Four +	60 (10.6)	
Mean number of children	3	

Source: Sample survey of the present study

of women had attained education above primary school level whereas the corresponding percentage amongst the men was nearly 75 percent (**Table-3.1)**.

Religion and Caste

A majority of the couples (50.5 percent) belonged to General Caste Hindu while 27 percent belonged to SC and 22 percent belonged to Muslims.

Type of Family

Nearly three fifth (57 percent) of the couples were nuclear families i.e. they consisted of a husband and wife and their unmarried children while, the rest were joint or extended families.

Occupational status

More than four fifth (85 percent) of women were housewives whereas one tenth were daily wage earner and the rest (5 percent) were service holder. As against this, more than half (56 percent) of the men were engaged in cultivating activities whereas one in every ten men were either service holder or small traders or business men. Men engaged in daily wage labour was 15 percent and the remaining 11 percent were found unemployed.

Income Status

An equal proportion (more than 32 percent) of couples belonged to less than Rs. 3000 income group and the group of Rs. 3000 to Rs. 5000 while amongst the rest 22 percent belonged to the income group of Rs. 5001 to Rs. 8000 and 9 percent and 3 percent belonged to the income groups of Rs. 8001 to Rs.10000 and Rs. 10000 and above.

3.2.B Selected Demographic Determinants of Women by Community Parity

One fifth of the couples had one child while two fifth had two living children. More than 27 percent had three children and 10.6 had four or more than four living children. The mean number of children of couples was high i.e. 3.the high mean number of children of the couples was related to the lower mean age at marriage (i.e. 19 years) and lower an age at first birth of child (i.e. 17 years) (**Table-3.1)**. However, the mean age at marriage, the mean age at first birth of child and the mean number of children of the couples were found to vary with caste and community. Accordingly the number of abortions and met need and unmet need of the couples were also found to differ from community to community (**figure-3.2**).

Table-3.2

Selected Demographic Determinants of Women by Community

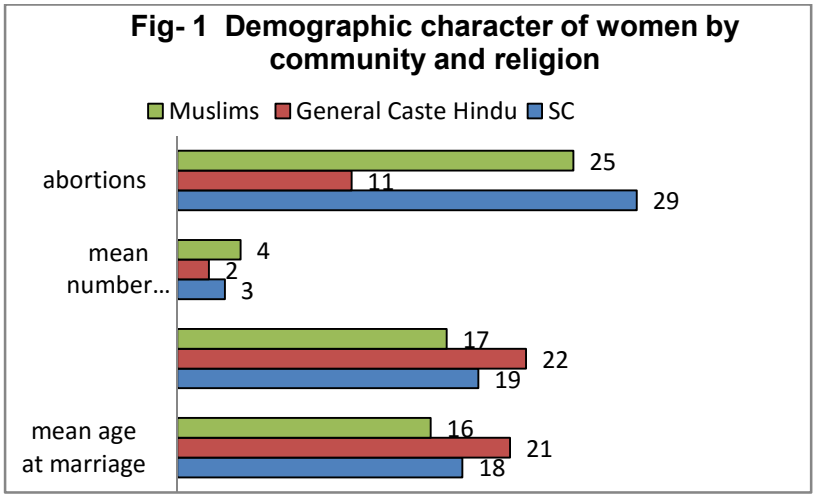
Demographic Background	SC	General Caste Hindu	Muslim	Total
Mean age at marriage (in years)	18	21	16	**18.3**
Mean age at 1st birth of child (in years)	19	22	17	**19.3**
Mean number of living Children	3	2	4	**3**
Abortion both natural and spontaneous	29.0	11.2	55.2	**31.8**
Use of Family Planning:				
Total Users (%)	34.7	50.2	15.1	**54.9**
Total Non –Users (%)	31.9	37.7	39.8	**46.1**
Use of Contraception by Methods:				
Female Sterilization (%)	62	29	10	**23.5**
Male sterilisation (%)	75	25	00	**5.5**
Total sterilisation	**62.3**	**28.6**	**9.1**	**24.8**
Spacing methods	**29.6**	**58.5**	**11.9**	**51.1**
Unmet need	**20.6**	**11.4**	**44**	**21.5**

Source : Sample survey of the present study

Couple Protection Rate

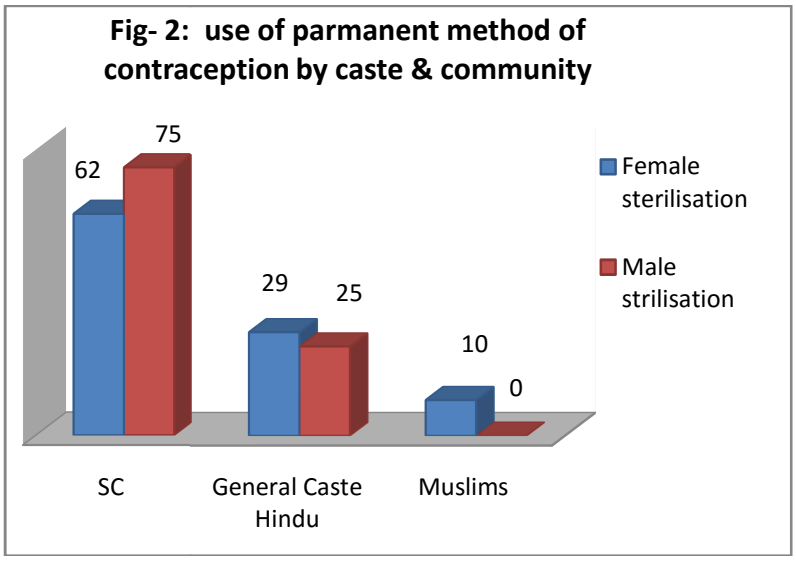
Little more than half of the couples in the present study was observed to use contraception (**Table-3.2**). Nearly one fourth of the couples had opted for permanent method of contraception (sterilization) for limiting was the size of the family. However, the proportion of female sterilization to total sterilization was 95 percent. However, use of both female sterilization as

well as NSV (male sterilization) had been observed to be larger amongst the SC couples (shown in **Table-3.2**).



Source: Sample of the present study

In the present field study area male sterilization (NSV) is found to be nil amongst the Muslims couples. The use of reversible methods was found larger in proportion amongst General Case Hindu couples followed by SC and Muslim couples.



Source: Sample of the present study

One fifth of the couples had unmet need for contraception. Amongst them 44 percent was Muslims while 21 percent and 11 percent were Sc and General caste Hindu (**Table-3.1)**.

Chapter- 4
Exposure and Access to Family Planning

4.1 Introduction

Adequate utilization of the family planning and reproductive health services depends upon a multiplicity of factors such as availability, accessibility of quality services, quality of care, social structure and health related beliefs. Most of these factors correlated and intertwined with awareness and gender inequality. Thus, issues regarding the level of awareness of the couples about the reproductive health and contraceptive health should be analyzed from the gender perspective.

In the present study to examine the level of awareness of the couples were examined in terms of exposure to the messages or information relating to various family planning methods and their accessibility. For this couples were asked separately whether they could recall hearing messages in a month prior to the survey. If they answered yes, the types and the sources of receiving such massages were kept in record. In

addition to the exposure to the availability to the services, their information on access to these services was also collected.

4.2 Exposure to Various Massages Relating to Family Planning

Differences existed amongst the husbands and wives relating to the exposure to messages on reproductive health and family planning. Comparatively a larger proportion of men (69.9 percent) than women (57.8 percent) reported that they recalled the hearing or seeing at least one message over the period in questions. Despite more than half of men and women were exposed individually to at least one message on reproductive health over last one month, only in 3 7.3 percent cases both, taken as couples, were exposed to at least one message.

Table – 4.1

Men and Women Exposed to Messages Related to Reproductive Health

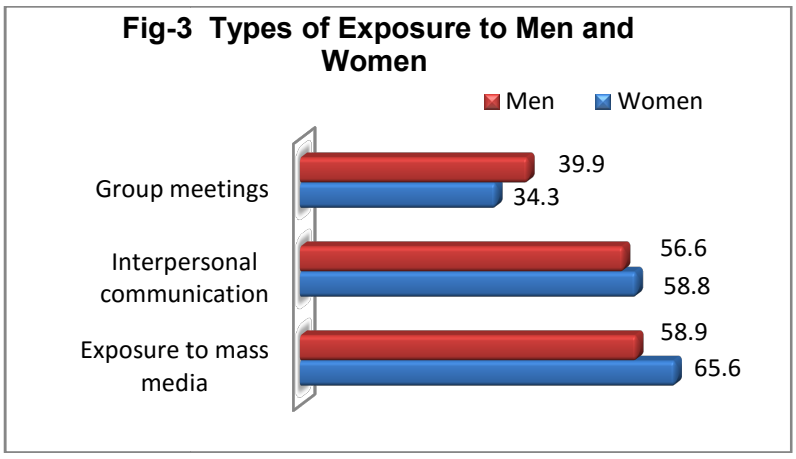
Messages relating to Reproductive Health	Men	Women	Both	Neither
Family planning	38.3	42.3	8.9	64.3
Pregnancy care	22.4	36.8	15.3	59.6
Delivery care	29.9	41.0	19.6	61.1
After child birth	19.1	38.3	20.5	56.3
Other reproductive problems	9.8	15.3	9.9	86.3
At least one of above messages	**69.9**	**57.8**	**37.3**	**21.9**

Source: Sample survey of the present sdudy

A considerable proportion of couples (21.9) reported neither of them was exposed to the message related to reproductive health. However comparatively more men than women were exposed to the messages on family planning **(Table - 4.1**).

4.3 Types of Exposure

Exposure to mass media is found to differ between men and women in the study areas. Women were more exposed to any information through the interpersonal interactions and communications while men are exposed through the mass media. In other words, women generally found it is convenient to discuss on the issues that is socially accepted such as regarding child bearings, pregnancies, post partum or pre-natal care.



Source: Sample survey of the present study

In the field study areas it was found that despite decade of efforts, issues like family planning and the use of contraception are still considered not to be socially acceptable in conversation amongst the women. As such, a larger proportion of exposed women (67 percent) heard such massages through mass media e.g. television and radio **(fig-3**).

On the other hand, though mass media has been the main source of all types of information to men yet, for the issues like family planning and reproductive health more than half of the total male respondents (51.1) in the study areas were exposed to these messages through interpersonal communication and group meetings **(fig-3).** This was because compared to women men had fewer inhibitions to talk about family planning and many of them felt that the other issues related to reproductive health were the areas confined to women.

4.4 Access to Family Planning and Reproductive Health Services

The reproductive health of women is affected by the factors like social, psychic, and economic costs of care. Access to care can be assessed in terms of cognitive access and physical access. Cognitive accessibility refers to a couple's awareness about the availability of

services. Physical accessibility refers to the distance covered and time taken to reach the services in need.

The present study has made an attempt to examine the accessibility to various reproductive health services and methods of family planning under the heads of services related to temporary (or spacing) methods of contraception, medical termination of pregnancy, permanent (or terminal) sterilization, pregnancy care and delivery care and post partum care (**Table - 4.2.1a and 4.2.1b**).

Table – 4.2.1.A

Cognitive Knowledge of Men and Women About Access to Various Reproductive Health Services

Reproductive health services	**Percentage of men and women with knowledge**			
	Women	**Men**	**Both**	**Neither**
Family planning	78.1	91.3	55.2	26.5
Medical termination of pregnancy	33.9	56.3	22.5	33.5
Terminal methods	88.5	93.9	79.5	39.2
Pregnancy care	95.9	72.9	69.9	0.0
Delivery care	97.5	74.9	71.5	0.0
Postpartum care	91.2	59.6	49.6	5.8
Other health related issues of women	81.5	45.3	45.2	15.2
Total	**567**			

Source: Sample survey of the present study.

In the field study area women were more aware of the availability of pregnancy, delivery and postpartum care and other gynaecological health related problems while men were relatively more aware about the availability of the family planning services. **Table-4.2.1a** shows that majority of women (more than 95 percent) were aware about the accessibility of facility of pregnancy, delivery and postpartum care. Services related to medical termination of pregnancy were known to only 33 percent of women. On the contrary, majority of men (91.9 percent) were aware of the availability of sterilization services whereas less than three fourth of men were aware of the availability of the services related to pregnancy and delivery care.

Apart from the individual cognitive level it also important to test the cognitive knowledge levels both the couple as a unit. It is observed that cognitive level of both partners was high about access to family planning services while it was found to be low about the services related to medical termination of pregnancy. More than half of the couples were also ignorant about the accessibility of the services related to postpartum care and services related to other gynaecological health problems.

Table- 4.2.1.B
Cognitive Knowledge of Men and Women about Various Family Planning Services

Contraceptive Methods	Men (N=518)	Women (N=443)	Both	Neither
Spacing methods				
Condom	54.8	42.2	39.5	28.9
Copper T	51.5	23.9	22.9	31.7
Oral contraceptive pills	81.0	91.2	79.8	5.9
Terminal methods				
Vasectomy	49.8	23.9	13.2	31.9
Female Sterilizations	72.2	81.2	65.8	9.1
NSV	28.2	11.3	9.5	55.6

Sources: sample survey of the present study.

Another finding of the present study was that a more than one fourth couples (26.5 and 33.5 respectively) reporting neither of them were aware of the accessibility of family planning services and services related to medical termination of pregnancy.

The field survey of the present study also showed that the cognitive level of men about various methods of family planning was higher than that of the women except the accessibility of oral contraceptive pills and female sterilization. Half of the total of 518 men, having the cognitive knowledge about the availability of the family planning services, was aware of the accessibility of condom and copper T (**Table- 4.2.1b**). However, the

individual cognitive level (either men or women) related with NSV (No Scalpel Vasectomy) has been found to be very poor. Only in 9.5 percent cases both, the couple as an unit, were aware of accessibility of NVS while, more than 55 percent couples were not aware of it.

So far the accessibility of female devices like, oral contraceptive pill and female sterilization are concerned couples' cognitive level was found to be high (i.e., 79.8 and 65.9 respectively).

4.4.1. Physical Access to Family planning

Cognitive level of access to various components of reproductive and family planning services was similar to physical access for both men and women. In other words, men and women who were aware about the availability and existence of services were also certain about their location.

Table-4.2.2 exhibits that women more or less considered PHC or Government health centers as the main source of reproductive health services. Less than three fourth of women knew that PHC / sub- centre were the source of sterilization services while, less than one fifth of women knew it was a source of temporary contraceptives. Only one fifth of women were aware of the source of medical terminated pregnancy services.

Table- 4.2.2

Knowledge of Men and Women about Physical Access to Contraceptive Methods

Some components of reproductive and family planning health services	Men	Women
Temporary methods of contraception	**69.5**	**28.9**
PHC / Sub-centre / MPHAS	11.3	14.2
Private clinic / hospitals	26.9	11.5
Medical shops	30.2	3.2
Anganwadi workers / ASHA/ health workers	1.3	--
Medical termination of pregnancy	**56.3**	**33.9**
PHC / Sub-centre / MPHAS	28.5	19.3
Private clinic / hospitals / voluntary agency	12.9	13.8
Government Medical College Hospitals	--	--
Medical shops	0.9	0.8
Terminal methods of contraception	**94.2**	**86.9**
PHC / Sub-centre / MPHAS	52.8	69.9
Private clinic / hospitals / voluntary agency	39.3	14.9
Government Medical College Hospitals	2.1	2.1
Pregnancy care	**72. 9**	**95.9**
PHC / Sub-centre / MPHAS	49.2	83.9
Private clinic / hospitals	21.3	20.1
Government Medical College Hospitals	2.5	2.5
Anganwadi workers / ASHA / Health workers	--	--
Delivery care	**74.9**	**97.5**
PHC / Sub-centre / MPHAS	59.2	72.2
Private clinic / hospitals	13.2	23.5
Government Medical College Hospitals	1.2	1.5
Others (at home) /Dhai	1.3	1.3
Postpartum care	**59.6**	**91.2**
PHC / Sub-centre / MPHAS	34.1	72.2
Private clinic / hospitals	22.1	12.6
Government Medical College Hospitals	1.3	4.3
Others (at home) / Dhai	2.2	2.1

Source: Sample survey of the present study.

Unlike women, men did not refer the PHC or government hospital as the main source of reproductive health services. A considerable proportion of men considered private hospital or clinics as the source of such services. For temporary methods also men equally considered private clinic or hospitals as an important source.

None of women ever mentioned Anganwadi workers or ASHA or other health workers as a source of temporary methods of contraception, despite the possibility of more women interacting with the workers. On the contrary, few men referred other health workers as a source of temporary methods of contraception.

4.5. Conclusion

In the study area it was found that more than half of the women (57.8 Percent) and men (70 percent) were exposed to at least one message on reproductive health service while more than 35 percent of both, taken as couples, were exposed to such message. The topic and kinds of message, however, to which they were exposed was largely controlled by gender roles of the society. More women were exposed to message related to pregnancy, delivery, postpartum care as men left them to the

domain of women. Men were more exposed to the message related to family planning.

Focus group discussion amongst the women and men revealed that women found comfortable discussing the pregnancy, delivery and postpartum health care, but not contraception. Social taboos associated with contraception such as, apprehension of being looked upon as 'uncultured' and or 'lacking modesty' restricted women from discussing such topics. Moreover, they preferred to refrain themselves from media in receiving such information. Husbands were more exposed to mass media and found more interested in the topics like sterilization and temporary contraceptive methods. Interaction with male health workers regarding the use of male contraception (vasectomy), as reported by the male respondents in the study, was found to be very poor. This was because the health workers were not free from the prevailing social gender taboos.

Gender differences were also found in the field of knowledge about cognitive as well as physical access to various reproductive and contraception services. A Large proportion of women were found aware of the availability and source of pregnancy, delivery and postpartum care and sterilization services. But, they were less aware of the availability and

accessibility to temporary methods of contraception and medical termination pregnancy facilities.

Chapter-5
Contraceptive Health

5.1 Introduction

The contraceptive behaviour of a couple determines the reproductive health of women. Contraceptive behaviour, as explained in earlier chapter, depends on a number of factors such as, cognitive levels of the couples about the family planning including pregnancy, planning the size of the family and spacing the birth of children and proper choice of contraceptives etc. Family planning means planning the reproductive behaviour of the couples. Hence it requires combined planning rather than individual planning. In other words, apart from individual planning combined planning has a direct bearing on the women's reproductive health. Combined planning can also be taken as men's constructive participation. In this chapter, focus is given on the couples' perception about pregnancy and family planning. This chapter also examines the role of husbands in terms of spousal communication on reproductive health and contraception.

5.2 Perception of Couples on Family Planning

First hand information about individual cognitive levels on family planning is very essential to understand a couple's reproductive behaviour. It also helps us to understand the gender differences toward reproductive control.

In the present study couple's perception on family planning has been examined mainly from three angles. First, couples perception about control over pregnancy, self-sufficiency in accessing contraceptive devices and their perception about pregnancy avoidance.

5.2.1 Control Over Pregnancy

Table-5.1 Below Exhibits The Perception Of Couple's Cognitive Level On Some Aspects Of Control Over Pregnancy. Some Questions Were Asked To The Couples Whether They Agreed With Some Traits Of Control Over Pregnancy. The Responses Were Analysed On A Scale Of Four I.E., Strongly Agree, Agree, Disagree And Strongly Disagree. The Responses Show That Every Nine Out Of Ten Women Agree That If One Of The Partners Does Not Desire It, They Could Not Have Sex. The Question Was Referred To Both The Partners.

But Majority Of Men And Women Wanted To Associate It With Husbands. They Believed That If A Husband Did Desire It, A Wife Could Not Have

Sex. More Than 83 Percent Of Women And 81 Percent Of Men Agreed That Women's Body Were Destined To Become Pregnant. Hence I Was Very Difficult To Avoid Pregnancy. Hence, Prevention Of Pregnancy Was Not In Ones Control. Thus, More Than Four Fifth Of The Couples Believed That Women Are Meant To Be Pregnant.

Table-5.1 Also Reveals That While Acknowledging The Association Of Pregnancy With Women, Almost All The Women Agreed That A Couple Could Limit The Child Bearing. However, Nearly One Fourth Of Men (22.5 Percent) Disagreed To It. At The Same Time Three Fourth Of Women Agreed That Luck Played A Big Part In Determining Whether A Woman Could Avoid Getting Pregnant While Comparatively Fewer Men Considered Luck As A Big Played A Big Part.

While Relying On Luck Women Also Accepted The Role Of Individual Behaviour. Out Of Ten Nine Women Agreed That If A Couple Were Careful Unwanted Pregnancy Would Rarely Occur. In Case Of Men It Was Eight Out Of Ten Agreed.

Table-5.1

Couples Reporting on Control over Pregnancy

Aspects related to control over pregnancy	**Women** (N=567)	**Men** (N=567)
A couple cannot have sex if one of them disagrees		
Strongly agree	47.3	32.9
Agree	38.7	48.9
Disagree	8.8	17.5
Strongly disagree	6.2	0.7
Pregnancy cannot be avoided if a women is meant to be pregnant, she will be pregnant		
Strongly agree	12.1	18.2
Agree	70.9	63.0
Disagree	15.2	15.1
Strongly disagree	1.8	3.7
A couple can limit the child bearing		
Strongly agree	70.9	50.5
Agree	21.2	27.0
Disagree	6.4	21.3
Strongly disagree	2.2	1.2
Whether a woman can avoid getting pregnant depends on her luck		
Strongly agree	35.9	21.5
Agree	34.9	31.2
Disagree	23.1	32.1
Strongly disagree	4.0	5.2
Unwanted pregnancy will rarely happen if a couple is careful		
Strongly agree	63.6	23.3
Agree	30.2	59.1
Disagree	5.1	16.1
Strongly disagree	1.1	1.5

Source: Sample survey of the present study.

Above data (**Table-5.1**) based on the statements given by the women in the field study area are found contradictory in nature. But, at the same time figures also suggests that majority of women believing in having control over pregnancy, provided they had control over their bodies. However, men's opinion did not vary. This was probably because they believed that woman's body was in their control.

5.2.2 Self-sufficiency Related to Accessibility to Contraception

Self sufficiency in obtaining a method of family planning refers the individual capabilities to obtain it. It also reflects gender differentials in a community. In the present study self-sufficiency was addressed only to those couples who were not using any contraceptive methods but wanted to use in future (**Table-5.2**). The responses were scaled in the same manner as the responses for control over pregnancy.

Table-5.2 exhibits that women (80 percent) were unaware of their capabilities while men (89percent) felt that they had the capability. Majority of men and women both (90 percent) cited the reason of not preferring a temporary method was that it was difficult to remember to use for avoiding pregnancy.

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Table-5.2

Percentage of Men and Women by Self-Sufficiency Related o the Use of Contraception

Aspects related to use of contraception		
Capable of obtaining a method of contraceptive	**Women**	**Men**
Strongly agree	5.9	37.7
Agree	14.9	55.3
Disagree	46.0	5.1
Strongly disagree	33.2	1.9
Difficult to remember to use contraceptives		
Strongly agree	43.1	30.1
Agree	46.5	59.9
Disagree	8.2	10.0
Strongly disagree	0.4	0.0
Can refrain from sexual activity in absence of contraception		
Strongly agree	4.2	.6
Agree	16.2	43.9
Disagree	66.7	45.1
Strongly disagree	12.9	6.4
Capable of using contraceptive every time		
Strongly agree	7.6	24.5
Agree	18.3	51.9
Disagree	41.2	20.3
Strongly disagree	32.9	3.3
Negotiating use of contraceptives impossible		
Strongly agree	9.2	0.9
Agree	38.1	30.1
Disagree	29.8	47.5
Strongly disagree	22.9	21.5
Capable of seeking treatment for reproductive health problems		
Strongly agree	15.8	17.8
Agree	52.9	61.9
Disagree	20.3	15.3
Strongly disagree	11.0	5.0
Total number of couples	**256 (45.1)**	

Source: Sample survey of the present study

Couples' opinion with respect to the memory was same. But the opinion was different when they were asked that whether they could refrain themselves from sexual activities in absence of contraceptives. Nearly 80 percent of women felt that they could not refrain themselves from sexual activities. This implies that women had no control over their bodies.

Nearly half of the men felt that they could refrain from it i.e., they felt that woman's body was under their control. Perception of men and women deferred about the capability of using temporary methods of contraceptive every time they wanted to use it. Nearly 75 percent of women believed that they were not capable of using a temporary method of family planning. On the other hand 75 percent of men believed that they were capable of using it as and when they desired.

Nearly half of women disagreed to the fact that they cannot negotiate the use of contraception while slightly more man (68 percent men) believed that they could negotiate with their wives.

The couples were asked whether they were capable of seeking treatment for reproductive health problem. Though more women replied that they were capable yet a considerable proportion of women (three out of ten) felt that they were not capable of seeking treatment for reproductive

health. At the same time, two of ten men felt that they were not capable in seeking treatment for reproductive health problem.

Findings from **Table-5.2** suggests that women had low self-sufficiency in the use of contraception as they had restricted information, poor cognitive access to family planning methods and little say in matters related to sexual activities. On the contrary women seemed to be more confident in negotiating the use of contraceptive with their husbands. They probably indicated the use a terminal method. In most of the areas of rural Darrang district, by and large, small family norm has been accepted. Unequal power structure relation in the family left little space for women to bargain. In such a situation it was difficult to negotiate the use of temporary contraceptive. Hence, women found comfortable in negotiating with their husbands in favour of terminal method. Unlike women more men were self-sufficient to obtain and use a method of family planning they desire.

5.2.3 Perception on Avoiding Pregnancy

Table-5.3 deals with the data related to the perception of couples on avoiding pregnancy in absence of contraception. The couples not using any contraception were asked how much avoidance of pregnancy was important to them. The responses were categorized as important, less

important and unimportant. Information was collected from the non-pregnant women currently not using any contraceptive but intended to use in future.

Couples who were uncertain about a future need for children were asked whether they felt limiting the child bearing was important to them. Cent percent women felt it was important whereas 86 percent men felt it was important and the rest felt it was unimportant.

Despite realizing the importance of not having more children (stop child bearing), all women could not make it sure that they were protected against getting pregnant. As such in response to the question that how much it was important to you that you make sure you were protected against getting pregnant, 83 percent felt it was important while rest 17 percent felt moderately important. Men's opinion in this respect was, more or less, in coherence with the previous answer. This implies that men were less concerned about the women's reproductive desire. Despite their unwillingness, women were not certain about acting in accordance with their will.

Table-5.3

Perception on Avoiding Pregnancy by Couples Not Using Contraception but Intended to Use in Future

Perception on avoiding pregnancy	Women	Men
To have no more children		
Important	100.0	56.9
Moderately important	0.0	29.4
Unimportant	0.0	13.7
if important, to make sure that protected against		
Important	82.6	44.8
Moderately important	17.4	41.5
Unimportant	0.0	13.7
Extent of importance to delay the birth of next		
Important	85.3	21.9
Moderately important	14.6	25.9
Unimportant	0.0	52.2
Extent of making sure that protected against		
Important	11.6	12.4
Moderately important	19.5	25.9
Unimportant	68.9	61.7
Total	**101**	

Source: Sample survey of the present study

Couples were also asked to what extent they felt it was important to delay the birth of next child and if they were interested, how much they felt it was important to make them sure to protect from getting pregnant. 85 percent of women felt it was important to delay the pregnancy but 15 percent were

not sure about protecting themselves from getting pregnant. This explains that majority of women were capable of protecting themselves from getting pregnant either by adopting family planning methods or persuading their husbands to postpone pregnancy.

5.3 Communication Between Husbands and Wives

Healthy communication between husband and wives helps to lead better conjugal lives. A healthy conjugal life based on better understanding helps to improve the reproductive and contraceptive health of couples. In this regard information gathered from the present field survey (shown in the **Table-5.4)** focus light on some important aspects of husband-wife communication. The table shows that nearly 7 out of ten couples had ever discussed issues related to fertility and contraception. But, there were differences in reporting between men and women. Moreover, differences vary by topic. More women than men reported that they had discussion with their husbands on the issues regarding number of children the couple wanted, time of using contraception, what method to be opted, who should use it. On the other hand, more men reported they had discussion on issues like spacing and postponement of next birth of child.

Table-5.4

Spousal Communication about Fertility and Contraception

Various aspect of fertility and contraception	**Women**	**Men**	**Dis-agree-ment between Couples**
Total number of children that they are going to have	58.2	49.5	8.7
Discussed prior to first pregnancy	23.5	31.8	8.3
Delay next pregnancy	4.1	7.2	3.1
Space between the birth of two children	6.2	8.1	2.1
Whether to use a contraceptive methods	49.8	27.3	22.5
Which method to be opted	47.5	38.3	8.7
Who should use contraception	49.3	39.9	9.4
Availability of the selected method	40.1	36.2	4.8
Health problems related to contraceptive usage	19.2	11.3	7.9
Seeking medical advice before using the method	12.7	10.9	1.8
Couples who ever discussed these issues	**58.7 (333)**	**56.6 (321**	**2.1 (12)**

Source: Sample survey of the present study

Difference in reporting was found to be greater about whether to use a method of contraception. An in depth analysis of these different reporting by couples implied that women often, on many occasion, assumed that they had discussed the matter with their husbands whereas men did feel the same. Men's silence in many situations was taken as an agreement. Couples normally did not like to discuss ay matter related to delay of next

pregnancy or spacing between two children. All these findings imply one thing that most of the couples preferred discussing about terminal method rather than temporary or reversal methods as they have attained their desired family size. In other words, duration of marriage had been found to be a major factor, on part of the men, to initiate such discussions.

5.4 Current Use of Contraception

In the present study area 55 percent (311) of the couples were currently using contraception at the time of survey. As reported by wives it was a little less than one fifth (23.4 percent) of total current users opted for terminal method (female sterilization). More couples opted for temporary methods of contraception. The use of OPC i.e., oral pill was comparatively high. It is worth to be mentioned that couples using the temporary methods (oral pill) belonged to General Caste Hindu and higher income groups **Table- 2 in Annexture-2**). On the other hand, couples opted for female sterilization was illiterate and belonged to the SC and lower income group. Mean age of the women opted for female sterilization was 29.8 years and mean number of children was four.

Table-5.5

Current Use of Contraceptives as Reported by Couples

Use of contraception by methods	Wives	Husbands
Permanent methods users-		
Female sterilization	23.4	21.8
Male sterilization	1.28	1.28
Modern temporary method users		
Copper-T	7.4	7.4
Oral pill	33.4	31.8
Condom	10.3	12.1
Total Traditional method users		
Withdrawal	2.6	24.5
Periodic abstinence	72.8	3.8

Source: Sample survey of the present study.

Use of male contraceptives, both modern and traditional, was found nominal. Male sterilization was very scanty. One in every ten couples currently using spacing methods, as reported, opted for condom while couples practicing withdrawal method to avoid pregnancy was very nominal.

Gender differentials in reporting the use of oral pill may indicate that in some cases husbands were not informed about the use of pill by their wives. It was also observed in the present study that the source of accessibility of oral pill of the rural women in the Darrang district were their

relatives and friends. This finding of the present study reveals that the couples' over dependency on female contraceptive devices in rural Darrang district in Assam. A few of them reported that their wives opted for sterilization for spacing the birth of children. This explains that men as a partner and couple as a unit did not have proper knowledge about the use of reversible and irreversible methods of contraception.

5.5 Contraceptive Morbidity

Out of 73 women opted for female sterilization 18.9 percent reported some illness while out of 104 oral pill users more than half (52.8 percent) reported some illness (**Table-5.6**). Couples suffering from contraceptive morbidity were also asked about where about of the source for their medical treatment. Most of them replied that they depended on traditional or herbal treatments. Couples' response about the motivational aspects whether ASHA / ANM / health workers had ever counseled them for treatment for contraceptive morbidity, was poor.

Table-5.6

Responses about Contraceptive Morbidity by Couples

Aspects related to contraceptive morbidity	Wives	Husbands
Post sterilization problem	18.9	16.6
Illness suffered by OPC users	47.2	43.2
Illness related to IUD	11.5	11.5
Consulted for medical treatment for illness related to sterilization	7.3	7.3
Received medical treatment for illness arose from OPC	--	--
Counseling by ASHA/ANM/health workers for treatment	--	--

Source: Sample survey of the present study.

The differences in response of men and women about the contraceptive morbidity (terminal and temporary methods) were analysed to understand some socio-cultural and socio-economic factors (of the couples using contraceptive) determining the morbidity (**Table-1 in Annexture-2**). Majority of the women suffered from morbidity related to female sterilization in the field study areas attended medical camp for sterilization. But due to lack of follow-up services they suffered from post operation ailment. Another reason for their ailment related post operation period was their lack of knowledge of and self-sufficiency of the couple as a unit, in accessing the medical treatment for the ailment.

In case of oral pill users, under reporting by men about their wives' contraceptive morbidity may be viewed as their ignorance. Men, in some cases were not informed by their wives about their act of adoption of temporary methods.

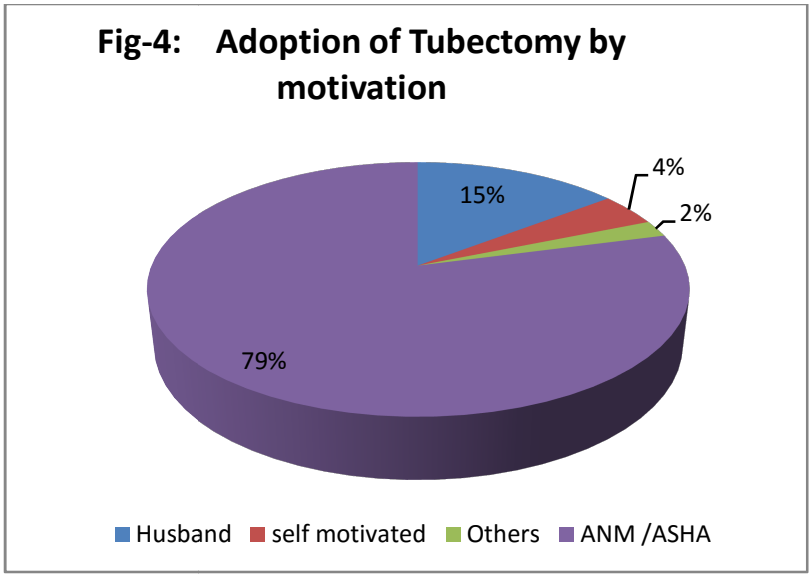
5.6 Motivation to Use Contraception

The motivations of the couples to choose a method of family planning differed. Compared to men (53 per cent) fewer women (32 percent) of women were self motivated. However, it was cent percent in case of Muslims couples because practice of modern contraceptives amongst the Muslims in rural Darrang was not socially accepted. Moreover, women were more dependent on others for the use of contraceptives. They lacked self-sufficiency related to usage of contraception.

The motivations of the couples to choose a method of family planning were also found to be differed by methods. A larger proportion of the couples adopted for female sterilization reported of being motivated by the heath workers or doctors. A larger proportion of the couples using reversible methods reported that their choice for the methods (for spacing between two births of children or avoiding the unwanted pregnancy) were self motivated. Comparatively a smaller proportion of women using

temporary method (oral pill) were self motivated or motivated by relatives or others.

Motivation by the health workers in this regard was found to be confined to permanent methods only. Report from PHCs and the respondents in the present study area had revealed one fact that provisions for monetary incentives female sterilization to both the motivators and beneficiaries of Tubectomy or Laparoscopy had resulted in large scale adoption of female sterilization in rural Darrang district of Assam.



Source : Sample survey of the present study.

Major proportion (i.e. 79.2 percent) of the total use of female sterilization in the rural area is found to be motivated by the health workers **(Fig:2)**. Provision for financial incentives to the motivators has induced the health workers to take more interest in motivating the couples for adoption of female sterilization in the rural area.

5.7 Conclusion

The perceptions of the couples about the control over pregnancy and avoidance of pregnancy and the couples self sufficiency in terms of using contraceptive methods have been discussed in details above. However, the study has observed that the perceptions of wives regarding control over their pregnancy differ from the perceptions of husbands. Many women in the present study considered that they had no control over their bodies whereas men felt that they had control over their wives' bodies. But, larger women believed that pregnancy could be avoided if a couple were careful. As they did not have any control over the sexual behaviour of the husband, they relied on their luck to avoid pregnancy. Men believed that women were meant to become pregnant and unwanted pregnancy could happen. Hence, compared to women men relied less on luck.

A majority of wives unlike their husbands reported their inability to access to and use a method of contraception. This implies women had less command over the reproductive and contraception choice. In other words, these women could not come out of the barrier of gender to obtain and use the temporary method of contraception to avoid unwanted pregnancy. The gender differentials related to perceptions about the importance of avoiding pregnancy reflect women's less self-sufficiency in reproductive and contraceptive choice in the present study. A larger proportion of women had expressed that though they have less control over their bodies they could convince their husbands to limit the child bearings. But they lacked efficiency in avoiding or spacing the pregnancies.

Though more than half of the couples had discussion on the matters related to family planning, husbands and wives differed in reporting in certain areas of reproductive health. Socio-cultural factors had been considered as the prime factors in fostering the inter-spousal communication. But, in most cases husband took the initiative in such discussion and they thought that wives could not initiate the discussion.

So far the current use of contraception was concerned it was observed that whether it was permanent or temporary method of contraception most of the couples felt convenient in using female contraceptives. This was

authenticated by the findings in the study area that only 2.4 percent case of male sterilization was reported. Moreover, the use of temporary methods in terms of oral pill was found to be in larger proportion than the male reversible contraceptive, condom.

Women were found to be motivated by others while men were self motivated in obtaining of a method of contraception. It indicates that women required prior approval of their husband for the use of family planning methods.

Contraceptive morbidity was found to be high in case of both the users of permanent and temporary methods of contraception. Obviously it was higher in case the women opted for sterilization. Apart from the factors such as ignorance on part of the couples, lack of awareness, gender norms the medical factor related to follow-up services during the post sterilization period was also counted as an important factor causing contraceptive morbidity amongst the women. On the other hand, morbidity arising from the use of oral pill was found to stem from the absence of follow-up services and awareness amongst the couple.

Chapter-6

Reproductive Behaviour, Decision making and Inter-spousal Communication

6.1 Introduction

Generally fertility or child birth occurs within the marital union in the Indian society. Hence to understand the reproductive intension of the couples it is essential to throw some light on some background characteristics of the couples under study, like marriage and pregnancy aspect. In this chapter, first, focus is given on certain aspects related to marriage like, age at marriage or means age at marriage and second on some aspects of fertility behaviour and decision making regarding reproductive intension and choice of contraception and inter spousal communication.

6.2 Age at Marriage of Wives

Age at marriage is considered as one of the prime background factors that has a strong impact on couples' fertility behaviour. Lower age at marriage

(as discussed in the previous Chapter 3) exposes the women to the risk of multiple pregnancy and hence unwanted pregnancy and poor reproductive health.

In the field study areas of the present study the mean age at marriage of the wives of the respondents was found to be 19 years and the mean age of husbands was 22 years. However, the mean age at marriage was found to vary with respect to the caste and community. For example, mean age at marriage of the wives in the village under the kuwari pukhuri PHC block was lower than the other villages. It was found to be higher in the Hazarikapara village (21 years).

In rural Darrang district decision regarding the marriage of a daughter is taken by the parents. In the present study areas in 25 percent cases daughters were not consulted by their parents before the marriage. In 87 percent cases they were consulted mere as a formality. Most of the daughters depend on their parents' choice as they think parents make the best decision for them.

6.3 Fertility Behaviour

Out of 567 wives having at least one living children with lower mean age at marriage were more or less exposed to multiple pregnancy, abortions

and unwanted pregnancy (**Table-3.2** in Chapter 3). As a consequence, mean age at first birth was 19 years. **Table-3.2** also showed that the mean number of living children was three and it was found to vary with respect to the caste and religion. For SC women it was found to be three, for General Caste Hindu women it was two and for Muslim women it was 4. More than one forth of the women had experienced abortions while more than 27 percent of them had experienced loss of at least one child. The percentage of abortion and loss of at least one child, however were also found to differ with respect to the caste and religion and it was highest amongst Muslim couples.

Table-6.1

Mismatch of Information on Pregnancy Reported by Husbands and Wives

Pregnancy related aspects	**Men**	**Women**
Number of live births ever occurred	567	567
Number of currently survival children	567	567
Number of non surviving children	193	190
Knowledge about date of last birth	493	493
Whether wife had abortion	193	205
Number of times wife had aborted	193	205
Number of times wife had still births	27	18
Currently pregnant	51	54
Month of pregnancy	51	54

Source: sample survey of the present study.

To test the level of knowledge awareness few questions relating to wives' pregnancy were asked to the husbands. The responses of the husbands to particulars about pregnancy were matched with that of the wives to have the idea about the couples attitude and males' responsibility towards the women's' reproductive health (**Table-6.1**).

By and large men and women reported same information related to the aspects like number of live birth, date of last birth. But their responses mismatched when questions on other issues like stillbirth, abortion were asked. It was observed in the field study areas that women did not want to provide information regarding stillbirth while, men did not mind giving details. Women reported stillbirths as infant deaths. Social beliefs associated with stillbirth takes women responsible for it. Infant's death occurs on account of a number of external factors while stillbirth is only associated with the mother. Hence women did not want to be held responsible.

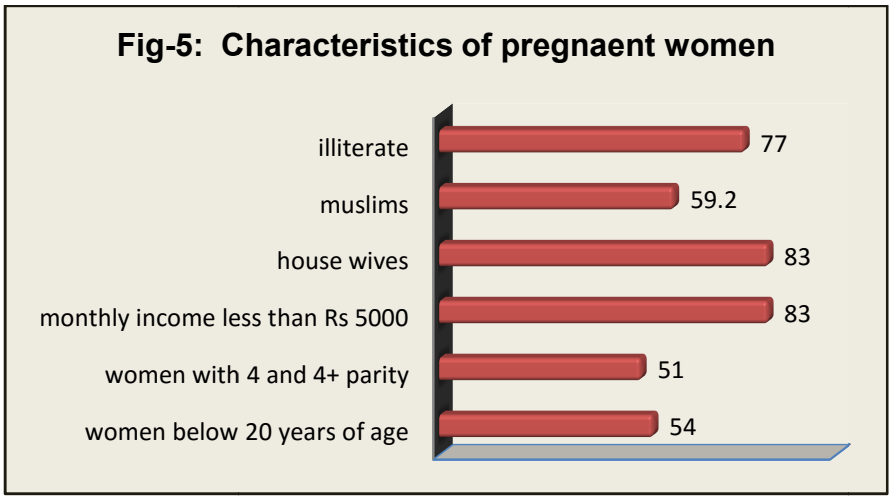
On the same ground women did not like to inform their husbands and parents in-law about their abortions. Hence fewer men knew about their wives' abortion. In the present study 12 women did not informed about their abortion that underwent. Due to these social taboos 3 women in the field study areas reported did not inform their husbands about their

pregnancy as they wanted to wait for a certain period for the confirmation of their pregnancy (**Table-6.1**)

The differences in the response of husbands and wives referred to the existence of gendered attitude. Some socio-cultural beliefs centering women in Rural Darrang district still were found to be strong enough to bring these differences in gendered attitude. In some rural areas of the district, especially in Kharupetia PHC block, women's relative position in the family was confined to her reproductive capabilities only. Hence, the desire to conceive amongst the women soon after the marriage was found prominent. As such proportion of unwanted or unplanned pregnancy was comparatively high.

6.4 Characteristics of the Pregnant Women

Out of a total of 256 couples not using any contraceptive during the survey period, 94 wives (16.6 percent) reported pregnant. A majority of them (54 percent) was below 20 years and half of them were of parity four and above. seventy seven percent (77 percent) of them were illiterate. Majority of them were house wives and from lower income strata (**Figure-5** below)..



Source: sample survey of the present study

6.5 Decision Making Regarding Reproduction and Contractive Use

The decision making power regarding the childbirth and the choice of contraception, particularly in a stereo type male dominated society lies with the husband. Many studies show that women's silent concurrence or lack of protest is interpreted as having been arrived at joint decision. It is seen generally that women neither question the decision of their husbands nor enter into any discussion with them (Khan and Patel, 1996).

Social and cultural factors including the gender norms, condition women's reproductive intentions i.e. the number of children they actually want and how they want their births to be spaced. Women often do not get the

support that they need to fulfil their reproductive intentions and hence, have an insignificant role in decision making process regarding the number of children that they give birth to (Barneett and Stein, 2000; Padma, 2005). It has been observed that the total fertility rate in many countries would have decreased by one child per women, if the women could have the total number of children that they wanted (Padma, 2005).

Table-6.2 shows the difference in responses by the couples on various issues of reproductive decision making. It is observed that the decisions relating to fertility and pregnancy were more or less wife oriented or joint decision. But the decisions relating to method choice or spacing between two children were taken by husbands. However, Decision relating to reproductive and contraception found to vary with respect to caste and religion.

Table-6.2

Mismatch of Information Reported by Couples about Decision on Reproductive Intension and Contraceptive Use

Decision about reproductive intension and contraceptive	Husbands	Wives
Number of child to bear		
Husband oriented	24.2	28.0
wife oriented	2.3	2.3
Joint decision	71.6	62.6
Sex composition of children		
Husband oriented	28.1	30.6
wife oriented	10.5	10.9
Joint decision	61.4	58.2
Limiting the size of family		
Husband oriented	20.2	23.7
wife oriented	15.2	15.2
Joint decision	64.6	61.1
Spacing the birth between two children		
Husband oriented	29.8	24.3
wife oriented	13.8	17.2
Joint decision	56.4	58.5
Choice of contraceptive		
Husband oriented	35.9	32.6
wife oriented	15.0	18.0
Joint decision	49.1	49.4
Adoption of sterilization		
Husband oriented	27.8	23.9
wife oriented	25.6	25.6
Joint decision	48.6	48.5
Choice of temporary methods for spacing		
Husband oriented	42.1	39.5
wife oriented	13.1	18.5
Joint decision	45.8	42.0

Source: sample survey of the present study.

6.5.1 Decision Regarding Total Number of Children by Community

In our field study it was observed that the decisions making power on the matters like total number of child bearing was highly conditioned to the prescribed gender roles of the society. It was one in every ten women reported (6.5 percent cases of a total of 567 couples with at least one living child), the decision regarding the total number of child bearing was taken by themselves while, in most of the cases (67.4 percent) it was a joint decision and the rest (i.e. 26.1percent) were decided by the husbands (**Table- 6.3**).

The same trend was observed in case of the SC and General Caste Hindu couples. But, a different trend was observed in case of the Muslim couples. More than half of Muslim husbands took the decision and the rest was taken jointly.

Table- 6.3

Decision Making on Reproductive Intension and Contraceptive Use by Community

No. of children	SC	General Caste Hindu	Muslim	Total
Husband Oriented	(16.8%)	(3.8%)	(54.3%)	(26.1%)
Wife oriented	(2.7%)	(1.4%)	--	(6.5%)
Joint Decision	(80.5%)	(94.8%)	(45.7%)	(67.4%)
	N = 165	N=279	N=123	N=567
Sex Composition of children				
Husband Oriented	23.9%	11.1%	62.9%	29.6%
Wife Oriented	8.8%	3.8%	--	10.9%
Joint Decision	67.3%	85.1%	37.1%	59.5%
	N=165	N=279	N=123	N=567
Spacing Between Children				
Husband Oriented	(25.7%)	(10.0%)	(68.1%)	(28.7%)
Wife oriented	(5.3%)	(7.6%)	--	(15.2%)
Joint Decision	(69.0%)	(82.4%)	(31.9%)	(55.9%)
	N=165	N=279	N=123	N=567
Use of Contraceptive				
Husband Oriented	(27.3%)	(32.8%)	(88.9%)	(33.9%)
Wife Oriented	(13.0%)	(18.9%)	----	(17.0%)
Joint Decision	(59.7%)	(48.3%)	(11.1%)	(49.1%)
	N=115	N=155	N=42	N=311
Adoption of Sterilization				
Husband oriented	30.8%	41.2%	100%	25.9%
Wife oriented	30.8%	--	--	25.6%
Joint Decision	38.5%	58.8%	--	48.5%
	N=45	N= 26	N= 02	N = 73
Use of Temporary Methods				
Husband oriented	12.9%	39.3%	66.6%	39.5%
Wife oriented	44.4%	11.9%	------	18.5%
Joint Decision	33.3%	48.8%	33.3%	42.0%
	(N=47)	N= 26	N= 19	N= 159

Source: sample survey of the present study.

6.5.2 Decision Regarding Total Numbers of Sons and Daughters

Table- 6.3 shows that a major proportion (i.e.60.0 percent) of the decision regarding the total number of living sons or daughters that the couples actually want to have, was joint decision while, 29.6 percent was found husband oriented and the rest i.e. 10.9 percent was wife oriented.

The same trend was observed in case of the SC and General Caste Hindu couples. Exception was found amongst the Muslims. Comparatively a higher proportion of the decision (i.e. 62.9 percent) was husband oriented and the rest (37.1 percent) was joint decision.

6.5.3. Decision Regarding Spacing between Two Children

Most of the decisions regarding the spacing between the children amongst the 567 respondents was also found joint decision (i.e.56 percent) and 28.7 percent was husband oriented while, a nominal proportion (i.e.15.2 percent) was wife oriented (**Table-6.3**).

The wife oriented decision regarding the space between the two children was 2.9 percent amongst the SC and 7.6 percent amongst General Caste Hindu while, it was found nil in case of the Muslim couples.

However, it is worthwhile to notice that SC and the General Caste Hindu women had a higher participation in the fertility related decision-making process as compared to the Muslim women.

6.5.4 Decision Regarding Choice of Contraception

More than thirty three percent of the total use of contraceptive, in case of 311 currently married couples using contraception in our sample study area was husband oriented while, 17.0 percent was wife oriented and the rest i.e. 49.1 percent was joint decision (**Table- 6.3**).

Amongst the Muslims more than four fifth of the total decisions regarding the use of contraception was husband oriented while, and the rest was joint decision.

6.5.5. Decision Regarding the Choice of Sterilization

More than twenty seven percent decisions of the total use of sterilization (73) was husband oriented while, 25.6 percent and 48.8 percent was wife oriented and the outcome of joint decision respectively (**Table- 6.3**).

The proportion of husband oriented and wife oriented decisions regarding the use of sterilization were found equal in percentage i.e. 30.8 percent. It was observed that the husbands of the less educated or illiterate and poor women belonging to the SC community were less concerned about the family and dependent on the earnings of the wives. In such cases, to get rid of multiple pregnancies, women often opted for the terminal method so that they could give much time for their work outside the home for their livelihood. On the other hand, amongst the General Caste Hindu women out of the total use of sterilization (17) major proportions i.e. 41.2 percent and 58.8 percent were found husband oriented and joint decision while, wife oriented decision was found nil. On the contrary, in a traditional male dominated Muslim society within the limited use of sterilization (2) cent percent was the husband oriented.

6.5.6 Decision Regarding the Choice of Temporary Methods of Contraception

In more than two fifth cases the decision regarding the choice of contraception for spacing the birth between two children were made by the couples jointly. Another two fifth of the decision was made by husbands.

However, decision making power of women was found to vary with socio-

economic and socio-cultural factors. SC women had more bargaining power in decision making regarding the choice of contraception as majority of them, in the field study area, were working women and from low income strata. Moreover, in most of the cases they were the sole income earner in the family. Proportion of joint decision was higher in case of the women belonging to the General Caste Hindu. Amongst the Muslims majority of husbands were found to make the choice of contraceptive as well as the number of child bearing (**Table-6.3**).

6.4 CONCLUSION

Thus, from the above discussion it follows that the fertility behaviour and decision making power of the partners as a couple largely depends on the social and cultural norms of the society. The decision regarding the number of children and the use of family planning irrespective of caste and religion, more or less lies with the husband in our society. Due to the unequal status of women in a traditional male dominated society women hesitate to take part in decision making process.

On the other hand, women in the other community including the privileged General Caste Hindu women were found to have less autonomy in the reproductive decision making process compared to their counter

parts. Women in the Muslim society were tightly bound by the traditional norms and culture and the male folk played the leading role in the decision making process. The Char women had no say in the decision making regarding the number of children and the use of contraceptive. But, Muslim women with better socio-economic and demographic background compared to the Char women, are found to participate jointly with the husband in certain spheres of reproductive decision making and a few take decision regarding the choice of contraception (spacing method). It is also observed that amongst the poor, illiterate or less educated and working women, the decision regarding the choice of terminal method to limit the size of the family laid with the women as they had the financial autonomy.

` Hence, finally it can be concluded that with the spread of education and urbanisation, the traditional cultural values of the society undergo a change. Female education and economic empowerment of women are the prime pillars of capacity building in women. This ensures greater participation of women in the decision making process including the reproductive decision and hence, the freedom of choice and equal right to women.

Chapter-7

Men's Preference for Female Contraceptive

7.1 Introduction

Men generally show preference towards the adoption of family planning methods (both terminal and temporary) by female (Kaur et al, 2014, Khan and Patel, 1997). About one third of Indian women adopt female sterilization for regulating their fertility (IIPS 2005-06). But, people from different socio-economic and cultural groups do not opt for female sterilization in equal proportion (Pradhan and Ram,2009). In India it is observed that poor and illiterate women from rural area generally prefer to opt for female sterilization while the upper- class women use spacing methods like IUD, OPC, periodic abstinence or withdrawal (Basu 2005; Rele et al, 1989). Social activists often argue that the programme that ignores vasectomy and promotes female sterilization is a clear cut evidence of human right violation (Chankapa 2010,Guota et al,2002). Several studies have showed that male respondents had fair knowledge

about contraception. But still gap existed between the knowledge and practice. The reasons of not using male contraceptive were mainly because of social taboos associated with male contraceptives, misconceptions about the side effects of such contraception, individual inconveniencies etc. (Kaur et al,2004; Char,A,2011, Makade KG, Padhyegurjar M, Padhyegurjar SB and Kulkarni RN, 2012).

In this chapter gender differential about the future reproductive intension of the couples who were not currently using any contraceptive but intended to use in future has been analysed.

7.2 Future Reproductive Intensions of the Couples

Nearly three fifth (60.6 percent) of the couples in the category of intended users (101) revealed their preference for the use of contraception. But, amongst them 60.6 percent women as against 71 percent of men could revealed their preferences for particular method (Table-7.1). The difference of almost 10 percent was because of women's dependency on their husbands. In other words women needed prior approval of their husbands' approval for the choice of contraception as they did not have any say in this regard.

Table-7.1

Intended Users Who are Sure Aabout What Method to be Used

Intended users	Women	Men
Sure about what methods to be used	60.6	71.1
Not sure about what methods to be used	39.4	20.9
Total	**101**	

Source: Sample survey of the present study

Amongst the 101 women who intended to use family planning methods in future and also revealed their individual preferences for methods more than three fifth women (66 percent) were with low parity (two) wanted to have more children. After achieving their desired number of children, they intended to opt for temporary methods (preferably Oral Pill or Condom or Copper-T) to avoid future pregnancy. The rest one third with higher parity (3 or more children) wanted to opt for Tubectomy to stop child bearings. Of the rest, though a few did not have want for children, they were uncertain about the use of contraception. This also indicates that they did not have ever discussed the matter with their husbands. Most of the women belonging from this category were less privileged and belonged to lower income group.

Table-7.2

Couples' Preference for Contraception by Methods

Intended to Use Contraception and Revealed Preference for Methods	Women	Men
Permanent method	27 (26.7)	33 (32.7)
Female sterilization	26.7	32.7
Male sterilization	--	---
Temporary methods	74 (73.3)	68 (67.5)
Oral pill	42.6%	56.1%
Condom	20.8%	26.9%
Copper-T	10.1%	17%
Total	**101**	**101**

Source: Sample survey of the present study

The gender differentials relating to the individual preferences for irreversible and reversible methods have been shown in the **Table-7.2**. the table shows that men preferred their wives to undergo sterilization instead of accepting vasectomy for themselves which is medically an easier and simpler and also a safe method. This was because of the prevalence of major misconception and misbelieves about the device as well as about women's work load in the house-hold.

It can also be also observed in **Table-7.2** that men preferred reversible contraception by female instead of condom which is a safe and easier

method to be followed without any side effect. The reason for such preferences has been analyzed in terms of the responses of the husbands.

7.3 Preference for Female Contraceptives

7.3.1 Why Males Prefer Female Sterilization?

Misconception and misbelieve about vasectomy prevails amongst men and women. Men believed that vasectomy leads to impotency which considered being a shame on part of them. Moreover after sterilization men would lose work efficiency which would lead to financial loss.

Table-7.3.1

Reasons why Tubectomy is Preferred over Vasectomy

Reasons	**%**
Being the main earner in the family, cannot take rest, male has to go out	20.6
Fear of side effects / reduces working capacity / Causes weakness	78.2
Fear of method failure / social consequences causing embarrassment in	87.3
No trouble if women under go sterilization / easier, less side effect and no	14.
Males are indivisualistics / less concerned about the choice of women	9.3
Others	5

Source: Sample survey of the present study

In case of device failure, if wives would become pregnant she would be considered as promiscuous. These social taboos and believes worked as the strong barrier in the way of adopting male sterilization. **Table-7.3.1** also shows that majority of men in the present study cited the reasons for preferring female sterilization (Tubectomy) over male sterilization (vasectomy) were: (i) the fear of method failure and its subsequent social consequences for the couples (87.3 percent) , and (ii) fear of side effect such as loss of work efficiency and weakness causing deduction in family income and financial loss (78.2).

Though a considerable proportion of men believed that it was wrong to blame a woman for getting pregnant arising out of the failure of the method related to vasectomy by her husband, they confessed that they could not convince the people and change their view.

Table-7.3.2

Comparison of Male's Attitude Towards Tubectomy and Vasectomy

	Vasectomy	Tubectomy	Both	Do not know
Easy to perform	20	51	11	28
Less chance of post operative complecation	12	55	9	24
Fewer side effects	13	59	6	22
Needs less rest	17	62	10	11

Source: Sample survey of the present study

Table-7.3.2 also shows the male's attitude towards Tubectomy and Vasectomy. Half of men (51percent) in the field study area of the present study believed that between Tubectomy and Vasectomy, Tuectomy was easier to perform and had less chance of post operative complications (55 percent). Almost three fourth of men believed that Tubectomy compared to vasectomy had fewer side effects and needed less rest.

7.3.2 Preference for Tubectomy over Vasectomy by Sterilized Couples

Reasons for preferring Tubectomy over Vasectomy by sterilized women in our present study has been analysed in the same pattern as it was done in **Table-7.3.1.**

Table-7.3.3

Reasons for Preferring Tubectomy by Sterilized Women

Reasons	**%**
Vasectomy could make men weak. Men would loose efficiency	65
Women stay at home and can take rest. Men cannot take rest and hence cannot stop working.	58
Vasectomy causes tension as it may fail. Wife's character is suspected.	28
Wife herself wanted to go under sterilization	20
Fear of operation	4
Other family member decided	9
Total	**73**

Source: Sample survey of the present study

Table-7.3.3 shows that nearly three fifth of couples who had opted for Tubectomy cited the reasons for preferring Tubectomy over Vasectomy cited the reasons like vasectomy would cause weakness and loss of efficiency amongst men and men cannot stop working as he had earn income etc. it is worth to be mentioned that one fifth of couples cied the reasons like women herself wanted to undergo sterilization while one fifth of them reported it was decided by other members of their families. During the interaction with the couples it was revealed that women in some cases decided to opt for Sterilization because they felt that their husband were less concerned in spacing between births. Since women had to bear the burden of child bearing and raring they had to opt for female sterilization to avoid multiple pregnancies.

7.3.3 Views of Health Workers at PHC

An informal discussion with several health workers and PHC staff (male MPW) about the reasons of male's preference for Tubectomy over Vasectomy revealed some facts which may be explained as follows. Couples were motivated to opt for sterilization as the health workers over emphasized the simplicity of female sterilization as a permanent method contraception like Laparoscopy that after operation women could continue their house hold chores on the same day. As a result, males asked their

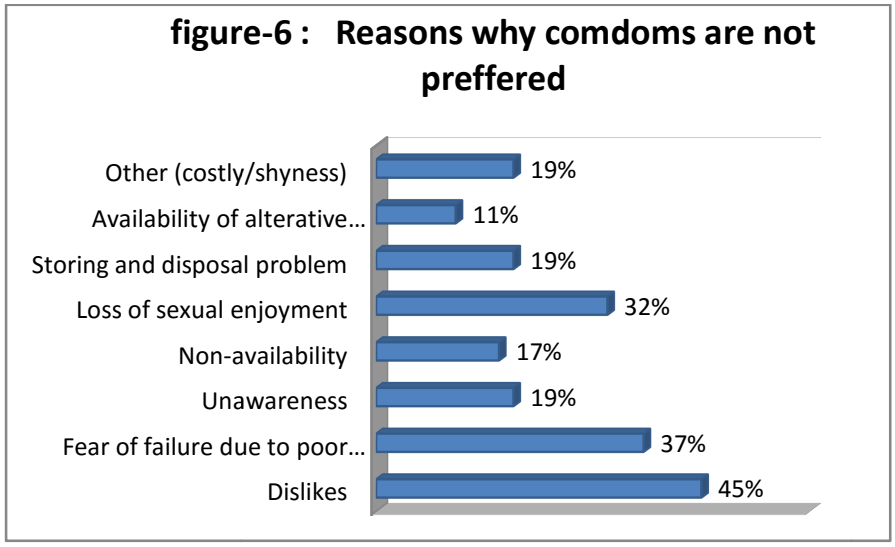
wives to get sterilized. Though Tubectomy compared to Vasectomy is considered complicated as a method of limiting the size of the family. But, with the recent projection of Laparoscopy as an easier method leniency towards the adoption of female sterilization by the couples has been observed.

Counter check of the questions in discussion also revealed another important fact that the health workers at PHCs took less interest in motivating the couples for family planning. Most of the health centers in rural Darrang district were emphasizing in providing prenatal and postnatal care to mothers and child immunization programmes. Moreover, most of these centres performed very poor as a service provider of spacing methods of family planning. This has been revealed by the couples cognitive level of accessing the family planning methods.

7.3.4 Preference for the Usage of Spacing Methods by Female

A detailed probing on why despite of the easy availability and easy way of using of condoms, men did not prefer to use them. The present study has analysed the responses of the respondents (men) about the reasons of not using condoms by males in eight categories.

Figure:2 shows the reasons cited by the men for not using condom was disliking of the method (45 percent), fear of failure and poor quality (37 percent), unawareness (19 percent), non-availability (17 percent), loss of sexual pleasure (32 percent), storing and disposal problem (19 percent), availability of alternative methods (11 percent) and others like costly or shyness in buying (19 percent).



Source: sample survey of the present study

Most of the reasons of using condoms cited by men are personal and important. But mainly two reasons such non-availability and unawareness about the usage was programme related and hence matter of concerned

for the programme managers. It is worthwhile to be mentioned that in some part of rural areas of Darrang District retail outlet was very poor. Moreover due to shyness men cannot get the access to the condom.

Generally resistance on the part of the men to use condom was mainly because of: (1) the use of condom caused interruption during the intercourse, (2) problems arose after it use in terms of storing and disposing on account of lack of privacy at home in the rural areas. They found it messy, dirty, repulsive and problematic and (3) poor quality of condom or incorrect use of condom resulting in unwanted pregnancy.

Hence, an in depth study is required to assess these inconveniencies are responsible for lower use of condom by male as compared to the use of other spacing methods by female.

7.4 Conclusion

Male's low participation in reproductive and contraceptive health often stems from the prevailing social gender norms, misconception and misbelieves related to male contraception. Moreover, improper motivation by the health workers about proper method choice results in over

emphasis on female contraception. Preference for female sterilization over male sterilization often leads to human right violation.

Most of the women in our study were found to opt for spacing method for limiting the size of the family to avoid unwanted pregnancy as their husbands were less concerned about the pregnancy of wives and did not want to adopt family planning method. Amongst the intended users, a proportion of women wanted to get sterilized after attaining their desired number of children as their husbands did not show interest of getting sterilized.

Both the male contraceptive whether it is vasectomy or condom, are safer and easier methods of contraception having no side effects. But their use in the field study area had been found to be comparatively low due to lack of awareness and misconception regarding the usage and choice of contraception. In this context, a better and focused counseling of men regarding the use of condom and vasectomy may yield a better result.

Chapter 8

Policy Implications based on the Study

Villages under study are well connected with the PHCs. But only 38 percent of couples (nearly two fifth) were exposed to at least one massage related to reproductive health and family planning.

Despite the efforts made by the Government officials in the health sector to promote client–oriented contraceptives, the shift was not observed. More massages related to temporary contraceptives were yet to reach the young married couples. Many women get married and pregnant at an early age, mainly because of gendered attitude. It is very difficult to stop the early marriage. But effort should be made to delay the early pregnancy by providing information related to health aspects. Adequate information and knowledge related to the usage of temporary methods of contraception can also be provided to the young married couples.

Women have limited knowledge about various methods of family planning. They do not have access to the methods. They need prior approval of

their husbands to use contraceptives. Thus, women's inaccessibility to the methods is the prime cause of their inability to obtain the methods when they actually need i.e. prior to the first pregnancy. Hence, the urgent need of the hour is to provide the right information to the young women, particularly to those who got married at early age.

The attitude of the health workers needs to be changed. Though a shift from target based to target free approach has been observed at the policy formulation level, the mindset of the workers has not yet changed.

It is found that women who have attained the desired size of family are motivated easily. Gender restriction on women prevents women to adopt the temporary methods despite their desire to use it to postpone the next pregnancy.

Inter spousal communication is found to have a positive relation on the usage of contraception. Hence efforts should be made to educate the husbands at their young age.

Effort should be made to remove the misconceptions about the use of family planning and convince men about the importance of contraception for the general health and wellbeing of the family. Strategies like

promoting education among women and husbands and educating the public (particularly the male members i.e. husbands) about the benefits of the small family norms, will help to promote the use of contraception and minimise the unmet need in the district.

Annexure -1

Socio-Economic and Demographic Characteristics of the couples opted for female steriliation

Socio – Economic And Demographic Characteristics	Wives (%)	Husbands (%)
Current Age of Respondents		
20--24 Years	---	
25--29 Years	34.2	31.5
30--34 Years & above	65.8	68.5
-Education of Respondents		
Illiterate	50.0	39.2
Up to Primary	18.8	39.5
Up to Middle	16.7	11.3
Under Matric	14.6	10.0
Caste/Communities :		
ST (Bodo)	32.8	
SC	39.2	
General Caste Hindu	23.0	
Muslims	5.0	
Mean Age at Sterilization	**29.8 Years.**	
Occupation of Respondents		
House-wife	87.5	--
Labourer/Daily Wage earner/ Service-holder	13.5	
Occupation of Husbands		
Farmer	45.8	
Trade/Self Emp./ Service holders	31.7	--
Daily Wage earner	22.5	
Monthly Income Status		
Less Than 5000	37.5	
5000-10,000	66.7	--
10,000-20,000 & above	167	
Mean Number of Living children	**4.0**	
Husband Wife Discussion		
Yes	45.8	--
No	54.2	
Motivated By		
Husband	14.6	
Respondent	4.2	--
Others	2.1	
ANM /ASHA	79.2	

Source: Sample survey of the present study.

Annexure-2

Socio-Economic and Demographic Characteristics Of the couples using temporary methods of contraception

Socio – Economic And Demographic Characteristics	Wives (%)	Husbands (%)
Current Age of Respondents		
20--24 years	20.2	10.2
25--29 years	46.3	32.9
30--34 years	20.5	41.2
35 years and above	18.5	25.7
Education of Respondents		
Up to Primary	19.9	8.7
Up to Middle	20.1	23.9
Under Matric	29.0	32.2
HSLC/HS pass/ above	31.0	35.2
Caste/Communities :		
ST (Bodo)	8.4	
SC	11.8	--
General Caste Hindu	54.6	
Muslim	25.2	
Occupation of Respondents		
House wife	81.1	--
Labour/ Daily wage –earner/service holder	18.9	
Occupation of Husbands		
Farmer	19.3	--
Trade/Self- employed/ Service-holders	77.3	
Daily wage- earner	3.4	
Monthly Income Status		
Less than Rs. 5000	22.7	
Rs.5000- Rs.10,000	217.6	--
Rs.10,000- Rs.20,000	21.0	
above Rs. 20,000	38.7	
Mean number of living children	**(2.9)**	
Husband Wife Discussion		
Yes	72.3	--
No	27.7	
Motivated By		
Husband	37.0	
Wife	23.5	-----
Others	10.1	
ANM /ASHA	29.4	

Source: sample survey of the present study.

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