MEN AS SUPPORTIVE PARTNERS IN WOMEN'S REPRODUCTIVE HEALTH: A STUDY IN URBANIZING VILLAGES OF GAUTAM BUDDHA NAGAR DISTRICT, UTTAR PRADESH

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DECLARATION

I, **Disha Tewari,** declare that the Ph.D. thesis titled **"Men as Supportive Partners in Women's Reproductive Health: A Study in Urbanizing Villages of Gautam Buddha Nagar District, Uttar Pradesh"** submitted by me for the award of the degree of **Doctor of Philosophy** of Jawaharlal Nehru University is a bonafide work and it has not been submitted, in part or full, to this University or any other University.

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DEDICATED

TO

MY MOTHER

AND

TEACHERS

WHO MADE

THIS

WORK

POSSIBLE

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(DISHA TEWARI)

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GLOSSARY

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Workers
CSSM	Child Survival and Safe Motherhood Programme
DLHS	District Level Household and Facility Survey
ICDS	Integrated Child Development Services
ICPD	International Conference on Population and Development
IUD	Intra-Uterine Device
IIPS	International Institute for Population Sciences
MCH	Maternal and Child Health
MOHFW	Ministry of Health and Family Welfare
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
OBC	Other Backward Classes
PHC	Primary Health Centre
PNC	Post-natal Care
RTI	Reproductive Tract Infection
SC	Scheduled Caste
ST	Scheduled Tribe
STI	Sexually Transmitted Disease
RC	Reference Category
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh

CHAPTER -1
INTRODUCTION

CHAPTER-1

INTRODUCTION

1.1 Introduction

This research is an attempt to understand the reproductive health issues through the lens of men's involvement in their wife's reproductive health in the context of urbanizing villages where the primary occupation is shifting largely from farming to other forms of earning livelihoods. Through this study, an effort is made to capture the role of husbands when the wife seek and utilize health-care services including decision-making on health-care. Many villages are affected by urbanization in nearby areas in the wake of developments in infrastructural and communications. Keeping this change in mind, the research primarily focuses on how the gender dynamics is played out and affects husbands' involvement regarding the health of women. Reproductive health as defined by the World Health Organization refers to a "State of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (United Nations Population Fund, 1996:45). The present study focuses on reproductive health behaviour that constitutes maternal health-care during and after pregnancy, choice and use of contraceptives, and decision-making around fertility regulation. The research is restricted to only these aspects as most of the maternal deaths occur at the time of child bearing or during pregnancy (due to health complications). Thus for the purpose of this research, husband's involvement in reproductive health is limited to seeking health-care by women, choice of contraceptive use, and fertility regulation.

According to Dudgeon and Inhorn (2004), some of the generalizations are made about men across cultures and have been empirically demonstrated. "Men have traditionally been portrayed, either explicitly or implicitly, as relatively unconcerned and unknowledgeable about reproductive health. They have been seen primarily as impregnators of women or as the cause of women's poor reproductive health outcomes through STI exposure, sexual violence, and physical abuse" (Dudgeon and Inhorn, 2004: 1381). This one-sided perspective of early policy-makers has discounted any possibility of men's involvement in reproductive health matters. Such lack of concern for men's involvement becomes more important in urbanizing villages where there are constant possibilities of new choices emerging as a result from

increased access and awareness to biomedicine, and institutionalization as well as medicalization of childbirth. This understanding of men's involvement particularly in decision-making processes is crucial to contemplate the increasing female feticide and infanticide occurrences, growing rates of sexually-transmitted diseases, and the spread of HIV-AIDS. Furthermore, understanding of urbanization is important to studying social change. Often times it is understood that urbanization promotes de-traditionalization. However, it certainly does not mean that tradition no longer plays any role. Traditions are chosen and often invented, and they have force only through the decisions and experience of individuals (Beck and Beck-Gernsheim, 2002: 25-26). This implies that with urbanization a set of new values permeate into the minds of people. Therefore, it is important to understand the process of urbanization in rural areas and the kinds of tension it creates between rural and urban value systems.

In addition to the issues of urbanization and decision-making, the institutional (biomedical) model of childbirth, and the role of State are crucial for understanding the changing perspectives and contributions of men to women's reproductive health. The International Conference on Population and Development (ICPD) took the first step to recognize men's role in reproductive health and stated:

> *"Innovative programmes must be developed to make information, counseling and services for reproductive health accessible to adolescent and adult men. Such programmes must both educate and enable men to share more equally in family planning and in domestic and child rearing responsibilities and to accept the major responsibility for prevention of sexually transmitted diseases..."*
> (United Nations Population Fund, ICPD 1994: 48).

The above statement underscores the importance of involving men through educating them and making information accessible to them in the matters of reproductive and sexual health. This is crucial in cultures where men are the main decision-makers on family and community. Furthermore, India's National Population Policy (2000) plays a crucial role in terms of being a "gender sensitive policy" (Ministry of Health and Family Welfare, 2000). This policy focuses on the unmet need for reproductive health services and convergence of service delivery system at the village level. It calls for the decentralization of the health programmes for the integration and co-ordination of service delivery and expects that services reach at the household level. Nonetheless, the National Population Policy also

addresses the need for the active involvement of men in planning families, supporting contraceptive use, helping pregnant women to stay healthy, helping after the baby is born and finally, being a responsible father (Ministry of Health and Family Welfare, 2000:11). In addition, the National Rural Health Mission aimed to target the villages and improving rural health-care service delivery system also plays a significant role to improve the reproductive health of women through increased outreach. Thus this research is an attempt to unfold the implications of urbanization through focusing on the influence of structural and socio-economic changes on reproductive health by concentrating on men's involvement that affects the reproductive health of their daughters, spouses, and daughters-in-law in their households.

1.2 Purpose of the study

The main purpose of the study is to look at the men's involvement in their wife's reproductive health including decision-making processes. The questions are asked to both currently married women and men from different households of the same villages. This is done to capture the differences in the responses of women and men to understand how the gender dynamics is played out and whether the expectations of women and men differ or match within the context of urbanizing villages. Comparison between women's and men's responses is important because it has been well established by various surveys that "women and men do not necessarily have similar fertility attitudes and goals" (Bankole, 1995 and Ezeh, 1993 cited in Bankole and Singh, 1998:15). Moreover, the perception that men influence reproductive decisions more being the head of the household and in control of family's assets may also be an exaggeration. The actual situation might vary over time and location. So, for this research which is based in urbanizing villages, it becomes crucial to understand whether men are the major decision-makers especially on the issues of women's reproductive health and also in what type of health decisions they are involved in. Furthermore, responses for various indicators of health-care are also compared across villages showing low urban characteristics and villages depicting high urban characteristics. This insight would provide an understanding of the influence of urbanization particularly on decision-making processes and the extent of involvement of men in women's reproductive health.

At the individual level analysis, an index of men's involvement in various decisions on women's reproductive health is constructed. The net effects of socio-economic, demographic, and women's empowerment on men's engagement are gauged to see what factors significantly affect involvement of men in various reproductive health matters. Also the study examines the differences between women's reporting and men's reporting and also explores the reasons behind differences in the reporting levels. Thus, overall, this study seeks to examine the influence of urbanization on men's involvement and also the differences between women's and men's perceptions on men's engagement in women's reproductive health. The area near the metropolis of Delhi is chosen for the current research. The Gautam Buddha Nagar District has been selected and a field investigation of eight villages has been carried out, the details are provided in the Chapter-3 on methodology.

1.3 A glimpse through changes in policies of India

In 1951, India introduced its population programme and became the first country in the world to announce family planning programme for fertility regulation. Ever since Family planning programme became an integral component of the country's population policy. Kulkarni (2009) has broadly recognized four phases in the evolution of the population programme since its' inception, starting from building-up (1951-66), intensification (166-77), setback and moderation (1977-93) and reorientation (1993 onwards). In the initial years (1951-1966) the need for fertility regulation was realized with a desire to lower the population growth rate as the economic growth was moderate. Contraceptive services to couples were provided to space children and an emphasis was made to popularize the rhythm method. Subsequently, the programme was strengthened by increasing family planning centres, health and extension workers (Kulkarni, 2009:15 and Chacko, 2001:197). By the end of this phase, family planning services were widely available in rural and urban areas through government outlets. The network of Primary Health Centres (PHCs) was also developed. Besides building public sector health system, India focused on several national disease-specific programmes that were launched to curb malaria, Tuberculosis (TB), leprosy, cholera, polio, etc.

The second phase (1966-76) was marked by several developments in the population programmes. A separate Department of Family Planning was established in 1966 by the Ministry of Health in the central government (Kulkarni, 2009:18). The 'target approach' was

adopted for contraceptive acceptance and several male and female workers were appointed at the peripheral level and extension educators were appointed in Primary Health Centres (PHCs). The Medical Termination of Pregnancy Act 1971 came in existence. It permitted safe and legal abortions by qualified medical professionals especially in cases of failure of contraceptives. In 1976, India's first 'National Population Policy' was announced. Monetary incentives were given to those who accepted sterilization to limit family size. A phenomenal rise in sterilization was witnessed during the emergency period of 1975-77. Under this coercive approach, people were pressurized to adopt sterilization, most of which were vasectomies (Kulkarni, 2009:20-21).

In the third phase (1977-93), the scope of family planning was broadened to include all aspects of health and welfare of the family. This was reflected when the name of the programme was changed from Family Planning Programme to Family Welfare Programme. Gradually acceptance of reversible methods increased, while acceptance of terminal method, i.e., sterilization fell steeply. The 1980s period marked more integration of family planning programme with health programme which was relatively free of controversies (Kulkarni, 2009:22).

The government of India took steps to strengthen maternal and child health services in India. Maternal and child health programme has been an integral part of the India's Family Planning Programme. Maternal health, child health and nutrition services were integrated with family planning services in the Fifth Five-Year Plan (1974-79) (IIPS and Macro International, 2007:191). The multipurpose health workers were recruited who were responsible for providing first aid and treatment to minor ailments along with health, family planning and nutrition and education at the sub-centre (Bhende and Kanitkar, 2006:523). The Integrated Child Development Services (ICDS) was also initiated in 1976 where the Anganwadi workers (AWW) provide children from birth to six years health, nutrition and education services, along with nutritional and health services to pregnant and breastfeeding mothers. Furthermore, an integrated Maternal and Child Health (MCH) and immunization programme was also initiated in 1992-93. The World Bank and the United Nations Children's Fund (UNICEF) funded MCH and the Child Survival and Safe Motherhood Programme (CSSM). The CSSM programme aimed at strengthening the immunization services in the states where

the services were not good (Bhende and Kanitkar, 2002:546). In the districts with high infant and maternal mortality rates, training was provided to traditional birth attendants to ensure safe motherhood component. Also distribution of aseptic delivery kits and strengthening the first referral units for dealing with high risk and obstetric emergencies were also provided to pregnant women (Bhende and Kanitkar, 2002:546).

Under the Reproductive and Child Health Programme (1996), female health workers (Auxiliary Nurse Midwives or ANMs) were also recruited to ensure that pregnant women at least have three antenatal visits, immunized against tetanus, took Iron and Folic acid prophylaxis. They were also responsible to monitor signs of complications, detect any problems of pregnancy, to provide advice and to counsel on preventive care, diet during pregnancy, delivery and post-delivery care (IIPS and Macro International, 2007:192). Programmes such as Oral Rehydration Therapy (ORT), the Universal Immunization Programme, the Maternal and Child Health Supplemental Programme were also integrated in the Reproductive and Child Health Programme (IIPS and Macro International, 2007:223).

In India, "Beyond Family Planning" measures were taken in the Seventh Five-Year plan (1985-90) to affect the course of fertility through age at marriage, female literacy, the status of women, old age security, and preference for sons. Moreover, reduction of infant mortality also became an important component of the health policy (Ramachandrudu and Kamalamma, 1997:6). Subsequently, the Eighth Five-Year Plan (1992-97) coincided with the Cairo conference in 1994. The Cairo conference influenced the government to change its policy from the target approach to that of the welfare of child and women. Another suggestion to incorporate decentralized planning at the grassroots level was made. The main instruments for such planning were the *Panchayat* institutions at the village level and those prepared by the *Nagarpalikas* at the town and the city level (Bhende and Kanitkar, 2002:535).

The National Population Policy (NPP) of 2000 was announced by the Government of India and was incorporated in the Ninth Five-Year Plan of 1997-2002 (Tripathi and Nandan, 2006: 7). This policy affirmed "the commitment of government towards voluntary and informed choice and consent of citizens while availing reproductive health-care services and continuation of the target free approach in administering family planning services" (Ministry

of Health and Family Welfare, 2000:2). The aim of this policy was to combat high birth rate and reduce infant mortality and maternal mortality rates in India. The immediate objective of NPP 2000 was to address the unmet needs for contraception. This policy also emphasized on increased participation of men in planning families who were usually excluded from the earlier population programmes (Ministry of Health and Family Welfare, 2000:11). Persisting gender inequalities in patriarchal societies ensure that men play an important role in deciding about access to and utilization of health, nutrition and family welfare services that are meant for women and children. So "an active participation of men is called for in planning families, supporting contraceptive use, helping pregnant women stay healthy, arranging skilled care during delivery, avoid delays in seeking care, helping after the baby is born and, finally, in being a responsible father" (Ministry of Health and Family Welfare, 2000: 11). Furthermore, the National Population Policy also laid emphasis on the importance of an effective development of the policies that focuses on the social well-being of people, with a stronger emphasis on gender equality and equity in programmes, thereby strengthening the quality of family planning and health services (Tripathi and Nandan, 2006: 8).

To improve the social and demographic indicators merely through increased investment was difficult, so the Government realized that in addition to the investment in the health sector, significant change in the social attitudes and behavioural responses of the people were also crucial to create awareness among masses. In this process, the role of women became critical in order to achieve social mobilization and community participation. The process of empowering women was carried forward into the social and economic spheres. Special emphasis was placed on ensuring the control of social infrastructure, particularly in health and education, in the public domain and was vested in women and women's organizations (Planning Commission: 2006).

In the Tenth Five-Year Plan (2002-2007), there is a continued commitment to providing essential primary health-care as well as emergency and life-saving services to the Indian masses. Furthermore, the services under the family welfare programme are provided free of cost, depending on the needs of the people served (Tripathi and Nandan, 2006: 4). The National Rural Health Mission (NRHM) is also developed which intends to cover the rural areas with focus on 18 states with weak health-care infrastructure. "NRHM is about

partnerships – partnerships with society, partnerships with non-governmental providers, partnerships with public institutions, partnerships with Indian Systems of Medicine and most of all partnerships with all wider determinants of health to ensure that a public health focus informs health action" (Ministry of Health and Family Welfare, 2009:4). The NRHM promoted partnerships with the non-governmental sector to improve outreach services like diagnostics, ambulance, etc. The aim of this project is to provide infrastructure, availability and access to health-care facilities and to provide improved referral services in the rural areas. Under the NRHM, the states have signed a Memorandum of Understanding with the Government of India, indicating their commitment to increase contribution to Public Health Budget preferably by 10 percent each year (Ministry of Health and Family Welfare, 2009:7). Another aim of the NRHM is to produce data for the Ministry of Health and Family Welfare for the effective use of resources. This will help to organize and manage the funds within the constraints of social, cultural, economic, epidemiological conditions. It is also recommended to make the NRHM a 'bottom up' approach to development (Banerji, 2005:8).

The RCH-II, a flagship programme of the Government of India on Reproductive and Child Health, was also launched in 2005 under the NRHM (Ministry of Health and Family Welfare, 2009:8). This programme focuses on improving the use of RCH services by the poorest and underserved populations. It further aimed at reducing the Maternal Mortality Ratio, the Infant Mortality Rate and Total Fertility Rate. To enhance the accountability of the states, this programme allowed states to have greater flexibility in programming and use of allocated funds (Ministry of Health and Family Welfare, 2009:8).

Thus there has been a constant effort of the Indian government to provide good health facilities to its citizens. The maternal health services have always been an important component of the health programmes. The issue of male involvement in women's reproductive health-care has been highlighted at least since the ICPD and the National Population Policy 2000. In this context, this research addresses the role of men as supportive partners in wife's reproductive health in villages under the process of urbanization.

1.4 Organization of the Thesis

This thesis is organized into seven chapters. Chapter-1, which is an introductory chapter, discusses different aspects of reproductive health-care and role of state in formulating policies that have a direct bearing on women's health outcomes. Chapter-2 is an attempt to review literature that covers different aspects of women's reproductive health; it also takes into account various socio-economic factors that influence men's involvement in women's reproductive health. It also tries to bring out the research gaps which are evident from the previous studies. Chapter-3 lays out the conceptual framework based on the literature review, methodology and scope of study. It also describes the study area and objectives of study. Chapter-4 presents information from the National Family Health Survey 2007-08 and District Level Household and Facility Survey (2007-08) along with the analysis of data at the individual level collected from women and men from different households of a sample of urbanizing villages near Delhi in the field investigation by the researcher. It also brings out the comparison between responses of women and men at the village level. Chapter-5 discusses husband's involvement in wife's reproductive health at the individual level. It also assesses the net effects of relevant socio-economic and demographic variables on various types of husband's involvement. Chapter 6- presents views of the local health workers on husbands' involvement in women's reproductive health. Data from the interviews of the health workers such as ANM, AWW and ASHA including narratives from them are analysed to get a holistic understanding of women's health scenario. Chapter-7 highlights major findings, strengths and limitations and discusses summary and conclusions of the research.

CHAPTER -2
REVIEW OF LITERATURE

CHAPTER-2

REVIEW OF LITERATURE

2.1 Introduction

The perceptions on the desirability of men's involvement in women's reproductive health-care have varied. In the past, men's involvement was opposed by women's health advocates who feared that adding men will damage the quality of the services provided to improve women's health and it would create a competition for already scare resources (Wegner et al, 1998:38). On the other hand, it was argued that if the designers of the programme carefully integrate men into the existing health-care structure that benefit both men and women, it would rather enhance the reproductive health-care services by including men's constructive roles in the broader reproductive agenda. After the 1994 United Nations International Conference on Population and Development in Cairo, the major individual and organizational focus of various international and national population programmes shifted to reproductive health and rights. One concern was the inclusion of men in women's reproductive health (Dudgeon & Inhorn, 2004). The Program of Action of ICPD (1994) reiterates that men play a significant role in women's sexual and reproductive health outcomes, so it added value to engage men as partners in programmes focusing on women's health. It called for "the equal participation of women and men in all areas of family and household responsibilities, including family planning, child-rearing and housework." According to the ICPD document, men play a key role in most societies and exercise power in nearly every sphere of life such as making decisions on family size, to the policy and programme decisions made at all levels in the government (UNFPA, 1996:29). So it is crucial to improve communication on sexuality and reproductive health issues between men and women so that they have an understanding of their joint responsibilities and act as equal partners in public and private life (UNFPA, 1996:28). The same message was reinforced at the 1995 World Conference on Women in Beijing stressing on "shared responsibility between men and women in matters related to reproductive and sexual behaviour is essential to improving women's health" (cited by Goldie: 2007). However, there are many barriers that hinder men's involvement in women's reproductive health.

Concerns such as lack of men's perspective on women's reproductive health, feeling out of place in reproductive health clinics which especially cater to women, and logistic constraints such as lack of trained male staff, male-friendly clinics, convenient hours, or separate waiting areas for men in pregnancy and delivery service centers are some of the hindrances that need to be addressed (Goldie: 2007). Nonetheless, role of men in decision-making processes regarding family size and composition has become an enduring concern in agrarian and patriarchal contexts. This is important because, with the increase in education and exposure to mass media, "traditional orientations, ways of thinking and lifestyles are recast and displayed by universalistic forms of learning and teaching, as well as by universalistic forms of knowledge and language" (Beck and Beck-Gernsheim, 2002: 32). Thus such issues as the attitudes of men towards conception, how they feel about pregnancy, and what they think about their wife's health needs become critical areas of inquiry if we have to understand how men's understanding of women's health-care needs affects women's reproductive health outcomes. In the agrarian context, where "personal decisions are strongly influenced and constrained by kinship, family and marriage relationships" (Dyson and Moore, 1983:45), the study of men's participation in decision-making processes will provide a fundamental connection to the "entire gamut of processes: cultural, economic, political and global" (Srivastava, 2001:10) within the context of urbanization. This will help to understand women's autonomy and agency in making decisions about their reproductive health and outcomes and the extent to which their husbands are supporting and influencing the decisions about the nuclear family that is an important aspect of urban life.

For the understanding of this theoretical framework, this review discusses research on the issues of men as supportive partners, urbanization and social change, the changing notions of masculinity, structural and functional changes in the joint family, and notions around the preference for male children within the rural Indian context. The conflict between traditional midwives and biomedical system of medicine within Indian context is also discussed. Notions around fertility, gender and identity are also discussed to understand the cross-cultural beliefs of fertility behaviour.

2.2 Conceptual issues needed to understand the role of men as supportive partners

Green and Biddlecom (2000) in their article on "Absent and Problematic Men: Demographic Accounts of Male Reproductive Roles," have shown extensively why initially men were kept out of demographic research pointing out towards methodological issues, theoretical issues and the context. They argued that it was convenient to get information from women on fertility behaviour more easily than men. Moreover, men could not accurately report about some events such as spontaneous or induced abortions or if men had multiple partners, this was often not reported leading to an ambiguity in modeling complicated unions that departed from monogamy, i.e., polygyny or extramarital affairs. However, with the growing interests of the social scientists and the feminists to bring into focus the varied social aspects of fertility and to broaden the understanding of social phenomena, there was a stress on including men in the fertility studies. Not only that, to broaden the context of fertility decision-making, to collect data on the status of women, and the wellbeing of children, inclusion of male respondents became important (Green and Biddlecom, 2000: 86, 88-89).

Why is men's engagement or involvement important in reproductive health? While thinking about this, one would wonder that in an Indian set up where most of the decisions are made by men, men's views concerning the role of wife become crucial to understand women's autonomy in reproductive health related matters. Thus the answer to this question lies in gender roles in decision-making on reproductive health where there is a need to promote equity and men as partners in the reproductive health, logically sharing the sexual lives and the burden of preventing diseases and complications. In many populations, men's knowledge of family planning is also quite discrete indicating that pill was the most recognized method, followed by the condom and female sterilization (Green et al. 1995: 11). The data are from the national health surveys of 15 developing countries. In addition, approximately one third of the women surveyed report using a contraceptive method involving male participation or co-operation (Green et al. 1995: 11).

There is a need to define men's involvement to understand the dynamics of relationships and decision-making regarding reproductive health-care. It is defined as "the various ways in which men relate to reproductive health problems and programmes, reproductive rights and reproductive behaviour. Men's involvement in reproductive health has two major dimensions.

One is related to the ways in which men accept and indicate support to their partners' needs, choices and rights in reproductive health; the other being men's own reproductive and sexual behaviour" (Green et al. 1995: 8). The present study focuses on the first aspect of the men's involvement with a special focus on decision-making regarding women's reproductive health-care issues. Educating men on reproduction and contraception is extremely important in male-dominant cultures where men already have an edge over women in decision-making processes.

Less obvious, but equally important is the impact of men's knowledge, perceptions, attitudes and behaviour on women's health. In regions where socio-economic and cultural factors allocate power and authority primarily to men, women are dependent on men for access to food, health services, and other factors that contribute to health status (Singh et al., 1998:388). Such a comparison was done by Jejeebhoy (2002) who studied two states of India, one was Uttar Pradesh (highly patriarchal) and the other was Tamil Nadu (more egalitarian) to explore contextual differences in spousal perceptions on women's autonomy. She observed that in Uttar Pradesh due to high gender imbalances, husband's assessment of women's autonomy had more influence on reproductive outcomes than women's perceptions about their own autonomy. She also noticed that men provided "more acceptable responses" on women's autonomy and women "strategically downplayed their autonomy" showing that they conform to social norms. Such differences are due to gender imbalances in the contextual setting of Uttar Pradesh. However, in Tamil Nadu, husbands' perceptions about women's autonomy are not significant (Jejeebhoy, 2002:307). Various factors relevant to decision-making involving men and women are discussed below. Before we proceed further, the two concepts, gender and women's empowerment, which are often used in literature, are discussed briefly.

2.2.1 Gender

The general definition of gender refers mainly to the expectations and norms shared within a society about appropriate male and female behaviour, characteristics and roles. The gender based power that is derived "from the social meaning given to the biological differences between men and women" can have a direct impact on the ability of the partners to acquire relevant information to their reproductive health, and their ability to make decisions

pertaining to their health (Blanc, 2001:190; Singh et al., 1998:389). Moreover, gender also manifests itself into different kinds of roles that are socially constructed. Men and women are trapped in socially sanctioned constructs of masculine and feminine behaviours and roles. Gendered roles are mainly seen as constructed in part through our culturally experienced bodies and the ways both women and men experience their bodies' experiences of gender and gender relations (Raju 2001: 4589).

Speizer et al. studied gender relations and the influence on reproductive health decision-making in Honduras. In their research they found that women from less urban areas, low educational level and socio-economic background tend to believe that husbands alone should make reproductive health decisions and household decisions. They also pointed towards generational changes in the attitudes of women; those in older ages tend to be more conservative as compared to their young counterparts. Another interesting finding suggested that women with more children gain more control over household resources, and they have greater ability to control their procreative lives as they gain exposure and access to health-care services (Speizer et al., 2005: 136).

However, Helzner (1996) cautioned against reinforcing gender inequalities by the "use of stereotypical relationship between the sexes-dominant men, submissive women" and argued that if we simply assume and then ignore such relationship in research, then consciously or unconsciously the research findings would worsen the gender inequalities rather than helping to redress them (Helzner, 1996:148).

But the role of gender is not uniform across sections of societies. Caste is a major factor in social behaviour in most of the Indian society. Greater constraints on women are as much a part of ritual purity and high-caste status as vegetarianism, teetotalism and the prohibition on performing manual labour (Dube, 1998: 154). The bias against women, particularly in north India and amongst upper castes, led them to suffer within both their parent's and in-law's families: "Indian women are far worse off than men, suffering greater hardships solely as a consequence of their gender" (Dube, 1998: 155). In contrast to upper-caste women, women in lower-caste and tribal families have greater rights and receive better treatment by their natal and in-law families, though they are not considered equal to men in status. However, in north

India, lower-caste women share some of the disadvantages faced by upper-caste women compared to their peers in south India (Dube, 1998: 156).

2.2.2 Women's empowerment

Kabeer (1999) conceptualized empowerment as a part of power. According to her empowerment is "the ability to make strategic life choices," she referred to empowerment as a notion of change which is "an extension in people's ability to make strategic life choices in a context where this ability was previously denied to them" (p: 436-437). She talked about another dimension of power which is related to "agency- the ability to define one's goals and act upon them." She suggested that agency is operationalized as 'decision-making' in the social science literature and can be expressed in many forms such as "negotiation, deception, and manipulation, subversion and resistance as well as more intangible, cognitive processes of reflection and analysis" (Kabeer, 1999: 438).

According to Raju (2006), empowerment is a "relational construct," i.e., women learning to negotiate, communicate, seek support, and defend their sense of 'self' with dignity with other players in the social environment who are asymmetrical in terms of power (Raju, 2006:291). Furthermore, women's empowerment constitutes a number of aspects. Questions on the magnitude of wife's earnings relative to her husband's earnings, control over the use of one's own earnings and those of the spouse, participation in the household decision-making, control over resources, freedom of movement, gender role attitudes, etc. were asked in India's National Family Health Survey to assess women's empowerment (IIPS and Macro International, 2007:449). The increasing use of the term 'women's empowerment' by various development players has resulted in multiple meanings and interpretations (Raju, 2006:291). NFHS-3 suggests that currently married and employed women in urban areas are more likely to decide how to spend their earnings as compared to their rural counterparts (IIPS and Macro International, 2007:453). However, the decision-making varies across religion and caste/tribe. It was seen that Hindu and Buddhist/Neo Buddhist husbands are primary decision-makers compared to other religion (IIPS and Macro International, 2007:454). However, sixty eight percent of the currently married women said that they alone or they jointly with their husbands are the main decision-makers about the use of their husband's earnings at the national level (IIPS and Macro International, 2007:458).

Jennings et al. (2014) inferred from their study on selected African countries that women who were more likely to use antenatal services were more empowered as they were more likely to "negotiate and involve their male partners in prenatal care-seeking." They argued that couples who made shared decision in other life domains were more likely to view "pregnancy as a shared domain" (Jennings et al., 2014:8-9). However, where they found negative relationship of husband's involvement in antenatal care, they mentioned that "women with greater participation in health-care and household decisions, including asset ownership, saw less of a need to invite spouses to ANC." Moreover, in some African countries male involvement in pregnancy was viewed as a "foreign concept" and synonymous with an infringement on "territory they did not want men to invade" (Jennings et al., 2014:9). So explanation to women's empowerment goes two ways, one where women voice their preferences and ask for husband's involvement in antenatal care and the other where they regard husband's involvement unnecessary and intrusive and regard this as a foreign concept which is being introduced by international agencies in their country.

2.3 Behaviour and attitude of men towards women's reproductive health

Men and older kin exercise authority over women and younger family members. Usually wives are dependent on a number of people for decision-making, especially decision involving going outside the household. Thus examining the attitude of husbands towards the wife is very important to understand the social dynamics of the inter-spousal relationship. In Uttar Pradesh, a study conducted in 1995-1996 indicated that men in urban areas were slightly more liberal in thinking about the wife compared to rural areas. Husbands having lower standard of education also had an impact over their thinking process and resulted in more conservative behaviour towards the wife (Singh et al., 1998:395).

2.3.1 Husbands' supportive and participatory role

India's Population Policy 2000 emphasized on active participation of men in family planning by supporting contraceptive use, helping their wife to stay healthy during pregnancy by taking care of dietary intake and seeking medical care. It also calls on husbands to be a "responsible father" by arranging skilled care during delivery, and helping new born baby and the mother (MOHFW, 2000:11). Moreover, since most of the "maternal deaths occur during or within the first 48 hours after delivery, the management of obstetric emergencies

has been one of the key points of intervention strategies to reduce maternal mortality" (Dudgeon and Inhorn, 2004:1387). There is little information on how men are involved during obstetric emergency, usually the information on husband's involvement in obstetric emergencies is provided by women after the event has taken place. So it is crucial to understand how men/husbands act as responsible partners and support the wife during different phases of pregnancy and participate in contraception use.

2.3.2 Husbands' involvement in pregnancy and delivery care

Why husband's involvement is important during pregnancy has been documented by Dudgeon and Inhorn (2004) in their study that suggests that stress caused by men during pregnancy may lead to premature delivery or men may introduce infection into the vagina of a wife during pregnancy which may also lead to preterm delivery (Dudgeon and Inhorn, 2004: 1387). Moreover, low birth weight baby is often an outcome of poor nutritional intake during pregnancy; since men mediate wife's access to economic resources in many parts of the world, women's nutritional status is heavily dependent on husband and relatives. Father's involvement in post-delivery care to the mother and the new born has been associated with improved outcomes for preterm and low-birth-weight babies' cognitive development (Dudgeon and Inhorn, 2004:1387). Moreover, a study in Kenya reflected that nearly 90 percent of women desire to involve men in antenatal care, post-partum visits, and family planning visits, however, fewer women wanted their husbands present during physical examinations or in labour ward or during delivery.

According to the NFHS-3, in India men under the age of twenty are less likely to be present at the time of birth of their youngest child. However, the trend changes with the increase in age of men and their presence during antenatal check-up of the mothers (IIPS and Macro International, 2007:203). At the national level, it is calculated that only twenty seven percent of the currently married women make decisions mainly by themselves on their own health-care (IIPS and Macro International, 2007:461).

In a study on men's involvement during pregnancy and childbirth in rural Ahmadnagar district of Maharashtra it was found that "men who had egalitarian gender role attitudes were more likely to assist the wife during pregnancy as compared to men who had traditional

gender role attitudes" (Singh and Ram, 2009: 97). A study from Maharashtra showed that many men accompanied the wife for their first check-up to confirm pregnancy; the wife generally went alone or with some female member of the family for subsequent visits. Delivery and post-delivery were found to be exclusively women's affair (Barua, 2000:6). Another study in tribal area of Gujarat in 1996 was conducted to understand perceptions of male members about reproductive health matters. When asked about the pregnancy care, most of the men (non-tribals and educated youth) talked about dietary prescription and proscriptions, the need to reduce the work load of women, a few mentioned about antenatal care (iron tablets and tetanus injections). In spite of such awareness, there was lack of information about women's menstrual cycle and when they are most likely to conceive (ARCH, 2000:14).

Analysis of the rural blocks of Ahmednagar district of Maharashtra by Barua et al. (2004) showed that husbands have the knowledge about prenatal, delivery and post-natal care, although it was not that in-depth. "Most husbands regardless of their knowledge voiced a sense of responsibility when it comes to accompany their wife for the check-ups or paying for the care" (Barua et al., 2004:5666). But they were excluded by the medical system from participating in the routine care and also the community considered maternal care as a women's domain. Husbands from the joint family were much less likely to be present during delivery as other women from the family take over the responsibility contrary to husbands from the nuclear family.

Thus these studies reiterate the need to involve men in women's reproductive health and urge for an active participation of men in supporting their partners mainly during pregnancy, delivery and post-delivery; however, this does not mean that men's involvement is less crucial thereafter. There is a need for sensitizing men about their responsibility in ensuring good reproductive health of their partners by creating more awareness and getting rid of myths and misconceptions regarding reproductive health matters.

2.3.3 Use of contraception

In a study by Bankole and Singh (1998) on couples' reproductive preferences and behaviour across 18 developing countries, results indicate that husbands tend to want more children than

the wife and want the next child sooner. Overall use of modern contraceptive method is lower among these countries, but husbands are more likely to report the use of modern contraceptive than their wife. However, it is interesting to note that mostly wives initiate the use of contraception to space births and to limit family size as compared to their husbands, since wives have a "better understanding of the benefit of spacing their children and the dangers associated with having babies in quick succession than their husbands" (Bankole and Singh, 1998:22).

Men oppose family planning due to a variety of reasons that include a fear of undermining their authority as the head of the household of the family, concerns that their wife will be unfaithful, assumptions that it is against religious teachings, worry about the side-effects of the contraceptives. An example of such belief system is cited in Nigerian men who oppose family planning because they believe that children are gift from god and polygamy is an adequate means of controlling fertility (Green et al., 1995: 8).

In addition, ignorance towards women's reproductive health needs may also contribute to make uninformed decisions that affect women's health. One reason for such ignorance is lack of primary source of information (Blanc, 2001:197). Family planning also seems to represent a power issue in the household. Rural groups generally agreed that men are the primary decision-makers of the family. In Namibia, almost sixty percent of the men agreed that men should alone determine the number of children (Green et al., 1995: 22).

A study of a multifaceted intervention programme 'PRACHAR' to spread awareness about contraceptive use and to improve reproductive health practices among married youth in the rural areas of Bihar informed that the norms and awareness about contraceptive use were modified at the community level (Jejeebhoy et al., 2015:123). A supportive environment around the new cohorts of youth was built by those who were exposed to the intervention programme. People started adopting modern contraceptive and birth spacing methods. The effect of the programme was not only restricted to those who were exposed, but spread among those who were indirectly exposed to the programme activities by being a part of the community. This suggested that once certain behaviour is modified at the community level, it spreads across its members and results in behavioural change at the societal level. Other studies have also been conducted by various nonprofit organizations. One such study in rural

Maharashtra on young husbands in 1995 by FRHS and Population Council revealed that many men still lack understanding about women's health problems and were ignorant about family planning (Barua, 2000:6).

To understand men's perception on family planning and to examine their knowledge, decision-making and perceptions on female sterilization, a study was conducted in rural Madhya Pradesh (Char et al., 2009:132). Men understood contraception as a means to space children, while family planning was synonymous with female sterilization. Men preferred female sterilization over other methods as a means to limit family size and gave social and cultural reasons for adopting it. The study found that the issue of male sterilization was not brought up by the health workers or was discussed as an option for men. Pertaining to the issue of decision-making on reproductive health, one-third men reported that they made decisions on their own, while more than half (around 60%) made a joint decision on the use of contraception (Char et al., 2009:136).

A research on men's attitudes and behaviours on family planning in rural areas of Kayseri, Turkey, demonstrated that although men approved towards using contraception, the actual users are fairly low, i.e. around 54% (Mistik et al., 2003:136). Many men perceived decision-making on the use of contraception as a joint responsibility, but they would prefer if the wife take the responsibility for using a contraceptive. Most of the group received information on contraception through mass media, but they desire doctors or medical professionals to give this information to them.

Biddlecom et al. (1997) did a study on spouses' views of contraception in the Philippines. Their study revealed a multifaceted decision-making process on the use of contraception. Spouses although discussed on these subjects, but it was either partial or limited. Moreover, Filipino wives assumed the responsibility of obtaining contraceptives, and sometimes decided about the contraceptive on their own, and at other times the husband appears to dominate the decision-making. Thus pointing towards complexity of the decision-making where Filipino men cannot simply have an upper hand in decisions to use contraceptives even though being a part of a strong patriarchal society (Biddlecom et al., 1997:114).

Men's lack of understanding of contraceptive method can affect couple's choice of the method. Dudgeon and Inhorn (2004) argued that among contraceptives used, only vasectomy is supposed to be completely under male control, while other methods such as condom and withdrawal require some negotiation and co-operation between spouses or partners to use the method effectively (Dudgeon and Inhorn, 2004:1383). For the female-centered methods, the use may be significantly influenced by the male partner as they mediate economic resources that are required to access these methods, or they may either indirectly sanction or prohibit women's use of female methods of contraception.

A male survey on evaluating men's knowledge, attitudes and practices regarding birth spacing and contraceptive use in Jordan found that education had a significant effect on the general knowledge about family planning. While most men acknowledged that it is a man's responsibility to plan pregnancies, around half of them believed that men's contraceptive use will increase if the health-care services are especially designed for them (Petro-Nustas, 1999:184).

Hogan et al. (1999) in their study on household organization and contraceptive use in Southern Ethiopia found that extended family structures promote high fertility, but with higher education women's ability to resist subjugation and acquire greater power in decision-making increases. However, only formal education does not alone contribute towards women's empowerment unless it is connected with income-generating abilities (Hogan et al., 1999:304). Women who were able to make family planning decisions with husband were found to be more knowledgeable about family planning methods and were more likely to use contraceptives. Thus women's ability to discuss family planning with their husbands and having knowledge and access about various methods lead to greater use of contraceptives as compared to their counterparts in Southern Ethiopia (Hogan et al., 1999:312).

John et al. conducted a study in Malawi on contraceptive use and found that sexual pleasure essentially determined whether to use contraception or not. Such methods were preferred which did not affect sexual pleasure and sexual appeal of the partner. This concept of sexual pleasure and satisfaction was very much ingrained in the society and both males and females regarded this as an integral element of a fulfilling married life. Mostly men feared the use of

modern contraceptives as they are greatly concerned about the impact of these methods on females' sexual appeal and sexual drive. "They have a common belief that women who use modern contraceptives lose their sexual appeal." While women think that using family planning methods reduces sexual pleasure and their husbands will get an excuse to justify extramarital affair, thus they risk unintended pregnancies or STIs by discontinuing family planning use (John et al., 2015:102-103). Thus this particular belief of sexual pleasure and satisfaction influenced the decisions about use and discontinuation of contraception.

Goldie (2007) in her study mentioned that involving men in family planning education and services could further erode women's control over reproductive health decisions. This is because many reproductive health services have allowed women a degree of autonomy over their own lives, and without gender equity, involving men may perpetuate existing gender inequalities (Goldie, 2007:4). Thus it is important to note women in different contexts and cultures respond differently to men's participation in their reproductive decision-making.

A study in Uganda by DeRose and Ezeh (2010) found out the role of community in determining the use of contraception and influencing household decision-making. Their study revealed that "women living in communities where neighbours had more autonomy in household decisions were more likely to use contraception." Also where communities have moved from "traditional gender roles in decision-making patterns" seem to be more receptive to contraception (DeRose and Ezeh, 2010: 436). Thus indicating that society (where an individual resides) significantly influence individual decision-making regarding family planning.

Furthermore, factors such as family size and son preference also influence contraceptive use, so a broader understanding of these relevant issues is explored in the subsequent sections.

Family Size

Traditional males and female roles influence power relations between couples and that in turn determines the preference for sons and daughters in the family. In certain settings where a

woman's status is determined by the number of sons she produces, there is an attempt to continue bearing children (Blanc, 2001:196).

A study in Agra conducted in the 1990s suggested that males still favoured large families and only about one-sixth of the men feel that even one to two children are adequate (Khan and Patel, 1997:7). The mean ideal family that people aspired to achieve is around 3.1 which is close to the NFHS estimates of 1992. People believed that having one daughter is important to do *'kanyadaan'* (gifting daughter through marriage), so that they get liberated after death.

Son Preference

Several studies have been conducted in India to illustrate strong son preference. A study by Miller in Punjab has revealed that in cases of first pregnancies a son is the most desired first child though a first daughter is not as great a disappointment as subsequent daughters are. Short pregnancy intervals in many cases exacerbate differentials in sex survival. Mothers who keep on feeding a previously born male child, neglect the smaller and weaker daughters born after him (Miller, 1989:201). "Female children are breast-fed less and weaned earlier than males; as a result, a majority of malnourished children are girls" (Dube, 1998: 155). A large number of girls die as they are given health-care more infrequently than boys. However, those who survive fail to achieve their full growth potential. Nonetheless, girls work longer hours than boys both in the household and on the land (Dube, 1998: 155). However, this does not mean that the birth of a daughter is not welcomed in the family. A daughterless mother is pitied for having missed the luxury of enjoying a daughter's company (Patel, 1994:82). Thus these kinds of ambivalent feelings towards the birth of a daughter challenges government's goal of promoting small family norms.

Moreover, in the Indian society, sons are usually regarded as the only true descendants of their patrilineage; therefore, a son enjoys a socially privileged status. Women who do not bear a son in the family feel incomplete and unfulfilled (Thapan, 2003:78). Often times bearing a son is associated with the prestige of a woman. If a woman's body fails to bear a son for the family, she becomes a source of shame, loses face and suffers from mental agony and brings the family dishonor (Thapan, 2003:78). Thus the desire of a mother to bear a male child is translated into the household's desire (Miller, 1989: 201). Furthermore, this belief

also overrides the maternal preference for spacing between her children. In addition to this, the birth of a son provides a woman a high household status and future old age security, which, a woman in a patrilineal society thinks, comes from her sons (Miller, 1989:202).

Works of many scholars in the urbanizing village context depict that women are still marginalized under asymmetrical power relationships (Khanna 2001:37). Strong son preference, the dowry system and the responsibility placed on the natal family for ritual ceremonies related to pregnant daughters have led parents to regard daughters as a moral, economic and auspicious burden (Khanna 2001:179; Van Hollen 2003:79). With new and widely available reproductive technologies, sex determination, and sex-selective abortion, female infanticide has declined but the population's sex ratio has been skewed tremendously (Khanna, 2001 and Arnold et al. 2002). This decline in female infanticide is because the psychological burden involved with abortion is lower than the neglect of a female child (Das Gupta and Mari Bhat, 1997:314). However, there are still many reasons that are associated with strong son preference. A study on the factors affecting sex-selective abortions in India and major states suggests that there is a small increase in son preference in Uttar Pradesh between NFHS-1 and NFHS-2 surveys (Retherford and Roy, 2003: 52). However, there is no significant result on the sex selective abortion in North India, the ideal sex ratio is higher for rural women, women with less education, having less exposure to mass media, etc. (Retherford and Roy, 2003: 52). This study is supported by the fact that in every state of India, women with two sons are more likely to use contraception than women with two daughters. Son preference is stronger in North and Central regions of India as compared to most of the Southern states (Mutharayappa et al., 1997: 11-12).

In addition to this, another socio-economic reason related to strong son preference is the burden of large dowries which the parents of female child have to bear at the time of her marriage. This makes the birth of a female child less welcomed. It is extremely difficult for under-privileged poor families to meet those large dowry demands, and this further reduces the preference for a female child (Miller, 1989:205).

Also contraceptive choices among men who wanted no more children in Nepal have been explored using Nepal Demographic and Health Survey (2001). This study by Dahal et al.

suggested that contraceptive use among men who wanted no more children was greatly dependent on the number and sex composition of their family. The findings confirmed that strong son preference determines use and non-use of contraception and especially influenced the choice of method used by men. The probability of using permanent method was highest among men with two living sons, and lowest among those who had only daughters (Dahal et al., 2008: 6, 12).

2.4 Urbanization and resulting structural changes

This section discusses influence of various changes brought about as a result of urbanization on gender roles, family structure and son preference which, in turn, may have a bearing on male involvement in women's reproductive health. Urbanization is defined as the change in the proportion of the unit's population which is urban. It occurs only when the rate of growth of urban population is greater than the rate of growth of the non-urban population (Bhende and Kanitkar, 2006:413). The present research focuses on men's involvement in women's reproductive health in urbanizing villages. In Gautam Buddha Nagar district, several villages are experiencing urbanization due to transformation of land use, environment, cultural diffusion and diffusion of information; all these factors alter the region's ecology, thus resulting in transformation from rural to urban lifestyle (Datta, 2004: 1). Urbanizing villages as defined by Datta, in her study on addressing urbanizing villages in the planning for Delhi Metropolitan Area, is that an urban village is the one that has acquired "urban character by virtue of reduction in its agricultural base by the process of acquisition of land holdings for public purpose or by its transformation into residential or industrial colonies (Datta, 2004:4). It occurs when the rural areas are converted into urban villages and as a consequence of it there is no agricultural land around the village. Furthermore, the transformation of rural to urban areas occurs in three main phases as suggested by Misra and Singh (1996) quoted by Datta (2004). These stages are pre-transition stage, transition stage and post-transition stage. The last stage in the conversion of a rural area into an urban area occurs when all around the old village site urban residential localities are built (Ramachandran, 2006: 316). These are the changes that are brought in the physical area, however, there are certain structural changes brought as a result of urbanization that changes the attitude and behaviour of people. These changes are discussed in the subsequent paragraphs.

2.4.1 Structural changes leading to changes in ideas

In a study on socio-economic structural change in Thailand, Masih and Masih (1999) discussed the structural hypothesis that recognizes the important role played by elements in the ideational hypothesis (such as changing the perceptions, ideas, and attitudes towards fertility control through institutions such as organized family planning, mass elementary education, etc.). These ideational changes are supported by a certain 'level' of socio-economic development in terms of the level of per head income, the level of poverty and landlessness, rate of urbanization, female participation in the work force, level of education (particularly of female education), rate of infant mortality, life expectancy at birth, the average age of female at first marriage, and so on (Masih and Masih, 1999:465). Thus implicitly ideational hypothesis emphasizes on the need for a minimum economic (such as, transport and communications), and social (such as, a few years of mass schooling, particularly female) infrastructural support.

2.4.2 Changes in family structure

Another study in Taiwan by Speare et al. (1973) to understand the influence of urbanization and resultant structural changes suggested that urbanization results in change of value placed on large families, thus affecting the family structure from the extended to the nuclear family. The study also reported that it was easy for most of the women to commute from many rural areas to work in factories, thus increasing the opportunities for female employment and "[may] be a more 'modern look' on the part of the total society, not just on the part of those who participate most directly in the process" (Speare et al., 1973: 334).

Joint Families

There is always a debate among social scientists on whether the large, joint or extended family is giving way to the conjugal or nuclear family, and if so whether it is an inevitable result of economic modernization (Caldwell et al., 1988: 108). A study by Wadley and Derr in Karimpur village of Uttar Pradesh has depicted that although the structure and function of joint families are changing due to urbanization, the families are still connected both ritually and economically (Wadley and Derr, 1993:403). Families may acquire different houses or build a partition in an existing house, but they still exchange farming labour. Relatives come together as a joint unit to marry their unmarried sisters, thus continuing the obligation to meet

marriage costs (Caldwell et al., 1988: 112). In rural north India, especially in joint families, the young couple resides in the husband's village where domestic authorities have control over the daughter-in-law's movements. Decisions about the fertility control are made when couples are residing with their parents-in-law (Caldwell et al., 1988: 128). The opinions of the elders are considered important in decision-making; the older male member in the family is the major decision-maker, while the mother-in-law is most effective in controlling and channelizing sexuality, especially that of her daughters-in-law (Jeffery et. al 1988:28; Wadley 1994:60).

Allendorf (2010) researched in Madhya Pradesh and her study was based on 2002 Women's Reproductive Histories Survey. She found that in nuclear families women who face very few difficulties with their husbands were more likely to use antenatal services and go for institutional delivery. While women in the joint families who enjoyed better relationships with their in-laws tend to obtain more antenatal care compared to those who have estranged relationships with in-laws. Also greater mobility and control over monetary resources that reflected greater agency of women resulted in women obtaining health-care for self (Allendorf, 2010:273). She stressed that by maintaining good relationships with in-laws, daughters-in-law were more likely to receive health-care services. There may be some exceptions where parents-in-law might deeply care for their daughter-in-law, but may not ensure that she gets antenatal care services or deliver in a facility as they themselves do not regard such care beneficial for the health of their daughter-in-law.

However, Allendorf (2013) did a separate study based on various surveys of DHS surveys to understand whether women in nuclear families are better off than those in the patrilocal extended families. This study found that patrilocal extended families were in fact beneficial to women than nuclear families. Women who resided in patrilocal extended families were more likely to go for antenatal check-ups, more likely to consume milk and curd and less likely to face physical violence (Allendorf, 2013:3).

Regarding contraceptive use, the domestic politics of contraceptive decision-making is very important to the decision about family size and the sex of children. In the rural North Indian context, a husband is considered as the sole decision maker in the family. A husband determines the ideal family size and what plans to make to space children. A woman is

restricted to take any actions within the joint household setting. But if they live separately in a nuclear household, a woman is more likely to influence her husband, but the chances are limited. Certainly household conditions and the will of husband become important for those women who are directly dependent on them for their economic and emotional support (Jeffery et-al, 1988:196-199).

Furthermore, a study to understand the effect of the type of household in determining the assistance provided by husbands at the time of pregnancy by Singh and Ram (2009) suggested that men from non-nuclear households were more likely to assist their wife for the check-ups as they received support and encouragement from other members of the household compared to those from the nuclear households who lack such kind of support from the other family members (Singh and Ram, 2009: 97).

White et al. (2013) did an interesting study to reveal the influence of mothers-in-law in affecting maternal health care accessed by their daughters-in-law in Mali. Results from the study showed that in cases where mothers-in-law showed negative association with maternal health-care, they were in greater agreement with traditional practices and doubted the efficacy of modern health-care and institutional delivery and considered them as "unnecessary or even detrimental." Mothers-in-law drew these inferences based on their own experiences of child birth, who themselves did not receive any modern health-care, so they were unlikely to promote their daughters-in-law to use those services (White et al., 2013:64).

Thus the changing role of joint families and especially the mothers-in-law is quite complex and needs to be situated within a context at the time of analysis without which it is difficult to get insights on the experiences of child-birth and access to health facilities by the daughters-in-law.

2.4.3 Generation of new identities and aspirations

Urbanization is understood as the cause and effect of the break-up of the old agriculture-oriented societies and a symptom of the beginning of urban industrial societies (Robinson, 1963: 291). Urban development changes the patterns of schooling and employment as more

and more people leave the farms and look for the newer opportunities created by urbanization. These two phenomena are largely responsible for the construction of new identities and aspirations among the rural population, especially among the youth. New patterns of individualization emerge that are linked to changes in "domestic and housing transitions" (Furlong and Cartmel, 1997: 40). However, the ability to make a successful transition depends on access to "[the] appropriate social and economic resources" (Furlong and Cartmel, 1997: 41). The villagers participate in two different social situations- the village and the city at one and the same time (Rao, 1970:220). The economic opportunities that the developing city offers initiate a series of new activities for the villagers that signal a departure from their traditional activities (Rao, 1970:221). An individual earner is found combining both traditional and modern occupations, one as primary and the other as secondary. Thus, there is a striking emergence of combination rather than the choice of any single occupation (Rao, 1970:225). This gives rise to new patterns of consumption under the impact of urban influences (Rao, 1970:226).

2.4.4 Changes in the meaning of sexuality

With rapid socio-economic transformation, the meaning of masculinity also changes. It acquires new meanings and roles within the social context of "class, caste and race... as well as patriarchies" (Anandhi et al., 2002). "Manliness... is an eminently relational notion, constructed in front of and for other men and against femininity, in a kind of fear of the female, firstly in oneself" (Bourdieu, 2001: 53 cited in Anandhi et al., 2002). This becomes an issue in the rural context where men do not associate openly with their wives and may be ridiculed "as effeminate and inferior" (Anandhi et al., 2002) if they indulge in women's matters like delivery and childbirth. They are key decision-makers whether they are husbands, fathers, partners, and brothers of pregnant women or in their social roles as leaders, elders, or healers (Ruth et al., 2001:13). However, studies have shown that with urbanization, the awareness of health and men's roles is changing. It has been often noted that the processes of urbanization and industrialization tend to diminish the dominance of husbands (Mitchell, 1971: 481).

2.4.5 Increasing awareness of men

A study conducted in the Uttar Pradesh concerning men's views on women's reproductive health-care suggests that husbands of the urban areas were able to name at least one warning symptoms of pregnancy and delivery complications (Singh et al., 1998:392). Also husbands in the urban areas were slightly more liberal in their thinking of their wife's social role as compared to the rural husbands (Singh et al., 1998:395; Moore, 1999 and Mahler, 2000). However, it was observed that although the men in the urban areas are slightly more aware about women's reproductive health compared to their rural counterparts, their levels of knowledge is still very low and needs attention.

2.4.6 Changes in fertility goals

Urbanization also induces change in the family size and a sharp decline in early marriages. Changes in economic conditions, educational levels, and family functioning have resulted in a drop of birth rates and family size (Mitchell, 1971: 489). There are also marked changes in women's role that have occurred in many countries since mid-century, suggest that change in the normative and attitudinal structure underlies fertility and childbearing. These are conditions conducive to bring change in fertility goals that help parents realize their responsibilities towards their children. Also there is a substantial shift in attitudes toward women's work and family roles. Thus an effort is made to synthesize on how to sensitize men towards women's reproductive health-care matters. For this purpose, health education and communication strategies to raise awareness of reproductive health issues target subgroups of men according to their various roles within the community (Ruth et al., 2001:14).

2.5 Related Issues

There are certain other issues related to urbanization and have a bearing on husband's involvement which is discussed here.

2.5.1 Spousal relation-verbal communication

Studies have shown that verbal communications between partners about reproductive health is low in many developing countries and contribute to gender based power inequities. Demographic and Health Surveys conducted in 1995 show that in sub-Saharan Africa, the

women's ability to discuss family planning with their husbands was below 50 percent compared to those in Latin American and Southeast Asian countries (Blanc, 2001:192). However, there is more communication between the partners if there is equality in the education levels of both of them. In India where women's autonomy is particularly low, education and involving men in reproductive health may be the only way to influence the poor health outcomes of women (Singh et al., 1998:389).

Husband-wife communication on contraception and reproductive goals suggest an egalitarian relationship between husband and wife. A study on Agra district suggests that the use of family planning methods is higher for the couples who discuss their reproductive goals compared to those who do not (Khan and Patel, 1997:2). Also in most cases the lower status of women in the family influences their life in controlling their sexuality and the reproductive goals.

In addition, the inter-spousal communication gets initiated with the childbirth that lends security and stability in the conjugal relationship of husband and wife. Sexuality is associated with modesty and is limited among spouses, it is considered as a private matter limited to spouses and there is a traditional inhibition in discussing about it openly in public. Parents do not talk about sexuality freely with their children. Under such a situation where there are very less avenues for a couple to interact freely especially in a joint family, children become a medium to initiate inter-spousal communication. Thus birth of a child provides a license to a woman to talk freely about sexual matters to her husband (Patel 1994:87).

Nevertheless, Furuta and Salway (2006) did a study in Nepal using demographic and health survey and found out, those individuals who discuss family planning methods were certainly broad-minded as they are open to "modern ideas" and therefore, were more likely to use skilled maternal health-care services. Moreover, communication between partners on the use of contraception reflected "a more open and egalitarian relation" between the couples (Furuta and Salway, 2006:24).

2.5.2 Changing practices of delivery care

In rural areas, there are traditional midwives, called *dais* in northern India. Given their limited knowledge and expertise, the *dais* are not expected to handle emergency situations and they direct women to the hospital. Furthermore, the daughters-in-law, usually at their natal homes for delivery, do not seek any kind of medical help by the health visitor in a village unless in cases of emergency.

Jefferys' study on the alternative systems of medicine in northern India argues that the government medical facilities do not match the needs of the people in rural areas (Jeffery et al., 1988:86). Private practitioners are expensive and out of the reach of poor villagers and middle class peasants. People have to seek medical help from local practitioners and often times from quacks: most of them who are women; therefore, have to rely on midwives during the childbirth. In majority of the cases, the lack of outreach and systematic surveillance on the part of health workers also discourage women from opting for medical facilities (Jeffery et al., 1988:86).

Since medical intervention is considered as the hallmark of modernity (Van Hollen, 2003:113), new practices have been co-opted by the *dais* in India. This is due to the emergence of high levels of technological interventions. Some of the *dais* use injections to enhance contractions which can be very harmful to the health of both mother and child and may lead to hemorrhaging. Despite the risk factors with the labour inducing drugs, the routinization of the use of these drugs, both by the *dais* and the medical practitioners in South India has become a symbol of modernity and intolerance of pain among women (Van Hollen, 2003:113). The use of drugs by upper and middle class women to relieve labour pain is associated with their inability to tolerate pain.

With the restructuring of the Indian economy, there is a wider competition between the National and the International corporations operating chains of hospitals and laboratories in urban centers. The provision of medicalized birth has fuelled new consumption practices among the growing number of middle class families in India. There is a recent shift in birth and pregnancy practices. Within domestic and kin relationships, class based identity plays a crucial role in deciding for the birthing place of a child. Donner (2003) examines recent shift

towards caesarean sections among middle class Bengali women in Calcutta. The discourse about caesarean sections drives women to choose hospitalized, 'unnatural' births. The virtue of caesarian sections being less dangerous along with the inability of modern women to tolerate labour pains frequently legitimizes the use of caesarean sections among middle-class women (Donner, 2003: 326). Donner argues that this discourse around efficacy of caesarian births has led middle-class women to operate under 'false consciousness' when they opt for caesarean sections. These women are ignorant about the probable health risks that are imposed on them in light of these modern birthing techniques, and relate it with modernity and safety. In addition, the cost of the government-subsidized hospitals has led to the availability of scientific medical practices to people of lower classes.

Ram (1994) illustrates that different power relationships exist between medical workers and illiterate, poor fisher-women in Tamil Nadu. The response of women to modern medical practices is a derivative of their social and class category. For these women, hospital is not the first choice, rather the last, and only in cases of emergency. The impolite behaviour of nurses towards fisher-women marks the difference between caste and class groups. This behaviour depicts the older forms of caste hierarchy mapped in new ways within a hospital setting (Ram, 1994:26). This hierarchy, in return, demoralizes women to seek hospital help and influence their decision of a birthing place along with their religious tradition that define pregnancy and birth as a normal daily activity.

Further, Ram (1998) relates how the new reproductive technology creates new identities for women based on their class and caste backgrounds in Tamil Nadu. The important question is how these women interpret the meanings of these fluid images and relate themselves to the modernizing world. The implementation of new reproductive technology entails different actions and behaviours. Mistrust and resentment is associated with hospital deliveries and it is usually associated with emergency. A stark contrast occurs between the behaviour of the midwives and the hospital nurses. Thus the preference of midwives over nurses is related to the behavioural treatment of the patients.

Another study by Van Hollen (2003) in Tamil Nadu, South India suggests changes in experiences of childbirth have come with modernity and the knowledge that embodies

childbirth has come out of the private space of household into the public space of hospitals. With the construction of the road infrastructure, medical facilities that were once inaccessible become available to far flung areas. The road network not only provides a conduit for the exchange of ideas, trade and commerce, but serves to connect different communities (Van Hollen, 2003: 25; 28). It is seen that women are under hegemony of the biomedical system, in which they lack any freedom to choose or even argue for better treatment. The question of reproductive rights and women's agency to choose a birthing place is frequently discussed under reproductive rights. The delivery of a baby in the hospital settings is related with modernity in the South Indian context. Women internalizing the idea of hospital delivery are reinforced by the state and various international organizations to adopt biomedical methods of childbirth. Although women from lower castes and class backgrounds are perceived as un-modern and backward once they enter the hospital setting (Van Hollen, 2003: 211), the imagery of modernity is still attached to the hospitalized birth. The attitude of medical professionals in the cases of illiterate and vulnerable women in many cases provides these women with no option to choose and they simply succumb to the will of these practitioners.

2.5.3 Symbolism and ritual initiation

Dube (1986) explains that biological reproduction in most parts of India is culturally described in terms of the "seed" and the "earth". The father provides the essence for the creation of the child through his semen, while the mother provides the nourishment and the safe environment for this seed to grow and develop into a child. A father's semen is culturally perceived as a part of his blood, and, therefore, the child receives his blood. The child is then capable of transmitting the same blood through the next successive generations. This notion, however, is only true in the case of a male child. Certain obligations, however, are placed on the mother as she is responsible for the well-being of the child. Certain do's and don'ts exist for the expectant mother, the most important being the fulfillment of pregnancy cravings. Any ailment of the child is traced back to the conditions to which a mother was exposed earlier during her pregnancy. High importance is placed on the mother-child bond. It is perceived that a child will never be able to pay back the debt owed to his mother. Thus the ancient medical texts provide a woman the moral right over her child, although the father is important in providing social identity to him/her.

The notions of purity and pollution are undergoing tremendous change due to the influence of modernity and changing aspirations of people that define their social status. These ideas change experience of childbirth under social transformation. Seymour (1999) demonstrates that there is a shift in menstrual restrictions and birthing pollution over a period of time in urban context of Orissa. Now women are considered as a marital partner and not just a child bearer. There is a declining importance of the rituals performed to observe menstrual and childbirth pollution. These biological processes had attained greater significance in the agrarian set-up but with the advent of development and spread of scientific knowledge, the restrictions around menstruation and childbirth are melting away.

The other dimension of reproductive health is to understand the power relationships between the mother-in-law and the daughter-in-law and how the sexuality of a woman is controlled in a social milieu. In the North Indian context, once a woman is married she has to work under the authority of her mother-in-law. The mother-in-law is the most efficient agent in channelizing the institution of patriarchy in the household (Jeffery et al., 1988; Patel 1994:75). Furthermore, the traditionally expected inhibitions and the values associated with modesty make it difficult for the parents to discuss sex and childbirth with their newly married children (Patel, 1994:87). There is little communication between the spouses when they are young and living in joint families. This is a hindrance in deciding about the health of the woman. In addition, a man has all rights over the sexual power of his wife (Jeffery et. al 1988:28; Wadley 1994:54). Under such situations, a woman is unable to discuss the questions regarding contraceptive use and limiting family size and she ends up having many children within few years after the marriage (Patel, 1994:85). Thus spousal communication is an important variable that is crucial to women's reproductive needs. It influences the decision-making of the couples about the family size and spacing between children.

2.6 Summarizing the literature review

From the literature review it is evident that the role of men in decision-making processes regarding women's reproductive health is extremely crucial and is context specific. The attitudes and perceptions of men change with their socio-economic environment and affect women's health. Urbanization causes socio-economic and structural changes and influences the participation and involvement of men in women's reproductive health. This is brought

about by better awareness on reproductive health, access to health center due to connectivity of health facility through roads, better medical infrastructure etc. In spite of all this, still many women are not able to access health-care facility and maintain good reproductive health. Socio-economic factors such as family constitution, existing power relations within the household, freedom to decide about own health-care, having access to money, and ability to go alone to the health center play a crucial role in a woman's life. To understand the men's participation it is thus necessary to study the changing role of men in the process of urbanization and how do they actually participate as decision-makers regarding women's reproductive health.

2.7 Emerging research issues

The above literature review provides a glimpse of major issues pertaining to women's reproductive health. However, it provides very less insight into how men act as supportive partner to women and help them at the time of need, or any complication, most importantly at the time of pregnancy and thereafter. Another important dimension needs more attention is how the attitude of men changes in a transition economy where the mode of subsistence is changing gradually from agriculture to other means of obtaining livelihood. Most of the studies are either done in the urban areas or the rural areas that provide a comparative account of the situations in both the context. This research is not situated in the clearly defined area; it focuses on the changing context where it is concentrated on men who are keeping pace with urbanization though still living in villages and following the same mode of living; thus they are getting urbanized but are not in a totally urban setting. In the process, how do those living in villages that have acquired more urban characteristics differ from those living in villages with low level of urban characteristics, especially with regard to male involvement in women's reproductive health-care? How the influence of urbanization changes men's aspirations and their views that impacts their decisions related to women's reproductive health matters needs more detailed study. How the change in aspirations is translated into behavioural change and shift in power dynamics, thus affecting gender attitude in general are some of the issues that this research is trying to explore.

CHAPTER -3
CONCEPTUAL FRAMEWORK AND METHODOLOGY

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3.1 Conceptual framework

This chapter discusses the conceptual framework, objectives of study, research questions, and research design. It also describes the context of research by giving background information on the study area. Furthermore, based on the research questions, a research design is formulated. From the review of literature, it is observed that men's engagement in women's reproductive health plausibly depends upon various socio-economic and demographic factors. In addition to these, indicators of women's empowerment also influence the degree of men's involvement in their wife's health-care decision-making.

At the individual level, background and socio-economic characteristics influence the degree of men's involvement in decision-making processes. One of the important background characteristics used for this research is the place of residence (specifically, the degree of urbanization of the place of residence). Other variables on urban influence such as place of work of the husband and contact with relatives living in urban as are also included in the study as these are expected to affect personal life besides socio-economic characteristics such as education, income and occupation. In addition, these variables are also crucial to understand how urbanization influence husband's participation in wife's reproductive health as these characteristics are believed to have a direct bearing on the awareness of men on health issues, their involvement in women's reproductive health and decisions pertaining to health.

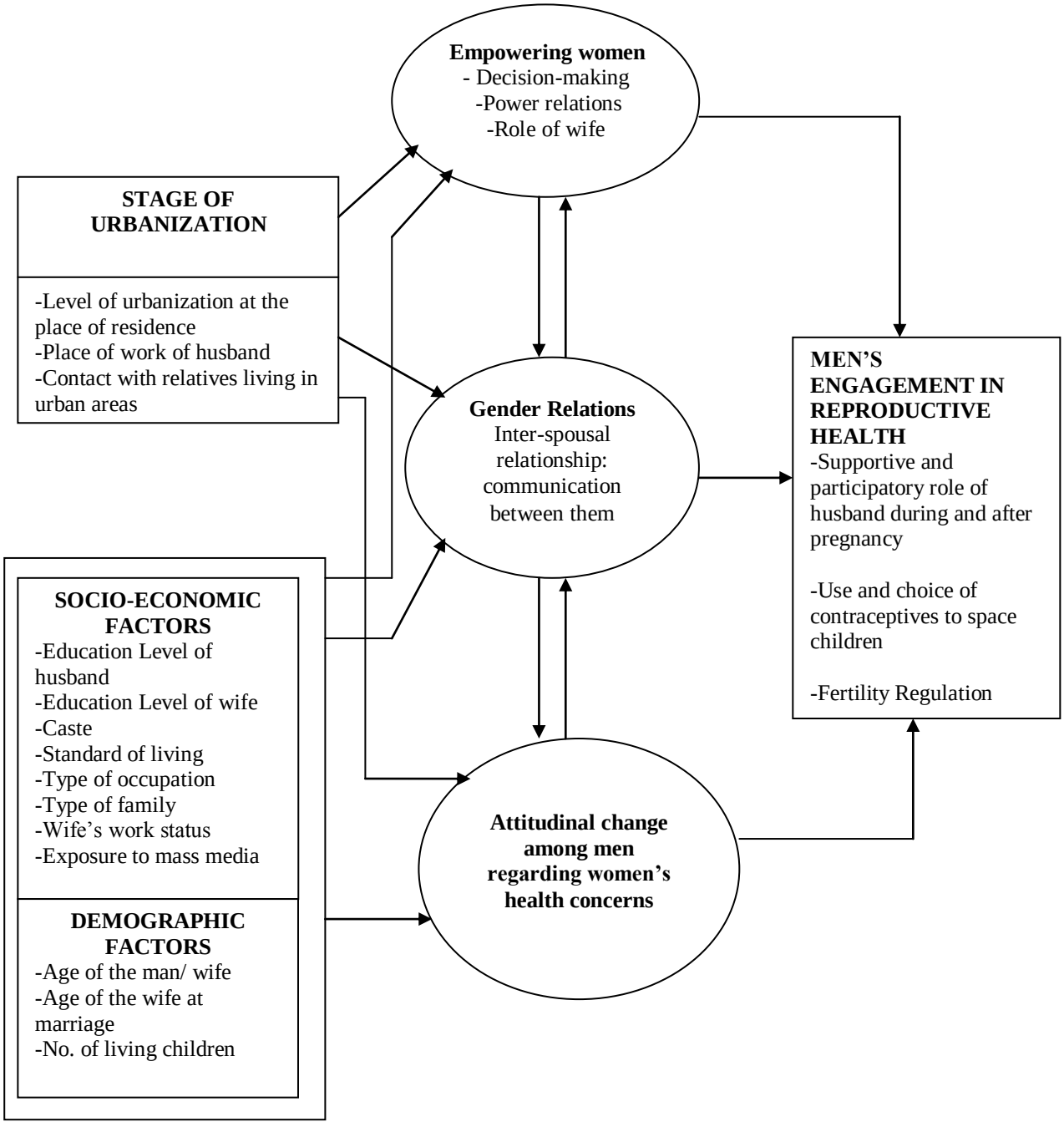
Other socio-economic characteristics included in this research are: caste, family type, wife's educational level, husband's level of education, nature and place of work of husband, and exposure to mass media. The demographic factors include age of wife/ husband, number of living children, age at consummation of marriage. These factors could possibly affect husband's involvement directly. However, the factors that may indirectly influence men's involvement are inter-spousal relationship (communication), women's empowerment indicators such as their decision-making ability, their role as wife, and behaviour and attitude of husbands regarding their wife's health concerns. These variables possibly play a role in

men's involvement during and after pregnancy, use and choice of contraceptives, and decisions on fertility regulation.

The conceptual framework is represented in the form of a flow chart in **Figure 3.1** in which the plausible influences of socio-economic and demographic factors on men's involvement in women's reproductive health are discussed.

FIGURE 3.1

A conceptual framework to analyse men's participation in wife's reproductive health



3.1.1 Urbanization

Regional factors such as transformation of villages from rural to urban mode of living contribute a lot towards change in behaviour of women and men, thus affecting reproductive health decision-making processes. Based on the literature, it has been observed that men living in the urban areas tend to be more informed than those in the rural areas. In addition, urban men are more liberal compared to their rural counterparts who tend to be conservative when it comes to women's reproductive health. The place of residence has an influence over reproductive health as it determines the availability and accessibility of services. It also constitutes the external environment and controls the resources available. The place of residence also influences access to health related information.

It is believed that urban population has better information and access to health services as compared to the rural counterparts. Many researchers have shown that these are very important for utilizing health-care services. Based on this premise, this research has looked at how the level of urbanization could influence behaviour and husband's engagement in reproductive health. Conceptually the behaviour of those living in villages with high urban characteristics may differ from those in villages with low urban characteristics. Nonetheless, their level of information on health related issues may change due to the contact with relatives living in urban areas, engagement in non-manual jobs and working outside the villages. People may get motivated as a result of their contact and may start to emulate urban practices and lifestyle which in turn could affect their perception and behaviour and thus may have a bearing on reproductive health outcomes of the wife.

3.1.2 Socio-economic factors

Various socio-economic factors may affect men's engagement in decision-making processes regarding women's reproductive health directly or indirectly. Socio-economic factors included for the study are education of a husband, education of a wife, family type-nuclear or joint, caste, standard of living, wife's work status, nature of husband's work, and exposure to mass media. The demographic factors include: age of a wife/ husband and number of living children. All these factors are discussed below:-

Educational level of wife

Literature from various regions suggest that women who are educated are better informed about their reproductive health needs and it is easier for the health workers to engage them in discussion on reproductive health.

Educational level of husband

Studies in many parts of the world have shown that with education, men's understanding of women's health needs increase. Men are more informed and are clear about the pregnancy complications if they are educated above high school level.

Family type

Type of family is an important indicator that determines what kind of support a wife receives during her pregnancy and who makes the decisions regarding reproductive health of a woman.

Caste

The caste system is embedded in the Indian society. It is one criterion that divides society into different hierarchies. Some sections, notably the Scheduled Castes (SC) and Scheduled Tribes (ST) are the most underprivileged within the Indian society. Mainly these are confined to rural settlements or hilly regions where they do not have easy access to health-care services. These are often poor and engaged in difficult jobs. Their low social status has resulted in lower awareness about women's reproductive health-care needs.

Standard of living

It is observed that economic status is a crucial variable that determines the health of a woman in the household. Women and men from high economic status are in a better position to incur expenditure needed to access health-care for wife when payments are involved. However, women and men with low standard may not have easy access to money and may not be able to utilize appropriate health facilities.

Wife's work status

This indicator plays an important role to determine the economic independence of the wife. The NFHS-3 survey has shown that women who earn have greater decision-making power compared to those who are financially dependent on their husbands. Thus it is an important indicator that has a direct impact on the reproductive health of a woman.

Type of occupation/nature of work of the husband

Occupation of the husband affects involvement of husband in wife's reproductive health needs because it determines the availability of husband in time of need. Furthermore, those engaged in urbane occupations, in particular, non-agricultural occupations, are likely to have urban influences.

Mass media exposure

This variable depends on access to information through mass media, government messages, interaction with other men in the community. The data suggests that in most of the cases men are not careless towards their wife's health care, but they are either misinformed or inadequately informed about the health requirements of the wife.

3.1.3 Demographic factors

The demographic factors that influence decision-making processes are age of the husband/wife and number of living children.

Age of husband/wife

Observations from NFHS-3 have suggested that men in younger ages are less involved in antenatal visits with their wife. However, the participation rate increases with the increase in age of men.

Number of living children

Number of living children is an important aspect to determine the reproductive health status of a woman. Women with more number of living children face higher risk of maternal morbidity and mortality. But it is possible that those with a higher number of children have

more say in decision-making. On the other hand, those with higher number of children are more likely to be confident of handling further pregnancies and the husband is complacent. The effect could be in either direction.

3.1.4 Intermediate variables

Women's empowerment

It is an intermediary variable that is affected by the social setting and a woman's economic dependence or independence and thus her say in the decision-making in her household and regarding her health-care affect husband's involvement.

Gender relations

The questions pertaining to women's perceptions regarding the weight of their point of view within the household and preferences regarding who should control the household budget are used to examine women's role in reproductive decisions including use of contraception. Also women's ability to go out of the house is used as an indicator of women's freedom of movement (Blanc, 2001:191; IIPS and Macro International, 2007).

Freedom of movement

This indicator takes care of the movement of wife outside the home to seek health-care for her. This would help to analyse whether she has the freedom to seek medical help on her own or whether it is influenced by husbands will as well. Greater freedom implies more empowerment enabling the woman to secure husband's involvement assertively. On the other hand, with greater freedom, the woman may be able to manage health-care herself and the husband's involvement may then be not needed.

Attitudinal change among men towards women's reproductive health

Studies have suggested that men's attitude towards adoption of family planning methods is more positive if they have at least one or two sons. Moreover, men who are influenced by urban mode of living and tend to have higher aspirations also hold a positive attitude towards limiting the family size and pay attention to their wife's reproductive health requirements.

Husband's knowledge about reproductive health issues

Literature suggest that if men are more informed about the health-care needs, they tend to be more involved in the women's reproductive health; else the women's health concern is understood as outside men's sphere of involvement.

3.2 Objectives of study

Based on the conceptual framework, the present study seeks to examine the role of men in decision-making across various indicators of women's reproductive health. Following objectives are drawn after reviewing studies from various parts of the world and in India.

1) To explore whether men from areas with high urban characteristics are better aware and informed regarding women's reproductive health-care needs compared to men from areas with low urban characteristics (during childbearing process- complications during delivery, knowledge of contraception).

2) To understand how structural and socio-economic transformations brought about by urbanization translate into men's engagement in reproductive health matters including participation in decision-making processes regarding reproductive health.

3) To study how men act as supportive partners with regards to fertility regulation and the use of contraceptives.

3.2.1 Research questions

Based on the objectives of study, the following questions are delineated to understand whether there is a difference in men's awareness level, degree of involvement, and their attitude and behaviour.

1) Does urbanization bring any change in men's perception and awareness regarding women's reproductive health-care issues?

2) To what extent do structural and socio-economic transformations brought about urban influences affect decision-making and husband's involvement regarding women's health-care needs at the time of pre-natal, natal and post-natal period?

3) How does urbanization influence men's engagement in decision-making regarding fertility regulation and contraceptive use to space or limit children? Who makes the decision on use and type of contraceptive to space or limit children?

4) Is there any gender-equity in decision-making?

3.2.2 Hypothesis

Specific hypotheses to be empirically tested thus are:

1) Men from areas with high urban characteristics are more likely to be aware and informed regarding women's reproductive health-care needs compared to men from areas with low urban characteristics (during childbearing process- complications during delivery, knowledge of contraception).

2) Structural and socio-economic changes brought about by urbanization are more likely to influence men's participation in decision-making processes regarding reproductive health.

3) Men from areas with high urban characteristics are more likely to get engaged in decision-making regarding fertility regulation and contraceptive use than their counterparts.

4) Men from areas with high urban characteristics are more likely to support gender-equity in decision-making regarding use of contraceptives and feel that communication for making family planning decisions is important as compared to men from areas with low urban characteristics.

3.3 Area of the study

The present study is conducted in the state of Uttar Pradesh. The Gautam Buddha Nagar district is chosen as this particular district is experiencing urbanization and there is emergence of villages with low urban characteristics and high urban characteristics.

Table 3.3.1 provides the socio-economic and demographic characteristics of the state of Uttar Pradesh. Uttar Pradesh is the most populous state of India, in 2011 its population was 199.8 million. The sex ratio per thousand males was 898 (females per 1,000 males) in 2001 which

was far less than many of the developed states in India (Registrar General, India, 2001). However, it has slightly improved in 2011 to 912 females over 1,000 males (Registrar General, India, 2011). Only 21 percent of the population of the Uttar Pradesh resides in urban areas, the literacy rate in Uttar Pradesh is 56.3 percent with women's literacy as 42 percent. The total fertility rate of Uttar Pradesh was high- 6.6 in 1971 which has come down to 3.1 in 2013 (Registrar General, India, 2010, 2013). The maternal mortality ratio was excruciatingly high 517 during 2001-03, this has also come down to 285 in 2011-13. Still UP performs poorly on most of the antenatal health-care indicators, the percentage of women consuming IFA tablets; getting tetanus toxoid injections which are fairly low.

TABLE-3.3.1: Socio-economic and demographic conditions in Uttar Pradesh

Characteristics	Uttar Pradesh	Reference Year	Uttar Pradesh	Reference Year
Population (in millions)	166.2	2001	199.8	2011
% to national Population	16.2	2001	16.5	2011
Sex Ratio (females per thousand males)	898	2001	912	2011
% Urban Population	20.8	2001	22.3	2011
Area (in sq. km.)	2,40,928	2001	2,40,928	2011
Population Density (persons per sq. km)	690	2001	829	2011
Literacy Rate (%)	56.3	2001	67.7	2011
Female Literacy Rate (%)	42.2	2001	57.2	2011
Maternal Mortality Ratio** (maternal deaths per 100,000 births) *(includes Uttar Pradesh and Uttarakhand)*	517	2001-03	285	2011-13
Total Fertility Rate#	6.6	1971	3.1	2013

Sources:- Census (2001 and 2011): Registrar General, India (2001, 2011); SRS: Registrar General, India (2001-2003, 2011-13); SRS#: Registrar General, India (2010, 2013)**

Nonetheless, according to the NFHS-3, less than one-quarter men in UP have information about importance of delivering in a health facility and the state ranks last in terms of information regarding importance of proper nutrition for the mother during pregnancy (IIPS and Macro International, 2007:205 and 211). Thus the prevailing situation makes UP a crucial state for investigation regarding reproductive health-care issues.

Table 3.3.2 provides a general overview of maternal health-care indicators of India and Uttar Pradesh as seen in the NFHS-3 (2005-06). Besides indicators for rural and urban

areas of Uttar Pradesh and for Delhi, the metropolis adjoining the Gautam Buddha Nagar district area also presented to facilitate comparison. The table gives the maternal health-care indicators for births during the five years preceding the survey. The table suggests that compared to the national level of 52 percent, only 27 percent of women in Uttar Pradesh have at least three antenatal visits. The institutional deliveries and assisted deliveries are 22 and 29 percent respectively that are far below the national percentage of 39 and 47 respectively. The rural urban differentials within Uttar Pradesh indicates that urban areas fare well in almost all the maternal health-care indicators compared to rural areas. While indicators for urban UP and Delhi reflect that Delhi has higher percentages of women seeking antenatal, delivery and post-natal care in comparison to urban UP.

TABLE-3.3.2: Maternal health-care indicators (India, Uttar Pradesh and Delhi), NFHS-3 (2005-06)

Maternal health-care indicators	India (%)	UP (Total %)	UP (Urban %)	UP (Rural %)	Delhi (Total %)
Women received at least 3 antenatal care visits	52.0	26.6	40.9	22.6	75.1
Births delivered in a health facility	38.7	22	39.9	17.5	58.9
Deliveries assisted by health personnel	46.6	29.2	50.5	23.8	64.1
Deliveries with postnatal check-up within two days of birth	37.3	14.2	31.1	9.9	58.4

Source:- NFHS-3: IIPS and Macro International (2007): 220

TABLE-3.3.3: Information on delivery and maternal care and family planning given to men by health workers, NFHS-3 (2005-06)

Information given to men by health workers	India (%)	UP (Total %)	UP (Urban %)	UP (Rural %)	Delhi (Total %)
Importance of Delivery in a Health Facility	43.3	21.8	33.4	18.0	47.7
Importance of proper nutrition to mothers during pregnancy	49.9	28.3	40.1	24.4	51.1
Family Planning for delaying birth of next child	40.4	22.6	34.9	18.4	48.1

Source:- NFHS-3: IIPS and Macro International (2007): 213

Table 3.3.3 gives the percentage of men between ages 15-49 whose youngest child was 0-35 months and were given specific information on pregnancy, delivery, and family planning information by the health worker or the health provider. This information was imparted during the mother's pregnancy whose delivery was not institutional. The table suggests that less than one-quarter of the men in Uttar Pradesh were given any kind of information regarding delivery by the health worker. The low figures suggest that there is still some gap in imparting information by health workers and seeking information on the part of men. On the other hand, the national figures are nearly fifty percent and shows that about half the men know the importance of proper nutrition to mothers during pregnancy. Within Uttar Pradesh, rural-urban differentials are clearly evident; more men from urban areas receive information on delivery, maternal care and family planning compared to those from rural areas. Again Delhi fares well in all the above mentioned indicators and demonstrates better coverage by health workers in giving information to men compared to urban Uttar Pradesh where the coverage is still less than the metropolis.

TABLE-3.3.4: Information on delivery and neonatal care received by fathers from sources other than health workers, NFHS-3 (2005-06)

Information gathered from other sources during pregnancy	India (%)	UP (Total %)	UP (Urban %)	UP (Rural %)	Delhi (Total %)
Breastfeeding the baby immediately after birth	35.6	24.0	26.8	23.3	36.6
Keeping the baby warm immediately after birth	32.6	24.7	30.6	23.3	36.0
Cleanliness at the time of delivery	44.4	40.1	45.3	38.8	36.3
Using a new or unused blade to cut the cord after birth	48.3	47.1	47.8	47.0	37.2

Source: NFHS-3: IIPS and Macro International (2007): 213

Table 3.3.4 gives the information gathered by fathers from sources other than the health worker. This suggests that nearly forty percent of men at the national and the state levels know about the importance of cleanliness at the time of delivery. The figures are almost similar for the use of new or unused blade to cut the cord after the birth for national and the state level.

Overall, one can see that in Uttar Pradesh less than 50 percent of the deliveries are institutional and the men's involvement and knowledge regarding the importance of various measures at the time of pregnancy is very limited. Thus it is important to note what kind of changes are triggered due to inflow of information and whether this information change the perceptions in areas that are located near to the National Capital Region and those that are far away from it, but still well connected by means of transportation. Keeping these things in mind, and also the process of urbanization of the villages near the National Capital Region in Uttar Pradesh, district Gautam Buddha Nagar is selected to understand the involvement of men in women's reproductive health-care. This particular district is surrounded by big cities like Delhi, Ghaziabad and Faridabad and is under strong influence of diffusion of information through migration of people. Both diffusion of information and migration of people have an impact not only at the community level, but these also change the attitude and behaviour of men and women and thus affecting gender dynamics at the household level. Therefore, it is interesting to study how urbanization has an impact on decision-making processes and whether it promotes men's involvement in women's reproductive health.

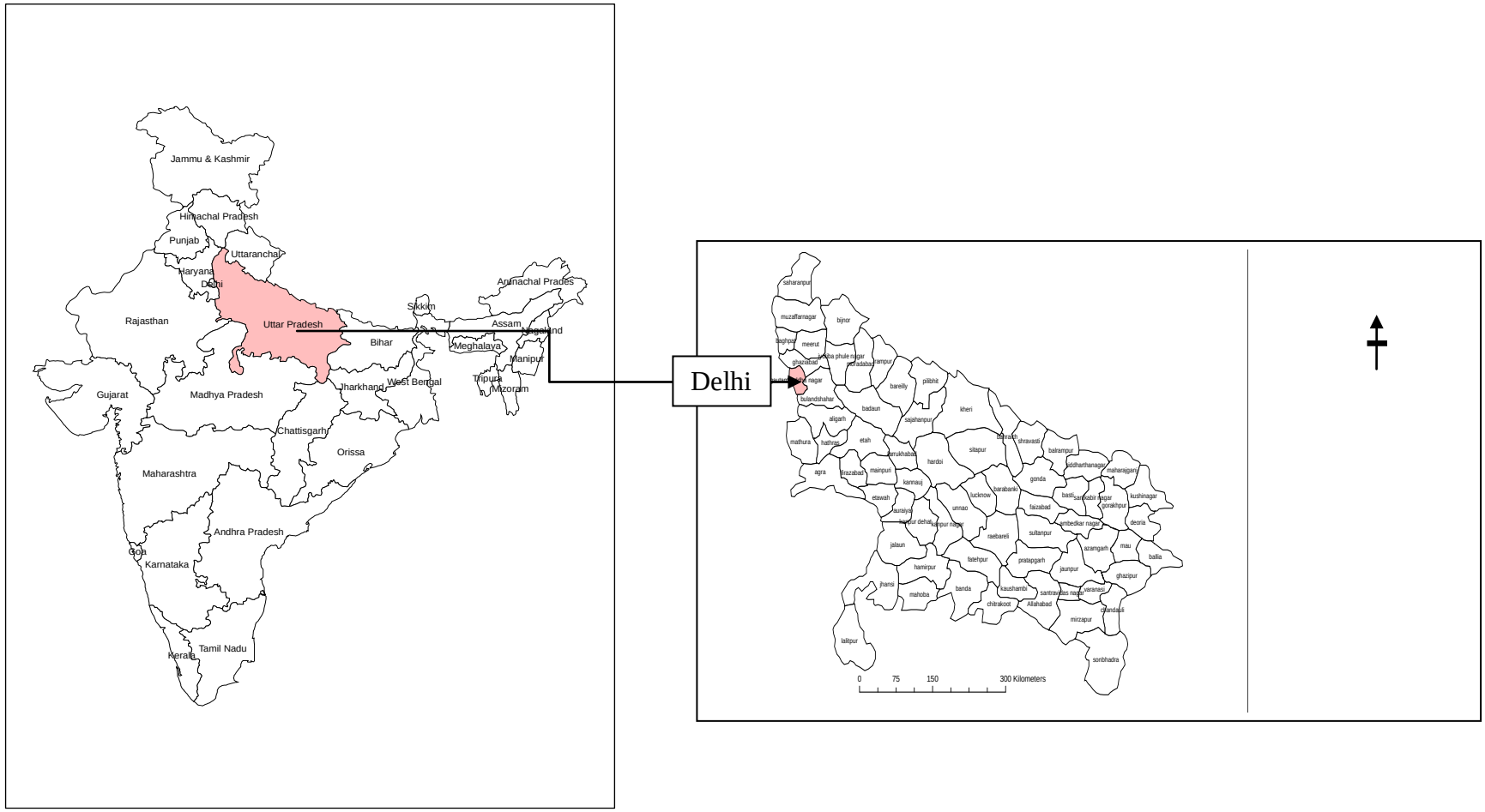
3.4 Overview of the region

This research focuses on reproductive health-care issues in Uttar Pradesh, which is located in the northern part of India. Uttar Pradesh is the largest state in India and has a high population density. District Gautam Buddha Nagar is chosen for the purpose of the study as it is adjoining the National capital 'Delhi' and is undergoing urbanization thus making it a suitable area under transition phase to study the research topic. Gautam Buddha Nagar district is located in north-western part of Uttar Pradesh and is experiencing development in terms of attracting industries and growth under The Greater Noida Industrial Development Authority (GNIDA).

The Gautam Buddha Nagar is one of the five districts in the Meerut division. It lies in the National Capital Region (NCR) consists of the capital city and important city centers from the neighboring states (Datta, 2004:2). It was formed on September 6th 1997 and includes Dadri, Noida and Greater Noida. It is an important industrial district of the Uttar Pradesh and spreads over an area of 1456 sq.km. It is formed by combining block Dadri from parental district Ghaziabad and Bisrakh; block Dankaur, Jewar & partial area of block Sikandrabad of parental district Bulandshahar. At present, the district has three tehsils (Dadri,

Jewar and Gautam Buddha Nagar) and four blocks namely Bisrakh, Dadri, Dankaur and Jewar. The district has 392 villages based on the information from the Primary Census abstract (2001). **Map 1** gives the location of Gautam Buddha Nagar in relation to other districts of Uttar Pradesh and National Capital Region-Delhi.

MAP-1: Location of Gautam Buddha Nagar District



The Gautam Buddha Nagar District is witnessing infrastructural changes in terms of construction of road networks, increase in transportation, educational institutions, biomedical health-care facilities, access to electricity and mass media. In Gautam Buddha Nagar District, with the advancement of GNIDA projects, agricultural land has been acquired to build the facilities which are a part and parcel of urban life (www.greaternoida.com, 2006). Under these circumstances, farmers whose main form of subsistence was agriculture are gradually losing their lands, which have been acquired by GNIDA to build infrastructure. The government gives compensation to these farmers for their lands but the employment provisions made for these farmers is yet not clear. However, these landless farmers are looking for new options like working as unskilled labour in the Multinational companies or getting engaged in petty business in and around their villages.

TABLE-3.4.1: Basic demographic indicators of District Gautam Buddha Nagar (2001 and 2011)

Demographic Indicators	**India**		**Uttar Pradesh**		**Gautam Buddha Nagar District**	
	2001	**2011**	**2001**	**2011**	**2001**	**2011**
Percentage Urban population	28.0	31.2	20.8	22.2	37.3	59.1
Density	324	382	689	829	939	1286
Sex Ratio	933	943	898	912	842	851
Percentage literate						
Percentage of literate males	76.0	80.9	68.8	77.3	82.6	88.06
Percentage of literate females	54.0	64.6	42.2	57.2	54.6	70.82
Total literates	65.0	73.0	56.3	67.7	69.8	80.1

Source:- Primary Census Abstract: Registrar General, India (2001 and 2011)

Table 3.4.1 discusses various indicators of district Gautam Buddha Nagar. There is a stark difference in the literacy levels of males and females. Males' literacy is over 83 percent in the Gautam Buddha Nagar, while female literacy is 55 percent in 2001. This has gone up to 89 percent for males and 71 percent for females in 2011, a noticeable change is observed for the literacy levels of females which is 16 percentage point more in 2011.

Thus the proximity to New Delhi, the National Capital Region and the fact that there are men working outside the traditional mode of employment makes the location of the district very strategic in terms of its access and flow of information particularly on health-care facilities and biomedical systems. Furthermore, the increase in population density, with the majority population still residing in rural areas, and urbanization make this district a suitable research area. Thus it is interesting to study how all the above factors, along with socio-economic

changes intersect and influence the attitude, knowledge and involvement of men in their partner's health related concerns.

3.5 Research design

This section discusses methodology, secondary data sources, sample design and implementation of methods in the field survey. It also presents relevant socio-economic variables used for the analyses of data.

3.5.1 Methodology

The methodology calls for analysis at two different levels to provide a holistic view of men's involvement in the reproductive health decision-making processes. The data is collected from married women and men from different households in villages with low urban characteristics and villages with high urban characteristics by field investigation to capture men's role in decision-making processes regarding women's reproductive health-care issues. This is done to understand whether there is a difference in reporting by women and men, and also to understand the influence of urbanization on the degree of men's involvement in decision-making processes in women's reproductive health. Furthermore, the level of urbanization would influence the behaviour of people living in two different sets of villages, and contact with relatives from urban areas, place of work would be crucial determinants to unfold the influence of urban aspects on husband's involvement in reproductive health.

To supplement this analysis, data at the micro level is taken from the NFHS-3 and is used to study the individual responses to various indicators of men's involvement in women's reproductive health for the state of Uttar Pradesh. Furthermore, analysis of the data from the NFHS-3 helps to understand the rural-urban disparities at the individual level.

The major sources of data used for the study are described below:-

3.5.2 Secondary data sources

National Family Health Survey (NFHS)

The third National Family Health Survey was conducted in 2005-06 (IIPS and Macro International, 2007). Interviews were conducted from both ever-married and never-married

women and men in the age group of 15-49 and 15-54 years respectively. In total 124,385 women and 74,369 men were interviewed from 29 states in India. For the present study, data on reproductive behaviour and intentions, knowledge and use of contraceptive, status of women is analysed at the individual level from women's file. To assess the involvement of men in decision-making role, attitude towards gender role is also looked at to understand how division of gender role in a family affects the decision-making dynamics regarding women's reproductive health-care.

District Level Household and Facility Survey (DLHS):

The District Level Household and Facility Survey (DLHS-3) is a nationwide survey covering around 601 districts from 34 states and union territories of India. DLHS-3 surveyed a total of 5,44,047 persons from 90,415 households in Uttar Pradesh, 81 percent of these are in rural areas and the remaining 19 percent are in urban areas (IIPS, 2010:1). This survey was conducted in 2007-08 for 70 districts in Uttar Pradesh and around 1,049 households are covered for the district Gautam Buddha Nagar. The survey was designed to provide deeper understanding of Reproductive and Child Health indicators, some of the important aspects are:

Utilization of antenatal care, check-up and immunization services
Nature of delivery care, especially the extent of institutional/safe deliveries
Contraceptive prevalence rates
Unmet need for family planning
Awareness about RTIs/STIs and HIV/AIDS

3.5.3 Primary survey: sample design and implementation

Sample size

Initially, the survey proposed to cover about 200 currently married women and 200 men each from different households in Gautam Buddha Nagar district of the Uttar Pradesh. Gautam Buddha Nagar district is located in the National Capital Region, shares its border with Ghaziabad district which is also an urban district of Uttar Pradesh. The villages in the district were classified by the percent of male workers outside agriculture (as seen in the 2001 census as at the time of field study, 2011 census data were not available). The share of male workers outside agriculture is well recognized as a key indicator of the degree of urban orientation of a

village and this is one of the variables used by the Registrar General of India to identify census towns. On the basis of this classification, two strata were identified, one with high urban characteristics (where more than 60 percent of male working population is engaged in non-agricultural activities) and the other with low urban characteristics (where less than 25 percent of male working population is engaged in non-agricultural activities) as these two strata represented villages at high and low levels in the process of urbanization. Out of 392 villages, 73 villages were identified as villages with high urban characteristics, and 135 villages were identified as villages with low urban characteristics. From each stratum four villages were randomly selected with Probability Proportional to Size (PPS). The villages are chosen based on the 2001 population.

Depending on size of the village, house listing was done for sampling purpose. In the villages with recent population growth, only households belonging to the original nucleus village (i.e., households having non-migrants and living in the older areas) were listed as the new households represent fresh migrants whose characteristics could be different altogether. If the village was large, then the sample was drawn by dividing it into various segments and choosing two segments from it. In order to avoid contamination and possible unease when both husband and wife are interviewed, it was decided to select currently married women of age 15-49 years from one set (sample) of households and currently married men of age 15-49 years from another set from each of the sampled villages (8 in all, and 4 from each stratum).

Further, as some non-response was anticipated, two samples of 30 households were proposed to be selected in each sampled village to interview married women from one sample and married men from the other. Two separate samples of 30 households each were drawn by doing systematic random sampling from each identified village. This was done by calculating the sampling interval (the number of households in the population divided by the number of households needed for the sample) based on the households in those villages chosen for the data collection. The samples constitute eligible women (currently married and age group of 15-49 years) and eligible men (currently married and age group of 15-49 years) for the purpose of primary survey (**Table 3.5.1**).

Thus the samples drawn from two sets of villages are:-

Samples drawn from villages with high urban characteristics

*30*4= 120 (currently married women)*

*30*4=120 (currently married men)*

Samples drawn from villages with low urban characteristics

*30*4= 120 (currently married women)*

*30*4=120 (currently married men)*

The response rate was very high and 238 currently married women and 231 currently married men were successfully interviewed. The survey was conducted for over 6 months in the year 2011-2012. A questionnaire was developed and finalized after pre-testing. Two separate interview schedules were prepared one for women and another for men in the local language, 'Hindi.' Initially a survey of (currently married men and women from different households in 8 villages) using a structured interview schedule was carried out. It would have been desirable to interview couples with husband and wife interviewed separately. However, this posed question of ethics because many would have objected to such separate interviews especially when there are questions on involvement of husband in reproductive decision-making of their wife. There is also strong likelihood of husband dictating responses to the wife to see that they match husband's responses. This could probably create situation of conflict between spouses. In order to avoid this situation, separate interviews were conducted. The other reason is being the possibility of contamination as one's responses may influence the responses of the other spouse.

Informed consent was taken from each respondent before initiating the interview. The purpose of study and the types of questions to be anticipated by the respondents were discussed beforehand. The respondents were given assurance that their personal details will be kept confidential and pseudonyms will be used while discussing the contents of the research in any form of presentation. Respondents were also informed that they can discontinue the interview and withdraw from it without any hesitation if they feel uneasy talking about or sharing very sensitive information on their personal life (questions on reproductive health).

TABLE- 3.5.1 Table on sample coverage

	Strata		
No. of villages	**I (Villages with high urban characteristics)**	**II (Villages with low urban characteristics)**	**Total**
No. of villages selected	4 out of 73 villages	4 out of 135 villages	8 out of 392 villages
No. of households selected (Women)	4*30	4*30	240
No. of households selected (Men)	4*30	4*30	240
No. of women interviewed	118	120	238
No. of men interviewed	116	115	231

Source: Survey conducted in Gautam Buddha Nagar district (2011-12)

The data is collected regarding relevant indicators to gauge men's involvement in women's reproductive health. The set of questions focuses on perceptions about women's reproductive health, future desire for children, views on antenatal or post-natal check-ups, and perceptions about the use of contraception to space children. Narratives from the interviews of women and men provided the basis for understanding the facts about types of treatment women received during their pregnancy and reproductive lives. In addition, some of these recorded narratives also aid in understanding the level of participation of men in women's lives, especially pertaining to reproductive health-related care. Further, the secondary data analysis gives a broader picture of men's involvement in women's reproductive health-care. This helps to analyse how different socio-economic indicators such as age at marriage, education level, occupation, access to information affect decision-making roles within families. Moreover, interviews with health service providers are also conducted to get deeper insights on the role played by them to persuade married women and men to use health-care services. Furthermore, details are asked from the health-care providers on husband's involvement in reproductive health to get a better understanding of the prevailing situation within two sets of villages.

Pictures taken while conducting interviews with a woman and a man

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)

Information collected from the primary survey

Besides, information on villages such as caste composition, local practices and data on special issues were collected.

Data collected through questionnaire and in depth interviews on:

- Socio-economic characteristics
- Demographic characteristics
- Aspects of husband's involvement
- Aspects of women's empowerment
- Gender relations within a household
- Narratives from men and women on awareness regarding reproductive health issues (pregnancy episodes, etc.)
- Interviews with health service-providers on husbands' participation in women's reproductive health

3.5.4 Statistical methods for analysis

This study was carried out using both the primary and secondary data analysis. Primary data was collected by conducting field survey of Gautam Buddha Nagar district in 2011-12. Secondary data at the individual level was taken from NFHS-3 survey that was conducted in 2005-06 on the involvement of men in welfare of the family. The published information is

used to study various indicators of women's reproductive health-care issues. The techniques used to analyse the data are:-

(1) ***Binary Logistic Regression:*** This method is used when the dependent variable is dichotomous. This is done in order to estimate the net effect of each variable on the decision-making process regarding the reproductive health care by both men and women. Since many of the dependent variables chosen are dichotomous (reported yes or no) the technique of logistic regression has been adopted for individual level data analysis (Retherford and Choe, 1993).

(2) ***Multinomial Logistic Regression:*** This is an extension of the logistic regression where the dependent variable has more than two categories. The reference category is chosen in order to compare the other dependent variables with it.

(3) ***Predicted probability:*** On the basis of the estimated coefficients of logistics (binomial or multinomial) regression, the predicted probabilities for various categories of the explanatory variables can be computed (Retherford and Choe, 1993). These can then be presented in the form of percentages as adjusted (adjusted for the effects of other explanatory variables) percentages for each category alongside the unadjusted percentages in a manner like the MCA in order to get a clearer understanding of the net effects of socio-economic and demographic variables on the dependent variable, in this case, husband's involvement.

The method of analysis described above is for the secondary data from the NFHS-3. A similar approach has been adopted for the analysis of the data collected in the field survey. However, there are some additional variables for which data are available in the field survey. The details on the specific variables used in the analysis of the field survey data and from NFHS-3 are discussed in the next section.

3.5.5 Details of specific variables used for the data analysis

Multivariate analysis of husband's involvement in wife's reproductive health: data from the field survey

Using data of the women and men from the field survey, detailed analysis is done to understand the effect of various socio-economic and demographic factors on the involvement

of men in different roles. First, Logistic Regression technique has been adopted to analyse quantitative data since the dependent variable (involvement) is dichotomous. This is done to estimate the net effect of each variable on the involvement of husbands in decision-making processes on women's reproductive health. In order to get a clearer idea of net effect, the adjusted percentages are calculated and presented alongside unadjusted percentages using predicted probability equation (the rationale has been described in the section 3.5.4). In addition, quotes from women and men are transcribed and translated to understand whether women and men have differences in opinion on husbands' involvement in decision-making or not.

The dependent variables chosen to carry out Logistic Regression are:-

Husbands can be involved in various aspects of a woman's reproductive health, pregnancy care, delivery care, post-natal care, contraceptive use, etc. eight such aspects are identified and a variable is constructed for each of the eight different aspects based on a set of questions asked for each aspect of husband's involvement. If the answer for any question is 'Yes,' the involvement is coded as 1, that is the husband is involved in any one or more activities listed for that particular aspect of involvement, otherwise it is coded as 0, that is the husband is not involved in any of the activities of that aspect. The variables used to gauge husband's involvement and participation during decision-making are:-

1) Husband's involvement in pregnancy care (Yes=1, No=0), questions included are:

i) Whether the woman received any special care by husband during the pregnancy.
ii) Whether husband was involved in making decisions on Antenatal Care (ANC).
iii) Whether husband accompanied for the ANC care.
iv) Whether husband paid for the ANC care.

2) Husband's involvement in delivery care (Yes=1, No=0), questions included are:

i) Whether husband made any special arrangement for the delivery.
ii) Whether husband accompanied to the place of delivery.
iii) Whether husband discussed about the place of delivery.
iv) Whether husband was present with wife at the time of delivery.
v) Whether husband paid for the delivery.

3) Husband's involvement in post natal care (Yes=1, No=0), question asked:

i) Whether husband was involved in making decision for the post natal care.

4) Husband's desire for additional child (Yes=1, No=0), questions asked:

i) Whether husband desire to have another child in the future.

5) Husband's involvement in getting contraceptive for wife (Yes=1, No=0), questions asked:

i) Whether husband helped wife to get contraceptive.

6) Contraceptive behaviour of Husband (Encouraged/discouraged wife=1, No=0), questions asked:

i) Whether husband encouraged wife to use contraceptive.
ii) Whether husband discouraged wife to use contraceptive.

7) Involvement of husband in getting sterilization services (Yes=1, No=0), questions asked:

i) Whether husband took care of wife after sterilization.
ii) Whether husband told wife what precautions to take.
iii) Whether wife discussed with husband before getting sterilized.
iv) Whether husband supported wife in getting sterilization done.

8) Involvement of husband during wife's sickness (Yes=1, No=0), questions asked:

i) Whether husband supported wife at the time of RTI infection.
ii) Whether husband helped wife when she was sick.

As has been noted earlier, both women and men were interviewed in the field survey and the same set of questions were asked; for reasons explained earlier in this chapter in section 3.5.3, the same couple was not interviewed but a sample of married women and another sample of married men were covered. The responses of women do differ somewhat from those of the

men. The variables listed above were obtained for both women and men. Thus there are two sets of analysis, one for responses from women and the other for responses from men.

List of Explanatory Variables:

Various socio-economic and demographic factors can influence husband's involvement. The explanatory variables chosen for the analysis are:-

URBANIZATION

- **Place of residence:** villages are divided into two types based on the stage of urbanization they are in, such as villages with low urban characteristics and villages with high urban characteristics. Villages having low urban characteristics are used as the reference category.

- **Place of work of the husband:** the husband's place of work is an important variable used for the study, and is divided into two types: whether the husband works within the village or husband works outside the village. Husband working within the village is used as the reference category.

- **Relatives living in urban areas:** contact with relatives is important to understand changes in personal life and decision-making. Two categories visiting relatives in urban areas or not visiting relatives in urban areas are used. Not visiting relatives in urban areas is kept as the reference category.

SOCIO-ECONOMIC VARIABLES

- **Educational level of wife:** is captured through different levels of education they have achieved. This variable is divided into three categories as wife with no education, wife with up to 8^{th} level of education and wife having education above 8^{th} level for the analysis purpose. No education is used as the reference category.

- **Educational level of husband:** is explained through different levels of education they have achieved. This variable is divided into three categories as husband with no education, husband with up to 8^{th} level of education and husband having education

above 8th level for the analysis purpose where no education is used as the reference category.

Note that as education of wife and education of husband are highly correlated, use of both the variables in a single regression is likely to lead to near multi-collinearity. Therefore, the analysis has been performed using the education of wife as an explanatory variable. However, an alternate regression has been carried out using education of husband in the place of education of wife. The results are shown in Appendix. Generally, these are quite similar to those based on the variable education of wife.

- **Family type:** this variable is looked in terms of whether a family is a joint family or a nuclear family and how it affects husband's involvement in various reproductive health matters. Here joint family is kept as the reference category.

- **Caste:** this is divided into three categories as: scheduled castes/ scheduled tribes, other backward classes, and others (other than scheduled castes/tribes and backward classes) for the study purpose. 'Others' is the reference category.

- **Standard of living:** the economic status is captured by standard of living variable by dividing it into three categories as: low standard, medium standard and high standard. Here low standard of living is kept as the reference category.

To construct the 'standard of living variable,' a set of 23 questions were asked to women and men on various assets in their households. If the answer for any question is 'Yes,' it is coded ranging from 1 to 4 based on the value of asset, else it is coded as 0 that is, they do not own that asset. An index of standard of living is obtained as low (scores of 10 or below), medium (scores between 11-20) and high (scores 21 and above) based on these scores.

- **Woman's empowerment:** This variable is divided into two categories as: a woman with low empowerment and a woman with high empowerment depending on the number of decisions a woman is involved in her household and whether she is able to communicate her needs to the husband or not. A woman with low empowerment is kept as the reference category.

To construct the 'woman's empowerment' variable, a set of 5 questions were asked from women and men on the woman's involvement in various decisions and activities. If the answer

for any question is 'Yes,' it is coded ranging from 1 to 2 based on the value of decision (2; very important/ 1; somewhat important), else it is coded as 0, that is wife is not involved. An index of 'woman's empowerment' is obtained as woman with low empowerment (scores between 0 to 5) and a woman with high empowerment (scores between 6 to 8).

- **Wife's work status:** whether a woman is working and earned money or not is used as an indicator of woman's work status for the present study. Wife who is not working is used as the reference category.

- **Type of occupation/nature of work of the husband:** this variable is categorized into husband engaged in a manual job or husband engaged in a non-manual job, where husband engaged in a manual job is kept as the reference category.

- **Exposure to mass media:** this variable is computed to study exposure to mass media (print media or television), and it is divided into wife/husband exposed to mass media or wife/husband is not exposed to mass media. Here wife/husband who is not exposed to mass media is kept as the reference category.

This variable is created by asking two sets of questions on whether a respondent (a woman or a man) reads newspaper or magazine; and/or listens to radio or watch TV. If the answer is 'Yes' to any of those questions, it is coded as 1, that is the respondent is exposed to some kind of media, else it is coded as 0, that is the respondent does not have any exposure to media.

DEMOGRAPHIC VARIABLES

- Age of a husband/wife: since the age of a husband and age of wife are highly interrelated and use of both the variables in a single regression equation would be close to multi-collinearity, only age of wife is used for the current study. Age of a wife is divided into two age groups, age up to 35 years and age from 36 years and above. Wife's age up to 35 years is kept as the reference category.

- **No. of living children:** this indicator is divided into three categories, a woman/man with 1 child, a woman/man with 2 children and a woman/man with 3 and above children for the purpose of this study. Woman/man with 1 child is kept as the reference category.

Multivariate analysis of the NFHS-3 data from women's file, Uttar Pradesh

Using data of the women from the state of Uttar Pradesh, a detailed analysis is done to understand the effect of various socio-economic and demographic factors on the involvement of men in different roles. Multinomial Regression technique has been adopted to analyse quantitative data since the dependent variable (involvement) is dichotomous.

List of Dependent Variables from NFHS-3 women's file

- **Desire for additional child of a woman:** this indicator has multiple responses where the desire for an additional child is divided into three categories 'desire to have no more children,' 'desire to have another child' and 'undecided.' Desire for no more children is used as a reference category.

- **Desire of spouses to have another child:** this indicator has multiple responses where a match between the spouses to have another child is categorized as 'both have the same desire,' 'desire of the spouses differs to have additional child' and 'undecided.' Both spouses have the same desire is used as a reference category.

- **Decision-making on use of contraceptives:** this indicator is divided into 3 types- husband and wife make a joint decision, mainly wife (respondent) decides and mainly husband decides. Husband and wife make a joint decision is used as the reference category.

- **Decision on woman's own health-care:** decision taken in the family on a woman's health-care is categorized as: 'woman has a say,' 'husband has a say' and 'other members have a say.' The reference category here is - woman has a say.

List of Explanatory Variables for multinomial regression:

- **Age of a woman:** This is categorized into three age groups of less than 24 years, 25-39 years of age and more than 40 years, using the middle age group (25-39 years) as a reference category.

- **Age of a woman at marriage:** is classified into young (15-19 years), middle (20-29 years) and high (30 and above years) where middle age is kept as a reference category.

- **Place of residence:** is divided into rural and urban residence where rural residence is the reference category.

- **Number of living children:** this variable is divided into three categories as no children, one or two children, and three or more children, where one or two children is used as a reference category for the analysis.

- **Educational level of a woman:** this variable is classified as no education, primary, secondary and higher education, keeping no education as the reference category.

- **Partner's educational level:** this is the husband's education and is divided into no education, primary, secondary and higher education, keeping no education as the reference category.

- **Caste:** this social indicator is categorized into three types: Others, Scheduled Castes/Scheduled Tribes (SC/ST), and Other Backward Classes (OBC), since the number of STs in the district is very small, the category of SCs is combined with STs. The category of 'Others' is used as a reference category.

- **Religion:** is organized into Hindus and Non-Hindus (include Muslims, Christians and other religious groups). Hindus is chosen to be the reference category here.

- **Wealth Index:** this variable is graded as poor class, middle class and rich class, keeping poor class as the reference category. The categorization based on ownership of assets and housing conditions is provided in NFHS-3 data files (For details, see IIPS and Macro International Report, 2007:43).

- **Exposure to mass media:** this variable is computed using the variables such as 'heard of family planning on radio, television or read in newspaper in the last month or seen family planning on wall paintings or hoardings'. Here no exposure to mass media is kept as a reference category.

- **Partner's Occupation:** is categorized into manual job and non-manual job based on the type of activities they are involved in. Partner engaged in manual job is kept as a reference category here.

- **Work status of a woman:** this variable is computed to get the work status of a woman and is categorized as non-worker, unpaid-worker and a paid-worker keeping non-worker as a reference category.

- **Bank savings of a woman:** is classified into a woman having bank savings or no bank savings and no bank savings is kept as a reference category.

3.6 Limitations of the study

Though the study aims at covering decision-making processes regarding women's reproductive health issues, the focus is on maternal health and fertility regulation. It is beyond the scope of study to cover all the aspects of reproductive health. The selected eight villages for the study purpose give an overview of the prevalent situation in those villages, so it is highly subjective and context specific. Thus this study provides data on the prevailing situations in an urbanizing set up that affect men's involvement in women's reproductive health issues.

CHAPTER -4

WOMEN'S REPRODUCTIVE HEALTH IN GAUTAM BUDDHA NAGAR DISTRICT: EVIDENCE FROM THE FIELD SURVEY

CHAPTER-4

WOMEN'S REPRODUCTIVE HEALTH IN THE GAUTAM BUDDHA NAGAR DISTRICT: EVIDENCE FROM THE FIELD SURVEY

4.1 Introduction

This chapter aims at presenting the findings on various aspects of women's reproductive health within the state of Uttar Pradesh and the district Gautam Buddha Nagar. The field survey in the district obtained information on various aspects of reproductive health as well as socio-economic conditions of the women and men, gender roles, and the process of decision-making. But before these results are discussed, a comparative picture of the reproductive health situation in the district (Gautam Buddha Nagar) and the state (Uttar Pradesh) is presented in order to highlight the contrast between household and health indicators at the state and district level. For this purpose, in the next section information on household facility, ANC and delivery care, delivery complications and treatment sought, knowledge on contraception and current use of contraceptives are discussed using data from the third round of the District Level Health and Facility Survey (DLHS-3) which is the latest survey that provides information at the district level (results from the fourth round of the survey, DLHS-4, conducted during 2012-13 were not available at the time of preparing this thesis). This is followed by information from the field investigation conducted in 8 villages of the district Gautam Buddha Nagar. It covers background conditions of the respondents, effects of urbanization on villages and influence of urbanization in personal life, maternal health, knowledge and use of contraception, and involvement of women in decision-making on various household issues, problems faced by women in seeking treatment when they are sick, and the importance of communication between spouses on various important health issues.

4.2 Evidences from District Level Household and Facility Survey (2007-08)

Table 4.2.1 gives some indicators of the household facility available in the state and the district. It is clearly seen that the availability of most of the household amenities in the Gautam Buddha Nagar District is nearly double of the availability at the state level. At the state level only 38 percent of the households have electricity supply, around 26 percent have

toilet facility and only 23 percent live in pucca houses in contrast to 75 percent, 52 percent, and 48 percent respectively in the Gautam Buddha Nagar district.

TABLE-4.2.1: Percentage of households with selected amenities, DLHS-3 (2007-08)

S. No.	Characteristics	Uttar Pradesh	Gautam Buddha Nagar District
1.	Electricity	37.9	74.5
2.	Drinking water	94.8	99.9
3.	Toilet facility	26.4	51.5
4.	Using LPG	10.3	22.6
5.	Living in Pucca house	22.8	48.4

Source:- DLHS-3 (2007-08): IIPS (2010): 49-50

Besides household amenities, health information was also collected in the field survey. The number of antenatal care visits and the timing of the first visit are important for the health of mother and developing fetus. Studies on the timings of the initial antenatal check-up, however, show that even when antenatal care is initiated as late as the third trimester, there is a substantial reduction in perinatal mortality (cited from Ramachandran,1992 by IIPS and Macro International 2007:196). DLHS-3 asked women (aged 15-49 years, who had their last live/still birth since January 1st, 2004 till the time of survey) questions on the antenatal care and complications. When the responses are compared for UP and the district Gautam Buddha Nagar, there is not much difference seen in the indicators except for check-up in the first trimester **(Table 4.2.2)**. More than 20 percent of women are going for three or more antenatal check-ups, around 35 plus percent take IFA tablets and more than half women are administered at least one tetanus toxoid injection. However, full antenatal check-up is extremely low in UP and in the district Gautam Buddha Nagar.

Another important thrust of the Reproductive and Child Health Program in India is to encourage women to have deliveries in proper hygienic conditions under the supervision of trained health professionals (IIPS and Macro International 2007:208). From **Table 4.2.3**, it is seen that percentages of women seeking institutional deliveries or who had deliveries at home is nearly same in the district as at the state level. Nearly three-fourths of women at state and district levels preferred to have home deliveries at the time of the DLHS-3 survey (it may be noted here that much of the DLHS-3 reference period (2004-06) was before the launch of the National Rural Health Mission; since the NRHM, there has been a huge rise in institutional deliveries which is not captured in the DLHS-3). Annual Health Survey (2012-13) suggests

that institutional deliveries both in the state of UP and the Gautam Buddha Nagar district are around 57%, though within the (Gautam Buddha Nagar district) there are rural-urban differentials, rural areas reported 54% institutional deliveries, while in urban areas 63% of the deliveries are institutional (Registrar General and Census Commissioner, 2012-13:122). Just one-fourth of women deliver in an institutional set-up. But a higher percentage of women go for home deliveries conducted by a skilled person in the district than the state average.

TABLE-4.2.2: Percentage of women (aged 15-49)* who received different types of antenatal care (ANC), DLHS-3 (2007-08)

Antenatal care indicators	Uttar Pradesh	Gautam Buddha Nagar District
Antenatal check-up in the first trimester of pregnancy	25.0	40.5
Three or more antenatal check-up	21.8	23.7
At least one tetanus toxoid injection	62.5	66.8
100+ IFA tablets/syrup	41.8	37.2
Full antenatal check-up#	3.3	1.7
No. of women (who had a birth in the specified period)**	**37,847**	**417**

Source:- DLHS-3 (2007-08): IIPS (2010): 76-77
***Women who had their last live/still birth since 01-01-2004**
**** Unweighted cases**
 # At least 3 visits for antenatal check-up, at least one TT injection received and 100+ IFA tablets/syrup consumed

TABLE-4.2.3: Percentage distribution of women (aged 15-49)* by place of delivery and assistance during delivery, DLHS-3 (2007-08)

Place of delivery and assistance characteristics	Uttar Pradesh	Gautam Buddha Nagar District
Percentage of women with institutional delivery	24.5	27.5
Percentage of women who had delivery at home	74.6	72.4
Assisted home delivery by skilled persons	5.5	13.4
Non-assisted home delivery	69.1	59.0
Percentage of safe deliveries (Institutional deliveries and home deliveries assisted by skilled persons)	*30.0*	*40.9*
No. of women**	**37,847**	**417**

Source:- DLHS-3 (2007-08): IIPS (2010): 80-81
***Women who had their last live/still birth since 01-01-2004**
**** Unweighted cases**

TABLE-4.2.4: Percentage of women (aged 15-49)* who had pregnancy, delivery and post-delivery complications and treatment seeking behaviour, DLHS-3 (2007-08)

Complications and treatment sought during pregnancy, delivery and post-delivery period	Uttar Pradesh	Gautam Buddha Nagar District
Percentage of women who had complication during pregnancy	64.0	50.3
Percentage of women who had delivery complication	66.2	53.8
Percentage of women who had post-delivery complication	18.8	11.4
Percentage of women who had (at least one) pregnancy complication and sought treatment for it	45.7	50.2
Percentage of women who had (at least one) post-delivery complication and sought treatment for it	61.1	69.1
No. of women**	**37,847**	**417**

Source:- DLHS-3 (2007-08): IIPS (2010): 87-88
***Women who had their last live/still birth since 01-01-2004**
**** Unweighted cases**

Questions pertaining to pregnancy, delivery and post-delivery complications were asked to women of ages 15-49, along with their treatment seeking behaviour (**Table 4.2.4)**. UP shows higher percentages of women with complications during pregnancy (64%) and who had delivery complications (66%) compared to women in the district Gautam Buddha Nagar. However, percentages of women seeking treatment for at least one complication during the time of pregnancy and delivery are nearly the same for UP and the Gautam Buddha Nagar with a difference of less than 10 percentage points.

Table 4.2.5 shows the knowledge of contraception among women of UP and the Gautam Buddha Nagar. Modern methods are widely known compared to traditional methods of spacing births. Almost all women are aware of sterilization. Among the three modern spacing methods offered by the government family planning programme (Pill, IUD and Condom), higher percentages of women have information on IUD in the Gautam Buddha Nagar district, followed by the knowledge of traditional methods such as rhythm method and withdrawal as compared to women in the entire state of UP. Injectables and emergency contraceptive pills are relatively less known as these contraceptives are not offered by the programme.

TABLE-4.2.5: Percentage of currently married women (aged 15-49) who are aware of specific contraceptive method, DLHS-3 (2007-08)

Contraceptive Methods	Uttar Pradesh	Gautam Buddha Nagar District
Any Method	99.4	100.0
Any modern method	99.2	100.0
Male sterilization	86.4	96.2
Female sterilization	98.6	99.9
IUD	82.8	97.3
Pill	91.4	99.3
Emergency contraceptive Pill	18.8	22.9
Injectables	74.1	83.4
Condom	88.8	95.2
Female condom	5.9	4.9
Rhythm method	70.5	97.2
Withdrawal	47.5	66.6
Other	0.9	0.9
No. of women*	**82,810**	**998**

Source:- DLHS-3 (2007-08): IIPS (2010): 113-114
***Unweighted cases**

TABLE-4.2.6: Percentage of currently married women (aged 15-49) who are currently using any contraceptive method, DLHS-3 (2007-08)

Contraceptive Prevalence Rate	Uttar Pradesh	Gautam Buddha Nagar District
Any Method	38.4	56.2
Any modern method used	27.2	40.4
Male sterilization	0.2	0.3
Female sterilization	17.5	26.4
IUD	1.0	2.7
Pill	1.3	2.9
Emergency contraceptive Pill	0.3	0.8
Condom	6.7	7.7
Rhythm method	9.1	14.1
Withdrawal	2.0	1.5
Other	0.0	0.0
No. of women*	**82,810**	**998**

Source:- DLHS-3 (2007-08): IIPS (2010): 120-121
***Unweighted cases**

The current level of contraceptive use, i.e., the Contraceptive Prevalence Rate is an indicator of the success of the family planning programs and also depicts the preference of couples for the use of certain contraceptives over the others. The Contraceptive Prevalence Rate for any method used is lower for the state of UP as compared to the Gautam Buddha Nagar **(Table 4.2.6)**. When it comes to actually using contraceptive, nearly 40 percent of women in the Gautam Buddha Nagar district use any modern method, and they also prefer terminal method (female sterilization) over the reversible methods.

Thus above discussion has shown that the Gautam Buddha Nagar district has better socio-economic conditions as compared to the state (UP). The indicators of reproductive health generally depict similar situation with in the district and the state, however, the Gautam Buddha Nagar district is doing better than the state in a few aspects like ANC check-ups, safe deliveries and contraceptive use.

The next section discusses findings from the primary field survey conducted in eight villages from the district of Gautam Buddha Nagar. Questions pertaining to household structure and composition, background information, information on health status were asked to women and men in villages with low urban characteristics and villages with high urban characteristics to draw a contrast between two types of villages and also to understand the differences between responses of women and men.

4.3 Evidences from the primary survey: Background and household characteristics

Table 4.3.1 shows the distribution of surveyed women and men by background characteristics, separately for those living in villages with low urban characteristics and villages with high urban characteristics. A total of 238 currently married women and 231 men from different households were interviewed for collecting data. Education depicts a contrast between less urban and more urban characteristics villages. Nature of work of the husband also shows marked difference between villages with low urban and high urban characteristics; this is to be expected as the stratification of the villages was done on the basis of nature of work. Responses from women in low urban characteristics villages indicate that around one-third of husbands got married at a low age (19 years and below), more women are still without any formal education, and nearly 64 percent of the husbands work within the villages and still 60 percent of husbands are engaged in manual activities. Largely the differences between responses of women and men are minor except for some indicators. Men reported more number of joint families as compared to women who have reported around 65 percent of nuclear families in villages with low urban characteristics. However, 64 percent women reported that their husbands have attained above 8^{th} level of education as compared to men's reporting which is 10 percentage points less for villages with high urban characteristics. Fewer women than men reported the caste as Other Backward Classes and Scheduled Caste. Women also reported lesser number of husbands are engaged in manual jobs compared to men's reporting in less urban characteristics villages. The difference lies in the classification as many husbands are engaged in multiple jobs, such as other secondary jobs along with primarily getting involved in agricultural activities or it is vice versa where majority of the husbands are engaged in non-agricultural activities along with some of the agricultural activities.

TABLE-4.3.1: Percentage distribution of currently married women and men by background characteristics, Field survey, Gautam Buddha Nagar district (2011-12)

Background Characteristics	Women Respondents from villages with		Men Respondents from villages with	
	Low Urban Characteristics	High Urban Characteristics	Low Urban Characteristics	High Urban Characteristics
Age of a woman				
Below 25 years	14.1	16.1	20.7	24.3
25-35 years	49.2	54.2	56.0	55.7
36 and above	36.7	29.7	23.3	20.0
Age of a husband				
Below 25 years	5.0	5.9	6.0	9.6
25-35 years	43.3	46.6	59.5	56.5
36 and above	51.7	47.5	34.5	33.9
Age at marriage (woman)				
Below 18 years	53.3	46.6	62.1	44.3
18-20 years	43.3	43.2	31.9	39.2
21 and above	3.4	10.2	6.0	16.5
Age at marriage (husband)				
19 years and below	36.4	26.1	38.8	32.2
20-24 years	53.4	62.6	52.6	50.4
25 and above	10.2	11.3	8.6	17.4
No. of living children				
1 child	9.2	11.9	12.1	16.5
2 children	21.7	27.1	29.3	37.4
3 and above children	69.1	61.0	58.6	46.1
Family Type				
Nuclear	65.0	62.7	41.4	43.5
Joint	35.0	37.3	58.6	56.5
Highest education level (woman)				
No Education	45.0	34.7	55.1	41.7
Up to 8^{th} level	34.2	32.2	25.9	20.9
Above 8^{th} level	20.8	33.1	19.0	37.4
Highest education level (husband)				
No Education	16.7	10.1	16.4	19.1
Up to 8^{th} level	23.3	26.3	30.2	27.0
Above 8^{th} level	60.0	63.6	53.4	53.9
Exposure to Mass Media				
No	16.7	10.2	11.2	7.0
Yes	83.3	89.8	88.8	93.0
Caste				
Others	42.5	41.5	24.1	37.4
OBC	36.7	45.8	43.1	52.2
SC	20.8	12.7	32.8	10.4
No. of women	**120**	**118**		
Nature of work (Husband)				
Manual	60.2	47.4	81.9	72.2
Non-manual	39.8	52.6	18.1	27.8
Place of work (husband)				
Within village	63.6	42.1	72.4	47.8
Outside	36.4	57.9	27.6	52.2
No. of women*/men	**118**	**114**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12).

***6 husbands do not work, so the total for nature of work of husband and place of work of husband is less than 238 for women respondents.**

TABLE-4.3.2: Percentage of currently married women and men with various assets in their households, Field survey, Gautam Buddha Nagar district (2011-12)

	Women Respondents from villages with		Men Respondents from villages with	
Products	**Low Urban Characteristics**	**High Urban Characteristics**	**Low Urban Characteristics**	**High Urban Characteristics**
Electricity	95.8	98.3	94.8	97.4
Mattress	50.0	47.5	41.4	56.5
Pressure Cooker	60.0	70.3	44.8	62.6
Chair	41.7	30.5	59.5	65.2
Cot/Bed	91.7	99.2	96.6	93.0
Table	17.6	30.5	34.5	49.6
Electric Fan	81.7	89.8	89.7	95.7
Radio/Transistor	0.8	7.6	47.4	36.5
B &W TV	11.7	13.6	39.7	25.2
Colour Television	73.3	81.4	50.0	69.6
Sewing Machine	51.7	63.6	67.2	63.5
Mobile Telephone	91.7	91.5	90.5	90.4
Any other telephone	0.0	4.2	4.3	3.5
Computer	4.2	8.5	2.6	6.1
Refrigerator	19.2	39.0	24.1	47.8
Watch/Clock	67.5	65.3	56.9	65.2
Bicycle	30.8	34.7	45.7	43.5
Motorcycle/Scooter	65.0	51.7	50.9	54.8
Animal-Drawn Cart	11.8	7.8	6.0	2.6
Car	5.8	12.7	6.9	8.7
Water Pump	7.5	17.8	12.9	4.3
Thresher	0.0	1.7	1.7	0.0
Tractor	12.5	5.1	3.4	0.9
No. of women/men	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12).

The ownership of assets in the households by village characteristics is presented in **Table 4.3.2** based on responses from women and men. Women reported higher use of pressure cookers, having tables at home, and higher use of refrigerators at homes; furthermore, percentages owning cars and water pumps are almost double in villages with high urban characteristics. Women in low urban characteristics villages reported higher ownership of motorcycles in the household, while usage of mobile phones is nearly the same as the women in villages with high urban characteristics. On the other hand, men suggested little lower levels of usage of pressure cookers at home, owning motors cycles and tractors in villages with low urban characteristics. However, use of pressure cookers, tables, refrigerators, motor cycles and scooters is higher for villages with more urban characteristics. Thus it is seen that villages with more urban characteristics are shifting towards urban mode of living depicting usage of assets that are commonly found and used in the urban areas. While the villages with less urban characteristics still show rustic characteristics as far as use and owning various household assets.

Moreover, the information on nature of work, housing conditions, ownership of assets, etc. clearly shows that villages selected from the stratum identified as one with high urban characteristics do, in fact, have higher urban characteristics (including education, nature of work, housing conditions etc.) than the villages from the stratum identified as one with low urban characteristics. Thus, the stratification made of sample selection on the basis of 2001 census Primary Census Abstract seems quite appropriate and comparison of villages from the two strata makes sense.

4.4 Urbanization and structural change

Since the foundation of this research rests on urbanization and the socio-structural changes brought about as a result of this process, women and men were exclusively asked questions to understand how their life is being influenced by urbanization.

TABLE-4.4.1: Percentage of currently married women/men who perceived changes due to urbanization in their villages, Field Survey, Gautam Buddha Nagar district (2011-12)

	Women Respondents from villages with		Men Respondents from villages with	
Changes brought by urbanization	**Low Urban Characteristics**	**High Urban Characteristics**	**Low Urban Characteristics**	**High Urban Characteristics**
Changes in lifestyle	96.7	95.8	87.1	92.2
Loosening of bonds with near family members	60.8	60.2	61.2	66.1
More nuclear families	76.7	66.1	60.3	70.0
No land for cultivation	65.0	57.6	62.1	84.3
Changes in primary occupation	65.0	61.9	71.5	87.8
Increase in the cost of living	94.2	83.1	88.0	95.7
Others	68.3	61.0	75.9	87.0
No. of women/men	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)

Table 4.4.1 presents responses on the changes that are brought within the villages as a result of the urbanization process. All women universally agreed that urbanization has brought a change in lifestyle and people are attracted towards acquiring urban living. However, relatively more women from low urban characteristics villages than others feel that their family bonds are loosening as a result of formation of nuclear families. Young married couples often set-up a new household immediately after their marriage as is evident from the field survey. Women also feel that there has been a rise in the cost of living as a result of

urbanization. On the other hand, men from high urban characteristics villages feel that there are more nuclear families; no land for cultivation, there is definitely a change in the primary occupation of men, and other changes that have swept in due to the influence of urbanization.

Across women and men, lesser percentages of men feel that there has been a change in lifestyle (87%) or the formation of nuclear families (60%) in low urban characteristics villages. In addition, men from high urban characteristics villages feel that there is no land for cultivation (84%), and the primary occupation has changed (88%). They also reported changes such as more girls attending schools, people now having lesser number of children, and have higher aspirations and career goals. Apart from these, there have been infrastructural changes within the villages such as construction of roads, availability of transport facility, etc. all attributing towards attaining urban mode of living. However, in high urban characteristics villages fewer women than men perceive the above mentioned changes as evident from the results; may be due to less mobility of women as compared to the male counterparts.

TABLE-4.4.2: Percentage of currently married women/men influenced by urbanization in personal life, Field Survey, Gautam Buddha Nagar district (2011-12)

	Women Respondents from villages with		**Men Respondents from villages with**	
Changes in personal life	**Low Urban Characteristics**	**High Urban Characteristics**	**Low Urban Characteristics**	**High Urban Characteristics**
Living in a nuclear family	65.8	61.0	37.1	40.0
Increase in communication between the spouses	81.7	89.0	81.9	88.7
More mobility	40.0	57.6	54.3	81.7
Decision-making in the household	70.0	73.7	82.8	87.8
Accessibility to health-care centre	46.7	61.9	54.3	83.5
Increase in awareness about health issues	77.5	88.1	64.7	73.0
Control over finances	52.5	39.0	77.6	90.0
No. of women/men	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12).

When women and men were asked about the changes in their personal life as a result of urbanization **(Table 4.4.2)**, women living in high urban characteristics villages point toward

more mobility, more accessibility to the health-care centre, and increased awareness about health related matters. However, women living in low urban characteristics villages reported to enjoy higher degree of control over finances as compared to women from high urban characteristics villages. A similar pattern is seen among men respondents from high urban characteristics villages who agreed to have more mobility, greater accessibility to health-care centre, increase in awareness about own health issues and greater control over the finances as compared to men from low urban characteristics villages.

There are some differences in opinions about influence of urbanization across women and men by place of residence. Around 66 percent of women from low urban characteristics villages feel that nuclear families have increased, and also the awareness about their own health issues, while men from the same villages feel that urbanization has resulted in more mobility, and higher degree of freedom in making household decisions. Men from high urban characteristics villages feel that they have been influenced by urbanization in almost all aspects of their personal life except living in nuclear families and there has been an increase in awareness about health issues as compared to women from high urban characteristics villages.

TABLE-4.4.3: Percentage of currently married women/men having contact with relatives on various aspects, Field Survey, Gautam Buddha Nagar district (2011-12)

	Women Respondents from villages with		**Men Respondents from villages with**	
Information on relatives	**Low Urban Characteristics**	**High Urban Characteristics**	**Low Urban Characteristics**	**High Urban Characteristics**
Relatives stay in urban areas	80.8	88.1	75.0	88.0
Family visit their relatives in urban areas	76.6	87.3	70.7	87.0
Relatives in urban areas visiting the family	71.7	78.8	67.2	86.1
Discussion of health issues with relatives living in urban areas	79.2	83.9	70.0	81.0
No. of women/men	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)

Furthermore, the linkages and network of women and men with their relatives living especially in urban areas were explored to have a greater understanding of attitudinal change

among women and men. **Table 4.4.3** shows that almost 87% of women from villages with high urban characteristics reported to have been visiting relatives living in urban areas. More men from high urban characteristics villages informed that their relatives stay in urban areas, they visited them with their family and they discussed health issues with relatives living in urban areas. Thus it seems that men from high urban characteristics villages are more informed and aware about the health related issues and must be experiencing higher influence of urbanization. However, there is no difference in the responses of women and men across place of residence on the information about relatives.

4.5 Care during pregnancy and delivery

Antenatal Care (ANC) refers to pregnancy- related health-care, which is usually provided by a trained health personnel be it a doctor, an ANM, etc. Ideally, ANC should monitor pregnancy for any signs of complications, detect and treat pre-existing and concurrent problems of pregnancy, and provide advice and counselling on preventive care, diet during pregnancy, delivery care, post-natal care and related issues (IIPS and Macro International, 2007:192).

TABLE-4.5.1: Woman's age at first birth, Field Survey, Gautam Buddha Nagar district (2011-12), (percentage distribution)

	Women Respondents from villages with		**Men Respondents from villages with**	
Women's age at 1st birth	**Low Urban Characteristics**	**High Urban Characteristics**	**Low Urban Characteristics**	**High Urban Characteristics**
15-19 years	55.8	47.5	47.4	52.2
20-24 years	40.0	44.9	45.7	39.1
25+	4.2	7.6	6.9	8.7
Mean age at first birth	19.5	20.2	19.6	20.0
No. of women/men	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)

TABLE-4.5.2: Maternal health-care received, Field Survey, Gautam Buddha Nagar district (2011-12), (percentage who received specific care)

Type of Care	Women Respondents from villages with		Men Respondents from villages with	
	Low Urban Characteristics	High Urban Characteristics	Low Urban Characteristics	High Urban Characteristics
Antenatal care				
Check-up received	44.2	70.3	43.1	60.0
TT Injection given	77.5	87.3	79.3	86.1
IFA tablets given	60.0	77.1	67.2	73.7
Delivery care				
Institutional Delivery	25.8	43.2	35.3	50.4
Home Delivery	74.2	56.8	64.7	49.6
Assisted home delivery by skilled persons	3.4	7.5	6.7	12.3
Non-assisted home delivery	70.8	49.3	58.0	37.3
Safe deliveries	29.2	50.7	42.0	62.7
Post-natal care				
Visit by a Health worker in 1st week	32.5	55.9	21.6	38.3
Women availed PNC care	35.0	53.0	20.7	39.1
No. of women/men	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)

Table 4.5.1 gives information on the age of the women/wife at the first birth of the child. Responses from both women and men indicate that mean age at first birth is around 19.5 years for women in villages with low urban characteristics, and little higher mean age, i.e. 20.2 years for women in villages with high urban characteristics. Questions pertaining to ANC care for the last pregnancy (excluding the current pregnancy) were asked to both women and men. **Table 4.5.2** provides information on types of antenatal care received by pregnant women/wives in low urban characteristics and high urban characteristics villages. Percentages of women going for antenatal check-ups, TT injections administered and taking IFA tablets are higher in villages with high urban characteristics as compared to villages with low urban characteristics. Within ANC care, most of the women received TT injections but fewer received check-up and IFA tablets in both the set-ups. Both women and men are aware of importance of administering TT injections during pregnancy and feel that it is necessary for the safe delivery and avoiding tetanus at the time of birth. But the need for check-ups and taking IFA tablets which constitute an integral part of ANC care is less strongly felt; many feel that unless there is a complication, there is no need for ANC check-ups. Field

investigation also suggests that many women avoid taking IFA tablets as they feel that these are "*garam"* that is, producing heat in the body, so they mostly avoid taking these as well.

A similar trend is evident from men's responses also; however, the levels differ for women's and men's responses. Men reported higher institutional deliveries and lower levels of visits made by a health worker in the first week of delivery and lower levels of women availing post-natal care (PNC) in low urban characteristics villages. On the other hand, women reported lesser number of institutional deliveries and more visits by health worker and are seeking PNC care. The reason for differences in responses across women and men is that women being at home reported more of health visits by the health workers and availing PNC care as contrary to men who are always out of the house for work and might not be aware of visits by health workers and the wife seeking PNC.

TABLE-4.5.3: Percentage of currently married women and men reporting various pregnancy complications, Field Survey, Gautam Buddha Nagar district (2011-12)

	Women Respondents from villages with		**Men Respondents from villages with**	
Problems	**Low Urban Characteristics**	**High Urban Characteristics**	**Low Urban Characteristics**	**High Urban Characteristics**
Vomiting	16.6	25.4	13.8	23.5
Swelling of hands and feet	21.6	21.1	17.2	24.3
Weakness/ dizziness	18.3	24.6	18.1	24.3
Headache	7.5	11.0	8.6	14.8
Bleeding	0.8	4.2	0.9	1.7
Convulsions	3.3	2.5	0.0	1.7
Abnormal foetal position	1.6	0.0	0.0	2.6
No/weak foetal movement	2.5	3.4	0.0	2.6
Others	0.0	2.5	0.0	2.6
No problem	68.3	64.4	75.9	60.9
No. of women/men*	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)
***Percentages add up to more than 100 because of multiple responses.**

Information is collected from both women and men on the prevalence of symptoms of pregnancy complications because documenting this is vital for planning services to reduce

maternal morbidity and mortality, (IIPS and Macro International, 2007:192). Women in high urban characteristics villages **(Table 4.5.3)** reported more pregnancy complications (morbidity is self-reported and not diagnosed) as compared to those living in low urban characteristics villages. Mostly higher percentages of women in high urban characteristics villages complained of vomiting (25%) and weakness (25%) than other women and reported swelling of limbs. Men from high urban characteristics villages also reported that their wife complained of vomiting (24%). The reporting is higher probably due to higher levels of awareness among women and men about the pregnancy complications in villages with high urban characteristics. There is a very less difference in reporting across women and men on pregnancy complications.

TABLE-4.5.4: Percentage of currently married women and men reporting awareness about health problems during delivery, Field Survey, Gautam Buddha Nagar district (2011-12)

Women Respondents from villages with			**Men Respondents from villages with**		
Health problems during Delivery	**Low Urban Characteristics**	**High Urban Characteristics**	**Health problems during Delivery**	**Low Urban Characteristics**	**High Urban Characteristics**
Premature labour	45.8	43.2	Premature labour	40.5	32.2
Obstructed/Prolonged labour	36.7	40.7	Obstructed/Prolonged labour	14.7	14.8
Convulsions	9.2	7.6	Convulsions	0.9	0.9
Abnormal position of the baby	55.8	57.6	Abnormal position of the baby	40.5	36.5
Bleeding	20.0	15.3	Bleeding	20.7	12.2
Others	0.0	0.0	Others	1.7	3.5
Not aware of any problem	19.2	20.3	Not aware of any problem	51.7	53.0
No. of women*	**120**	**118**	**No. of men***	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)
***Percentages add up to more than 100 because of multiple responses.**

TABLE-4.5.5: Percentage distribution of currently married women and men reporting women/wives having health problems during the last delivery, Field Survey, Gautam Buddha Nagar district (2011-12)

Women Respondents from villages with			Men Respondents from villages with		
Health problems during Delivery	**Low Urban Characteristics**	**High Urban Characteristics**	**Health problems during Delivery**	**Low Urban Characteristics**	**High Urban Characteristics**
Premature labour	4.4	7.8	Premature labour	6.4	5.6
Obstructed/Prolonged labour	5.9	10.4	Obstructed/Prolonged labour	3.4	3.8
Convulsions	1.8	1.9	Convulsions	0.0	0.0
Abnormal position of the baby	2.7	6.8	Abnormal position of the baby	4.4	9.9
Bleeding	2.6	1.7	Bleeding	0.0	0.9
Others	0.9	0.0	Others	0.0	0.9
No problem	81.7	71.4	No problem	85.8	78.9
No. of women*	**120**	**118**	**No. of men***	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)

Table 4.5.4 and **Table 4.5.5** give data on women/husbands who are aware of problems that could arise during delivery and who actually had problems while delivering their child in the last pregnancy. Although there is not much difference in the awareness levels of women and men across low urban and high urban characteristics villages, there is a difference in levels of reporting by women and men. Lesser men have knowledge about health problems during delivery as compared to women especially on complications like obstructed/prolonged labour, convulsions, and abnormal position of the baby. Also there is higher percentage of men (52%) in low urban and (53%) in high urban characteristics villages who are not aware of health problems that their wife may come across at the time of delivering a child. Women in low urban characteristics villages also reported other problems they face at the time of delivery such as feeling weak, and having emotional issues other than physiological problems although the percentage is minimal.

Women in high urban characteristics villages encountered more delivery complications (30%) as compared to their counterparts (18%) in low urban characteristics villages **(Table 4.5.5)**. The justification given by older women of higher delivery complications among women in villages with high urban characteristics is that these women work less and rest

more and thus have more delivery complications as compared to those from villages with low urban characteristics. The other reason that came to light as part of fieldwork is that there is no older member to check and guide pregnant women from villages with high urban characteristics as a result of nuclear families; whether these women have taken proper nutrition or rested, so these women might tend to neglect their health that result in more delivery complications. However, there is no stark difference in men's reporting from low urban and high urban characteristics villages.

4.6 Contraception: Knowledge and use

India launched the National Family Planning Program in 1951 with an objective of curbing the birth rate to an extent necessary to stabilize population to be consistent with the national economy. Over time, the programme was strengthened and a number of approaches, clinic, cafeteria, extension, incentive/compensation, camp, target, post-partum, social marketing of contraceptives, etc. were attempted. A National Population Policy was announced in 1976 but soon there was backlash as a result of coercive tactics and the programme was revamped and renamed as Family Welfare Programme. There was paradigm shift globally after the 1994 Cairo Conference and in 2000 a new National Population Policy was announced that gave priority to address unmet need for contraception and sought to achieve the medium-range objective of bringing the total fertility rate down to replacement level by 2010 and population stabilization by 2045 (Ministry of Health and Family Welfare, 2000). With time, contraceptive awareness has become nearly universal in India, contraceptive practice has risen and fertility has declined substantially (IIPS and Macro International, 2007:111). But there are large regional variations and Uttar Pradesh has lagged the national level in contraceptive prevalence and fertility transition.

The field survey in the Gautam Buddha Nagar district collected information on various aspects of family planning such as knowledge and awareness of various contraceptive methods, mean age at first use of contraception, method used for the first time. In addition, information on ever use, current use and future use of contraception was also collected to understand how women and men are involved in making informed choices about reproductive health decisions. The principal findings from the field investigation on these aspects are described below.

TABLE-4.6.1: Percentage of currently married women and men having knowledge about types of contraceptive use, Field Survey, Gautam Buddha Nagar district (2011-12)

	Women Respondents from villages with		Men Respondents from villages with	
Type of contraceptive	**Knowledge/ Information (Low Urban Characteristics)**	**Knowledge/ Information (High Urban Characteristics)**	**Knowledge/ Information (Low Urban Characteristics)**	**Knowledge/ Information (High Urban Characteristics)**
Female Sterilization	94.2	92.4	98.3	96.5
Male Sterilization	77.5	77.0	94.8	84.3
Pills	69.2	82.2	74.1	76.5
IUD or Loop	65.0	68.6	28.4	42.6
Injectables	18.3	28.8	22.4	43.5
Condom/ Nirodh	68.3	72.9	91.4	87.0
Female Condom	3.3	6.0	1.7	10.4
Rhythm Method	7.5	14.4	11.2	13.0
Withdrawal	4.2	12.7	5.2	8.7
Emergency Contraception	5.0	11.9	6.9	11.3
Any other method	2.5	5.1	0.0	6.1
	120	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)

Table 4.6.1 gives information on knowledge about various contraceptives by type of village and gender. Women in villages with low urban characteristics tend to have lesser knowledge about pills, injectables and traditional methods such as rhythm method (8%) and withdrawal method (4%) as compared to their counterparts in villages with high urban characteristics who have more information about use of emergency pills (12%) and traditional methods and are more aware of options available for spacing children. Men in villages with low urban characteristics have higher knowledge about male methods such as male sterilization and condoms, while those in villages with high urban characteristics have more knowledge on Intra-Uterine Device (IUD)/loop (43%) and injectables (44%), female condoms (10%) and emergency contraceptive pill (11%).

When knowledge levels are compared across women and men, data depict that knowledge on female sterilization among women and men is almost universal. Furthermore, it is seen that overall women tend to have less knowledge about contraceptive methods as compared to men, though the levels differ across villages with low urban and high urban characteristics.

Women and men from villages with high urban characteristics show similar levels of information on traditional methods of contraception as compared to their counterparts in villages with low urban characteristics.

TABLE- 4.6.2: Percentage of currently married women and men by the first method used for contraception, Field Survey, Gautam Buddha Nagar district (2011-12)

	Women Respondents from villages with		Men Respondents from villages with	
Contraception	**Low Urban Characteristics**	**High Urban Characteristics**	**Low Urban Characteristics**	**High Urban Characteristics**
Mean age of couple at 1st use of contraception	26.6	25.6	28.0	27.3
Method used for the 1st time				
Female Sterilization	38.3	28.0	12.1	17.4
Male Sterilization	0.0	0.0	0.0	0.0
Pills	10.8	15.3	4.3	7.0
IUD or Loop	10.8	4.2	0.9	0.0
Injectables	0.8	0.8	1.7	1.7
Condom/Nirodh	16.7	29.7	31.9	21.7
Female Condom	0.0	0.0	0.0	0.0
Rhythm Method	2.5	0.8	0.9	1.7
Withdrawal	0.8	0.0	1.7	2.6
Emergency Contraception	0.0	0.0	0.0	0.0
Any other method	0.8	0.0	0.0	0.0
Never used any method	22.5	23.7	51.0	50.0
No. of women/men*	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12).
***Percentages do not add to 100 percent because some reported multiple use of contraception at the same time**

Age at first time use of contraceptive gives a sense at what level does the couple decide to use contraception. From the **Table 4.6.2,** it is revealed that there is not much difference in the ages at first use of contraception for women and men and across low urban and high urban characteristics villages. However, if the preference is seen for the methods, higher preference is seen for terminal method: female sterilization, followed by a male method namely, condom use among women. But information from men reveals higher use of condoms followed by female sterilization in villages with low urban characteristics. This demonstrates low reporting of female sterilization by men for method used for the first time. Female sterilization is a terminal method of contraception and perhaps men were little hesitant in talking about it openly as compared to reporting 'condom use' which is a commonly used method by them. In addition, women reported that one in every four do not use any

contraception, while men reported around one in every two do not use any contraception. Thus there is a stark difference in reporting of women and men across villages.

TABLE-4.6.3: Percentage distribution of currently married women (from villages with low urban and high urban characteristics) by method of contraception used/intended, Field Survey, Gautam Buddha Nagar district (2011-12)

Type of contraceptive	Ever Use (Low Urban Characteristics)	Ever Use (High Urban Characteristics)	Current Use(Low Urban Characteristics)	Current Use (High Urban Characteristics)	Future Use (Low Urban Characteristics)	Future Use (High Urban Characteristics)
Female Sterilization	43.3	29.7	43.3	29.7	30.9	28.9
Male Sterilization	0.0	0.0	0.0	0.0	0.0	0.0
Pills	13.3	16.1	5.8	9.3	7.4	13.3
IUD or Loop	10.8	5.1	2.5	0.8	4.4	2.4
Injectables	0.8	0.8	0.0	0.8	1.5	4.8
Condom/ Nirodh	23.3	33.9	15.0	28.0	29.4	34.9
Female Condom	0.0	0.0	0.0	0.0	0.0	0.0
Rhythm Method	2.5	1.7	0.8	1.7	1.4	1.2
Withdrawal	1.7	0.0	0.8	0.0	0.0	0.0
Emergency Contraception	0.0	0.0	0.0	0.0	0.0	0.0
Any other method	0.8	0.0	0.0	0.0	0.0	0.0
Never used/Non-users/Do not intend to use	22.5	23.7	31.8	29.7	25.0	14.5
No. of women*	**120**	**118**	**120**	**118**	**68#**	**83#**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)
***Percentages do not add to 100 percent because of multiple responses, # Future use of contraception is relevant to only 151 non-sterilized respondents**

TABLE-4.6.4: Percentage distribution of currently married men (from villages with low urban and high urban characteristics) by method of contraception used/ intended, Field Survey, Gautam Buddha Nagar district (2011-12)

Type of contraceptive	Ever Use (Low Urban Characteristics)	Ever Use (High Urban Characteristics)	Current Use(Low Urban Characteristics)	Current Use (High Urban Characteristics)	Future Use (Low Urban Characteristics)	Future Use (High Urban Characteristics)
Female Sterilization	12.1	17.4	12.1	17.4	31.4	15.8
Male Sterilization	0.0	0.0	0.0	0.0	1.0	0.0
Pills	4.3	7.0	3.4	2.6	1.0	3.2
IUD or Loop	0.9	0.0	0.9	0.0	1.0	0.0
Injectables	1.7	1.7	1.7	1.8	1.0	0.0
Condom/ Nirodh	32.8	25.2	25.0	24.3	23.5	35.8
Female Condom	0.0	0.0	0.0	0.0	0.0	0.0
Rhythm Method	0.9	1.7	0.0	0.9	0.0	0.0
Withdrawal	1.7	2.6	0.9	2.6	1.0	3.2
Emergency Contraception	0.0	0.0	0.0	0.0	0.0	0.0
Any other method	0.0	0.0	0.0	0.0	0.0	0.0
Never used/Non-users/Do not intend to use	51.0	50.0	56.0	50.4	40.2	42.1
No. of men*	**116**	**115**	**116**	**115**	**102**	**95**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12).
***Percentages do not add to 100 percent because of multiple responses, # Future use of contraception is relevant to only 197 non-sterilized cases respondents**

Ever use of contraceptives provide a measure of cumulative experience of a population with family planning (IIPS and Macro International, 2007:119). In **Table 4.6.3** and **Table 4.6.4**, women who have ever used a method prefer to use terminal methods like female sterilization followed by condoms and IUD/loop. However, women in low urban characteristics villages who reported ever use of contraceptives opted for female sterilization (43%) or inserting IUD/loop (11%), while those in high urban characteristics villages reported using condoms (34%) as a spacing method. This holds true for women using any current contraceptive method also. Higher percentages of women choose terminal female method over male methods as people have an understanding that it is in our culture that women go for female sterilization and not men, *"aisa hi hota hai ki auratein operation kerwatin hain"* (this is what happens, it is always women who go for sterilization), so nobody challenges this practice, not even the women who have internalized this practice and most of them end up choosing female sterilization. But prior to 1977, male sterilization dominated and preference for female

sterilization is a recent development that started after the emergency period. This practice has been well documented by various national health surveys also. These surveys show that female sterilization is widely known and opted by women without any resistance. When women are asked about the future use of contraception, women both in villages with low urban characteristics and high urban characteristics prefer to go for terminal method, i.e., female sterilization or reversible method, i.e., condom. Contraceptive use pattern does not differ much among men across residence for ever use and current use of contraception, although when men were asked for future intension of using contraception, mostly prefer female sterilization or condoms over other methods. But it is interesting to note that there is higher level of reporting by women especially for female spacing methods compared to reporting by men. The possibility of lesser reporting by men could be because some of them perhaps thought that they have to report only male methods and did not mention about female methods. The reason being most women use female methods such as IUD, pills without informing their husbands. Moreover, it was revealed during the field investigation that some women went ahead and chose female sterilization and got the operation done at their parent's place without either informing or prior discussing it with the husbands. Reporting on other methods such as emergency contraceptives, injectables, and female condom is very less mostly because these methods are not widely promoted or covered by the government programmes on family planning. Moreover, these methods are very expensive family planning methods.

Across women and men, differences in ever use of method again reaffirms that women opt for female methods and especially female sterilization, followed by pills and IUD, while men (from low urban characteristics villages) prefer to use male method, i.e., condom over other methods. This is again similar for current use and future intention to use any method where higher percentages of women reported female methods (sterilization and pills) and men reported male methods of contraception in both types of villages.

When non-users of contraception are compared among low urban and high urban characteristics villages, it is seen that one in every five women refuses to use any method. When the future intention is asked, higher proportion of women (25%) choose not to use any spacing method in villages with low urban characteristics. Furthermore, more than fifty percent of men have never used, and were currently not using any contraceptive method, while 2 in every 5 men did not intend to use any contraception in the future also. This pattern is similar for men in low urban and high urban characteristics villages.

4.7 Reproductive Tract Infections and Sexually Transmitted Diseases: Knowledge and symptoms

An integrated agenda for NRHM is to promote awareness and knowledge on RTIs/STIs in order to make health facilities accessible for testing and treatment seeking to ensure healthy sexual life, free from any fatal infection (IIPS, 2010:22). Thus, it is recognized that aspects of reproductive health beyond maternal health need attention. This section throws light on RTIs/STIs infections that women may have had and whether they sought treatment for the same (in case of any infection). **Table 4.7.1** gives a comparative status of ever-married women aged 15-49 years in the state of Uttar Pradesh and the district Gautam Buddha Nagar who have reported some sort of infection and sought treatment thereafter as reported by the DLHS-3. Compared to the state level, around 60 percent of women heard about RTI/STI in the district Gautam Buddha Nagar. Also 27 percent of women reported abnormal vaginal discharge at the district level, though at state level one in every five woman has this infection.

TABLE-4.7.1: Percentage of ever-married women (aged 15-49) who reported RTI/STI problem during three months prior to the survey and among them percentage sought treatment for the problem, DLHS-3, 2007-08

RTI/STI Indicators	Uttar Pradesh	Gautam Buddha Nagar District
Percentage of women who heard about RTI/STI	29.1	60.3
Percentage of women who reported any abnormal vaginal discharge	19.8	27.0
Percentage of women who have any other symptoms of RTI/STI[1]	19.9	16.6
Total no. of women*	87,564	1034
Percentage of women who sought treatment for any RTI/STI[2]	40.0	44.2
No. of women having any RTI/STI[2]	**25,266**	**327**

Source:- DLHS-3: IIPS, 2010: 143-144

***Unweighted cases, [1] excluding women having any abnormal vaginal discharge, [2] any RTI/STI (excluding abnormal vaginal discharge problem or other RTI/STI problem)**

TABLE-4.7.2: Percentage of currently married women/men reporting RTI symptoms, Field Survey, Gautam Buddha Nagar district (2011-12)

RTI Symptom	Women Respondents from villages with		Men Respondents from villages with	
	Low Urban Characteristics	High Urban Characteristics	Low Urban Characteristics	High Urban Characteristics
Vaginal/Urethral discharge	19.2	22.9	7.8	2.6
Genital Itching	0.0	1.7	6.0	2.6
Genital Sores	1.7	0.0	0.0	0.9
Painful Coitus	0.8	1.7	0.9	0.0
Spotting after coitus	0.0	1.7	0.0	0.0
Menstrual disorder	8.3	6.8	3.4	7.0
Lower abdominal pain	17.5	21.2	9.5	8.7
Lower backache	25.0	29.7	22.4	17.4
Dysuria	10.0	10.2	19.0	13.0
No RTI infection	60.0	58.5	66.4	73.9
No. of women/men	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)
***Percentages do not add to 100 percent because of multiple responses**

In the field survey, questions on any symptoms of Reproductive Tract Infections were also asked. **Table 4.7.2** gives information of RTI symptoms among women as reported by women and men in low urban and high urban characteristics villages. Reporting by both women and men does not differ much by residence on the pattern among women suffering from RTIs. However, there is an enormous difference in the responses of both women and men. In villages with low urban characteristics, women reported higher levels of vaginal/urethral discharge (19.0%) and 'lower abdominal pain' (18%) as compared to reporting by men where the levels are fairly low. Also women in villages with high urban characteristics reported higher percentages of vaginal/urethral discharge (23%), 'lower abdominal pain' (21%) and 'lower backache' (30%), while men's reporting is at least 10 percentage points lesser for all the above problems. Almost 74 percent of men reported that their wife does not have any infection compared to women (59%) in villages with high urban characteristics. This suggests that many men even in villages with high urban characteristics are oblivious of the fact that their wife has some sort of RTI infection and she needs clinical intervention for it.

4.8 Women's empowerment: Decision-making and status of women in their households

An important element of empowerment is the outright rejection of unequal rights and privileges that derive from and are assigned solely on the basis of a person's sex. Examples of common normatively ascribed rights of husbands include the right to be the key decision-maker on major household decisions, the right to control wife's behaviour and body (IIPS, 2010:72).

TABLE-4.8.1: Percentage distribution of the opinion of ever-married men (aged15-49) on wife's say in various household decisions, NFHS-3 (2005-06), India

Decisions in the household	Wife should have a greater say	Wife should have an equal say	Wife should have a lesser say
Making major household purchases	5.4	67.5	26.5
Making purchases for daily household needs	36.9	39.6	22.9
Visits to her family or relatives	12.1	60.7	26.5
What to do with money which wife earns	20.1	63.9	14.6
How many children to have	1.4	88.5	9.5

Source:- NFHS-3 (2005-06): IIPS and Macro International: 72

In NFHS-3, ever-married men were asked about their opinion on relative weightage given to their wife's decision-making on specific household decisions **(Table 4.8.1)**. They were specifically asked whether wife should have a greater say, or both of them make decisions or is it the man of the household who should make decisions and thus wife should have a lesser say (IIPS and Macro International, 2007:72). For almost all decisions, men say that their wife has an equal say, and there is a very small percentage of men agreeing that their wife should have a greater say in decision-making. Two decisions where men agreed that their wife should have a lesser say are the decisions on making major household purchases and visiting her family and relatives. Women should have a greater say in making purchases for daily household needs depicting that here men's intervention is less, perhaps men's impression is that buying kitchen items for daily use is the women's domain.

TABLE-4.8.2: Percentage of currently married women and men reporting women's/wives role in decisions in the household, Field survey, Gautam Buddha Nagar district (2011-12)

Various decisions	Women Respondents from villages with		Men Respondents from villages with	
	Low Urban Characteristics	High Urban Characteristics	Low Urban Characteristics	High Urban Characteristics
Deciding about the daily menu	83.2	81.4	94.8	80.0
Obtaining health-care for self	70.0	83.1	87.1	75.7
Purchasing petty items	75.0	76.3	64.7	49.6
Purchasing major items	8.3	14.4	37.9	50.4
Saving money for emergency use	45.0	45.8	49.1	70.4
Others	32.5	35.6	44.0	62.6
No. of women/men	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)

In the field survey, the researcher asked a series of questions on decision-making in the household to both women and men from different families. It is seen that **(Table 4.8.2)** almost 83% of women living in villages with high urban characteristics make decisions on obtaining health-care for them as compared to 70 percent of women in villages with low urban characteristics; however, for other decisions there is hardly any difference in the levels by the place of residence. But more men from low urban characteristics villages than other men reported that their wife is involved in deciding about the daily menu, obtaining health-care for self, and purchasing petty items, while men from villages with high urban characteristics reported that their wife decides about purchasing major items, saving money for emergency use and other decisions at the household level. This difference denotes 'more say' of wife in decisions pertaining to money matters from high urban characteristics villages because of a change in the family structure, mainly a shift from joint family to nuclear families, wherein the family's decisions are now replaced by the couple's decisions and more so the wife's decisions that are confined within the boundaries of households. Higher percentages of men from low urban and high urban villages agreed that their wife is involved in making almost all the household decisions, although percentages of women respondents indicate lesser involvement in making household decisions. When explored further to

understand the reasons behind differences in women and men's reporting, it is observed that if a wife does not express her opinion while making some decisions then it is deemed that a wife agrees to husband's will and is in agreement with him.

Furthermore, status of a woman as a decision-maker, weightage given to her opinions and decisions are the markers of her importance within the household. It is often contested by many scholars that young women without any child are not given much importance in decision-making in rural context, but once they become mothers; they get the right to express opinion while making decisions in the household. The section below sheds light on the status of women and her importance in various household decision-making indicators; also whether the wife is able to sit and talk to her about her needs is also discussed in this section.

TABLE-4.8.3: Percentage distribution of currently married women/men showing their/wives status in the household, Field survey, Gautam Buddha Nagar district (2011-12)

Woman's status	**Women Respondents from villages with**		**Men Respondents from villages with**	
	Low Urban Characteristics	**High Urban Characteristics**	**Low Urban Characteristics**	**High Urban Characteristics**
Communication with husband about needs				
Frequently	35.0	46.7	14.7	10.4
Most often	41.7	36.4	63.8	61.8
Rarely	23.3	16.9	21.5	27.8
Woman's status as a decision-maker at home				
Not Important	10.8	10.2	12.9	6.1
Somewhat Important	47.5	37.3	64.7	60.0
Very Important	41.7	52.5	22.4	33.9
Woman's involvement in decision-making at home	86.0	82.2	91.4	90.4
Decision about spending family's income				
Husband	26.7	34.8	69.8	68.7
Wife	5.8	2.5	0.0	0.0
Joint Decision	52.5	45.8	19.0	23.5
Others	15.0	16.9	11.2	7.8
No. of women/men	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)

Table 4.8.3 gives indicators of wife's communication with her husband about her needs and her status in the household. Women from high urban characteristics villages frequently communicate with the husbands about their daily needs; and nearly one in every two women perceive their status as very important in their households' while women from low urban characteristics villages think that their status is somewhat important in their houses. In addition, there is no difference across women's responses by residence when it comes to spending family's income. At both the places women contribute at similar levels while making decisions on spending family's income. However, men's responses do not vary much across villages, 34 percent of men from high characteristics villages feel that their wife enjoys very important status as a decision-maker in the household, while 22 percent men from low characteristics villages think so. When responses from women and men are compared across villages, some clear differences are seen. While 35 percent women from low characteristics villages think that they communicate with their husbands about the daily needs very frequently, only 15 percent of men from these villages said so. Similarly, in villages with high urban characteristics, 47 percent of women said they communicate frequently with husband in contrast to only 10 percent of men. Though a majority of husbands consider their wife's status at home as very important or somewhat important, women do not hold the same perception in villages with low urban characteristics. Men from both types of villages reported that nearly 70 percent of the husbands solely make decisions about spending family's income, much fewer women (27 percent in low urban characteristics villages and 35 percent in high urban characteristics villages) felt so. Besides, one in every two women considers her status as very important in decision-making at home, only a third or fewer men feel so. Clearly, there is huge difference between the perceptions of women and men on women's status and decision-making power within the household.

TABLE-4.8.4: Percentage of currently married women/men reporting women/wives seeking permission to go to places, Field survey, Gautam Buddha Nagar district (2011-12)

A woman need to seek permission to go to	Women Respondents from villages with		Men Respondents from villages with	
	Low Urban Characteristics	High Urban Characteristics	Low Urban Characteristics	High Urban Characteristics
Health-care clinic	69.2	67.8	70.7	68.7
Shopping	70.0	79.7	83.6	84.3
Natal home	97.5	97.5	96.6	98.3
Meet friends	58.3	48.3	56.9	68.7
Work	10.0	8.5	9.5	21.7
Any other place	90.0	74.6	86.2	87.8
No. of women/men	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)

Freedom of movement or going out of the home is an important indicator of women's autonomy and empowerment. This is particularly true largely in a patriarchal society like India and that too in the state of Uttar Pradesh which has a long tradition of *purdah* system. **Table 4.8.4** shows generally the small differences across village type. More women in low urban characteristics villages have to seek permission in going out to meeting friends and visiting any other place compared to other women. While more men from villages with high urban characteristics as compared to other men admit that their wife has to take permission to meet her friends, and going out for work.

TABLE-4.8.5: Percentage of currently married women reported (from villages with low urban and high urban characteristics) facing specific problems in seeking treatment, Field survey, Gautam Buddha Nagar district (2011-12)

Problems	Low Urban Characteristics		High Urban Characteristics	
	Big Problem	Small Problem	Big Problem	Small Problem
Getting permission to go	4.2	10.0	3.4	11.9
Getting money for the treatment	3.3	17.5	2.5	19.5
Distance to the health centre	38.3	35.0	5.1	34.7
Having to take transport	38.3	29.2	5.9	27.1
Finding someone to go with you	6.7	34.2	4.2	18.6
Concern that there may not be any health worker	5.8	22.5	6.8	13.6
Concern that there may not be a female health worker	2.5	11.7	4.2	8.5
Concern that there may not be any drugs available	2.5	10.0	4.2	7.6
No. of women	**120**		**118**	

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)

TABLE-4.8.6: Percentage of currently married men (from villages with low urban and high urban characteristics) who reported their wives' facing specific problems in seeking treatment, Field survey, Gautam Buddha Nagar district (2011-12)

Problems	Low Urban Characteristics		High Urban Characteristics	
	Big Problem	Small Problem	Big Problem	Small Problem
Getting permission to go	8.6	52.6	1.7	22.6
Getting money for the treatment	17.2	56.0	11.3	30.4
Distance to the health centre	72.4	22.4	20.9	31.3
Finding transport	62.1	27.6	21.7	34.8
Finding someone to go with you	28.4	34.5	5.2	20.9
Concern that there may not be any health worker available	50.9	39.7	26.1	24.3
Concern that there may not be a female health worker	54.3	32.8	30.4	22.6
Concern that there may not be any drugs available	53.4	31.9	30.4	22.6
No. of men	**116**		**115**	

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)

Many factors can prevent women from getting medical help, so in order to capture the reasons that discourage women in seeking treatment at the time of any ailment, a series of questions were asked both from women and men. **Tables 4.8.5 and 4.8.6** give percentages of women and men who reported specific problems that women have to face in seeking treatment when they are sick. Women from low urban characteristics villages encounter more problems because of the distance of the health center and having to take transport to reach the health facility. These factors hinder women in low urban characteristics villages to seek treatment, especially when they are sick. This does not mean that women in more urban villages do not face any problem, but they consider them small to deal with. On the contrary, men from low urban characteristics villages feel that their wife has to face problems at every level when it comes to seeking health-care at the time of sickness. More men in the villages with low urban characteristics think that distance to the health center, finding transport, finding somebody to accompany their wife, wife's concern that there may not be any health worker available and concern that if he is there, there may not be a female health-care provider and the availability of the drugs at the health centers are the problems that their wife has to face when she is sick, adding an extra load on her when seeking treatment. Nonetheless, there has been a difference in perceptions, and concerns between women and men across the villages. Generally more men whether from low urban characteristics villages

or from high urban characteristics villages show their concern that the wife has to face big problems when it comes to seeking treatment at the time of any sickness than women themselves. From the women's perspectives, they are able to deal with the problems more successfully as contrary to the belief that men hold for them.

4.9 Importance of communication with husband

Many scholars believe that in Northern India, traditions of respectful avoidance mean that women in their marital homes (especially when living with their in-laws) should veil (observe *purdah*) in the presence of elder men, and there is little communication between the couples when they are young and living in joint families (Jeffery et. al 1988:28; Wadley 1994:54). Moreover, it is considered inappropriate to talk about reproductive matters explicitly by the spouses mainly because the social mores constrain them to do so (Lambert and Wood 2005). In order to explore the degree of communication between wife and husband, this section sheds light on the interaction between the couples on various occasions.

Around 28 percent women from villages with high urban characteristics always communicate with their husbands on a day when something does not work out, while majority of them usually talk to their husbands on daily activities where women are involved in their households **(Table 4.9.1)**. However, a large proportion of women from low urban characteristics villages reported that they seldom talk to their husbands when things do not work out. The pattern remains the same for husbands also who always communicate with their wife in high urban characteristics villages, but in low urban characteristics villages husbands talk seldom on daily activities with their wife. More than one in every two women from high urban characteristics villages feels that it is important to share information with husbands. However, pattern among men invariably differs as men from low urban characteristics villages feel that their wife usually discuss with them about any difficulties they have on some bad days. Furthermore, nearly 40 percent of the husbands from high urban characteristics villages always discuss with their wife on daily activities. Only around 22 percent of men from low urban characteristics villages feel that it is very important to share information with their wife, while 42 percent from high urban characteristics villages feel so. Nearly half of the women from low urban characteristics villages stated that they seldom

discuss with their husbands information about difficulties and daily activities but this was not the perception of men from these villages.

TABLE-4.9.1: Percentage distribution of currently married women/men reporting communication with husband, Field survey, Gautam Buddha Nagar district (2011-12)

Indicators	Women Respondents from villages with		Men Respondents from villages with	
	Low Urban Characteristics	High Urban Characteristics	Low Urban Characteristics	High Urban Characteristics
Wife's discussion with husband on difficulties				
Always	14.1	27.3	27.6	13.0
Usually	36.4	42.7	53.4	51.3
Seldom	46.3	27.4	16.4	20.9
Never	3.2	2.6	2.6	14.8
Husband's discussion with wife on daily activities				
Always	19.9	31.6	31.0	40.0
Usually	30.6	34.2	42.2	22.6
Seldom	46.3	31.6	21.6	21.7
Never	3.2	2.6	5.2	15.7
Importance about sharing information with each other				
Very important	43.8	56.8	21.6	41.7
Somewhat important	52.9	36.4	58.6	25.3
Not important	3.3	6.8	19.8	33.0
No. of women/men	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)

Supplementary to this, more women from high urban characteristics villages than those from low urban characteristics villages believe that they discuss difficulties with their husbands every time. Furthermore, 57 percent of the women from high urban characteristics villages feel that it is very important to share information with husbands and to communicate with husbands while making family planning decisions. Again far lesser number of men from high urban characteristics villages hold the same opinion as women do.

Additionally questions were asked from both women and men who are currently using some kind of contraceptives to get a sense of equity among them while making decisions on contraception. **Table 4.9.2** indicates that both women and men from villages with high urban characteristics understand the significance of communication for making family planning decisions and consider it very important as compared to their rural counterparts. In addition,

when question was asked from the ever-users of contraception on who is the most important source of support to the wife when using contraceptives, both women and men agreed that husbands are the biggest supporters followed by the health workers, though there are large differences in reporting levels across men from villages with low urban characteristics and villages with high urban characteristics.

TABLE-4.9.2: Percentage distribution of currently married women/men reporting communication on family planning decision-making with husband, Field Survey, Gautam Buddha Nagar district (2011-12)

	Women Respondents from villages with		Men Respondents from villages with	
Indicators	**Low Urban Characteristics**	**High Urban Characteristics**	**Low Urban Characteristics**	**High Urban Characteristics**
Importance of communication for making family planning decisions				
Very important	55.0	72.9	29.3	41.7
Somewhat important	42.5	25.4	45.7	20.9
Not important	2.5	1.7	25.0	37.4
No. of women/men	**120**	**118**	**116**	**115**
The most important source of support wife received when using contraceptives (ever-users)				
Husband	43.0	52.2	52.6	86.2
Health-worker	21.5	11.2	8.8	1.8
Others	19.4	22.2	1.8	3.4
No support	16.1	14.4	36.8	8.6
Ever use of contraceptives women/men	**93**	**90**	**57**	**58**
Discussion about the use of contraception (current users)				
Always	3.3	29.2	5.6	12.8
Usually	46.7	20.8	8.3	5.2
Seldom	46.7	41.7	83.3	33.3
Never	3.3	8.3	2.8	48.7
Discussion about the type of contraceptive to use (current users)				
Always	3.3	27.1	2.8	7.7
Usually	46.7	18.8	11.1	5.1
Seldom	43.3	33.3	66.7	38.5
Never	6.7	20.8	19.4	48.7
Discussion about when to use contraceptive (current users)				
Always	3.3	25.0	2.8	7.7
Usually	50.0	16.7	2.8	5.2
Seldom	36.7	31.2	19.4	25.6
Never	10.0	27.1	75.0	61.5
No. of women/men#	**30**	**48**	**36**	**39**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12)
 # Total includes the current users of some kind of contraceptives and excludes who are sterilized

Further, results suggest that higher percent of women in villages with high urban characteristics tend to report indulging in discussing about the use of contraception, type of contraception and when to use contraception compared to their counterparts from villages with low urban characteristics, while reports by men do not show any differentials by residence. This suggests that more women from high urban characteristics tend to discuss regarding contraceptives and might have more say while making decisions on contraception as they are actively involved in the discussion. Moreover, men from villages with high urban characteristics reported that they seldom discuss with their wife about contraception. Thus the results indicate that some kind of equity exists among couples from villages with high urban characteristics, although it is at a very preliminary level, and couples do communicate to discuss family planning matters.

4.10 Discussion

The findings on various health indicators at the state, district and village levels throw light on the prevailing health conditions of women's reproductive health. Though the Gautam Buddha Nagar district is more urbanized than the state level, there are no visible differences in many indicators of reproductive health-care between the district and the state except for first trimester antenatal care, number of safe deliveries and contraceptive use. Within the district, stark differences are seen across villages with low urban characteristics and villages with high urban characteristics in some aspects. Higher percentages of wives and husbands have received education above 8^{th} level and are engaged in non-manual jobs in villages with high urban characteristics. Men from high urban characteristics villages feel that there are many structural changes brought about as a result of urbanization and that has triggered many changes in their villages. There are more nuclear families, no land for cultivation and there is definitely a change in primary occupation of men due to urbanization. When asked about the changes in the personal life, both women and men agreed to have greater mobility and accessibility to health-care centre, increased awareness on own health issues and greater control over the finances.

Most of the women from villages with high urban characteristics go for antenatal check-ups, while both women and men are aware of the importance of administering TT injections during pregnancy. In addition, these women and men also reported more pregnancy complications as compared to their counterparts in villages with low urban characteristics.

Generally, fewer men have knowledge about various delivery complications as compared to women who reported to have greater knowledge than men.

When data on contraception are analysed, women from high urban characteristics villages tend to have greater knowledge about traditional methods of contraception and they are aware of more options available to them to space children such as modern methods as well as emergency pills. There are no differences in the knowledge levels of women and men from villages with high urban characteristics. Across residence and gender higher preference is given to terminal methods of contraception such as female sterilization followed by the use of condoms.

Responses on RTI symptoms reveal that there is no difference in reporting across residence. However, when compared across gender, women reported RTI symptoms more commonly compared to men revealing that even men from villages with high urban characteristics are less informed about Reproductive Tract Infections and pay less attention to the fact that the wife needs medical attention.

Almost 83% of the women from villages with high urban characteristics agreed to obtain health-care for them, although there are no observable differences in other decisions pertaining to the household by residence. Moreover, women with high urban characteristics frequently communicate with their husbands about their daily needs and 50 % of them perceive their status as ‘very important’ within their households.

Thus to conclude, there are visible differences across residence and gender on various health-care indicators of women’s reproductive health. Residence being the variable of interest does show its influence on many health indicators at the gross level, however it does not mean that residence solely affects these indicators. There are many socio-economic and demographic factors that influence reproductive health, so in order to understand the net effect of residence and other factors a detailed analysis is done using various regression techniques in the next chapter.

CHAPTER -5

HUSBAND'S INVOLVEMENT IN WOMEN'S REPRODUCTIVE HEALTH

CHAPTER-5

HUSBAND'S INVOLVEMENT IN WOMEN'S REPRODUCTIVE HEALTH

Since the 1994 International Conference on Population and Development (ICPD) in Cairo, several changes have been made in India's Reproductive and Child Health Programme. The Programme of Action, agreed by 179 countries, unequivocally links programmes to improve sexual and reproductive health by addressing the gender values and norms that harm both women's and men's health and impede development. Involving men as an integral and prominent part marks the shift from family planning program to a broader reproductive health agenda (Greene et al., 2006:4). Ever since, the Reproductive and Child Health Programme in India envisages the involvement of men in women's reproductive health. Health workers are encouraged to provide expectant fathers necessary information on several aspects of maternal and child health-care when they meet them (IIPS and Macro International, 2007-06:201).

This chapter makes an attempt to examine how involvement of husbands in reproductive health is influenced by various socio-economic and demographic factors. The analyses is based on the data from the researcher's field survey in the district Gautam Buddha Nagar in which information was obtained from both women and men of different households on reproductive health issues questions. Also questions on contraceptive use, desire for additional child, husband's support during RTI infection, and husband's engagement during wife's sickness were asked from women and men to understand the differences in their opinion and understanding level between wife and husband. Initially this chapter gives information at gross level on husbands' involvement in various decisions regarding their wife's reproductive health[1]. Later, this chapter discusses results on the net effects of various socio-economic and demographic factors on husband's involvement from the field investigation. The details on socio-economic and demographic indicators used for the analyses are given in Chapter-3. This is complemented by information obtained by the researcher during her fieldwork, through observations and interactions with respondents and other persons in the study villages and the insights gained from these.

[1] *NOTE: Terms 'men for husbands' and 'women for wives' have been used interchangeably throughout the chapter; the information is obtained only on currently married women and men and thus the men refer only to married men (husbands) and the women only to married women (wives).*

Moreover, some of the aspects of reproductive health and fertility desires were covered in the third round of the National Family Health Survey (NFHS-3) as well which had a large sample for the state of Uttar Pradesh as a whole. Some of the background variables are similar and therefore, relevant results based on the analysis of this data are also discussed to provide a greater understanding of role of husbands in decision-making in women's reproductive health. Note that the explanatory variable, namely, level of urban characteristics in the village of residence is not available in the NFHS data files. Therefore, the variable rural or urban place of residence is used which gives an idea of urban influences though this is not the same as the variable on the level of urban characteristics used in the analysis of the primary survey data. The details on the NFHS-3 data are given in Chpater-3. The NFHS-3 data are used primarily for multivariate analysis given the large sample size. However, the analysis based on the NFHS-3 is for the state of Uttar Pradesh and not for the district of Gautam Buddha Nagar since the NFHS sample does not permit an analysis at the district level and the data files do not identify the district anyway.

5.1 Husbands' providing care to the wife during and after pregnancy

This section describes various aspects of pregnancy, delivery care, and post-natal care received by women especially focusing on their husbands' involvement during this crucial phase of life (pregnancy) when there are higher chances of maternal mortality and morbidity.

Table 5.1.1 presents details on various kinds of supports extended by husbands during the last pregnancy of wife. This includes type of specific pregnancy care received by wife from her husband, decisions on antenatal check-ups, and who accompanies and pays for ANC.

Around 76 percent of women living in high urban characteristics villages said they received special care by their husbands at the time of pregnancy; 65% of their husbands made sure that the wife is taking proper food; husbands are also particular of giving rest to the wife and observed abstinence during the pregnancy. In addition, husbands both in low urban and high urban characteristics villages decided about whether the wife should go for ANC check-up or not and also accompanied them for ANC check-up though the differences across place of residence are not that obvious.

TABLE-5.1.1: Percentage of currently married women/wives whose husbands supported pregnancy care, Field Survey, Gautam Buddha Nagar district (2011-12)

Indicators of Husband's support	Women Respondents from villages with		Men Respondents from villages with	
	Low Urban Characteristics	High Urban Characteristics	Low Urban Characteristics	High Urban Characteristics
Percentage of women who received specific pregnancy care from husbands				
Type of special care received				
Proper food intake	54.2	65.3	52.6	61.0
Gave rest	32.5	53.4	35.3	50.4
Stressed on maintaining hygiene	15.0	18.6	8.6	12.2
Abstinence	25.0	37.3	26.7	26.1
Regular check-ups	22.5	29.7	23.3	27.8
Other support	0.0	0.8	0.0	0.0
Received some special care by husband	60.0	76.3	56.9	67.8
No. of women/wives#	**120**	**118**	**116**	**115**
#Percentages do not add to 100 because of multiple responses				
Decision on antenatal check-ups taken by (Percentage distribution)				
Husband	58.5	67.9	46.9	45.6
Wife	20.8	21.4	28.6	29.4
Mother-in-law	15.0	8.3	24.5	25.0
Relatives	5.7	2.4	0.0	0.0
Visit by a Health Worker	*80.0*	*84.3*	*57.1*	*63.2*
Person accompanied for ANC (Percentage distribution)				
Husband	35.8	40.5	47.0	53.0
Wife went alone	5.7	10.7	0.0	1.5
Mother-in-law	18.9	15.3	0.0	5.9
Mother	0.0	1.2	16.3	13.1
Relatives	0.0	7.3	2.0	3.0
Not relevant (ANC check-up at home)	39.6	25.0	34.7	23.5
Person who paid for ANC (Percentage distribution)				
Husband	41.5	58.3	61.2	69.1
Wife	7.5	7.0	0.0	0.0
Mother-in-law	11.4	8.3	4.1	7.4
Friends	0.0	1.4	0.0	0.0
None (ANC check-up at home)	39.6	25.0	34.7	23.5
No. of women/wives*	**53**	**84**	**49**	**68**

These are the women/wives who received some kind of care from their husbands, so total does not add up to 238

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12).

Higher percentages of husbands paid for ANC check-up in high urban characteristics villages as compared to husbands from low urban characteristics villages mainly because in low urban characteristics villages pregnant women undergo ANC check-ups at home from ANM or AWW. The pattern is similar for men respondents also where they indicated that husbands from high urban characteristics villages took care of proper food intake, gave rest to the wife, and around 68% of the wives received some kind of special care by them. In addition, men reported that women from low urban characteristics villages prefer to have ANC check-up at home by AWW or ANM.

There are differences in responses of women and men across place of residence. Higher percentages of women from high urban characteristics villages believed that their husbands observed abstinence (37%) and gave special attention and care to them during pregnancy (76%) as compared to men's responses from those areas. Furthermore, women from low urban characteristics villages admitted that mostly their husbands made decisions on ANC check-ups (59%), while men from low urban characteristics villages admitted that higher percentages of their mothers make decisions on ANC check-ups (24.5%). Women from low urban characteristics villages and from high urban characteristics villages reported that they were visited by a health worker for ANC check-ups as compared to men who reported lesser visits by health workers for ANC check-ups. In both types of villages, higher percentages of husbands than women felt that they accompanied the wife for ANC check-up and pay for that as well.

TABLE-5.1.2: Percentage of currently married women/wives with type of care during delivery and post-natal care, Field Survey, Gautam Buddha Nagar district (2011-12)

Types of care taken by husband	Women Respondents from villages with		Men Respondents from villages with	
	Low Urban Characteristics	High Urban Characteristics	Low Urban Characteristics	High Urban Characteristics
Preparation made by husband for delivery (all deliveries)				
Was available	21.7	50.0	29.3	27.8
Called the doctor	7.5	11.0	8.6	11.3
Called the Trained Birth Attendant/ *dai*	32.5	28.0	33.6	24.3
Kept medical kit ready	14.2	16.1	7.8	22.6
Called the relative for delivery time	17.5	14.4	3.4	13.0
No help received from the husband	27.5	20.3	47.4	44.3
Husband discussed about the place of delivery	20.8	35.9	19.0	33.0
Husband present with wife at the time of delivery	69.2	73.7	44.0	54.8
Paid for delivery				
Husband	69.2	75.4	84.5	90.4
Mother-in-law	25.0	21.2	11.2	7.9
Others	5.8	3.4	4.3	1.7
No. of respondents	**120**	**118**	**116**	**115**
Percent of deliveries in institutions	**25.8**	**43.2**	**35.3**	**50.4**
Accompanied to the place of delivery (for those who had institutional deliveries); percentage distribution				
Husband	77.4	70.6	70.7	63.8
Mother-in-law	12.9	18.6	24.4	27.6
Others	9.7	10.8	4.9	8.6
No. of respondents	**31**	**51**	**41**	**58**
Percent who received any post-natal care (PNC)	**35.0**	**53.4**	**20.7**	**39.1**
Decision on PNC (for those who received post-natal care)); percentage distribution				
Husband	64.3	57.2	29.2	35.6
Wife	21.4	34.9	62.5	46.7
Others	14.3	7.9	8.3	17.7
No. of respondents	**42**	**63**	**24**	**45**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12).

Information about different types of care women received during delivery and post-natal care is given in **Table 5.1.2**. Around one in every two women in high urban characteristics villages agreed that their husbands were available and present with the wife at the time of delivery. In cases of institutional deliveries, around 71 percent of husbands accompanied the wife to the place of delivery in high urban characteristics villages. While just 36 percent of all the women reported that their husbands discussed where the birth of babies should take place in high urban characteristics villages. Out of the women who received post-natal care, nearly 35 percent women reported that they were also involved in decision-making on post-natal care in villages with high urban characteristics.

However, more than 30 percent men in low urban characteristics villages reported that they called the Trained Birth Attendant (TBA), while 23 percent men in high urban characteristics villages kept the medical kit ready. From both the types of villages, more than 40 percent of men admitted that they were not involved in any kind of preparation for the delivery. According to men's reporting around 35 percent of deliveries/births were institutional in low urban characteristics villages, however, in high urban characteristics villages in around 33 percent of cases, men have discussed about the place of delivery and around 55 percent men were present with their wife at the time of delivery. The reason for availability of men may be attributed to the nature of work that makes it possible for more number of men to stay at home during delivery time in high urban characteristics villages. But around 80 percent of men reported that their wife did not receive any type of PNC in villages with low urban characteristics and 61 percent in high urban characteristics villages. Thus the percentage of women who received no post-natal care is fairly high in both the types of villages as reported by both women and men.

Differences across responses from women and men indicate that higher percentages of women feel that their husbands are involved in making preparations for the delivery, while men feel that they are not that much involved in both low urban and high urban characteristics villages. Higher percentages of men (35%) in low urban characteristics villages and 50% in high urban characteristics villages reported institutional deliveries as compared to women. Around one in every four women in villages with low urban characteristics and one in every five women in villages with high urban characteristics gave

credit to their mothers-in-law for supporting them by paying for the delivery, be it at home or outside home, while men in both the kinds of villages gave credit to their mothers for paying money at the time of delivery. Higher percentages of women also feel that their husbands made decision on seeking PNC across low and high urban characteristics villages.

5.2 Desire for additional child

In order to obtain information on fertility preferences, both currently married women and men were asked questions on their desire to have an additional child in the future. They were also queried about the desire of the spouse (as known to the respondent). The desire for an additional child is controlled for the number of children that women and men currently have.

TABLE-5.2.1: Percentage of currently married women/men who desire an additional child, Field Survey, Gautam Buddha Nagar district (2011-12)

	Women Respondents from villages with		Men Respondents from villages with	
Contraception	**Low Urban Characteristics**	**High Urban Characteristics**	**Low Urban Characteristics**	**High Urban Characteristics**
Husband's desire for additional child				
Couples with one living child	100.0	78.6	93.0	94.7
Couples with two living children	11.5	21.9	20.6	32.6
Couples with three or more living children	4.8	4.2	10.3	7.5
Wife's desire for additional child				
Couples with one living child	100.0	71.4	93.0	94.7
Couples with two living children	23.1	18.8	26.5	20.9
Couples with three or more living children	2.4	4.2	8.8	7.5
No. of women/men	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12).

In **Table 5.2.1,** the differences by level of urbanization and by gender of the respondent are not very large. Most women and men with one child wanted to have another child. But after two children, only a minority, about a fifth wants another child and among those with three children, very few desire to have another child. The responses do not vary systematically by the type of village of the respondent. Responses from men show slightly higher desires for additional children after two or three children than women. Men have reported their

preference to have at least three children, one daughter and two sons. However, there are a few educated young men who opined to have one child if their first child is a son so that they can provide best facilities to their child. This was an important fact revealed during the fieldwork.

TABLE-5.2.2: Multinomial regression results from NFHS-3: Desire for additional child

	Background Characteristics	**Exp(B)**	**Sig.**		**Background Characteristics**	**Exp(B)**	**Sig.**
Dependent Variable: Desire for additional child (Reference: No more)							
	Residence				**Residence**		
Have Another	Urban	0.78	**0.013***	***Undecided***	Urban	1.07	0.87
	Rural (RC)				Rural (RC)		
N = 7395	**Pseudo R^2**	**0.455**			**-2 Log likelihood**	**4082.868**	
Dependent Variable: Match between desires of spouses for additional child (Reference: Both have same desire)							
	Residence				**Residence**		
Desire of spouse differs	Urban	0.79	**0.029***	***Do not know***	Urban	0.63	**0.00****
	Rural (RC)				Rural (RC)		
N = 7123	**Pseudo R^2**	**0.094**			**-2 Log likelihood**	**7625.385**	

Significance level- ** 1% level; *5 % level
Source: NFHS-3 Women's File (2005-06)
Variables controlled are: age of a woman, residence, highest education level, religion, wealth index, no. of living children, exposure to mass media, age at marriage, partner's education level, work status of a woman, partner's occupation, caste, bank savings

The NFHS-3 also collected data on desire for a child/an additional child from both husbands and wife and, as mentioned at the beginning of this chapter, a brief analysis of this aspect based on these data is presented here for the state of Uttar Pradesh. A multinomial logistic regression is carried out with the desire for an additional child, the categorized dependent variable with 'desire for no more children,' 'desire to have another child,' and 'undecided' as three categories ('desire to have no more' is used as the reference category) with a number of relevant socio-economic and demographic explanatory variables. As the desire heavily and obviously depends on the number of living children one has, the analysis has been performed

separately for those with one, two, and three and more living children; those with no children are not included since for them the desire for a child is nearly universal and there are no differentials as such. For the sake of brevity, only the regression coefficients for the key variable of interest, place of residence (rural or urban) to assess the role of urbanization, are shown here (**Table 5.2.2**, upper panel). The results in **Table 5.2.2** suggest that place of residence does play an important role and influence desire for an additional child. A woman's desire to have another child is lower in urban residence. This finding from NFHS-3 supports the observation from the field survey where women from villages with high urban characteristics did not want to have additional child once they have two children. A similar analysis has been carried out for the dependent variable on match between the desires of spouses, with the three categories, 'both have same desires' (reference), 'desires differ,' and 'do not know'. The results (**Table 5.2.2**, lower panel) show that there is more agreement between urban couples to have an additional child than rural couples. This reveals that in urban areas some kind of equity exists in decision-making between the couples, which is reflected through their agreement level and match between desires in deciding about an additional child.

TABLE-5.2.3: Percentage of currently married women/wives who are encouraged or discouraged by husband for using contraception, Field Survey, Gautam Buddha Nagar district (2011-12)

	Women Respondents from villages with		**Men Respondents from villages with**	
Contraception Use	**Low Urban Characteristics**	**High Urban Characteristics**	**Low Urban Characteristics**	**High Urban Characteristics**
Husband encouraged wife to use contraceptive				
Couples with one living child	18.2	35.7	7.1	42.1
Couples with two living children	50.0	41.9	17.6	58.1
Couples with three or more living children	35.4	49.3	35.3	43.4
Husband discouraged wife to use contraceptive				
Couples with one living child	0.0	7.1	0.0	0.0
Couples with two living children	11.5	34.4	11.8	7.0
Couples with three or more living children	3.7	8.3	5.9	3.8
No. of women/men	**120**	**118**	**116**	**115**

Source:- Survey conducted in Gautam Buddha Nagar district (2011-12).

From **Table 5.2.3**, it is clearly evident that husbands encourage the wife to use contraception after the second and the third child in both types of villages. But a good proportion of husbands from high urban characteristics (as reported by women and men) want their wife to use contraception especially even after the first birth; this may be to promote spacing among the children. Regarding discouraging the wife to use contraception, only a small minority were reported to have done so and the levels do not differ much across low urban and high urban characteristics villages as reported by women and men, the exception being that women from high urban characteristics villages reported that husbands discouraged them to use contraception after two children, although men did not report the same. This is because some husbands want at least three children in their family, two sons and one daughter which is considered as an ideal family size by many, they feel that it is necessary to have two sons in case one goes out to work, the other son can stay back at home and be a parents' support in old age.

TABLE-5.2.4: Multinomial regression results from NFHS-3: Decision-making on use of contraceptives

	Background Characteristics	**Exp(B)**	**Sig.**		**Background Characteristics**	**Exp(B)**	**Sig.**
Dependent Variable: Decision maker for using contraceptives (Reference: Joint decision)							
	Residence				**Residence**		
Mainly wife (respondent)	Urban	1.19	0.25	***Mainly husband***	Urban	0.67	0.14
	Rural (RC)				Rural (RC)		
N = 3743	**Pseudo R^2**	**0.059**			**-2 Log likelihood**	**2753.181**	
Significance level- ** 1% level; *5 % level							
Source: NFHS-3 Women's File (2005-06)							
Variables controlled are: age of a woman, residence, highest education level, religion, wealth index, no. of living children, exposure to mass media, age at marriage, partner's education level, work status of a woman, partner's occupation, caste, bank savings							

The NFHS-3 data also allow us to assess the influence of urbanization on the role of spouses in decision-making on the use of contraceptives. Multinomial logistics regression analysis has been carried out for the state of Uttar Pradesh, with decision-making as the categorized dependent variable, with 'husband and wife make a joint decision,' mainly wife (respondent) decides,' and 'mainly husband decides' as the three categories; 'husband and wife make a joint decision' is used as the reference category. As before, only the coefficients for the key

explanatory variable of urbanization (place of residence- rural or urban) are presented in **Table 5.2.4** and the list of other explanatory variables is shown at the bottom of the table. The results depict that residence does not show any significant effect when controlled for other socio-economic and demographic factors.

TABLE-5.2.5: Percentage of currently married women/wives who received care from husbands after sterilization operation, Field Survey, Gautam Buddha Nagar district (2011-12)

	Women Respondents from villages with		Men Respondents from villages with	
Sterilization care	**Low Urban Characteristics**	**High Urban Characteristics**	**Low Urban Characteristics**	**High Urban Characteristics**
Precautions taken by husband after wife's sterilization				
Did not allow the wife to lift heavy things	5.7	8.6	7.1	10.0
Did not allow the wife to work with water for washing clothes and utensils	13.5	0.0	0.0	0.0
Did not allow the wife to cook	0.0	0.0	0.0	15.0
Gave rest to the wife	51.9	62.9	93.0	75.0
Some type of care received by women after sterilization	71.1	71.5	100.0	100.0
No. of women/men*	**52**	**35**	**14**	**20**

Percentages are calculated for sterilized women only
Source:- Survey conducted in Gautam Buddha Nagar district (2011-12).

Data on sterilization of wife from women respondents depict that around 70 percent of the husbands provide some care to their wife after the sterilization operation across low urban and high urban characteristics villages (**Table 5.2.5**). In low urban characteristics villages, husbands do not let the wife work with water for washing clothes or utensils, while those from high urban characteristics gave rest to their wife which helps in faster recovery. On the contrary, all men reported that they cared for their wife after the sterilization operation and provided some sort of care, nearly 93 percent gave rest to their wife from low urban characteristics villages, while two-thirds of husbands claimed to have given rest to their wife from high urban characteristics villages. Across women and men, men reported of providing higher levels of care to their wife, though the levels reported by the women are at least 30 percentage points lesser than men.

5.3 Husbands' support to wife at the time of RTI infection

Most often women suffer silently with Reproductive Tract Infections (RTI) that cause discomfort and also adversely affect their economic productivity. RTI can result in some serious long-term complications in women such as pelvic inflammatory disease (PID), cervical cancer, infertility, spontaneous abortion and ectopic pregnancy, the latter of which may lead to maternal death (Prasad et al., 2005:73). Thus information about the incidence of reproductive tract infections among women gives an indication of morbidity levels among women.

TABLE-5.3.1: Percentage of currently married women/wives by husbands' support in case of RTI infection, Field Survey, Gautam Buddha Nagar district (2011-12)

	Women Respondents from villages with		**Men Respondents from villages with**	
Involvement of Husband	**Low Urban Characteristics**	**High Urban Characteristics**	**Low Urban Characteristics**	**High Urban Characteristics**
Husband's behavior when wife had RTI infection (Percentage distribution)				
Supportive	68.0	66.6	56.4	63.3
Indifferent	0.0	0.0	0.0	3.3
It is a woman's matter	6.0	16.7	33.3	26.7
Did not know what to do	26.0	16.7	10.3	6.7
Percentage of women who received different kinds of support from husband at the time of RTI infection*				
Took to the hospital	44.0	50.0	20.5	43.3
Avoided intercourse	4.0	6.3	7.7	0.0
Gave rest	6.0	8.3	7.7	16.7
Took care of medicines	26.0	16.7	35.9	20.0
No. of women/men*	**50**	**48**	**39**	**30**

Percentages are calculated for women/wives with RTI infections, and they do not add to 100 because of multiple responses
Source:- Survey conducted in Gautam Buddha Nagar district (2011-12).

Table 5.3.1 suggests that about two-thirds of husbands were supportive of the wife if she suffered of an RTI infection. There is no conspicuous difference in the responses of husbands and wife and in low urban and high urban characteristics villages. But more women than men reported that the husbands did not know what to do about it and more men than women reported that this is women's matter (and hence there is nothing for them to do). When the women suffering from RTI in the past one year were asked about the specific support they received from husbands, women from low urban characteristics villages commit that one in

every four women received some kind of support from their husbands, support in the form of taking care of the medicines that their wives are having during the time of infection. However, when a similar question is asked from men, mostly men from high urban characteristics villages informed that they took their wives to the hospital and also made sure that they got rest. On the other hand, more women and men from low urban characteristics villages than high urban characteristics informed that the husbands took care of them by keeping a check on the medicines intake and availability of medicines.

5.4 Husband's involvement during wife's sickness

This section focuses on husband's involvement in routine life when wife falls sick and is not able to perform her daily chores. The extent and nature of how husbands support the wife during sickness provides a clue of how sensitive and caring husbands are towards the wife.

TABLE-5.4.1: Percentage of currently married women/wives by husband's involvement during sickness, Field Survey, Gautam Buddha Nagar district (2011-12)

Husband's involvement during wife's sickness	Women Respondents from villages with		Men Respondents from villages with	
	Low Urban Characteristics	High Urban Characteristics	Low Urban Characteristics	High Urban Characteristics
Husband's attitude when wife is sick (percentage distribution)				
Supportive	77.7	86.4	96.6	99.1
Unconcerned	8.3	4.3	1.7	0.0
It is a woman's issue	14.0	9.3	1.7	0.9
Husband help when wife is sick*				
Takes to the doctor	76.7	66.9	44.0	59.1
Provides economic support	27.5	27.1	59.5	61.7
Sees that wife is recovering	19.2	28.0	26.7	34.8
Indifferent	0.0	0.0	0.0	0.0
It is a woman's issue	0.8	2.5	1.7	0.0
Women reporting positive change in men's attitude in past 5 years	84.2	88.0	83.6	89.6
No. of women/men	**120**	**118**	**116**	**115**

Percentages do not add to 100 because of multiple responses
Source:- Survey conducted in Gautam Buddha Nagar district (2011-12).

Women from high urban characteristics villages reported that their husbands were more supportive (86%) when they are sick and they see to it that the wife was recovering from the sickness compared to husbands of women in low urban characteristics villages (**Table 5.4.1**).

Moreover, husbands in low urban characteristics villages actually take their wife to the doctor, the reason cited by women is that they are still dependent on their husbands for taking them to the health center during any sickness, but husbands do not follow up there after. While the men from high urban characteristics villages reported that in 60 percent of the cases they take their wife to the doctor contrary to those from low urban characteristics villages. However, the pattern for other kinds of care and support does not vary much for husbands across place of residence. Also almost universally women and men agreed that there is a positive change in husband's attitude towards their wife in the past 5 years. Husbands have become more concerned and are actively involved in reproductive health matters than ever before.

A comparison of responses across women and men shows that higher percentages of women (77%) from low urban characteristics villages feel that their husbands take them to the doctors, while men from both low urban and high urban characteristics villages feel that they are very supportive and even provide economic support to their wife so that the wife can stock medicines and fulfill any dietary requirement to overcome the sickness.

TABLE-5.4.2: Multinomial regression results from NFHS-3: Decision on own health-care

	Background Characteristics	**Exp(B)**	**Sig.**		**Background Characteristics**	**Exp(B)**	**Sig.**
Dependent Variable: Final say on own health (Reference: Respondent has a say)							
	Residence				**Residence**		
Husband has a say	Urban	0.83	0.019*	***Others have a say***	Urban	0.26	0**
	Rural (RC)				Rural (RC)		
N = 8648	**Pseudo R^2**	**0.194**			**-2 Log likelihood**	**9832.588**	

Significance level- ** 1% level; *5 % level
Source: NFHS-3 Women's File (2005-06)
Variables controlled are: age of a woman, residence, highest education level, religion, wealth index, no. of living children, exposure to mass media, age at marriage, partner's education level, work status of a woman, partner's occupation, caste, bank savings

The NFHS-3 had also collected data on who has final say on the woman's health-care which allows us an understanding of influences on decision-making on woman's own health-care. Multinomial analysis of the data for Uttar Pradesh on who has a final say on woman's health-care, with three categories, woman (reference category), husband, and others, was carried out

with place of residence (rural or urban) and relevant socio-economic variables as explanatory variables. **Table 5.4.2** shows the results; again only the coefficients of the urbanization variable are shown and other variables are listed at the bottom. With urban residence, husbands have a lesser say in decisions regarding seeking health-care by the wife thus implying that urban women have more say when it comes to making decisions on their own health as compared to their rural counterparts; when effects of other variables are controlled. This informs that women in urban areas are more empowered as they are aware of their health needs and in many instances are not dependent on their husbands to assist them to the health centre.

5.5 Multivariate analysis of husband's involvement in wife's reproductive health: Data from the field survey

Husband's involvement in various aspects of wife's reproductive health is possibly influenced by a number of factors, data on which have been obtained in the field survey from both women and men. As some of the explanatory variables are interrelated, multivariate analysis is necessary to assess the net influences of various factors on husband's involvement. Since the response variables, involved in a particular aspect or not, are dichotomous, the logistic regression technique has been adopted as described in Chapter-3. A list of explanatory variables is also explained there. The regression results along with adjusted and unadjusted percentages are discussed in the subsequent sections. These are complemented by the insights gained during the field investigation by the researcher which are based on observations, interviews and narratives.

5.5.1 Involvement of husbands in providing pregnancy care- regression analysis

A husband can help during the pregnancy of wife in various ways, taking her to health workers, arranging for preventive care, special food, giving rest, etc. Overall, 69 percent of the husbands were involved in taking care of the wife during her last pregnancy **(Table 5.5.1)**. With education, there is greater involvement of husbands during pregnancy as compared to uneducated women. In addition, a gap is seen in the level of involvement by wife's age. Large differentials are also seen by husband's nature of work, exposure to mass media and women's empowerment.

TABLE-5.5.1: Involvement of husbands in pregnancy care (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in pregnancy care	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	159			77	77
36 and above	79	-1.162	**0.313*** **	53	50
No. of living children					
1 Child ®	25			92	88
2 Children	58	-1.332	0.264	78	65
3 and above children	155	-1.306	0.271	62	66
Family Type					
Joint Family ®	86			77	74
Nuclear Family	152	-0.408	0.665	64	66
Caste					
Others ®	100			72	68
OBC	98	-0.105	0.901	69	65
SC/ST	40	0.643	1.902	60	80
Education of a woman/wife					
No Education ®	95			47	58
Up to 8th level	79	0.753	**2.124***	77	74
Above 8th level	64	0.872	2.391	91	77
Standard of living					
Low ®	51			49	58
Medium	118	-0.165	0.848	63	54
High	69	1.879	**6.550****	94	90
Woman's/Wife's work status					
Not working ®	188			70	72
Working	50	-0.763	0.466	64	55
Husband's nature of work					
Manual job ®	130			56	59
Non-manual job	108	0.959	**2.609****	84	79
Media exposure					
No exposure to mass media ®	32			44	49
Exposed to mass media	206	0.964	**2.621***	73	72
Women's empowerment					
Low empowerment ®	101			53	51
High empowerment	137	1.320	**3.744*****	80	80
Residence					
Villages with low urban characteristics ®	120			60	63
Villages with high urban characteristics	118	0.539	1.714	78	74
Husband's workplace					
Within the village ®	129			60	63
Outside the village	109	0.599	1.820	80	75
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			40	56
Visit relatives in urban areas	195	0.688	1.990	75	72
Constant		-0.759	0.468		
% of husband's involvement	**69**				

®- Reference Category, -2 log likelihood = 187.327, Nagelkerke R Square =0.512, Significance level- *** at 1%, ** at 5%, * at 10%; N= 238. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

Since many of the background characteristics are possibly associated, logistic regression was carried out to assess the net effect. Thirteen independent variables are used as explanatory variables with husband's involvement in wife's pregnancy care as the dichotomous dependent variable. The results show significant effect of wife's age, wife's education, standard of living, husband's nature of work, exposure to mass media and women's empowerment. In the case of older women, husband's involvement is significantly lower. Odds ratio for women with education is twice as high as those for uneducated women. Standard of living enhances husband's involvement as odds ratio is high. Being residents of villages with high urban characteristics and husband's place of work do not show any significant effect on involvement. However, husband's engagement in non-manual job is likely to raise husband's involvement in pregnancy care.

In order to have a clearer idea of the net effects, adjusted percentages (adjusted for the effects of other variables) are calculated for each category and presented alongside the unadjusted percentages in **Table 5.5.1**.This again shows that gaps by education are wide and even after controlling for other factors, though they narrow somewhat, the gaps still persist. The same is true for the demographic factor, i.e., wife's age and also for husband's nature of work and mass media. The effect of women's empowerment almost remains unchanged. Those with higher levels of empowerment have greater involvement of husbands; the adjusted percentages are 59% and 79% for husbands engaged in manual work and non-manual work respectively. However, for the variable of interest mainly the level of villages with urban characteristics, the net gap is not significant.

The regression is also re-run by replacing education of wife by education of husband and the results are nearly identical to those in the text above, except that husband's place of work also shows a significant effect on husband's involvement during pregnancy as seen from **Table 1** of appendix. The odds ratio for husband working outside the village is twice as high compared for the husband working within the village. When adjusted percentages are calculated, it is seen that gaps by husband's place of work are wide and even after controlling for other factors, though they narrow somewhat, the gaps still persist; the adjusted percentages are 62% and 77% for husbands working within the village and outside respectively.

TABLE-5.5.2: Involvement of husbands in pregnancy care (Responses from men)

Background Characteristics	Total no. of men	B	Exp (B)	Percentage husbands involved in pregnancy care	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	181			73	72
36 and above	50	-1.216	**0.297*** **	40	43
No. of living children					
1 Child ®	33			82	75
2 Children	77	-0.624	0.536	73	61
3 and above children	121	-0.374	0.688	58	67
Family Type					
Joint Family ®	133			71	71
Nuclear Family	98	-0.482	0.618	59	60
Caste					
Others ®	71			76	88
OBC	110	-0.041	0.960	65	68
SC/ST	50	-0.372	0.689	54	60
Education of a woman/wife					
No Education ®	112			53	59
Up to 8th level	54	0.154	1.167	69	63
Above 8th level	65	0.956	**2.601***	88	79
Standard of living					
Low ®	59			53	57
Medium	81	0.520	1.682	68	69
High	91	0.511	1.667	74	69
Woman's/Wife's work status					
Not working ®	194			64	63
Working	37	0.847	2.333	78	80
Husband's nature of work					
Manual job ®	178			62	66
Non-manual job	53	0.105	1.110	79	68
Media exposure					
No exposure to mass media ®	21			52	74
Exposed to mass media	210	-0.423	0.655	68	65
Women's empowerment					
Low empowerment ®	165			57	56
High empowerment	66	1.452	**4.271*****	89	85
Residence					
Villages with low urban characteristics ®	116			60	64
Villages with high urban characteristics	115	0.164	1.178	72	68
Husband's workplace					
Within the village ®	139			58	62
Outside the village	92	0.488	1.630	79	72
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	49			65	70
Visit relatives in urban areas	182	-0.199	0.820	66	65
Constant		0.949	2.584		
% of husband's involvement	**66**				

®- Reference Category, -2 log likelihood = 234.506, Nagelkerke R Square = 0.321, Significance level- *** at 1%, ** at 5%, * at 10%; N= 231. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

The results based on men's responses on question pertaining to their involvement during wife's last pregnancy showed that around 66 percent of husbands were involved in their wife's pregnancy (**Table 5.5.2)**. Wide gaps are seen for level of education of women. With education, there is greater involvement of husbands during pregnancy as compared to women with no education. Women's empowerment shows that with increase in empowerment levels more husbands are likely to get involved in providing pregnancy care to their wife.

In addition to calculating the unadjusted percentages, logistic regression is carried out as many background characteristics may be associated with each other. Husband's involvement in wife's pregnancy care is used as a dichotomous dependent variable with thirteen covariates (explanatory variables). The results show significant effect of wife's age, wife's education, and empowerment on husbands' involvement in pregnancy care. In case of older women, husband's involvement is significantly lower. Odds ratio for women with high education is twice as high as women with no education. Women's empowerment improves the level of husbands' involvement in pregnancy care as odds ratio is high. Husband's place of work and nature of work do not significantly affect their involvement, and neither does contact with relatives in urban areas. In addition, villages with high urban characteristics also do not show any significant effect.

The adjusted percentages are calculated for each category to get a good idea of the net effects alongside the unadjusted percentages (**Table 5.5.2)**. This again depicts that there are wide gaps by education and even after controlling for other factors, though the gaps narrow down, they still persist. The same is true for wife's age, the gap narrows substantially from 73% to 40% (for the unadjusted percentages) to 72% to 43% (for the adjusted percentages). However, for the level of villages with urban characteristics, which is the variable of interest, the gap narrows substantially but the net gap remains insignificant.

When the regression is re-run after replacing wife's education by husband's education, the results are identical for wife's age and women's empowerment, though family type and a woman's work status demonstrate a significant effect on husband's involvement during pregnancy as seen from **Table 2** of appendix. Husbands from nuclear family are less likely to get involved in providing pregnancy care. Furthermore, the odds ratio for a working woman is twice as high as compared to non-working woman. When adjusted percentages are

calculated, it is seen that gaps by family type and a woman's work status are wide though they narrow somewhat, the gaps are still visible; the adjusted percentages are 63% and 82% for a non-working and a working woman respectively.

Involvement of husbands in pregnancy care- Insights from field work

There is not much difference in the responses of both women and men. Women reported a little higher percentage of their husbands involvement compared to men themselves. Both women and men agreed that husbands took special care of the wife during pregnancy and they were involved in making decisions on seeking antenatal care and many a times accompanied their wife for the ANC check-up. Husbands also paid for the ANC check-up such as for the transportation costs or private consultation fees to the doctor, etc. many quotes from women and men reflect that husbands are indeed mindful of their wife's needs during pregnancy and do try to provide as much care as possible at their end. A woman quoted, *"earlier the facilities were less, therefore, it was very difficult to commute; now the things have started improving, and that is why more and more men are accompanying their wife to the doctor for ANC check-up."* Another woman said, *"men have to arrange money, a vehicle to take his wife, so basically a man has to look after the logistic support when he takes his wife for the check-ups."* These quotes from women reflect on the kinds of problems a husband faces while arranging pregnancy care for his wife. They also revealed that commutation was a big problem earlier that hindered many couples to seek pregnancy care, as the things have started to improve; many women are actively utilizing the health-care available to them.

In addition, husbands also agreed that they were engaged in providing care to their wife during pregnancy, a man quoted, *"people [men] are now aware of women's reproductive health issues, and their understanding has also developed with their wife, now they are giving due importance to their wife."* Another husband said, *"She does not go alone, I have to go along with her."* Assisting wife is an important aspect reported by many husbands in providing pregnancy care to their wife, so husbands said even though they provide financial support to her; they still have to be physically present and accompany their wife to the health centre.

Moreover, health workers who work within the villages also have witnessed changes in the men's participation level and have highlighted their contribution in bringing about a change in the husband's role as a care provider. An AWW from a village with low urban characteristics said, *"when we get a chance to meet the couple during the home visits, we try to educate the husband on reproductive and sexual health issues, especially about contraception and pregnancy. We tell the husband of a pregnant woman to take care of her, particularly her dietary intake, if she is not getting proper nourishment, like feeding her green vegetables, protein rich diet. We tell him that giving her rest is also very crucial, if she doesn't have a healthy pregnancy (have some complication during the pregnancy) how will she give birth to a healthy baby?"* By stressing on the need to pay more attention towards the wife, health-care providers try to educate husbands about the need and importance of pregnancy care.

Thus it is obvious from the results and narratives that many husbands are supporting their wife during pregnancy and are making possible efforts on their part.

5.5.2 Involvement of husbands in delivery care-regression analysis

A delivery is obviously an important event not only for the woman but also for the household. This requires considerable resources including engagement of members of the household. The support of the husband can be very crucial at this time. The husband can be involved in many ways, arranging for safe delivery, transport if necessary, getting medicines and special food, and taking care of expenditure.

The overall involvement of husbands in delivery care was 85 percent as stated by women respondents (**Table 5.5.3)**. Wide gaps are seen by wife's age, standard of living, by husband's nature of work and by exposure to mass media. Furthermore, logistic regression is carried out to assess the net effect of background variables that are probably associated with each other. The results show significant effects of wife's age, standard of living, husband's nature of work, exposure to mass media and visiting relatives in urban areas. In case of older women, husband's involvement in delivery care is significantly low. The situation is different for those whose husbands are involved in non-manual jobs; the odds ratio is twice as high as compared to the women whose husbands are involved in manual jobs. Odds ratio for women

who are exposed to mass media is five times higher than those who are not exposed at all. Odds ratio for women who visit their relatives in urban areas is twice as high as those who do not visit relatives in urban areas. Other demographic factor and place of residence do not show any significant effects on the husbands' involvement in delivery care.

In order to get nuances of the net effects of various background characteristics, adjusted percentages are calculated besides unadjusted percentages in **Table 5.5.3**. This again reiterates that gaps by women who visit relatives in urban areas are wide; the adjusted percentages are 73% and 87%. Even after controlling for other factors, the gaps for women who visit relatives in urban areas are visible though they narrow somewhat. The same is observed for wife's age, husband's nature of work and exposure to mass media. In addition, for the variable of interest mainly the villages with high urban characteristics, the gap narrows substantially after controlling for other factors, but the net effect remains insignificant.

TABLE-5.5.3: Involvement of husbands in delivery care (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in delivery care	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	159			91	91
36 and above	79	-1.710	**0.181*** **	75	65
No. of living children					
1 Child ®	25			92	86
2 Children	58	-0.234	0.792	88	83
3 and above children	155	-0.056	0.946	83	86
Family Type					
Joint Family ®	86			85	80
Nuclear Family	152	0.558	1.746	86	88
Caste					
Others ®	100			82	81
OBC	98	0.302	1.352	88	86
SC/ST	40	0.901	2.463	88	92
Education of a woman/wife					
No Education ®	95			78	89
Up to 8th level	79	-0.459	0.632	87	83
Above 8th level	64	-0.625	0.535	94	81
Standard of living					
Low ®	51			76	77
Medium	118	-0.036	0.965	82	76
High	69	1.989	**7.309****	97	96
Woman's/Wife's work status					
Not working ®	188			85	85
Working	50	-0.066	0.937	88	85
Husband's nature of work					
Manual job ®	130			80	79
Non-manual job	108	0.901	**2.463***	92	90
Media exposure					
No exposure to mass media ®	32			63	56
Exposed to mass media	206	1.760	**5.815*****	89	88
Women's empowerment					
Low empowerment ®	101			79	81
High empowerment	137	0.482	1.619	90	88
Residence					
Villages with low urban characteristics ®	120			82	85
Villages with high urban characteristics	118	0.044	1.045	89	86
Husband's workplace					
Within the village ®	129			81	81
Outside the village	109	0.742	2.099	91	90
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			65	73
Visit relatives in urban areas	195	0.904	**2.469***	90	87
Constant		-0.975	0.377		
% of husband's involvement	**85**				

®- Reference Category, -2 log likelihood =145.837, Nagelkerke R Square = 0.352, Significance level- *** at 1%, ** at 5%, * at 10%; N= 238. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12)

The regression analysis is done again by replacing education of wife by education of husband; the results are nearly identical (**Table 3** of appendix), except education of husband, women's empowerment, and husband's place of work show significant effect on involvement of husband in delivery care. Husbands with higher education are less likely to get involved as compared to uneducated husbands, while husbands of women with high empowerment and husbands who are working outside the village demonstrate greater involvement as compared to women with low empowerment and husbands who work within the village. When adjusted percentages are calculated, wide gaps are seen by education of husband even after controlling for other factors, the adjusted percentages are 96% and 77% for uneducated husband and husband with higher education. The effect of empowerment of women on husband's involvement in delivery care remains unchanged.

In case of results based on men's responses, the level of involvement of husband's in wife's delivery care is very high , i.e., 98 percent as reported by men. Further logit analysis is not carried out and also differentials are not shown as there are no observable differences between the two percentages for the background characteristics. Furthermore, such a high level of involvement reveals that there is universal involvement of husbands in their wife's delivery as perceived by husbands.

Involvement of husbands in delivery care- Insights from field work

The differences in the involvement of husband in delivery care are very prominent in the reporting of women and men. The sole reason behind this is that women consider emotional support and physical presence of husband very important at the time of delivery, although men consider providing logistic support (finances, transportation, medical supervision) as important aspects of involvement during delivery.

When both women and men were asked questions about husband's role in providing delivery care, men universally reported their greater involvement as compared to women. Men considered any kind of care provided by them as their involvement. When men arranged somebody to accompany their wife to the place of delivery and paid for the delivery, they regarded this as an involvement in the delivery care. On the contrary, women considered physical presence of the husbands more important especially during the time of delivery

whether it was a case of institutional delivery, or a home delivery. Women did not consider paying for the delivery as an important element of husband's involvement, but men did regard it as their engagement in delivery care. Besides making payments, husbands also made arrangements for transportation in case of some emergencies (as cited by many men) and also secure support from the relatives who could take care of the wife post-delivery. A quote from a woman who calls for an emotional support from the husband, *"a woman requires an emotional support from her husband in such a crucial time which is very difficult to get…"*

Husbands totally have a different set of ideas in their mind for the kind of support they extended to their wife at the time of delivery, like arranging money or a vehicle to take wife to a health centre in case any emergency arises, or calling a relative to be with the wife at the time of delivery and also help her post-delivery. A husband quoted, *"I arranged money and a vehicle in advance so that if emergency arises, I can take my wife to the health centre."* However, this does not mean that every husband is so sensitive and thinks so much in advance about what to arrange if an emergency arises, there were husbands who were not educated and did not know what arrangements to make to support their wife. But it would be impolite to say that they are not supportive. Still in many cases, many husbands at least arranged some relative to assist their wife at the time of delivery and help her out with the daily chores once the baby is born.

Moreover, many women pointed out that they did not want to give birth in a health facility if everything at their end was fine and if there was no problem at the time of delivery despite living in villages with more urban characteristics. Mostly the reason cited by them was the absence of friendly environment in the hospitals which they get at home. On probing further, they revealed that they feel tensed when they come to the health facility, and feel emotionally insecure. So, in many cases even though they undergo all the antenatal check-ups and seek advice from the health workers to deliver in a health facility, they tried to escape it when there were no complications in the delivery. Even men also supported this practice of not going to a health facility for delivery. They also added that a home delivery is "hassle free" and did not require much running around. But they did take their wife to the hospitals in cases of emergency or if wife wanted to deliver in the hospitals.

Many health workers also commented on how they took care of women so that delivery results in a healthy baby. An ANM from the village with low urban characteristics said, *"as such there is no problem, but when we try to immunize them [pregnant women] or give them injections then the problem arises. Suppose a woman does not want to listen to us, we try to rope in the oldest member in the family, especially the mothers-in-law, and ask her to intervene in this matter, some mothers-in-law do take interest themselves, they will call us and say our daughter–in-law wants to discuss some health issues with you, could you please come to our house, while some are pretty harsh, they would not let us talk to their daughter-in- law in their presence…we also try to persuade women to deliver in a hospital facility whether public or private to safeguard a mother and the baby against any delivery complication."* Health workers tried to bring in other older and more experienced members of the family to ensure that a pregnant woman gets all the necessary care she deserves at the time of delivery, thus pointing towards a crucial role played by other important members of the family. So efforts are made by the husbands and other family members to take care of a woman and provide her care for a safe delivery and the birth of a healthy child.

5.5.3 Involvement of husbands in post-natal care

Women and the new born do need special health-care for some time after the delivery. This is to ensure the recovery of the woman and survival of the infant. The husband has an important role to play here.

The results for husbands' involvement in post-natal care showed that merely 26 percent of husbands were involved when it comes to making decisions about post-natal care (**Table 5.5.4)**. Education of a woman is one of the significant factors that increase husband's involvement in post-natal care. With education of a woman, there is greater involvement of husband in post-natal care as compared to an uneducated woman.

TABLE-5.5.4: Involvement of husbands in post-natal care (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in post-natal care	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	159			31	31
36 and above	79	-0.666	0.514	16	19
No. of living children					
1 Child ®	25			48	39
2 Children	58	-0.781	0.458	31	23
3 and above children	155	-0.579	0.560	21	26
Family Type					
Joint Family ®	86			43	32
Nuclear Family	152	-0.385	0.681	17	24
Caste					
Others ®	100			30	28
OBC	98	0.025	1.025	27	28
SC/ST	40	-0.377	0.686	18	21
Education of a woman/wife					
No Education ®	95			13	19
Up to 8th level	79	0.157	1.170	23	22
Above 8th level	64	1.363	**3.909****	52	48
Standard of living					
Low ®	51			16	23
Medium	118	0.173	1.189	25	26
High	69	0.374	1.453	38	30
Woman's/Wife's work status					
Not working ®	188			28	30
Working	50	-0.826	**0.438***	22	16
Husband's nature of work					
Manual job ®	130			20	25
Non-manual job	108	0.117	1.124	34	28
Media exposure					
No exposure to mass media ®	32			3	5
Exposed to mass media	206	2.268	**9.664****	30	33
Women's empowerment					
Low empowerment ®	101			13	12
High empowerment	137	1.753	**5.773*****	36	43
Residence					
Villages with low urban characteristics ®	120			23	28
Villages with high urban characteristics	118	-0.136	0.873	31	25
Husband's workplace					
Within the village ®	129			19	21
Outside the village	109	0.629	**1.875***	35	34
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			19	33
Visit relatives in urban areas	195	-0.409	0.664	28	25
Constant		-3.789	0.023		
% of husband's involvement	**26**				

®- Reference Category, -2 log likelihood = 208.289, Nagelkerke R Square = 0.357, Significance level- *** at 1%, ** at 5%, * at 10%; N= 238. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

The results of the logistic regression analysis depict that wife's education, a woman's work status, exposure to mass media, women's empowerment and husband's place of work significantly affect husbands' involvement in post-natal care. Odds ratio for women with higher education is thrice as high as those for uneducated women. Odds ratio for women who are exposed to some kind of mass media is 9 times higher than those who are not exposed to any sort of mass media. For working women, husbands are less likely to get involved in providing post-natal care to wife. However, husbands who work outside the village are more likely to get involved in post-natal care as compared to those who work within the village. Various aspects of urbanization do not show any significant effect on husbands' involvement.

The adjusted percentages are calculated in **Table 5.5.4** in order to get a precise idea of net effects of background characteristics on dependent variable. This again shows wide gaps by education and even after controlling for other factors, though the gaps narrow down, they still remain quite visible. Similar situation persists for women's empowerment. The effect of exposure to mass media remains unchanged. Those with exposure to mass media have greater involvement of husbands in post-natal care as compared to those who are not exposed to mass media at all; the adjusted percentages are 5% and 33%. In addition, for the villages with high urban characteristics (variable of interest), net effect is not significant.

The regression is re-run when education of wife is replaced by education of husband. The results are very similar to those in the text above, except for wife's age. Husbands of older women are less likely to get engaged in post-natal care as seen from **Table 4** of appendix. When adjusted percentages are calculated, the effect of wife's age remains unchanged, the adjusted percentages are 32% and 17% for wife's age below 35 years and for wife's age 36 years and above respectively.

TABLE-5.5.5: Involvement of husbands in post-natal care (Responses from men)

Background Characteristics	Total no. of men	B	Exp (B)	Percentage husbands involved in post-natal care	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	-	-	-	-	-
36 and above	-	-	-	-	-
No. of living children					
1 Child ®	33			18	11
2 Children	77	0.307	1.360	13	14
3 and above children	121	-0.318	0.728	6	8
Family Type					
Joint Family ®	133			10	8
Nuclear Family	98	0.623	1.865	10	14
Caste					
Others ®	71			14	7
OBC	110	0.475	1.608	7	10
SC/ST	50	0.953	2.594	10	16
Education of a woman/wife					
No Education ®	112			4	7
Up to 8th level	54	0.753	2.213	11	14
Above 8th level	65	0.656	1.927	20	13
Standard of living					
Low ®	59			3	6
Medium	81	0.130	1.139	6	7
High	91	1.379	3.97	18	20
Woman's/Wife's work status					
Not working ®	194			8	9
Working	37	0.415	1.515	19	14
Husband's nature of work					
Manual job ®	178			7	10
Non-manual job	53	0.067	1.069	21	10
Media exposure					
No exposure to mass media ®	21			5	15
Exposed to mass media	210	-0.479	0.619	10	10
Women's empowerment					
Low empowerment ®	165			2	5
High empowerment	66	2.702	**14.902*** **	29	43
Residence					
Villages with low urban characteristics ®	116			6	8
Villages with high urban characteristics	115	0.405	1.500	14	12
Husband's workplace					
Within the village ®	139			5	8
Outside the village	92	0.544	1.722	17	13
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	49			4	7
Visit relatives in urban areas	182	0.471	1.602	12	11
Constant		-6.168	0.002		
% of husband's involvement	**10**				

®- Reference Category, -2 log likelihood = 100.613, Nagelkerke R Square = 0.402, Significance level- *** at 1%, ** at 5%, * at 10%; N= 231. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12), Note: Wife's age is dropped from the analysis.

As reported by men, only about 10 percent of husbands were involved in their wife's post-natal care decision-making process (**Table 5.5.5)**. Neither the demographic factors, nor mass media, husband's nature nor place of work show notable differentials for husbands' involvement in post-natal care. Only with high women's empowerment, there is greater involvement of husbands in post-natal care as compared to those with low empowerment.

The results from logistic regression also reveal that only women's empowerment has a significant impact on husbands' involvement in post-natal care. Odds ratio for women with high empowerment is 14 times higher than those with low empowerment. Socio-economic and demographic factors such as age of a woman, number of living children do not affect husbands' involvement significantly. Other background variables like husband's engagement in non-manual job, women exposure to mass media, visiting relatives in urban areas, husbands working outside the village have high odds ratio but do not show any significant effect on husband's involvement in post-natal care.

Furthermore, the adjusted percentages are calculated to understand the net effects of background variables for each category alongside unadjusted percentages in **Table 5.5.5**. This again depicts wide gaps in the level of involvement by women's empowerment. Women with high empowerment have greater involvement of husbands; the adjusted percentages are 5% and 43%. For the variable under consideration, i.e., villages with high urban characteristics, the gap narrows down slightly from 6% to 14% (for the unadjusted percentages) to 8% to 12% (for the adjusted percentages) after controlling for other factors but the effect remain insignificant.

Besides this, when the logit regression is re-run by replacing wife's education by husband's education, the results are identical (**Table 5** of appendix). With high standard of living, there is greater involvement of husbands in providing post-natal care as compared to those from low and medium standard of living. When adjusted percentages are calculated, the gap narrows down slightly and remain visible for the standard of living. The adjusted percentages are 4% and 21% for low and high standard of living respectively.

Involvement of husbands in post-natal care- Insights from field study

Women reported that their husbands were more involved in making decisions about post-natal care as compared to men themselves. The differences in the responses arise because once the delivery is normal and mother and the baby are fine, men do not interfere much. Generally other members of the household such as husband's mother or sister play a bigger role in taking care of the new born baby and the mother. Husbands get more involved when such support from the family is missing or in cases of nuclear families. Furthermore, providing financial support becomes main concern of the husbands after a new member is added to the family, so they do not focus much on the post-natal care. A young woman (below 30 years) said that her husband was very supportive even after the delivery, *"he did not even let me work for almost a month and gave me full rest, he took me and the baby to the dispensary for the check-up and kept track of baby's injections."* Young husbands who are now living in nuclear families are taking more interest in post-natal care as they do not get any support from the family post-delivery, so their role as a care-provider becomes all the more important.

However, from a men's perspective, they usually tried to avoid going to the hospital unless there was a need. Very few men took their wife and a new born baby to seek post-natal care and understood the need for a post-natal check-up and mostly tried to avoid getting involved in it. A man quoted, *"when everything is normal, then there is no need to get into the trouble of going to the hospital for check-ups. However, if there is any requirement, then I take my wife to see a doctor."* This quote reiterates the fact that once the delivery is normal, mostly husbands resume their work and have little information on whether a health worker visits their home to meet their wife' or the baby for post-natal check-up at home.

While the health workers themselves feel that the things are improving and will progress once the husbands are actively involved. An AWW from the village with high urban characteristics felt that, *"things will definitely improve if they [husbands] get to know how to deal with health issues around delivery and post-delivery. Those who already know, they educate others also. Now-a-days almost everybody is aware, but those who do not have information on these issues and remain under the control of their family will also take proper care of their wife once they get information and become aware of the requirements of their wife."*

This quote suggests that creating awareness among husbands is very crucial on the issue of post-natal care by discussing the benefits it extends to the mother and a baby post-delivery even though there are no visible complications.

5.5.4 Husband's desire for additional children- regression analysis

Fertility regulation heavily depends on desire for additional children. Both women and men were asked if they wanted an additional child. Responses from women are analysed to understand husband's desire for additional child in **Table 5.5.6.** Results show that merely 16 percent of the husbands have the desire for an additional child. The desire to have an additional child decreases with the increase in wife's age and number of children. Wide gaps are seen for women with three or more children as compared to women with one child. Large differentials are also visible by education of wife, working status and empowerment level.

Logistic analysis results show significant effects of age of the woman, number of living children, education of a woman, wife's work status and women's empowerment. Odds ratio for women with 2 or more children is low as compared to those with one child. In case of woman with education up to 8^{th} level, odds ratio is 7 times high as compared to uneducated woman. For older women and women who are working, husband's desire to have an additional child is significantly lower. Husbands of women with high empowerment are also likely to have lesser desire for an additional child.

TABLE-5.5.6: Husbands' desire for additional child (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands' desire for additional child	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	159			23	31
36 and above	79	-2.453	**0.086****	3	4
No. of living children					
1 Child ®	25			88	100
2 Children	58	-6.686	**0.001*****	17	21
3 and above children	155	-8.223	**0.0002*****	5	5
Family Type					
Joint Family ®	86			28	26
Nuclear Family	152	-0.936	0.392	10	12
Caste					
Others ®	100			17	15
OBC	98	-0.254	0.776	11	12
SC/ST	40	1.115	3.051	28	35
Education of a woman/wife					
No Education ®	95			7	14
Up to 8th level	79	1.980	**7.242****	23	54
Above 8th level	64	-1.703	0.182	22	3
Standard of living					
Low ®	51			8	19
Medium	118	-0.302	0.740	19	15
High	69	-0.140	0.869	17	17
Woman's/Wife's work status					
Not working ®	188			19	22
Working	50	-1.811	**0.163***	6	4
Husband's nature of work					
Manual job ®	130			16	16
Non-manual job	108	-0.002	0.998	17	16
Media exposure					
No exposure to mass media ®	32			13	29
Exposed to mass media	206	-0.862	0.423	17	15
Women's empowerment					
Low empowerment ®	101			24	35
High empowerment	137	-1.754	**0.173****	11	9
Residence					
Villages with low urban characteristics ®	120			15	12
Villages with high urban characteristics	118	0.826	2.283	18	23
Husband's workplace					
Within the village ®	129			18	23
Outside the village	109	-0.975	0.377	15	10
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			12	6
Visit relatives in urban areas	195	1.325	3.762	17	20
Constant		5.904	366.440		
% of husband's involvement	**16**				

®- Reference Category, -2 log likelihood = 79.365, Nagelkerke R Square = 0.725, Significance level- *** at 1%, ** at 5%, * at 10%; N= 238. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

Net effects of socio-economic and demographic factors are also measured by calculating adjusted percentages to get a clear view of their effect on husbands' desire for an additional child. Results support that gaps by wife's age and number of children are wide and even after controlling for other factors, the gap widens. As expected, husbands of women with 3 or more children have lesser desire as compared to husband of a woman with one child; the adjusted percentages are 100% for woman with one child and 5% for woman with three and more children. For women's empowerment, the gap between unadjusted percentages and adjusted percentages almost doubles when controlled for other factors. However, for the place of residence which is a variable of interest the net gap is not significant.

The regression is re-run by replacing education of wife by education of husband and the results are almost identical as discussed earlier (**Table 6** of appendix). However, the effect of family type is significant for husbands' desire to have an additional child. Husbands from nuclear family are less likely to have a desire for an additional child as compared to those from joint family. When adjusted percentages are calculated, the effect by family type remains unchanged; the adjusted percentages are 29% and 11% for joint family and nuclear family respectively.

TABLE-5.5.7: Husbands' desire for additional child (Responses from men)

Background Characteristics	Total no. of men	B	Exp (B)	Percentage husbands' desire for additional child	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	181			34	44
36 and above	50	-3.428	**0.032***	4	2
No. of living children					
1 Child ®	33			94	98
2 Children	77	-4.826	**0.008*****	27	29
3 and above children	121	-6.329	**0.002*****	9	8
Family Type					
Joint Family ®	133			30	25
Nuclear Family	98	0.250	1.284	23	30
Caste					
Others ®	71			24	32
OBC	110	-0.442	0.643	26	23
SC/ST	50	-0.106	0.899	34	30
Education of a woman/wife					
No Education ®	112			25	34
Up to 8th level	54	-0.613	0.542	24	22
Above 8th level	65	-0.656	0.519	34	21
Standard of living					
Low ®	59			25	27
Medium	81	0.609	1.839	32	41
High	91	-0.515	0.598	24	18
Woman's/Wife's work status					
Not working ®	194			28	28
Working	37	-0.141	0.868	22	25
Husband's nature of work					
Manual job ®	178			28	30
Non-manual job	53	-0.641	0.527	25	19
Media exposure					
No exposure to mass media ®	21			14	12
Exposed to mass media	210	1.077	2.937	29	29
Women's empowerment					
Low empowerment ®	165			27	30
High empowerment	66	-0.456	0.634	29	21
Residence					
Villages with low urban characteristics ®	116			23	21
Villages with high urban characteristics	115	0.659	1.933	31	34
Husband's workplace					
Within the village ®	139			27	39
Outside the village	92	-1.295	**0.274****	27	15
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	49			24	27
Visit relatives in urban areas	182	0.030	1.031	28	27
Constant		3.920	50.420		
% of husband's involvement	**27**				

®- Reference Category, -2 log likelihood = 146.553, Nagelkerke R Square = 0.602, Significance level- *** at 1%, ** at 5%, * at 10%; N= 231. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

Responses from men are explored regarding their desire for an additional child (**Table 5.5.7)**. Results depicted that only 27 percent of overall husbands have the desire for an additional child. The desire to have an additional child reduces with the increase in wife's age and number of living children. Wide gaps are seen for husbands with three or more children as compared to husbands with one child.

Logistic regression analysis is done further to understand the net effect of various background characteristics over husbands' desire for an additional child which is a dichotomous dependent variable here. The results illustrate significant effect of wife's age, number of living children, and husband's place of work. Odds ratio for men with two or more number of living children is low as compared to those with one child. In the case of older women and husbands who work outside the village, husband's desire to have an additional child is significantly lower. Being residents of villages with high urban characteristics do not show any significant effect on husbands' desire to have an additional child.

Net effect is also gauged by calculating the adjusted percentages of each category alongside unadjusted percentages to get a clear view of the situation in **Table 5.5.7**. This again shows that gaps by wife's age and number of living children are wide and even after controlling for other factors, they increase slightly. Men with three or more number of living children have lesser desire for an additional child as compared to men with one child; the adjusted percentages are 98% and 8% for men with one child and 3 or more children respectively. The effect of age of a woman and husband's place of work are also seen. For the place of residence (the variable of interest), the gap increases slightly from 23% to 31% (for the unadjusted percentages) to 21% to 34% (for the adjusted percentages) after other factors are controlled though the net gap is not significant.

The results are nearly identical after re-running the regression by replacing wife's education by husband's education as seen in **Table 7** of appendix. Again husbands of older women, men with two or more children and those working outside the village have lesser desire to have an additional child. When adjusted percentages are calculated, the gaps by wife's age, number of living children and husband's place of work slightly increases even after

controlling for other factors. The adjusted percentages are 38% and 15% for husbands who work within the village and those who work outside the village respectively.

Husband's desire for additional child- Insights from field study

Men reported to have a little higher desire for an additional child as compared to women who expressed that their husbands do not desire to have an additional child. Most women do not want to have more than two to three children and may have reported their own desire as the husband's desire as well. While men wanted at least two sons so that when one goes out of the village in search of a job, the other son could stay back home with the parents. Although things are changing due to urbanization, but son preference is still one of the major driving forces that still determine the number of children a couple desires to have. If the first born child is a son, then husbands who are young and living in villages with more urban characteristics usually do not want to have more than two children. In addition, husbands claim that now their aspirations have shifted from producing more children to providing quality education and better standard of living to a fewer number of children and look into the welfare of the family as a whole. A woman supported the idea that now-a-days people have higher aspirations like urban people and they understand the need for a small family size. She quoted, *"people now just do not depend on agriculture; they are going out in search of new jobs and they also send their girls to school. Now more children are studying and people, who can afford transportation, even send their children to study in schools located outside the village."*

A husband from village with low urban characteristics shared a similar feeling as the woman above. He said, *"people are now involved in agriculture and are doing other professional jobs also. Earlier we used to stay in the village, but now Delhi and Noida are very near, so we can easily go there." However,* another man from village with high urban characteristics expressed his feeling and said, "*People are marrying when girl attains 18 years and so are the boys when they reach marriageable age... After looking at growing inflation these days, thinking of people is changing... When we sit with good people we hear good things that will definitely change our outlook towards life…but still we need at least one son in the family."* This man particularly emphasized the preference for at least a single son in the family and expressed the views which prevailed in his community.

Nonetheless, with women's empowerment, things move both ways, either women do not want much involvement of husbands or they ask for their husbands' involvement. With the growing percentages of women considering their status as joint decision-makers, they are involved in making some important decisions at home. So, things have started appearing to change as the husbands take into account the opinion of their wife especially in the villages with more urban characteristics and do not neglect their wife's decisions anymore. However, narratives from above suggest that son preference is still a very important factor that influences a husband's desire for an additional child in the family. Husbands usually want at least two sons and a daughter, so that one son always remains with his parents and the other one could go out for work.

5.5.5 Husband's involvement in getting contraception- Regression analysis

While many women may desire to use contraceptive, procuring this on their own may have difficulties. Husbands can provide support in this situation.

Around 46 percent of husbands were involved in getting contraceptives for wife as seen from **Table 5.5.8**. Women with higher number of children demonstrate greater involvement of husbands in getting contraceptives for them as compared to women with one child. In addition, large differentials are seen by education of a woman, work status and women's empowerment.

TABLE-5.5.8: Involvement of husbands in getting contraceptive for wife (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in getting contraception	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	159			45	43
36 and above	79	0.378	1.459	48	52
No. of living children					
1 Child	25			20	12
2 Children ®	58	2.080	**8.002*** **	57	53
3 and above children	155	1.956	**7.068*** **	46	50
Family Type					
Joint Family ®	86			42	45
Nuclear Family	152	0.036	1.036	48	46
Caste					
Others ®	100			49	50
OBC	98	-0.417	0.659	45	40
SC/ST	40	-0.021	0.979	40	50
Education of a woman/wife					
No Education ®	95			36	37
Up to 8th level	79	0.294	1.342	47	44
Above 8th level	64	0.970	**2.638** **	59	61
Standard of living					
Low ®	51			37	46
Medium	118	0.090	1.094	45	48
High	69	-0.148	0.863	54	42
Woman's/Wife's work status					
Not working ®	188			41	41
Working	50	0.850	**2.339** **	64	62
Husband's nature of work					
Manual job ®	130			42	44
Non-manual job	108	0.169	1.184	50	48
Media exposure					
No exposure to mass media ®	32			28	30
Exposed to mass media	206	0.772	2.165	49	48
Women's empowerment					
Low empowerment ®	101			33	34
High empowerment	137	0.874	**2.396*** **	55	55
Residence					
Villages with low urban characteristics ®	120			42	44
Villages with high urban characteristics	118	0.121	1.128	50	47
Husband's workplace					
Within the village ®	129			38	41
Outside the village	109	0.452	1.571	55	52
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			30	38
Visit relatives in urban areas	195	0.412	1.509	49	48
Constant		-4.377	0.013		
% of husband's involvement	**46**				

®- Reference Category -2 log likelihood = 279.547, Nagelkerke R Square = 0.247, Significance level- *** at 1%, ** at 5%, * at 10%; N= 238. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

When the logistic analysis is carried out for thirteen independent variables keeping involvement of husband in getting contraceptive as a dichotomous dependent variable, the findings suggest that there is significantly more likelihood of husbands' involvement in getting contraceptives for their wife with increase in number of living children and wife's level of education. The odds ratio for women with three children and above is 7 times higher than women with just one child. The odds ratio for women with high education is twice as high for those with no education. Women's empowerment further enhances the chances of husbands' involvement in getting contraceptive for wife as odds ratio is high. Other factor such as wife's work status also influence husband's involvement and husbands of working women are more likely to get involved in getting contraceptive for wife. Various aspects of urbanization do not show any significant effect on husbands' involvement in getting contraceptive for wife.

To get a clearer picture of the net effects, adjusted percentages are presented along with unadjusted percentages in **Table 5.5.8**. This again shows that gaps by number of living children, and wife's education are wide when controlled for other factors. The gap narrows down slightly for work status of women from 41% to 64% (for the unadjusted percentages) to 41% to 62% (for the adjusted percentages). The net effect remains unchanged for women's empowerment and the adjusted percentages are 34% and 55% for women with low empowerment and women with high empowerment respectively.

When wife's education is replaced by husband's education to gauge the effect of socio-economic and demographic factors on husbands' involvement, the results are similar to the ones discussed above except for media exposure that shows significant effect on husbands' involvement when controlled for other factors (**Table 8** in appendix). The odds ratio for women who are exposed to media are twice as high as compared to those who are not exposed to any media. When adjusted percentages are calculated, the gaps by number of living children, wife's work status, woman's empowerment and exposure to mass media are wide and even after controlling for other factors, though they narrow somewhat, the gaps still persist.

TABLE-5.5.9: Involvement of husbands in getting contraceptive for wife (Responses from men)

Background Characteristics	Total no. of men	B	Exp (B)	Percentage husbands involved in getting contraception	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	150			13	14
36 and above	48	-0.416	0.659	13	10
No. of living children					
1 Child	-	-	-	-	-
2 Children ®	77			5	4
3 and above children	121	2.054	**7.803*** **	18	25
Family Type					
Joint Family ®	110			11	13
Nuclear Family	88	-0.005	0.995	16	13
Caste					
Others ®	61			13	8
OBC	98	0.861	2.365	14	17
SC/ST	39	0.605	1.831	10	14
Education of a woman/wife					
No Education ®	100			11	11
Up to 8th level	49	0.913	2.492	20	23
Above 8th level	49	0.039	1.040	10	11
Standard of living					
Low ®	53			11	8
Medium	69	0.360	1.434	13	11
High	76	1.152	3.164	14	21
Woman's/Wife's work status					
Not working ®	166			12	12
Working	32	0.732	2.079	19	22
Husband's nature of work					
Manual job ®	155			12	11
Non-manual job	43	0.707	2.027	19	21
Media exposure					
No exposure to mass media ®	19			21	38
Exposed to mass media	179	-1.549	**0.212***	12	12
Women's empowerment					
Low empowerment ®	145			8	9
High empowerment	53	1.424	**4.152*** **	26	30
Residence					
Villages with low urban characteristics ®	126			11	11
Villages with high urban characteristics	72	0.376	1.457	16	16
Husband's workplace					
Within the village ®	126			9	10
Outside the village	72	0.748	2.114	21	20
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			16	20
Visit relatives in urban areas	155	-0.654	0.520	12	12
Constant		-4.227	0.015		
% of husband's involvement	**13**				

®- Reference Category -2 log likelihood = 119.125, Nagelkerke R Square = 0.299, Significance level- *** at 1%, ** at 5%, * at 10%; N= 198. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12), Note: Men with 1 child are dropped from the analysis.

In the above **Table 5.5.9**, around 13 percent of the husbands were involved in getting contraceptives for their wife as reported by men. With the increase in number of children (men having 3 or more), there is greater involvement of husbands in getting contraceptives for their wife as compared to men with two children. Similarly husbands of women with high empowerment are more likely to get involved in getting contraceptive for the wife.

Since there is a greater possibility of association among background characteristics, logistic regression is done to assess the net effect of various socio-economic and background variables on dependent variable. Number of living children is the only demographic factor which shows a significant effect on husband's involvement in getting contraceptives for the wife. The results show that men with three or more children are more likely to get involved in getting contraceptives for their wife. Odds ratio for men with three or more children is 7 times higher as compared to those with two children. Further, odds ratio for husbands of women with high empowerment is four times high as compared to those with low empowerment. Additionally, husbands who are exposed to mass media are less likely to get involved in getting contraceptives for their wife. Moreover, villages with high urban characteristics do not show any significant effect on husbands' involvement in getting contraceptives for their wife.

When adjusted percentages are calculated to illustrate the net effects along with unadjusted percentages as given in **Table 5.5.9**, it is seen that wide gaps still persist for number of living children; the adjusted percentages are 4% and 25%. The same is true for women's empowerment and exposure to mass media. Furthermore, the net gap is not significant for the variable of interest mainly the villages with high urban characteristics.

The regression is also re-run by replacing education of wife by education of husband, and results are nearly similar to those discussed in the text above, except for standard of living that shows significant effect on husband's involvement in getting contraceptive for wife (**Table 9** of appendix). Husbands with high standard of living are more likely to get involved as compared to those who are from low standard of living. When adjusted percentages are calculated, the gaps by number of living children, standard of living and women's empowerment are wide and even after controlling for other factors they slightly increase; the

adjusted percentages are 6% and 24% for husbands from low standard and high standard of living respectively.

Involvement of husbands in getting contraceptive for wife- Insights from field study

There is wide difference in reporting among women and men. As shown in the tables above, mostly women reported three times higher involvement of their husbands in getting contraceptive for them. Women usually get male contraceptives from the health workers within the villages when their husbands encourage them to procure it, so men do not consider this as their engagement in getting contraceptive for their wife. Husbands only considered it as their involvement when they spend their own money or go to the health centre themselves to get contraceptives for their wife.

Most of the women responded that their husbands help them in getting contraceptive as compared to men themselves. Women did not go out to buy contraceptives on their own and basically were dependent on husbands to make it available for them. Mostly women reported that they used male methods as compared to female methods of contraception, probably out of convenience followed by sterilization (that does not require husband's help in making it available every day). During the fieldwork, many women also reported to have been using contraception without seeking their husband's permission, but they did not talk about this issue openly in the public. This suggests covert use of contraception by women. Men respondents did not count their involvement when they used male methods of contraception and thus they did not consider any help provided by them to their wife in getting contraception. Moreover, they also reported that their wife gets free contraceptives from the health workers which did not require husband's intervention in procuring contraception anymore.

A woman revealed a very important piece of information of how her husband encouraged her to get contraceptive from a health worker. She mentioned that it was difficult for the wives and husbands to go to the health centre and get any contraceptive, so many husbands encouraged their wife to get free supplies from the health workers residing in their village. She said, "w*omen in the villages have limited access to a health-centre and their mobility is also restricted. Mostly all the villages are connected by the highways and good roads, but it*

is very difficult for the walkers to go across these roads… so the husbands convinced their wife to get condoms from the health workers which are free of cost."

5.5.6 Husbands' involvement in decision-making on contraceptive use- Regression analysis

Often, women use contraception; in India and in many other populations, use by women is much more than by men. In such situations, a husband may get involved in decision-making about contraceptive use by the wife. In particular, the husband may encourage or discourage the use by wife. Overall, 42 percent of the husbands were involved in decision-making on contraceptive use by the wife (**Table 5.5.10)**. Large differentials are seen in contraceptive behaviour of husbands (whether the husband encouraged or discouraged use of contraception) by number of living children, family type, media exposure and women's empowerment.

Logistic regression result from **Table 5.5.10** provides information on the net effects of various background characteristics on contraceptive behaviour of husbands. The results indicate significant effect of number of living children, family type, exposure to mass media and women's empowerment on husbands' contraceptive behaviour. Odds ratio for women with two or more children are thrice as high as those for women with one child. Similarly, contraceptive behaviour of husbands of women who are exposed to mass media is more likely to get influenced as compared to those who are not exposed to any kind of mass media. The nature and place of work of husband do not affect significantly husbands' involvement in decision-making on contraceptive use. However, women with high empowerment are more likely to affect their husbands' contraceptive behaviour. Place of residence does not show a significant effect on husbands' involvement in decision-making on contraceptive use.

TABLE-5.5.10: Husbands' involvement in decision-making on contraceptive use (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in decision-making on contraceptive use	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	159			42	42
36 and above	79	-0.008	0.992	42	4 1
No. of living children					
1 Child ®	25			24	20
2 Children	58	1.195	**3.305****	48	45
3 and above children	155	1.149	**3.155****	42	44
Family Type					
Joint Family ®	86			47	52
Nuclear Family	152	-0.673	**0.510****	39	36
Caste					
Others ®	100			39	40
OBC	98	0.096	1.100	46	42
SC/ST	40	0.223	1.250	38	45
Education of a woman/wife					
No Education ®	95			40	49
Up to 8th level	79	-0.510	0.601	42	37
Above 8th level	64	-0.510	0.601	44	37
Standard of living					
Low ®	51			29	33
Medium	118	0.499	1.647	43	45
High	69	0.347	1.414	48	42
Woman's/Wife's work status					
Not working ®	188			38	38
Working	50	0.647	1.909	54	54
Husband's nature of work					
Manual job ®	130			38	39
Non-manual job	108	0.284	1.328	45	45
Media exposure					
No exposure to mass media ®	32			22	21
Exposed to mass media	206	1.134	**3.108****	45	45
Women's empowerment					
Low empowerment ®	101			31	30
High empowerment	137	0.845	**2.328*****	50	50
Residence					
Villages with low urban characteristics ®	120			38	41
Villages with high urban characteristics	118	0.040	1.041	45	42
Husband's workplace					
Within the village ®	129			37	38
Outside the village	109	0.364	1.439	47	46
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			26	29
Visit relatives in urban areas	195	0.664	1.943	45	45
Constant		-3.613	0.027		
% of husband's involvement	**42**				

®- Reference Category, -2 log likelihood = 288.768, Nagelkerke R Square = 0.181, Significance level- *** at 1%, ** at 5%, * at 10%; N= 238. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

In order to get a clearer understanding of net effect, the adjusted percentages are calculated and shown beside unadjusted percentages for each category. This again shows wide gaps by number of living children and family type and even after controlling for other factors, the gaps slightly increase. The net effect remains unchanged for women's empowerment and the adjusted percentages are 30% and 50% for women with low empowerment and women with high empowerment respectively.

After re-running the regression by replacing wife's education with husband's education, the results do not show much change and are similar to the ones discussed above (**Table 10** of appendix). Here also number of living children, family type, exposure to media and women's empowerment show significant influence on the contraceptive behaviour of the husbands. Contraceptive behaviour of the husbands from nuclear families is less likely to get influenced as compared to the husbands living in joint families. When adjusted percentages are calculated, it is seen that gaps by number of living children and family type are wide and even after controlling for other factors, though they narrow somewhat, the gaps still persist; the adjusted percentages are 52% and 36% for husbands in joint family and husbands in nuclear family respectively.

TABLE-5.5.11: Husbands' involvement in decision-making on contraceptive use (Responses from men)

Background Characteristics	Total no. of men	B	Exp (B)	Percentage husbands involved in decision-making on contraceptive use	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	181			40	42
36 and above	50	-1.190	**0.304****	20	18
No. of living children					
1 Child ®	33			27	15
2 Children	77	0.887	2.428	39	31
3 and above children	121	1.550	**4.711****	36	46
Family Type					
Joint Family ®	133			34	32
Nuclear Family	98	0.330	1.391	38	40
Caste					
Others ®	71			38	27
OBC	110	0.772	**2.165***	41	44
SC/ST	50	0.236	1.267	20	31
Education of a woman/wife					
No Education ®	112			24	28
Up to 8th level	54	1.114	**3.047****	50	54
Above 8th level	65	0.303	1.353	43	35
Standard of living					
Low ®	59			24	20
Medium	81	0.613	1.846	32	31
High	91	1.499	**4.478*****	46	52
Woman's/Wife's work status					
Not working ®	194			35	35
Working	37	0.155	1.167	41	39
Husband's nature of work					
Manual job ®	178			31	34
Non-manual job	53	0.321	1.378	49	41
Media exposure					
No exposure to mass media ®	21			33	65
Exposed to mass media	210	-1.325	**0.266****	36	33
Women's empowerment					
Low empowerment ®	165			25	27
High empowerment	66	1.405	**4.077*****	61	60
Residence					
Villages with low urban characteristics ®	116			23	24
Villages with high urban characteristics	115	1.113	**3.042*****	48	49
Husband's workplace					
Within the village ®	139			29	34
Outside the village	92	0.151	1.163	45	38
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	49			31	39
Visit relatives in urban areas	182	-0.206	0.814	37	35
Constant		-3.150	0.043		
% of husband's involvement	**36**				

®- Reference Category, -2 log likelihood = 232.158, Nagelkerke R Square = 0.352, Significance level- *** at 1%, ** at 5%, * at 10%; N= 231. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

Around 36 percent of husbands were involved in making decisions about contraceptive as reported by men (**Table 5.5.11**). With women's education there is greater influence on husbands' contraceptive behaviour as compared to uneducated women. In addition, wide gaps are seen in involvement of husbands in decision-making on contraceptive use by wife's age, number of living children, caste and standard of living. Place of residence significantly affects contraceptive behaviour of husbands.

As many of the background characteristics are possibly associated, logistic regression is carried out to assess the net effects on the dichotomous dependent variable. Contraceptive behaviour of husbands is chosen as a dependent variable with thirteen independent variables. The results show significant effect of wife's age, number of living children, wife's education and women's empowerment on contraceptive behaviour of husbands. Older women have significantly lower influence on husbands' contraceptive behaviour. In case of women with more three or more children odds ratio is 4 times higher than those with just one child. Odds ratio for educated women up to 8^{th} level is thrice as high as compare to uneducated women. However, place of residence significantly affects husbands' contraceptive behaviour, the odds ratio for husbands residing in villages with high urban characteristics are thrice as high as compared to those living in villages with low urban characteristics.

Furthermore, adjusted percentages are also calculated and presented alongside unadjusted percentages to get a greater understanding of the net effects of various background characteristics. The results are given in **Table 5.5.11**. This again shows that gaps by number of living children are wide and they increase after controlling for other factors. The effect of place of residence (which is a variable of interest) remains unchanged. Those men who are living in villages with high urban characteristics, their contraceptive behaviour is greatly influenced as compared to men from villages with low urban characteristics, the adjusted percentages are 24% and 49% for men living in villages with low urban characteristics and men living in villages with high urban characteristics respectively.

The regression is also re-run by replacing education of wife by education of husband and the results are nearly identical as those in the text above (**Table 11** of appendix). Wife's age, number of living children, caste, standard of living and women's empowerment significantly

influence on contraceptive behaviour of husbands. Men from villages with high urban characteristics are greatly influenced as compared to the men from villages with low urban characteristics as far as their contraceptive behaviour is concerned. When adjusted percentages are calculated, it is seen that gaps by wife's age, number of living children, caste, standard of living are wide, though they narrow somewhat, but still persist. The adjusted percentages are 25% and 48% for men living in villages with low urban characteristics and men living in villages with high urban characteristics respectively.

Husbands' involvement in decision-making on contraceptive use- Insights from field work

Husbands are involved in either encouraging the wife to use contraception or discouraging the wife to discontinue contraception. Women respondents consider that their husbands played a greater role in encouraging or discouraging the use of contraception. While for men respondents this question did not arise who largely reported using male methods of contraception.

Most women consider that their husbands played a crucial role in determining whether to encourage their wife to use contraception or discourage her. To use or disuse contraception depends on husband's inclination and preference, however, some women did claim that they used contraceptives, especially reversible female methods without communicating it to their husbands and if somebody enquired, they stated that it was their husband's will to use contraception.

The above intention of husbands was also confirmed by many health workers who were aware of the couple's preferences to use contraception by virtue of their work at the community level. Many health workers reported that most women find themselves helpless to make any decision on health and contraceptive per se as their husbands did not follow the advice given by these health workers because it is usually a man's domain to decide what he wants. One AWW from the village with high urban characteristics reported, *"when we speak to these village women, they say that they understand and agree to what we [health worker] tell them but all these things fall in the realm of men".* The health worker reiterated the words of a woman she recently met in the context of husband's contraceptive behaviour, *"it is the husbands choice that matters the most. If they [husbands] agree to what you [health worker]*

say only then we are able to comply by it…"And husbands usually do not follow everything you say." This statement reflects that husbands mainly make decisions on the use of contraception, but in many cases they are not the only ones, they also take into consideration wife's will also. In some cases where husbands do not support their wife, then a wife takes a lead and decides on her own to use contraception or disuse it even without informing her husband.

5.5.7 Husbands' involvement in getting sterilization services- Regression analysis

As has been noted, the common contraceptive method used is sterilization and that too of women since very few men undergo a vasectomy these days. But are men involved in securing sterilizations for wives? This involvement is explored in this section. This is to be noted that the regression analysis is for all respondents (women/men) with two or more living children since they are considered as potential acceptors of sterilization (women/wives with one child are not expected to undergo sterilization and none of such women were in the sample).

Overall 38 percent of the husbands were involvement in getting sterilization services (**Table 5.5.12)**. Wide gap is seen in the level of involvement for women with 3 and above children as compared to those with 2 children. Similarly, wide gap by wife's age, caste, education of wife are also visible. Additionally, large differentials are also seen by place of residence and husbands place of work.

Logistic regression results are obtained to assess the net effects of various background variables on the dichotomous dependent variable, i.e., husband's involvement in getting sterilization services. It is evident from the results that demographic factors such as wife's age and number of living children significantly influence husbands' involvement in sterilization. Odds ratio for women with older ages is 6 times high as compared to younger women. Likewise, odds ratio for women with three and above living children is four times high as those for women with two living children.

TABLE-5.5.12: Involvement of husbands in getting sterilization services (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in getting sterilization services	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	137			22	24
36 and above	76	1.877	**6.534*** **	67	67
No. of living children					
1 Child	-	-	-	-	-
2 Children ®	58			14	17
3 and above children	155	1.479	**4.388*** **	47	48
Family Type					
Joint Family ®	73			33	40
Nuclear Family	140	-0.112	0.885	41	37
Caste					
Others ®	87			33	34
OBC	93	0.805	**2.237****	47	54
SC/ST	33	-1.178	**0.308***	24	14
Education of a woman/wife					
No Education ®	91			52	50
Up to 8th level	74	-0.671	0.511	34	34
Above 8th level	48	-1.207	**0.299****	19	23
Standard of living					
Low ®	50			40	45
Medium	102	-0.335	0.715	39	37
High	61	-0.428	0.652	34	35
Woman's/Wife's work status					
Not working ®	166			40	38
Working	47	-0.079	0.924	32	37
Husband's nature of work					
Manual job ®	121			36	38
Non-manual job	92	0.048	1.049	40	39
Media exposure					
No exposure to mass media ®	31			42	33
Exposed to mass media	182	0.270	1.309	37	39
Women's empowerment					
Low empowerment ®	88			36	34
High empowerment	125	0.287	1.332	39	41
Residence					
Villages with low urban characteristics ®	110			45	49
Villages with high urban characteristics	103	-0.907	**0.404****	31	28
Husband's workplace					
Within the village ®	116			40	31
Outside the village	97	0.667	**1.948***	36	47
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	40			45	38
Visit relatives in urban areas	173	-0.021	0.980	36	38
Constant		-2.056	0.128		
% of husband's involvement	**38**				

®- Reference Category -2 log likelihood = 204.648, Nagelkerke R Square = 0.418, Significance level- *** at 1%, ** at 5%, * at 10%; N= 213. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12), Note: Women with 1 child are dropped from the analysis.

In case of women with higher education, husbands' involvement is significantly lower. Further husbands from OBC caste are more likely to be involved in getting sterilization services as compared to husbands from other castes. Husbands' involvement for women residing in villages with high urban characteristics is also lower as compared to those living in villages with low urban characteristics. However, husband's place of work shows significant effect on husbands' involvement in sterilization and husbands who work outside the village are more likely to get involved as compared to those who work within the village.

To get a clearer idea of the net effects, the adjusted percentages are calculated for each category and shown along with unadjusted percentages (**Table 5.5.12)**. This again presents that gaps by caste are wide and even after controlling for other factors, though they narrow little bit, they still persist. The adjusted percentages are 34% and 14%. The same is true for education of a woman and place of work of husband. Regarding the variable of interest namely place of residence, the gap widens little bit from 45% to 31% (for the unadjusted percentages) to 49% to 28% (for the adjusted percentages).

When the regression is re-run after replacing wife's education with husband's education, the results are nearly similar to those discussed above, except that husband's place of work has lost its significance in affecting husband's involvement in getting sterilization services (**Table 12** of appendix). Factors like wife's age, number of living children, caste, husband's education, and residence show significant effect on husband's involvement in sterilization. When adjusted percentages are calculated, it is seen that gaps by caste, husband's education and place of residence widen and even after controlling for other factors, gaps still persist. The adjusted percentages are 48% and 28% for husbands residing in villages with low urban characteristics and villages with high urban characteristics respectively.

As noted earlier in this section, this analysis is based on all women with two or more children who are considered as potential acceptors. But one could enquire into the involvement in case of those who had actually been sterilized. Out of 213 women with two or more living children, 87 had undergone sterilization as reported by women respondents. In 81 of the cases, there was involvement of husband. Thus, for those sterilized, husband's involvement was nearly universal.

TABLE-5.5.13: Involvement of husbands in getting sterilization services (Responses from men)

Background Characteristics	Total no. of men	B	Exp (B)	Percentage husbands involved in getting sterilization services	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	150			18	20
36 and above	48	-0.672	0.511	15	11
No. of living children					
1 Child	-	-	-	-	-
2 Children ®	77			9	8
3 and above children	121	1.392	**4.022****	22	26
Family Type					
Joint Family ®	110			14	16
Nuclear Family	88	0.176	1.192	22	19
Caste					
Others ®	61			18	15
OBC	98	0.444	1.559	19	22
SC/ST	39	-0.296	0.744	10	12
Education of a woman/wife					
No Education ®	100			17	17
Up to 8th level	49	0.232	1.261	20	21
Above 8th level	49	-0.239	0.788	14	14
Standard of living					
Low ®	53			15	12
Medium	69	0.577	1.780	13	20
High	76	0.496	1.641	22	19
Woman's/Wife's work status					
Not working ®	166			14	14
Working	32	1.283	**3.606****	31	38
Husband's nature of work					
Manual job ®	155			17	17
Non-manual job	43	0.082	1.085	19	18
Media exposure					
No exposure to mass media ®	19			26	38
Exposed to mass media	179	-1.183	0.306	16	16
Women's empowerment					
Low empowerment ®	145			12	14
High empowerment	53	0.875	**2.399***	30	28
Residence					
Villages with low urban characteristics ®	126			14	14
Villages with high urban characteristics	72	0.486	1.626	21	21
Husband's workplace					
Within the village ®	126			13	14
Outside the village	72	0.722	2.059	25	25
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			21	21
Visit relatives in urban areas	155	-0.309	0.734	16	16
Constant		-2.901	0.055		
% of husband's involvement	**17**				

®- Reference Category -2 log likelihood = 150.587, Nagelkerke R Square = 0.242, Significance level- *** at 1%, ** at 5%, * at 10%; N= 198. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12, Note: Men with 1 child are dropped from the analysis.

Nearly 17 percent of the men were involved in getting sterilization services (**Table 5.5.13)**. Wide gap is seen for men with 3 or more number of children as compared to men with 2 children. Furthermore, wide gaps are also seen by wife's work status and women's empowerment. With high women's empowerment, there is greater involvement of husbands in sterilization as compared to women with low empowerment.

Logistic analysis is done to assess the net effects of various backgrounds characteristics on the dependent variable because there is a possibility that background characteristics may be associated with each other. The results demonstrate significant effect of number of living children, wife's work status and women's empowerment on the involvement of husbands in getting sterilization services. Odds ratio for men with 3 or more children is four times as high as those for men with 2 children. Similarly, odds ratio for working women is thrice as high as those for women who do not work. Furthermore, husbands of women with more empowerment are more likely to get involved in getting sterilization services as compared to the husbands of those with low empowerment. Place of residence does not show any significant effect on husbands' involvement in sterilization.

The adjusted percentages are also given along with unadjusted percentages in **Table 5.5.13** to get a clearer idea of the net effects of socio-economic variables on the involvement of husbands in getting sterilization services. This again reiterates that gaps by number of living children are wide; the adjusted percentages are 8% and 26%. Gaps by wife's work status increases from 14% to 31% (for the unadjusted percentages) to 14% to 38% (for the adjusted percentages). However, the gap narrows down by women's empowerment. Further, for the place of residence which is the variable of interest, the net gap is not significant.

The regression is re-run again by replacing wife's education by husband's education; the results are almost similar to the ones discussed above. Again number of living children, wife's work status and women's empowerment significantly affect husband's involvement in sterilization (**Table 13** of appendix). The results for the adjusted percentages are also similar, there is a slight increase in the gap by wife's work status, and adjusted percentages are 15% and 37% for the wife who does not work and for the working wife respectively.

A total of 34 wives out of 198 had undergone sterilization as reported by men respondents and in all of these cases, there was involvement of husband.

Involvement of husbands in getting sterilization services- Insights from field study

Almost twice the number of women reported higher percentages of their husband's involvement in getting sterilization services as compared to men respondents. During the survey, it was felt that now women feel that they should take charge of their health, and they are the ones who ask for their husbands' support after getting the sterilization operation done and want to limit the number of children they want to nurture, while men respondents do not seem to be very particular about their wife's sterilization. They thought that women were getting the sterilization operations for a very long time and this was not something new which required their involvement. They heard about many family members earlier who underwent this operation with no or little complications. Generally women themselves were aware of what precautions to take as there were many cases present within the same village they are residing in. A quote of a woman from village with high urban characteristics said, *"husbands mainly feel that sterilization is a small operation, it just requires some rest once it is done. Moreover, women have been doing that very commonly, so they don't require much attention."* This quote supports the findings and reinforces the fact that men in villages with high urban characteristics do not pay heed or are little involved in the sterilization process.

In support to the above statement, one man gave his opinion why he did not get involved much once his wife got the operation done. He opined that, "w*omen have been getting the operation done, everybody gets it done in our village and everybody knows what precautions to take, if someone doesn't know then her peer would tell her what to do…"* so men are usually little concerned about the recovery of their wife. But some men do take extra care of their wife and take care of all the necessary precautions to be observed once their wife gets operated, though the number of husbands who are involved is very limited.

5.5.8 Husbands' involvement during wife's sickness

In the preceding sub-sections, various aspects of husband's involvement in wife's reproductive health were discussed. The respondents, both women and men, in the survey were also asked about the involvement of husband at the time of wife's sickness or at the time of RTI infection. Do they help out the wife in some way, such as taking her to the doctor, procuring medicines, giving rest etc. when she is sick?

Table 5.5.14 shows that 85 percent of husbands were involved in some way during their wife's sickness. Wide gaps are seen by caste and women's empowerment that significantly affect husbands' involvement during sickness.

Because many of the background characteristics are associated, logistic regression is carried out to assess the net effects of various explanatory variables on the dependent variable. The results show significant effect of caste and women's empowerment on husbands' involvement. Odds ratio for women from OBC is thrice as high for those from other castes. Husbands of women from OBC and from SC/ST are more likely to get involved in their wife's sickness as compared to others. The odds ratio for women with high empowerment is four time high as compared to women with low empowerment. However, the aspects of urbanization do not show any significant effect on husbands' involvement during their wife's sickness.

Net effect is gauged using adjusted percentages along with unadjusted percentages in **Table 5.5.14**. Results show that gap by caste is wide, and even after controlling for other factors, the gap increases. On the other hand, gap by women with high empowerment also increases slightly from 77% to 93% (for the unadjusted percentages) to 72% to 92% (for the adjusted percentages). The net gap for the variable of interest, i.e., the place of residence is not significant after controlling for other factors.

TABLE-5.5.14: Involvement of husbands during wife's sickness (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in wife's sickness	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	114			87	86
36 and above	55	-0.104	0.901	82	84
No. of living children					
1 Child	17			88	80
2 Children ®	37	0.798	2.222	89	90
3 and above children	115	0.262	1.300	83	84
Family Type					
Joint Family ®	116			86	83
Nuclear Family	53	0.638	1.893	83	90
Caste					
Others ®	60			77	69
OBC	72	1.029	**3.349****	90	88
SC/ST	37	2.043	**7.713****	89	94
Education of a woman/wife					
No Education ®	85			80	82
Up to 8th level	50	0.307	1.360	88	86
Above 8th level	34	0.806	2.238	94	91
Standard of living					
Low ®	51			76	76
Medium	118	0.890	2.434	89	88
High	-	-	-	-	-
Woman's/Wife's work status					
Not working ®	136			85	87
Working	33	-0.619	0.538	85	78
Husband's nature of work					
Manual job ®	109			82	82
Non-manual job	60	0.731	2.077	92	90
Media exposure					
No exposure to mass media ®	27			70	81
Exposed to mass media	142	0.339	1.403	88	86
Women's empowerment					
Low empowerment ®	81			77	72
High empowerment	88	1.565	**4.782*****	93	92
Residence					
Villages with low urban characteristics ®	88			84	89
Villages with high urban characteristics	81	-0.608	0.544	86	81
Husband's workplace					
Within the village ®	94			80	78
Outside the village	75	1.051	2.861	92	91
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	42			71	77
Visit relatives in urban areas	127	0.708	2.030	90	87
Constant		-2.082	0.125		
% of husband's involvement	**85**				

®- Reference Category -2 log likelihood = 107.395, Nagelkerke R Square = 0.323, Significance level- *** at 1%, ** at 5%, * at 10%; N= 169. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12), Note: Women from high standard of living are dropped from the analysis.

The results are re-run after replacing wife's education by husband's education. The results are nearly similar to the text above. Again caste and women's empowerment significantly influence husband's involvement in wife's sickness (**Table 14** of appendix). Odds ratio for men from OBC caste is thrice as high for those from other castes. Husbands from OBC caste and from SC/ST castes are more likely to get involved in their wife's sickness as compared to husbands from other castes. When adjusted percentages are calculated, the gaps by caste and women's empowerment are wide and even after controlling for other factors, they increase slightly. The adjusted percentages are 68% and 94% for the husbands from other castes and husbands from SC/ST castes respectively.

In case of results based on men's responses, it is observed that involvement of men is nearly universal; almost 98 percent of men were involved during their wife's sickness. Further analysis of unadjusted and adjusted percentages is not carried out, first, because there is universal involvement of husbands during their wife's sickness. Second, because there are no observable differences between the two percentages (unadjusted and adjusted) for the background characteristics.

Involvement of husbands during wife's sickness- Insights from field study

Women respondents reported to have less involvement of their husbands during their sickness as compared to men respondents. Women's dependency over men has decreased tremendously since women either receive help from AWW and ANM or the ASHA worker. These women also go to the nearby health facilities due to increased availability of transportation and road connectivity especially in villages with high urban characteristics. Thus women are able to commute on their own. In addition, men's awareness and attitude towards their wife's health has also changed. Men reported that generally women procrastinate in seeking health-care for them and use home based medications until the emergency arises. Men also felt that women need a push from their husbands or male counterparts; and they actually do not take a prompt action when it comes to seeking health-care for them. Women in most cases actually tried to avoid seeing the doctors by giving excuses that their condition did not need any intervention, it would improve on its own and they end up using home remedies. This practice is not just limited to villages with low urban characteristics, but is also followed in villages with high urban characteristics. However, in villages with low urban characteristics, women's negligence towards health affected them

more because of lack of proper facilities of transportation to commute and consult a doctor. A woman from a village with low urban characteristics reported, "i*t is important to note that women need a push from their husbands or male counterparts; they actually do not take a prompt action when it comes to seeking health-care for them. They actually try to avoid seeing the doctors by giving excuses that their condition does not need any intervention, it would improve on its own, this is not necessarily in the rural domain, but occurs too in the urban set up also. In rural areas, it affects more because of lack of proper facilities to commute to the health-centre and consult a doctor."* Another woman said, *"Women procrastinate seeking health-care for self and use home-based medications until emergency arises…"*

On the other hand, a man opined, *"people [men] understand small things and issues and difficulties and pay heed to what their wife say, they take their wife to the doctors…"*Another young man from a village with high urban characteristics said, *"Women have to take charge of their health, they are the one who convey about their ill health and communicate it to their husbands. Women have to learn to raise their voice and raise an alarm and demand good health for themselves. This effort of women should be in conjunction with their male partners' support."*

Thus the above quotes reflected that a woman is expected to act responsibly towards her health and needs to inform her husband when she feels sick and requires medications. Many a times, it is not that a husband is insensitive and does not want to help his wife out; but it is the lack of communication or many a times miscommunication between them that lends up into a woman suffering in silence for a long period of time. So women have to be aware of not neglecting their own health until the time it is too late.

5.6 Discussion

The analysis of the data from the researcher's field survey in the Gautam Buddha Nagar district as well as the analysis at the state level from NFHS-3 data reveal that there are differences in overall involvement of husbands' in women's reproductive health as reported by both women and men from the different households of the selected villages. In trying to understand the reasons behind differences in women and men responses, it is crucial to understand the perspective and behaviour of women and men separately. It is difficult to draw conclusions by ignoring the gender differences at the conceptual level as both women and men have different sets of expectations from each other. Women may perceive one kind of involvement of their husbands more important, while men may not hold the same opinion like their wife on the same kind of involvement and have totally different expectations and ideas attached to it. So in order to highlight the differences at the individual and at the gender level, an effort was made in this chapter to understand the nuances of husbands' involvement in various kind of support they extend to their wife related to health per se. This was done by critically analyzing each type of involvement while situating it within the socio-economic and demographic context and especially exploring the effect of urbanization and changes it brought about in the value system attached to reproductive health and husbands' involvement.

In the present research which intersects between husbands' involvement and different aspects of urbanization at the village level, mostly the results present a scenario where, at the gross level, women and husbands from villages with more urban characteristics are better informed and involved in making reproductive health decisions such as husbands supporting wife and proving pregnancy, delivery and post-delivery care. However, there are obvious differences at the reporting levels, where women tend to state higher involvement of their husbands as compared to men themselves, mainly because the attitude and expectations differ and so are there reporting levels.

Results from multivariate analysis bring out the differences in the reporting levels very clearly and also mention the factors that affect husbands' involvement at various levels in their wife's reproductive health. Various aspects of urbanization such as place of residence, husband's place of work and visiting relatives from urban areas do show significant effect on some indicators of husband's involvement. Likelihood of husband's involvement in delivery

care significantly increases when they visit relatives from urban areas. Place of husband's work outside the village also raises the chances of husbands getting involved in providing post-natal care and helping wife in getting sterilization services. However, the variable of interest, i.e., place of residence has a pronounced effect only on the involvement of the husbands in decision-making about contraceptive use and also in getting sterilization services. It demonstrates that husbands from villages with more urban characteristics actively participate in encouraging wife or discouraging wife to use contraceptive. Some other social indicators like education of a wife or the husband along with women's empowerment stood out to be the most important variables affecting husband's involvement.

Thus results from the field survey clearly demonstrate that different aspects of urbanization affect husband's involvement only for a particular kind of engagement, while other socio-economic and demographic variables play a greater role in influencing husband's involvement. The reason behind this is that almost all the villages in the Gautam Buddha Nagar district are connected by roads and have access to health-care centres. Moreover, people residing in villages with high urban characteristics and villages with low urban characteristics are also aware of information available on health. The difference in their behaviour arises due to the change in the social structure at the village level. It was observed that in villages with high urban characteristics a couple usually makes decision on the family size and husbands seem to be actively engaged in taking care of their wife, here nuclear family has become the primary unit as compared to joint family in the villages with low urban characteristics. Husbands have taken up non-manual jobs that have fixed working hours as compared to manual jobs such as engagement in agriculture which requires a fulltime attention, so the onus of providing health-care to the wife falls on the other family members and not just the husband. The testimonials given by the health workers also reveal similar situations on the ground level.

The next chapter throws light on how the health workers are managing different aspects of reproductive health and the challenges they meet while working within the villages. Also how they address and overcome the difficulties help in understanding the nuances of women's reproductive health within villages with low urban characteristics and villages with high urban characteristics.

CHAPTER –6

PERSPECTIVES OF HEALTH WORKERS ON MEN'S INVOLVEMENT IN WOMEN'S REPRODUCTIVE HEALTH-CARE

CHAPTER-6

PERSPECTIVES OF HEALTH WORKERS ON MEN'S INVOLVEMENT IN WOMEN'S REPRODUCTIVE HEALTH-CARE

The present research tries to examine men's involvement and decision-making processes on women's reproductive health. In the previous chapters, responses from both women and men are analysed to understand the role of various socio-economic and demographic factors on men's participation and involvement in the villages with low urban characteristics and villages with high urban characteristics. This chapter looks at the nuances of men's involvement in women's reproductive health-care from the lens of health workers who work at the grassroots level, and live in the settings similar to the population they cater to. This is expected to complement the information obtained from women and men interviewed in the survey as the health workers are closely engaged with the population especially in matters of reproductive health and observe and interact with couples in the villages. For this purpose, some health workers from the study villages were interviewed and their perspectives on men's involvement, the nature of involvement, reasons for involvement and non-involvement were recorded. A qualitative approach was adopted as the purpose was to obtain their perspectives and views. Health workers from the study villages were contacted for this and interviewed subject to their availability. As no probability sampling as such was done, no statistical analysis has been performed here. Instead, narratives have been used to have a deeper understanding of men's involvement. The Auxiliary Nurse Midwife (ANM) or the female health worker, the Accredited Social Activist (ASHA), and the Anganwadi Worker (AWW) are the principal health and nutrition providers at the village level. It may be noted that there are hardly any male health workers in villages these days, as the positions of male health workers are not being filled and almost all the grassroots health workers are female. A total of 25 health workers (16 Anganwadi Workers-AWW, 8 Auxiliary Nurse Midwives-ANM and 1 Accredited Social Health Activist-ASHA) were interviewed ensuring that at least 10 health workers are interviewed from each set of villages, i.e., villages with low urban characteristics and villages with high urban characteristics. The survey-instrument for these interviews had both closed ended and open ended questions, allowing narratives to be recorded, pertaining to their observations on husband's involvement in the wife's reproductive health.

The duties and the roles of the grassroots workers (ANM, ASHA and AWW) overlap since all of them work as 'team leaders' of the village health team. The roles of ANM include providing reproductive health services in rural areas (antenatal care, delivery services, post-natal care and family planning and contraceptive counselling). They are also responsible for providing Iron and Folic Acid tablets, injections- Tetanus Toxoid, and work as skilled attendants at birth of a baby. Moreover, ASHA is responsible for encouraging institutional delivery, facilitate referral care, and motivates newly married women and men (with recent delivery) to use family planning. They also assist ANMs in immunization and in special social mobilization camps (Ministry of Health and Family Welfare, 2012:83). The Anganwadi workers (AWWs) come under the auspices of the Integrated Child Development Schemes (ICDS), an initiative taken up by the Central Government in 1975. It is one of the world's largest community based outreach programme that offers a package of health, nutrition and education services to the children below 6 years of age and pregnant and nursing mothers. An anganwadi serves as a focal point for the delivery of services covering a population of about 1000 in both rural and urban areas (Sandhyarani and Rao, 2013:1277). Roles and responsibilities of AWWs include working close to the community, making home visits for educating parents and providing information, education and counselling on breastfeeding, nutrition education during and after pregnancy, and also motivating couples to adopt family planning methods thus running the programme smoothly with the participation and support from the community. They also assist the ANM in the distribution of IFA and Vitamin A. They are also engaged in guiding the ASHAs under Rural Health Mission in the delivery of health-care services (Sandhyarani and Rao, 2013:1279-1280). Though the AWWs are not part of the Department of Health (they are covered by the Ministry of Women and Child Development), given their role in nutrition services and association with the ANMs, they are involved in the health services as a whole.

6.1. Background characteristics and work profile of the interviewed health workers

Table 6.1.1 provides the background information of the health workers interviewed in the survey. A majority of the health workers who were interviewed were over 35 years of age, and have work experience of less than 10 years. However, most of them did have education above high school level.

TABLE-6.1.1: Background of health workers

Background information on health workers	Number of health workers
Age of health-providers	
Up to 35 years	8
Above 35 years	17
Place of work	
Villages with low urban characteristics	12
Villages with high urban characteristics	13
Education of health-providers	
Up to High school	8
Above High school	17
Years of work experience	
Up to 10 years	14
Above 10 years	11
Total no. of health workers interviewed	**25**

Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

After getting the background information, the health workers were asked questions on the type of issues they usually cover when talking about health-care to both women and men. Six health issues were identified: maternal health-care during pregnancy, family planning, safe sex, RTIs/STIs, menstrual regulation/abortion/post-abortion care, and health and nutrition education. Additionally, the information on various age groups is also noted to get a sense of a range of ages covered by these health workers. **Table 6.1.2** reveals that majority of the health workers effortlessly discussed all the six health issues with women in all the reproductive age groups and almost everyone mentioned the middle age groups, i.e. between 20-34 ages for women. Though many did discuss these with men, this was not as common as discussing with women; this is understandable since reproductive health issues are closer to women than men and the interviewed health workers are all women. The argument they provided in support of 20-34 age group is that even young and married women and men (below 20 years) are very immature to understand the complex issues of care during pregnancy, family planning, Reproductive Tract Infections and health and nutrition education. These providers found it very easy to discuss all such issues of health with little older population who were usually of their age group. Moreover, these health workers easily convey their messages to women of older ages who already have two to three children, but sometimes these women were also little reluctant in listening to their advice.

TABLE-6.1.2: Information given by the health workers to women and men by age groups

	Information given to women by health workers			Information given to men by health workers		
	Age Group			Age Group		
Issues that are covered by health workers	**Below 20 years**	**20-34 years**	**35 and above years**	**Below 20 years**	**20-34 years**	**35 and above years**
Maternal health -care during pregnancy	18	25	23	7	17	8
Family planning	17	25	23	7	17	8
Safe sex	16	24	21	6	16	6
Reproductive Tract Infections/ Sexually Transmitted Infections	16	20	18	6	14	6
Menstrual regulation/ abortion/ post-abortion care	20	23	21	6	14	6
Health and nutrition education	20	23	21	7	15	8
Total no. of health workers interviewed	**25**					

Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

Speaking to older men about health-care issues pertaining to women is always challenging to the health workers because these men are generally older than the health workers. Moreover, these health workers who are "women" themselves and generally belonged to the same village and considered themselves as the daughters-in-law of the village; felt very shy to talk about health and sexuality issues to these men. However, some health workers who have been working on the ground for more than 10 years reported that they did not feel shy either talking to older women or older men. They considered conveying information on health and sexual issues to the community as their utmost priority and responsibility and bother less about their own social position within the village.

During the survey, when questions were posed about the mode of transferring information to both women and men by these health workers, they answered that they usually considered organizing group meetings of women or men to disseminate information on health-care issues (**Table 6.1.3**). In a group meeting, it is very easy for them to usually communicate the pressing issues of health and sexuality without any hesitation. Nearly half of them agreed to providing information to individual man or a woman.

TABLE-6.1.3: Mode of giving information

Information disseminated through	Number of health workers
Individual Man	12
Individual Woman	14
Couples	6
Group of Men	5
Group of Women	24
Meetings	11
Other means (Specify)	1
Total no. of health workers interviewed	**25**

Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).
Note:- Due to multiple responses, the numbers add up to more than 25.

Furthermore, a question related to the kind of training received by the health workers was asked. This is a very relevant issue to explore as many of these health workers reported that they have not received any training on how to transfer information to men who constitute an integral part of couple counselling. **Table 6.1.4** depicts that almost all of the health workers received training on providing information related to pregnancy, followed by delivery care, family planning, safe sex. Since only about half of the health workers reported to have received any kind of training on gynecological problems, abortion and abortion care, STDs, these issues which contribute toward the major reasons for high maternal mortality in Uttar Pradesh get least attention and coverage by the health workers as they lack proper training to handle these areas.

TABLE-6.1.4: Training received on different areas of health-care

Issues	Number of health workers who received training in the special issues of health-care
Care during pregnancy	25
Delivery care	24
Gynaecological problems	17
Family Planning	23
Abortion care	14
Post Abortion care	14
Safe sex	21
Sex education	19
STD	13
HIV	20
Total no. of health workers interviewed	**25**

Source:- Survey conducted in Gautam Buddha Nagar District (2011-12)

6.2. Issues of counselling

Counselling is one of the core areas covered by health workers at the grassroots level. It helps to build a relationship of trust and faith between the health workers and their beneficiaries. It is a way in which women and men communicate their fears directly to the health workers which they have in their minds related to reproductive and sexual health issues. Moreover, counselling lays the foundation of proper psychological development of expectant mothers and fathers by educating them to take proper care of the developing foetus so several questions on counselling were asked to these health workers such as what type of people they counsel, whether they provide counselling jointly to couples or is it done separately. Additionally health workers were also asked to give their opinion and feedback if they have witnessed any changes in certain behaviour and practices of both women and men. The **Table 6.2.1** shows that all the health workers provided counselling on pregnancy care to expectant mothers and on family planning/contraception to married women. Around two-thirds of the health workers also took pains to counsel the husbands of the expecting women. Most of the health workers agreed that they counsel couples on dual protection who already have two children. Talking to married men separately again appears to be a daunting task for the health workers in terms of providing counselling them on family planning and sexual issues.

TABLE-6.2.1: Counselling given by health workers to women and men

Counselling given on	**Number of health workers**
Pregnancy care to expectant mothers	25
Pregnancy care to husbands of expectant mothers	20
Family planning/ contraceptive use to married women	25
Family planning/ contraceptive use to married men	15
Use of contraceptives to unmarried women	4
Use of contraceptives to unmarried men	2
Use of contraceptives to newly married couples to avoid early birth	14
Dual protection to couples with two children	23
Reproductive Tract Infection to married women	20
Reproductive Tract Infection to married men	10
No. of health workers interviewed	**25**

Source:- Survey conducted in Gautam Buddha Nagar District (2011-12)

Moreover, counselling married young couples on the use of contraceptives to avoid an early birth also appeared to be another difficult area to be addressed by these health workers. Generally young couples are expected to start their family soon after their marriage, and

counselling them about the contraceptives in the beginning of their married life is not welcomed by the community members. People perceived this action of the health workers an attempt to limit fertility and family size of the young couples. Besides some of these practical problems faced by health workers, health workers lack enough training on combating issues of Reproductive Tract Infections, so counselling given by them to both women and men is very limited.

Very few health workers reported to have counselled unmarried women and men on contraceptive use, mainly because it is a taboo to discuss contraception before marriage and health-providers did not feel comfortable talking about such issues to unmarried people. Only in some cases where either a young unmarried woman or a man approaches with certain questions in mind, health workers helped them to clarify those doubts or direct them to proper channels of information.

TABLE-6.2.2: Joint counselling provided to the couples

Issues	**Number of health workers**
Ante Natal check up	24
Pregnancy	23
Post pregnancy care	23
Use of contraception	22
Infant care	23
Total no. of health workers	**25**

Source:- Survey conducted in Gautam Buddha Nagar District (2011-12)

Many health workers were very comfortable talking to couples on various issues of health-care and providing joint counselling to them, especially when they went for home-visits and were not interrupted by the other family members of the households **(Table 6.2.2)**. Almost all the areas of reproductive health from antenatal check-ups to pregnancy care, post pregnancy care, infant care were very well covered by the health workers. Use of contraception was again a less talked about topic compared to other topics, but still health-workers provided counselling to couples on that as well.

TABLE-6.2.3: Opinion of health workers on joint counselling given to the couples on contraceptive use and family planning

Opinion on counselling given to the couples on contraceptive use and family planning	Number of health workers who agreed
May encourage safe sexual behaviour	25
Will reduce the numbers of unwanted pregnancies	25
Would result in healthy child birth	25
Would reduce risk of RTIs	17
Would reduce the risk of gynaecological problems	25
Total no. of health workers interviewed	**25**

Source:- Survey conducted in Gautam Buddha Nagar District (2011-12)

Questions pertaining to the opinion of health workers on joint counselling were further explored to understand what kind of behavioural changes in the couples were expected by them after counselling has been done, i.e., what is the output of the effort they were making on ground to convince the couples (**Table 6.2.3**). Mostly health workers agreed that counselling to the couples on family planning would encourage safe sexual behaviour, and would result in the reduction of unwanted pregnancies. As a result of this, there would be proper spacing between births; fewer babies will be born resulting in the birth of a healthy child. However, it was difficult for them to comprehend how counselling would help to reduce the risk of RTIs, since health workers themselves have a limited exposure on this issue, although they understood the importance of counselling in reducing gynecological problems. It is crucial to understand in which contexts these health workers operate. In the next section, the barriers, problems and situations they were exposed to in the field are explored on the basis of their verbatim replies and narratives which were transcribed by the researcher.

6.3. Findings from the interviews: difficulties encountered by the health workers when addressing reproductive and sexual health issues and solutions to those problems

Some in-depth questions were asked to the health workers who worked very close to the community they lived in and their verbatim responses were analysed to understand the potential barriers they faced in providing information to both women and men (married) on reproductive health issues. The analyses of these responses are very useful to understand the context in which health workers operate. It is important to understand, for example, how health workers think the communities they live in respond to the issue of women's health? Whether involvement of men is increasing at the village level? How do the community

members respond to the services these health workers provide them? Whether people support these services or not? These are some of the questions that this section tries to address.

6.3.1 Addressing issues to married women

One of the first questions asked from these health workers during the field survey was on the difficulties they encountered while addressing issues related to sexual health amongst married women. Many health-workers talked openly about their field experiences and how women responded to them and also reported problems encountered by them. The principal difficulties faced by them are noted here.

1) <u>Lack of trust and faith in the services of health workers</u>

Many anganwadi workers both in the villages with low urban characteristics and high urban characteristics reported lack of trust and faith in them. This is the most significant issue that they encounter. In both types of villages, the elderly woman of a household was always suspicious about the information these health workers would provide to their daughters-in-law, who were usually very young. Mothers-in-law were very protective about their daughters-in-law and wanted to check the content of information beforehand.

> *"Generally girls get married by the age of 19 or 20 years, and we try to educate women up to the age of 49 or 50 years…With the help of women's association "mahila mandal ke madhayam se" we try to inform women. We also have a lot of material with us like books and materials on reproductive health, posters also… But there are very few men and women who show trust in us, they always think and say that we keep on talking about such things (reproductive health issues) since this is our task. Some women understand what we do easily but men do pose a problem"* ***(AWW from the village with low urban characteristics).***

> *"In majority of the cases, older women of the households want us to talk to them directly and not to their daughters-in-law. They want to get the crux of our talk beforehand and want to be sure about the content of our talk. These mothers-in-law themselves want to educate their daughters-in-law on similar topics and so they want to gain firsthand information from us. They consider us as outsiders and so we have to take their permission first, explain the reason for visiting them. Older women also feel insecure that these health workers from outside would criticize and would provoke their daughters-in-law against them. They prefer that their young daughters-in-law remain within the confines of the household and do not get exposed to what is happening in the outside world"* ***(AWW from the village with high urban characteristics).***

2) Inhibition in front of mother-in-law

The second obstruction faced by these health workers is their own inhibition to talk freely in the presence of mothers-in-law. Many health workers who did not have much field experience and were young found it awkward and uneasy to communicate to daughters-in-law in the presence of their mothers-in-law.

> *"Usually the mother-in-law accompanies the pregnant woman to the health centre. They feel that we are sitting idle, we do not have anything constructive to do, they do not want their daughters-in-law to listen to our useless talk. So first we have to convince the mother-in-law very carefully that "mother if you do not take all this information seriously, then your daughter-in-law will face many problems in the future when she will conceive and she could also develop some complications. If you follow our advice then your daughter-in-law will have easy and safe delivery. Then the counter question by mother-in-law is that is it something new, we also gave birth in our days, they (my in-laws) never sent their daughter-in-law alone, and they always assisted them.*
>
> *We always ask mother-in-law to send their daughter-in-law on every Saturday because we distribute supplementary food to them, mother-in-law would say no we don't want to send our daughter-in-law. We still try our best to convince mothers-in-law. When I started this few years back, at that time I felt quite hesitant in talking in front of the mothers-in-law as it was very difficult to convince them, but since then, there is a lot of improvement, people are more aware, now more and more women come and even unmarried girls also come to us"* ***(AWW from the village with low urban characteristics).***

Mostly the health workers expressed their despair that due to a mother-in-law's suspicious behaviour, it was at times difficult to carry out their work smoothly. On the other hand, health workers also reported improvement over the years as people are more informed and comprehend things easily.

> *"When we visit their homes, it is a bit difficult to convey our message to pregnant women because their mother-in-law is always tensed; they are concerned about what the health worker is going to tell her daughter-in-law. If we call them for the meeting at our centre, then the daughters-in-law easily understand what we are saying, else at home we also feel some inhibition and daughters-in-law are also not willing to sit and share their time and views with us. We tell mother- in- law that we have to give nutritional supplement to these pregnant women, or somebody has come from the government, and so we want you to meet them, only then they send their daughter- in- law"* ***(AWW from the village with high urban characteristics).***

3) Hesitation to talk in front of husbands of women

Many health workers admitted that they did not talk to women on health issues when their husbands were around in the household and felt hesitant in discussing reproductive health topics.

> *"Usually we cannot talk to husbands, so we educate wives to tell their husbands about reproductive and sexual health issues. Women say that there is nobody at home who could educate them, they say "we just want to eat, do everything [produce children] make merry, and remain carefree." Moreover, we cannot chase their husbands in order to educate them, so we tell these women to have faith in your husband and once he will have faith in you, he will take care of your health"* ***(AWW from the village with high urban characteristics).***

4) Lower education of women

Education plays an important part in deciphering the messages that these health workers want to convey to the women of their community. Health workers came across a variety of women in the villages. Some women understood and followed the information very easily, while took time to process information as many of them were uneducated. Thus, education limited the understanding of these women who were unable to get the messages across and in turn they were not able to benefit from the advice of these health-workers. Some workers remarked that many women were less intelligent (described as with less brain) to understand the issues on health.

> *"We always treat other women like us, but they are less intelligent and they are unable to follow our instructions properly. Some women do not even follow what their husbands tell them, some say ok we will follow what you tell us to follow for the sake of their health and life without scrutinizing it"****(AWW from the village with low urban characteristics).***

An AWW talked about uneducated women and said it was not easy to pass on information to illiterate women or expect them to follow everything that was conveyed to them. There job was to educate them, but whether they were able to understand or not is least of their concern. They said, "…we cannot just sit with them every day to make them understand the issues of health."

"They are under the control of their husbands. Educated women are able to follow what we say, and many people [husbands] have this "thinking" that they do not follow the advice of their wife. Illiterate women do not understand in one go, they will ask their neighbours, relatives, mother-in-law whether it is ok to follow what Anganwadi didi (sister) is saying or not" ***(AWW from the village with high urban characteristics).***

"Our role is to give the information and now it is up to them to understand or not…we try to make them understand as much as we can. Especially in case of uneducated women, no woman would even complain that she is not able to get the content of the talk or have difficulty understanding certain thing…they simply keep nodding their heads" ***(ANM from the village with high urban characteristics).***

5) <u>Miscellaneous difficulties faced by health workers</u>

Asking for medicines

Women generally approach the Auxiliary Nurse Midwife (ANM) in case of sickness for medicines. Most women from the villages were aware that ANMs got medicines free of cost from the government. When ANMs refused to give medicines, they got into trouble with these women.

*"We get medicines from the government. A lady came to ask for some fever medicines from me, so I said, no I cannot give this medicine to you and she started fighting with me, "why can't you give fever medicines to me." My concern is that what if these women give the fever medicines to small kids; this would be very harmful to them. So we say no to them and they get angry on us and complain that you do not give us medicines. We get syrup for smaller kids and tablets for older people"****(ANM from the village with high urban characteristics).***

Institutional delivery

Most ANMs question that when the government is providing facilities free of cost for delivery to these women, why still most of the women they work with prefer delivering their babies at their home. One of the ANMs from a village with high urban characteristics gave the below statement

"ASHAs go with everybody, they provide all sorts of help and when government is giving facility then why people are not availing it? We do not get any benefit from pregnant women, we are still willing to go, but people think since ASHA gets the money, she insists on institutional deliveries" ***(ANM from the village with high urban characteristics).***

Shy Women

Some women shy away and did not like to discuss issues of sexually transmitted diseases in public or with the ANMs or AWWs. They liked to change the topic of discussion by pretending to know everything about STDs and RTIs.

"When we tell ladies about STD and STI, they say we already know about all this. They question us, "Do we call you to discuss all this?" Some do not want to listen to what we say, some say we have heard about it...some shy away and do not make eye contact and some who do not have any difficulty, they carefully listen to what we say" ***(ANM from the village with low urban characteristics).***

<u>Solutions suggested by health workers to overcome the above mentioned problems</u>

Besides an array of problems encountered by the health workers while counselling women, a few of them did discuss about the ways to overcome some of the problems stated before. Here are some success stories.

"We weigh the pregnant ladies, it is very important to take the weight to check the development of the baby, we also tell husbands above 35 years how to take care of the wife, or else we tell these ladies to inform their husbands about the issues we spoke to them" ***(AWW from the village with low urban characteristics).***

"We also inform women about various other health issues. On every Saturday, we call a meeting of all pregnant women, give them nutritional food, tell them about benefits of Iodine, Iron folic acid tablets, vitamin A, and when do they have to go for the check-ups. Regarding informing the husbands, whenever we visit homes of these pregnant women, we inform their husbands there itself; we do not call a meeting of the husbands though. We do this every week. Generally when we are talking to their wife, husbands also come and sit with us and listen to what we are saying, so it is a kind of giving information to husbands as well" ***(AWW from the village with high urban characteristics).***

"We get a formal training and every month we have a meeting where we get training of how to explain health issues to men and women, we also get materials such as informative books which have all the information in them, so we publicly talk in the meetings to explain various health issues to women. We also get posters. Some educational materials which we do not have, we borrow them from

ASHA which we use sometimes to explain about health" ***(ANM from the village with low urban characteristics).***

"We also tell wives about the dual protection in order to space children or not to have any more conceptions, or to avoid future conceptions…" ***(ANM from the village with high urban characteristics).***

The above mentioned stories narrated by ANMs and AWWs from villages with low and high urban characteristics reiterate the fact that there are various measures that these health-workers are taking in order to get the message across to married women and their husbands. Whether it is counselling a couple, calling for meetings, convincing mothers-in-law, getting training on counselling, using various education materials, many of these health-workers make every possible effort to keep women of their community healthy despite facing many difficulties on the ground.

6.3.2 Addressing reproductive health issues to married men

The next issue discussed with these health-workers is related to men and their responses towards the wife's health, husband's concerns regarding reproductive health in general. Like in the case of women, an exploration of the difficulties faced by the health workers when they encounter married men while addressing reproductive health is made. Although the health workers do not have to educate men separately on women's health issues, during the field survey an effort was made to get their reflections on whether and how men responded to women's health issues in order to get insights of men's involvement and participation in their wife's health. Certain factors which made it difficult for the workers to discuss reproductive health matters with men are listed here.

1) <u>Inattentive husbands</u>

Many health workers narrated that usually husbands did not give much attention to the details of information given to them on reproductive health issues. Only a handful of husbands who listened to the health workers very seriously, acted according to the advice given to them.

"Some husbands do not listen to us, we have to tell them again and again. They listen to us only by constantly feeding them with information. We tell them to listen to us with a cool head. Some husbands listen to us very seriously and also act accordingly" ***(AWW from the village with low urban characteristics).***

2) <u>Mismatch in health workers' age and men from the villages</u>

Now-a-days, young husbands are found to be more attentive and they participate when the health workers visited their homes. They usually showed their interest in their wife's health. Even the health workers felt free to communicate with young husbands. But when it comes to imparting information and knowledge to older men, health workers who were generally daughters-in-law of the same village feel shy. The social convention is such that they cannot question or ask older men to listen to their advice as they use veil in front of them. They were also hesitant in communicating with older men as they were not comfortable in talking to them in public. In a rural setting, women of younger ages do not talk, argue or give advice to older men, so it becomes a complicated situation for health workers to ask for men's participation in women's reproductive health issues especially when men are older to them.

> *"We can educate men who are of our age; we cannot speak in front of the older men because we veil or cover our head in front of them* ***(AWW from the village with low urban characteristics).***

> *"Those men who are older to me, I do not talk to them as I am not comfortable talking to them. So I only give information to their wife, while those who are younger to me they easily grasp what I am trying to tell them. I am not sure whether they follow my advice or not once they get the information. I cannot sit at the anganwadi centre for the entire day, I leave after 2 p.m. daily"* ***(AWW from the village with low urban characteristics).***

One of the health workers also agreed that she only talked to men of her close family, relatives and who were younger to her.

> *"No, I do not talk to men about these issues, I talk only to those who are close relatives and that too younger to me, and I only give information to them only. I am very new to this place, so I am not familiar with everybody and moreover, men do not come to the anganwadi centre to collect information from me"* ***(AWW from the village with high urban characteristics).***

The health workers also suggested that if the government wants to engage men in women's reproductive health, then the government should appoint some male health worker who would be able to address the issues of reproductive and sexual health. A quote that highlighted the hesitation of an anganwadi worker while talking to men of her village,

"The biggest difficulty is that we are the daughters-in-law of this village, if we make people understand then others will say "look at the daughter-in-law of such and such, she is openly talking about such (sexual) issues without any shame" and this becomes a matter of discussion in the entire village. "His wife has become so bold, she talks to every men like this." This is the entire problem, so we also feel inhibited in talking to men [husbands] in public" ***(AWW from the village with high urban characteristics).***

3) Education of the husbands

One of the basic factors that influenced husbands' participation in women's health is education. Health workers stressed on the role of education and seriousness of husbands' participation in understanding the health issues. They also insisted that willingness of husbands to listen to them and follow their advice were important factors that determined future steps husbands would take to ensure good health of the wife.

"Some men are uneducated, some feel shy, some do not trust us, and some feel that this is our daily job to talk about reproductive health and they do not take it seriously. But still many men come to talk about all this" ***(AWW from the village with low urban characteristics).***

A quote from an ANM who said,

"Even though men are educated they lack the willingness to listen and follow what we tell them. Some educated men who take interest in their wife's health would approach us and ask us questions pertaining to their concerns regarding their wife's sickness or pregnancy conditions" ***(ANM from the village with low urban characteristics).***

4) Lack of interest and concern

Another difficulty that health workers revealed was the lack of interest and concern of husbands in the wife's health. Men generally did not participate in any meetings conducted by these health workers, but some of them come and sit along with their wife to understand the conversation and in this way indirectly gain some information from the health workers. However, those men who wanted the wife and family to remain healthy; they engaged better with the health workers and asked questions pertaining to health.

"Men do not usually come to our meetings, may be just one will come once in a while otherwise mostly ladies come. No men listen to us willingly, when their wives sit with them and when we educate their wives they also sit along and listen to some things that we convey to their wives; otherwise it is quite difficult to make men understand. Men are educated here, but still they have the rustic touch in them. Only those men who are concerned about wife's health and their children's health do take pains to collect information from us" ***(AWW from the village with low urban characteristics).***

5) <u>Only those (men) who love their wife care for them</u>

The discussion on love and emotional attachment came up in many villages with high urban characteristics. Health workers frequently mentioned about the loving relationship between a couple and the intent of men in these relationships to care for the wife's health needs.

"Some husbands understand and listen to us carefully when we talk to them about reproductive health issues such as pregnancy and family planning and they are willing to do what we ask them to do" ***(AWW from the village with high urban characteristics).***

"Those who love the wife; they are willing to understand without creating any fuss about it. They say that "my wife will suffer then I will also suffer seeing her in pain," so they understand that they have to help their wife ***(AWW from the village with high urban characteristics).***

6) <u>Peer pressure and societal arrangements</u>

Health workers spoke about the societal arrangements that did not allow husbands to willingly help the wife in her crucial days of pregnancy. It is very interesting to note that a health worker from a village with high urban characteristics talked about peer pressure and a husband feeling insulted when helping his wife in daily chores. A local unerstanding that prevails in such villages is that a woman who does not work during pregnancy ends up having a cesarean baby or a delivery with complications. With growing caesarian sections even in the villages, husbands buy this argument very easily without enquiring into the details about caesarian sections.

"This is due to societal arrangements that husbands are not able to solve their wife's problems, like they should help in their wife's work when she is pregnant. If he helps her, then his peers would make fun of him, "see he is doing female's task" then the husband gets discouraged and he does not help his wife. Husbands think that their peer would make fun of them "he is his wife's servant" or sometimes they feel insulted doing their wife's job. They do not understand the importance of helping their wife, so that she will have an easy delivery and she would be out of any danger or complication. She will only cook, wash clothes, press clothes, look after in-law. Husbands think that if wife does all the work, she will not have any problem/complication during delivery" ***(ASHA from the village with high urban characteristics).***

7) <u>Husbands approach only when problem arises</u>

A very unique feature of many villages with high urban characteristics was that husbands approach the health workers when there was crisis in their home. Husbands come to them especially when something goes wrong despite consistent efforts made by these health workers to convince them to take good care of the wife. Such husbands then understand the importance of guidance and counselling provided to them by these health workers.

*"If the wife has some problem then her husband frequently approach us and ask for our help, opinion and guidance that such and such problem has occurred in our house, what should we do now?****(ANM from the village with high urban characteristics).***

"Some husbands are those types who once have a bad experience, only then they understand the value of our counselling, but by then it is too late" ***(AWW from the village with high urban characteristics).***

8) <u>Problem of alcoholism</u>

Villages with high urban characteristics were phenomenally facing this problem of alcoholism that is increasing at a very fast pace. People in these villages have received compensation money from the government in lieu of land acquired by the government. This sudden influx of money in the village economy has prompted increased consumption of alcohol, domestic violence and abuse of wife. This matter was raised by an anganwadi worker who thought that dealing with alcoholism had become a difficult task within her village.

"Women complain that their husbands drink alcohol and do the mistake (which results in conception) and then realize later on. So many cases of domestic violence, wife abuse have come up in the village and dealing with the situation like this is a daunting task" ***(AWW from the village with high urban characteristics).***

6.4 Addressing the issue of husband's involvement for ANC visits

Ensuring quality ANC visits is one of the key issues addressed by the reproductive health programme in India. It aims at promoting ANC visits, especially in rural areas where women have limited access to health facilities. Health workers at the village level are the major drivers in promoting ANC check-ups by women, thus question on how women's health could be improved when husbands accompany the wife for the ANC visits was asked from them. This is done, first to understand the existing scenario in the villages with low urban characteristics and villages with high urban characteristics, and second to know the opinion of these health workers about engaging husbands in ANC visits (whether husband's involvement would encourage women seeking more ANC visits or not).

1) <u>Nuclear families</u>

When the health workers were asked what kind of practice existed in their community regarding ANC visits, a few of them reported that they see young men accompanying the wife to the health centres for the ANC check-ups. These husbands, especially living in nuclear families, made decisions about accompanying their wife to the health centre and even took interest by asking questions to the health workers on the progress of the pregnancy.

"Yes, we have seen many husbands coming along with their wife; those who are now living in nuclear families, always assist their wife to the health centres. Especially those men who are little educated, who go out and see the world, and sit in a good society/company are actively participating these days. Young men understand the importance of everything and now they come along with their wife to the health centre and even take care of their wife at home also" ***(ANM from the village with high urban characteristics).***

2) <u>Husbands make arrangements if they are unable to accompany their wife</u>

Health workers also told that many husbands ensure that somebody accompanied the wife for the ANC visit when they were unable to come along with them. Husbands demonstrated concern by requesting either ANMs or AWWs to go with their wife to the health centre in some cases where they could not be present due to some engagement elsewhere.

> *"It is like the husband goes along, make consultations with the doctor when his wife has some issue, he gets the medicine, even requests us to go along with his wife to the doctor when he cannot go himself. Many people give us the money that if the government doctor is not available then take my wife to a private doctor, we also help many people where the family members are not able to afford at that moment, so we provide some monetary support to those women thinking that we can collect from them later on…"* ***(ANM from the village with low urban characteristics).***

3) <u>Husbands take interest in health issues and spread awareness</u>

Some husbands showed interest in assisting their wife to the health centre for the preliminary tests such as blood tests and ultrasound and they requested the ANM or ASHA if they could be present with their wife. Health workers also felt that when husbands showed their involvement, they gained knowledge on various health issues which they shared with the peer group. This helped to spread awareness about reproductive health amongst the community members.

> *"Many a times we take pregnant ladies for ultrasound, blood tests and all, but when husbands want to accompany them, then we advise them to get these tests done for their wife, whether it is breech birth or not"* ***(ASHA from the village with low urban characteristics).***

> *"Yes, husbands who take interest in their wife's pregnancy can also guide others, his peers, and provide them information on various health issues"* ***(AWW from the village with low urban characteristics).***

4) Husbands listen to what doctor advises them and do not trust their wife

Question of trust arises when husbands are absent at the time of health check-ups. Many health workers reported that some husbands did not trust their wife or listened to what their wife said. Thus they eventually failed to understand the necessity of rest or providing better nourishment to their wife during pregnancy and post-delivery. This situation could only be improved when more and more husbands increasingly accompanied their wife for the health check-ups. At the health centre, doctors targeted the husbands, they made them understand about their wife's requirement for rest and good nutrition and husbands also agreed and followed the advice of the doctors.

> *"Husbands are least moved by what wife tell them, so when they go along with their wife they will listen to what the doctor is saying who specifically target the husbands, then they get moved and think deeply about their duty as a husband. Suppose if a doctor advises a woman to take bed rest and she comes back home and tell her husband what the doctor has advised her, then her husband will not trust her, but if the doctor convey the same thing in front of the husband then he listens to it seriously. Like when a woman has her delivery, when doctor says she will not work for 2 weeks and will take rest with the baby, then the husband agrees to it. They call their mother or sister or any other relative to help their wife after the delivery. Some husbands say, she will take rest and I will work instead, they are ready to help on their own. We have witnessed that when the doctor says what to do and what not, it has a very positive affect on husbands"* ***(ANM from the village with high urban characteristics).***

> *"Yes, if husbands assist their wife then it is better, because on several occasions women forget some information given by the doctor on their way back home. If men are with them they would help to retain that information and can supplement to it. There is also a credibility issue, some men might think that his wife is making up things and asking him to provide proper nourishment during pregnancy, so it is important that husband also has confidence in his wife, so if he comes along then he knows that this is something not made up by his wife, but advised by us [health workers]"* ***(ANM from the village with high urban characteristics).***

6.5 Addressing the issue of involving husbands to improving women's health in general

When health workers were asked how a woman's health could be improved by involving her husband in general and what should be done in order to persuade husbands in women's health issues, several concerns and explanations were shared by the health workers.

1) <u>When husbands take better care of their wife and will provide emotional support to her, health will improve</u>

In their conversations, the health workers emphasised on involving husbands and other family members in taking care of the pregnant women. They said when husbands understood the requirements of their wife, they informed other family members of her needs, especially those who were responsible for providing better nourishment and care to the wife, i.e., her health will improve once the entire family gets involved, and she remains healthy during her pregnancy.

> *"Yes, it would help, because husbands stay at home and if they take care of the wife, then wife will also take better care of herself. This is so because husbands will make other members of the family understand in a better way and then others will also take good care of her, especially taking care of food, nourishment, rest etc. so automatically wife will remain healthy, and her essential needs will be fulfilled by the family members"**(AWW from the village with low urban characteristics).***

2) <u>More awareness</u>

Things will only improve when husband's awareness level increases about his wife's health increases so that he will know what steps he should take in a situation where his wife needs medical care. Health workers emphasised the fact that when a husband become aware, he usually spread and share this information with his peer group and would encourages other husbands to take necessary steps in improving their wife's health.

> *"When the issues such as safe abortions (when the wife go for abortion and the couple do not want another child, when women have reproductive tract infections) will be discussed with the husbands, then the occurrence of cervical cancer will reduce and other health complications can be curtailed" **(AWW from the village with high urban characteristics).***

Health workers also told that many husbands took initiative in gaining information on place of delivery, proper diet, and they also accompanied their wife for the check-ups. When husbands got involved to this extent in ensuring safe deliveries, women tend to remain healthy.

> *"Husbands of pregnant women ask us where their wife's delivery should take place. They also gather information on proper diet, indeed they show more interest than wife, and many a times their mothers tell them the place of delivery. Husbands also go along with the wife for the antenatal check-ups* ***(AWW from the village with high urban characteristics).***
> *For general health also we appeal to husbands that when the wife is anaemic, get her blood test done routinely, take care of her dietary intake, we also inform that in the government hospitals, iron tablets are available free of cost, give them green vegetables… we tell them they do not have to feed their wife anything expensive, one type of lentil is enough, but she has to regularly consume that. She should not take any fried food* ***(ANM from the village with high urban characteristics).***

3) <u>Empowering women</u>

Health workers encouraged women to ask their husbands and shared their feelings when they were suffering from some health issue. They prompted women to inform their husbands about their health requirements and asked their husbands to intervene whenever necessary.

> *"Suppose a woman is in labour while going to the hospital requires something, and then she can ask her husband to bring that and her husband would get that for her. We also tell that she should not suffer behind the doors, we tell them to come out and discuss about their problems with their husbands. Now-a-days husbands accompany their wife at the time of delivery to the hospitals"* ***(AWW from the village with high urban characteristics).***

6.6 Addressing the issue of maternal mortality

The whole aim of this research is to understand the ways in which men act as supportive partners in women's reproductive health. It is crucial to understand the participation of husbands and their knowledge about reproductive health issues of their wife. Second, by knowing whether men give attention to health issues, the problem of maternal mortality could be addressed in a better way (here) in the context of urbanizing villages. Thus a series of questions from the health care providers were specifically asked to health workers on how

educating men regarding women's reproductive health issues could actually curb maternal mortality. It is very interesting to note that these health-workers knew the importance of engaging men in women's reproductive health and they made consistent efforts to inform, and make men more and more aware about these issues.

1) Husbands are the major decision-makers

Many health-workers have reported that now husbands made decisions on where to conduct the delivery. They did not listen to what other members of the family said. Largely husbands took the wife either to the government health facility or to a private hospital for the delivery.

> *"These days husbands are the major decision-makers in their households. Both men and women are equally aware about health these days. In our village, it is not that people are not aware of the things, for delivery they either go to public or a private hospital only. There are very few home deliveries. Whether rich or poor, here everybody prefers to deliver in a hospital"* ***(ANM from the village with high urban characteristics).***

2) Support from the community: people are willing to help in need

Health workers working in villages with low urban characteristics frequently found that members of the community came forward to help those who were in need, in whatever way they could, be it lending money to them at the time of financial crisis or helping with the transport especially around delivery time.

> *"Women who need some consultation from a doctor, we take them to Noida hospital (the government hospital in the district), there is transportation available here. We provide some assistance to those who cannot bear the expenses, but in time of need, everybody is willing to help. Nobody says no to it. Those who deliver in a government facility, they get the incentives from the government, but those who deliver somewhere else do not get anything"* ***(ANM from the village with low urban characteristics).***

3) Timely treatment

It is a well-known fact that receiving timely treatment helps to reduce maternal mortality. By giving more information to the husbands, health workers felt that women will no longer suffered in isolation. Men they spoke with, have become more sensitive to their wife's requirements at the time of pregnancy and delivery.

> *"When husbands will take care of their wives' treatment, and will secure more information on these issues, women [wives] will get all the tests done; this would help to treat all their ailments"* ***(AWW from the village with low urban characteristics).***

> *"When we provide information to the husbands, only then maternal mortality can come down, timely and routine check-up is necessary. What happens is that at the time of delivery, women generally suffer from prolonged labour, there is loss of blood also but still husbands say delivery will take place at home. So when the husbands are aware and they know that they have to take the wife to the hospital while she is in labour, only then the mortality can come down. In the rural context if a woman is in labour for many days, an untrained dai (birth attendant) is called, and she convinces the family that birth can take place at home and this at times results in complications during delivery"* ***(AWW from the village with high urban characteristics).***

4) Health workers scold husbands to persuade them

Sometimes scolding husbands could also result in engaging them in their wife's health. Health-workers, who have established themselves well in the community, use their influence to persuade husbands to take proper care of the wife and sometimes even scold them. However, it was not that easy to persuade elderly men, when the health worker herself could not engage with elderly men independently.

> *"People, who do not follow our instructions, get scolding from us." We say "we told you earlier, if you do not take precautions then this thing would happen, we have to tell them to send their wives to the hospital in cases of emergency"* ***(AWW from the village with low urban characteristics).***

5) Emotional support and persuasion by husbands

To overcome maternal mortality, health workers usually tell the husbands that women need emotional support besides other essential things. They expressed that at this crucial time,

women felt lonely and helpless, especially when they had to go out for check-ups. So health workers urged the husbands to arrange somebody who could accompany their wife.

> *"Because husbands take better care of their wife, they will take her to the doctor on time, for check-ups. Wives cannot go alone, especially at this critical time when they need emotional support, they consider themselves weak and helpless and need somebody's support to take care of their needs. Here in the village, it is very difficult to get the antenatal check-up done and at least three check-ups are mandatory during pregnancy, so they have to go out of the village to get that done. We do keep IFA tablets in our centre from the ANM so that if some pregnant woman asks for it, she doesn't have to go far looking for them. The nearest sub-centre is also 2-3 kms. far from here; they have to even cross the highway which is difficult for the walkers to cross on foot."*

> *"Yes the maternal mortality will come down, if the husband is involved in his (wife's) health, he knows about her sickness, involved in every misery of hers, her condition will definitely improve. If he knows, what is his wife doing for the entire day? What are the problems she is facing, then the situation will definitely improve"* ***(AWW from the village with low urban characteristics).***

6) <u>Health workers convince husbands to go for institutional deliveries</u>

Husbands are constantly reminded by the health workers to consider institutional delivery over home delivery. They also inform them that birth attendants were not qualified to conduct delivery at home, that they had minimal experience of handling deliveries after working with doctors as assistants in their clinics. Health workers informed husbands especially from lower class that their wife would receive better care in government hospitals, in addition to getting financial support from the government.

> *"Some people want that delivery should be conducted at home, but we always tell them that you will not be able to maintain hygiene and give proper medicines on time, if required. You will get all sorts of attention and facilities in a health- care centre that would be able to save both mother and the child. We also tell that if you are thinking of conducting the delivery at home, first the dai (birth attendant) will not be trained, here mostly we find untrained dais, they have been assisting doctors for many years, so have gained some experience. Earlier we used to have trained dais, but not now.*
> *Another thing is that, if the mother and child stay in these unhygienic surroundings, there are more chances of contracting infections. In the hospital, she will receive better care. Some people who are not that well off, and are unable to provide facilities and food to their wife, such women will certainly get much more attention in the hospital, and will get better care. Women also get check-ups done from the government on 3rd or the 4th day after the delivery and*

also receive some kind of financial support from the government" ***(ANM from the village with high urban characteristics).***

7) <u>Husbands go to the hospital only in cases of emergency</u>

On the issue of maternal mortality, it was observed that health workers played a key role in informing husbands about regular health check-ups of their wife. These workers knew that in many instances women suffered from prolonged labour pain and also demanded their husbands to rush to the hospital only when the labour pain reached its pinnacle. In such circumstances, both mother and the child are at higher risk of losing their life.

"A woman suffers for a long time at home, husbands and mother-in-law are convinced by the dai that the delivery can be conducted at home. Nobody wants to go to the hospital then. But when the things go out of control and wife cannot bear the pain, and then she is rushed to the hospital. In some cases it happens that the baby dies in his mother's womb because of suffocation or any other complication. If a particular pregnant woman is a caesarean case, then also she is suffering at home when nobody consults a doctor, so such kind of a woman dies. Thus husbands should take their wife for check-ups during pregnancy, so that they may know about any unforeseen complications that might arise in the future or at the time of delivery. And also husbands get to know about the due date from the doctor, if by then the baby is not born, then they should again take their wife for check-up and enquire about the situation. Only then maternal mortality can be curtailed ***(AWW from the village with high urban characteristics).***

6.7 Some stories from the health workers about prevailing situation and husband's engagement in reproductive health

Even though health workers who worked in the villages faced several problems and difficulties, they were very persistent in their effort to make a difference in the lives of the women. Despite many problems reported by health workers in both types of villages, there were a few positive features that point towards a change in men's perspective and behaviour and their engagement in women's reproductive health concerns.

Health workers tried to convince the husbands to take better care of the wife at the time of pregnancy by constantly coaxing them, reminding them of the health check-ups, and most

importantly making the elders of the family understand the importance of healthy mother and a healthy child.

> *"If they [husbands] don't listen to us, first we try to make their family members understand that why this information on health is so crucial, then we try to bring in the husband* ***(AWW from the village with low urban characteristics).***

Health workers have consistently made efforts to open up with the male members of the society by telling them the importance of good health and why husbands' contribution is important for a healthy pregnancy and family planning.

> *"Yes, they are willing to understand, we do not feel shy, this is not an issue to be shy of, so people (husbands) are willing to hear us these days and also share their concerns with us. We go for the home visits and when we find their husbands, we tell them "look at your wife, she is so thin, you are not taking care of her seriously, you need to understand the importance of good health during pregnancy. You have to timely get her immunized, get all the tests done on time"* ***(AWW from the village with high urban characteristics).***

Awareness amongst the husbands, especially from the villages with high urban characteristics on women's reproductive health issues is high and those who are young take prompt actions in taking their wife to the doctors as there are many options available to them within their vicinity these days.

> *"Earlier nobody was bothered to talk about their wife, but now many are aware and they ask questions to us. Young husbands do not listen to their parents now; they take their wife for the check-ups and to the doctors when they find her sick"* ***(ANM from the village with high urban characteristics).***

An anganwadi worker shared a success story during the field survey where she persuaded a very poor lady to take charge of her life and become economically independent.

> *"One lady with three children, two of them were tidy and one was very dirty and looked weak, came to the anganwadi centre and said her husband left her at her parents' place and brought her back now. She was grieving that today my kids did not even have tea, what to talk about milk. She borrows money from others to feed her children. I told her that people are working on the construction site of the highway, we will take care of your two kids at the anganwadi centre and you work there at the highway. Whether your husband agrees to it or not, you start working*

there. Once you start working you can at least take better care of your kids and feed them properly."

So if a woman like this comes to our place, we guide them according to the present situation and tell her, "Do not think that husband would go and earn for you and feed you. Take charge of your life, you have to be financially independent first." Women are afraid that their husbands would hit them if they get to know that she is working, but we tell her to politely explain to the husband when he is not drunk that you have to work and be independent" ***(AWW from the village with high urban characteristics).***

One health worker from a village with low urban characteristics shared her experience from the field and said that in her area, deliveries generally took place in the hospitals. Women were very keen at being immunized and immunizing their children on time, and they themselves took the initiative of asking these health workers when they were going to visit their neighbourhood next time.

"Now-a-days deliveries are conducted in the hospitals, pregnant ladies get immunized. Women are willingly getting immunized; they also give polio drops to their kids, now they themselves ask us when the doctor/ANM is going to come for immunization, TT injections. Even before we tell them about the date, they would approach us and enquire from us. The situation is such that if we are walking through their locality, they will ask when ANM didi (sister) is going to come for immunization and check-ups" ***(AWW from the village with low urban characteristics).***

During the field survey, there was a mother-in-law who mentioned that her daughter- in- law had first child through caesarean and second child was delivered at home under medical supervision. The reason she cited for this was that whenever they took her to the hospital her pains stopped. She said,

"Whenever we took her to the community health- centre, her pains stopped, we took her there twice. Later we asked a doctor to come to our home, she administered some injections, gave her glucose drip and the baby was born at home without caesarean" ***(ANM from the village with high urban characteristics).***

Moreover, many health workers have also documented a change in the attitude of present day mothers-in-law. They said that these days, mothers-in-law were concerned about the health of their daughter-in-law and their grandchildren. Mostly the educated ones were already aware of what measures to take to ensure good health of the mother and the child, and those who

were uneducated assisted their daughters-in-law and listened to the health workers and took their advice. This situation holds true for both the villages with low urban characteristics and the villages with high urban characteristics.

> *Many mothers-in-law take a lot of interest and listen very seriously what we explain to their daughters-in-law. Now the things have changed, the way earlier mothers-in-law used to do, now the new age mothers-in-law are not doing the same things, they understand the things and take them very seriously and also take appropriate steps. They take care of their family, kids and also their daughters-in-law. They are pretty aware of the surroundings, they want their kids to be healthy and so their daughters-in-law. Many illiterate mothers-in-law are also very good, just one or two may be bad, otherwise mostly are good. But only thing is that they are not willing to send their daughters-in-law alone, they will always come along, and assist them and take the guidance first. They do not trust us, they always think that we might tell their daughter-in-law something against them, or something unwanted, so the old ladies are afraid of those things. So when we ask the daughters-in-law to come to the association/meetings their mothers-in-law either do not send them or come themselves to collect the supplementary nutrition or else would come along with their daughter-in-law. And they enjoy listening to us and sometimes takes it as a joke, make fun of us also"* ***(AWW from the village with low urban characteristics).***

Besides sharing their experiences about the role of mothers-in-law, these health workers also told how the attitude of husbands have changed in the present scenario and what kind of care they extended to the wife. Earlier, husbands used to get involved only when there was an emergency situation, but now-a-days they are more informed, involved and listened to these health workers, and so fewer cases of mis-happenings are reported each year.

> *"Earlier husbands never used to get involved so much until the time things/ situation aggravated. Mothers-in-law are also well informed about their daughters-in- law and take interest in their health. Earlier it was like the way mothers-in-law have delivered their kids at home, their daughters-in-law will deliver similarly, but now, we have very few cases of still birth or babies dying after birth. It is now that if we get a case in one year we also get worried why this has happened; we also go and ask them when your delivery took place in the hospital then how come your baby expired? What was the problem with the baby, although we go and tell them ourselves, that if you are going to deliver, arrange the things before time…some ladies even counter question us that you yourself delivered at home then why are you asking us to go to the hospital? Why so? So we tell them what we have faced why do you want to face similar situation, you should opt for better options…"* ***(ANM from the village with low urban characteristics).***

"We still get many cases where ladies do not listen to us, we can only tell them, but we cannot feed them or coax them. There was a case where a pregnant woman was not coming to get the TT injection for the first time, so we had to bring her forcefully, she was so much afraid of the injections. So I had to send my helper, literally pushed her to come here…She said, "I am afraid of the injections," so I told her, you are not afraid of delivering a baby but you are afraid of the injections…" ***(AWW from the village with low urban characteristics).***

Health workers constantly made an effort to convince husbands to use the medical facilities available around the village, be it private or government health facility.

"I told husbands to take their wife to Nithari (where there is a government hospital), if you cannot take her to a private facility take her to a government facility then when we have the facilities around our village ***(AWW from the village with low urban characteristics).***

6.8 Perceptions of the health workers on husband's involvement

Thus, it is evident from the testimonials given by the health workers during the field survey that husbands are actively getting involved in their wife's reproductive health, more so in villages with more urban characteristics, and are aware of wife's health requirements. Health workers mentioned a number of challenges they encountered while working within the community. There are some unaddressed problems that husband and wife face when it comes to access health-care facilities. Health workers still feel that husbands are not acting responsibly towards many health issues such as institutional deliveries (many husbands still considered it unnecessary and do not encourage wife to go for institutional delivery), taking wife to the health-centre in case of illness, etc. However, they have stated that the young generation is more aware and taking positive steps to improve the quality of health of their family, especially the wife and the children, they cater to their needs as promptly as possible. Moreover, due to increased access to health-care facilities now-a-days, it has become easier for women to utilize the services; however, the situation is a little different for those residing in villages with low urban characteristics. Although things have improved a lot and are not that grim at the moment as there are apparent changes in the behaviour, perceptions, and engagement of husbands, health of the women does not get enough attention it deserves. To overcome this, women also have to be responsible towards their health and should not neglect it anymore.

CHAPTER –7
SUMMARY AND CONCLUSIONS

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7.1 Introduction

Prior to the International Conference on Population and Development (ICPD, 1994) in Cairo, the population programmes were women-centric and excluded men especially in reproductive health matters of the women. It is for the first time that in 1994 gender inequalities in patriarchal societies and inclusion of men in reproductive health were talked about. Men who play a crucial role in making reproductive health decisions have to be integrated in the population programmes to have good reproductive outcomes for women. The Programme of Action adopted by the ICPD lays stress on developing innovative programmes to make information, counselling and services for reproductive health available to adolescents and men (UNFPA, 1996:48). The main objective was to involve and engage men to share more equally the responsibilities in family planning, domestic and child-rearing responsibilities and to prevent sexually transmitted diseases. The programme also emphasized to involve women in leadership roles, family planning, decision-making, management, implementation, organization and evaluation of services (UNFPA, 1996:48). It also appealed that both women and men have access to information, education and services that are required to achieve good sexual health and they are able to exercise their reproductive rights. The Programme of Action also called for "responsible sexual behaviour, sensitivity and equity in gender relations," it underlined that when these are instilled at early ages; it helps to enhance and promote respectful and harmonious partnerships between men and women (UNFPA, 1996:56). Moreover, India's Population Policy 2000 also reiterated active participation of men in family planning, supporting contraceptive use, helping pregnant women to stay healthy by taking care of their dietary intake and seeking medical care, arranging skilled care during delivery, helping new born baby and the mother, in short to become a "responsible father" (MOHFW, 2000:11).

7.2 Summary of the findings

The main purpose of the present research is to examine the involvement of men/ husbands in the wife's reproductive health by situating it within the context of urbanizing villages. The questions kept in mind during the whole study are related to the role played by men in decision-making across various aspects of women's reproductive health such as decisions around pregnancy and delivery care, and use of contraceptives. Husband's involvement is also explored when wife is sick or dealing with reproductive tract infection etc. and in securing contraception for the wife. An attempt has been made to study the factors that influence men's involvement and their active participation and whether this involvement varies across villages with low urban characteristics and villages with high urban characteristics. The principal findings of the study are summarized here.

In order to address the research questions, a field study was carried out by the researcher in the Gautam Buddha Nagar district of Uttar Pradesh. The district was chosen because, being adjacent to Delhi, this district is undergoing rapid urbanization. From the district, villages with relatively high urban characteristics (where more than 60 percent of male working population is engaged in non-agricultural activities) and villages with relatively low urban characteristics (where less than 25 percent of male working population is engaged in non-agricultural activities) were identified and four villages were selected from each of these two strata at random with probability proportional to size. From each selected village, a sample of 30 married women of reproductive ages and a sample of 30 married men were taken for personal interview (for ethical reasons, in order to avoid interviewing both husband and wife, the married women and men were selected from different households). In all, 238 married women and 231 married men were interviewed. A comparative picture of the background characteristics of the respondents reveals that education of both women and men shows contrast between low urban and high urban characteristics villages. Around 35% of both women and men from villages with high urban characteristics have education above 8^{th} level compared to their counterparts. The nature of work of the husband also shows differential at the village level. Women reported more than 50% of their husbands being engaged in non-manual jobs; however, men themselves reported around 30% of them being engaged in non-manual jobs. Above 50% of both women and men reported that mostly husbands work outside the village. Moreover, women reported higher percentages of nuclear families as compared to men who reported around 20 percentage points less than women, i.e., around

41% and 44% in villages with low and high urban characteristics villages respectively. Largely the differences between responses of women and men are minor except for some indicators. Men reported that higher percentages of women (the wife) are uneducated, and most of them belonged to OBC class as compared to women's reporting and caste classification. The difference among women's and men's reporting lies in how they classify education and their caste status. Generally women from OBC considered themselves as belonging to general caste based on their high standard of living and did not identify themselves as backward classes anymore.

In addition to the field survey, the study has also utilized the data from the National Family Health Survey-3 for Uttar Pradesh that was carried out earlier (during 2005-06) for some analysis. Besides, the researcher interviewed a number of grassroots level health workers from the study area and sought their perceptions on male involvement in women's reproductive health- care. This has been useful to gain a deeper understanding of the research issues.

7.2.1 Husbands' awareness about reproductive health issues

In order to explore whether men in villages with high urban characteristics are more aware of women's reproductive health needs as compared to their rural counterparts survey data is examined; this helps to unfold the awareness levels of husbands on complications during pregnancy, delivery and knowledge about various contraceptives. Moreover, results are examined to unravel whether women and men from areas with high urban characteristics are better informed regarding women's reproductive health care needs compared to women and men from areas with low urban characteristics.

Awareness on pregnancy complications

The questions on various pregnancy complications were asked to both women and men to understand their awareness about pregnancy complications. Women from villages with high urban characteristics stated more pregnancy complications such as vomiting, weakness and swelling of limbs compared to women from low urban characteristics villages. Similarly larger percentages of men from villages with high urban characteristics also commonly documented that the wife suffered from vomiting, weakness and swelling of limbs during

pregnancy compared to other men. This seems to be due to their educational attainment and exposure to different sources of information.

Familiarity with delivery complications

Furthermore, knowledge about problems during delivery was also gauged across women and men in different sets of villages. Results demonstrated that although there is not much difference in the awareness levels between women and men across villages with low urban and high urban characteristics regarding health problems a wife may face during delivery, there is a difference in level of reporting by women and men. Fewer men have knowledge about health problems during delivery as compared to women especially on complications like obstructed/prolonged labour, convulsions, and abnormal position of the baby. Also higher percentages of men from both types of villages reported that they were not aware of health problems that the wife may come across at the time of delivering a child compared to women. Moreover, women from villages with low urban areas reported other problems like feeling weak and having emotional issues like expecting more support from the family members apart from talking about physiological problems.

Knowledge about various family planning methods

Besides knowledge on pregnancy and delivery complications, women and men were questioned on their knowledge and awareness about various contraceptives in order to gauge which family planning methods are commonly known within the villages. Both women and men from villages with high urban characteristics have information on various birth control and spacing methods such as traditional methods, emergency pills, injectables besides having knowledge about most commonly used methods such as female sterilization, IUDs and pills. However, in villages with low urban characteristics women tend to be less informed than their male counterparts about various contraceptive methods except for pills, IUD/loop and condom, while women and men from villages with high urban characteristics showed nearly similar levels of information on traditional methods. Covert use of some female methods such as pills and IUDs was documented by women during the field survey and that is also one of the reasons why higher percentages of women reported having more awareness about pills and IUD/loop.

Thus in short, there are notable differentials in awareness levels of women and men on various issues of health in the two sets of villages from the district Gautam Buddha Nagar. Women and men from villages with high urban characteristics demonstrated higher levels of information; while women and men from villages with low urban characteristics are also taking forward steps towards gaining information and increasing their awareness levels especially around pregnancy, delivery and family planning methods.

7.2.2 Role of urbanization and men's participation in various aspects of women's reproductive health

One of the objectives of the present study is to understand how structural and socio-economic changes brought about by urbanization translate into men's participation in women's reproductive health. During the fieldwork, both women and men were asked questions on how urbanization has influenced their villages, this information is gathered to provide a background information on villages and to show that there are some villages which are more influenced by urbanization compared to other villages which are under less influence of urbanization. Both women and men reported several types of changes brought about as a result of urbanization at the village level and also in their personal lives. Women universally agreed that urbanization has broadly changed the lifestyle of the people and people are attracted towards acquiring urban mode of living. However, relatively more women than men feel that their family bonds are loosening as a result of formation of nuclear families. On the contrary, more men from villages with high urban characteristics as compared to women felt that there are more nuclear families and there is definitely a change in the primary occupation of men due to non-availability of land for cultivation. Other changes that have swept in the villages due to the influence of urbanization are increase in number of migrants settling in the villages, thus harming the unity of the village as they bring in new ideas and values along with them. A man from a village with low urban characteristics showed his discontent and said, *"We have very few people from outside, but in a nearby village due to migrants settling in there is lack of unity now."* Another man from a village with high urban characteristics said, *"People are not just dependent on agriculture anymore, they are going out for jobs and also sending their kids to study outside the village."* Many people are now happy that girls are getting better opportunities to attend schools, and there is better infrastructure and connectivity to Delhi and nearby cities. However, they are also concerned about losing their own identity and engagement in agriculture which used to be their primary occupation.

Both women and men also reported changes in their personal life but there are some differences in their opinion about the influence of urbanization by place of residence. Mostly women from low urban characteristics villages reported that they have started living in nuclear families and have greater control over finances, while women from villages with high urban characteristics felt that their awareness about own health-care issues has increased. Men from villages with high urban characteristics shared that urbanization has resulted in more mobility, and higher degree of freedom in making household decisions because earlier when they used to live in joint families older male member was the head of the household and made all the important decisions about the family. Since, the couples these days enjoy more decision-making power, the earlier 'collaborative decisions' of the joint family have now been replaced by 'couples' decision.' This is also confirmed by Allendorf in her study from Madhya Pradesh where she observed that in the life course, a woman starts her married life with in-laws and over time, the joint family undergoes transition into nuclear family due to various reasons. Thus "husbands customarily have greater decision-making power in nuclear families" and in a nuclear family their role as a decision-maker is likely to be crucial (Allendorf, 2010, 265, 273). Although very few men both from low and high urban characteristics villages felt that they are now living in nuclear families as a result of changes brought about by urbanization. This is a situation something similar to what Wadley and Derr and Caldwell et al talked about in their studies. Wadley and Derr in their study in Uttar Pradesh found that the structure and function of joint families changed due to urbanization, and the families were still connected both ritually and economically (Wadley and Derr, 1993:403). Families, even though nuclear in nature, still exchanged farming labour and relatives came together as a joint unit to marry their unmarried sisters, thus continuing the obligation to meet marriage costs (Caldwell et al., 1988: 112). Mostly men as compared to women reported changes in almost all aspects of their personal life except for increase in awareness about health issues. Most of the changes in attributes as a result of urbanization point towards changes in the family structure from joint/extended families to nuclear families which have resulted in higher mobility, more decision-making power, and greater control over finances. However, men generally did not relate themselves being a part of nuclear families although they might be living in different households because conceptually and mentally they still consider that all kin are a part of one family and whenever there is any family occasion all of them unite together and participate in it.

Another aspect of urbanization was explored during the study that is contact with relatives living in urban areas. Studies have revealed that contact with relatives and sharing information with them result in behaviour change such as "co-residence with non-relatives or with peer relatives enhances opportunities of contact and sharing of new ideas and values, which legitimizes contraceptive use" (Hogan et al., 1999:304). So in order to understand whether there is an influence of relatives on husband's involvement, a series of questions were asked from both women and men. Almost three in four respondents reported that they have relatives living in urban areas and these respondents also visit them. They also exchange information and discuss health issues with relatives living in urban areas. So certainly there is an exchange of knowledge and information between people who live in villages and their relatives from urban areas. A man quoted, *"…if we sit among good people [relatives who are educated and have clear information and understanding] and exchange of ideas takes place, then things will definitely change."* Thus results at the gross level indicate that relatives from urban areas also influence certain behaviour of women and men who live in villages.

Information is also collected on different types of care received by women/wife during pregnancy, delivery and post-delivery. Around 60% and above women and men reported that a wife received special care by her husband at the time of pregnancy. Majority of them reported that taking care of food intake and giving rest to the women/ wife are the two major types of care extended by husbands, however, as reported by women and men other types of care such as going for regular check-ups, maintaining hygiene and abstinence received less attention by husbands. Both women and men reported that women who received antenatal care, decision on antenatal care was made by their husbands and husbands accompanied and paid for the antenatal check-ups followed by the mother-in-law who was also involved in the cases where husbands could not make decisions alone or, accompany or pay for the antenatal check-ups.

At the time of delivery, women and men reported that the type of care wife received from her husband included calling the birth attendant, and husband's being personally available in case any support is required. However, nearly one-fifth women and half of men reported that their husbands are not involved in preparing for the delivery. Nonetheless, women and men from villages with high urban areas reported that husbands are involved in discussing about the place of delivery; they are present at the time of delivery and paid for it compared to the ones

from villages with low urban characteristics. Of those women who had institutional deliveries, around three-fourths reported that their husbands accompanied them to the place of delivery followed by the mother-in-law. Here again the role of mother-in-law appears to be very crucial as they come next, just after the husband in making important decisions. Allendorf suggested that by maintaining high-quality relationships with the family members (especially with the mother-in-law), a woman gets encouragement to obtain health-care for her, or either family members get engaged in other activities like paying doctor's fees, accompanying her to the health centre or by communicating health-related information to her (Allendorf, 2010: 266). But she also cautioned that even though parents-in-law deeply care about their daughter-in-law, they may not ensure that she receives check-ups or delivers in a health facility as they do not regard such care beneficial to her (Allendorf, 2010: 273). In this present study, many husbands stated that in their absence they requested their mothers to accompany the wife to the health-centres and to be present with them while making antenatal consultations, or at the time of delivery.

Post-natal care received least importance in villages with low urban characteristics where majority of women and men reported that a wife did not receive post-natal care after the delivery, mainly the reason mentioned was that if everything goes fine and there is no complication after the delivery, seeking post-natal care is avoided. It is only customary that a health-worker visits within the first week of delivery. Moreover, most men reported that they were not even aware of the visit by a health-worker within the first week of birth of a baby.

When questions pertaining to husband's support at the time when wife had RTI infection were asked to women and men, both reported that husbands are supportive and the kind of care a wife received at the time of RTI infection included taking her to the hospital followed by taking care of the medicines. There are differentials at the village level though, higher percentages of women and men from villages with high urban characteristics stated that they took the wife to the hospital, while more number of women and men from villages with low urban characteristics reported that the husbands took care of the wife's medicines for RTI infection as compared to their counterparts in villages with high urban characteristics. Additionally, questions were also posed on general sickness of the wife to understand the role of husband. Women and men reported that husbands were supportive to the wife and took her to the doctor, provided economic support by spending money on the treatment and ensured

that the wife recovered from her ailment, although men reported higher percentages of them being more concerned and supportive compared to women's reporting. This particular difference among women's and men's reporting reflect that husbands are inclined to give more socially "acceptable responses" during the survey and they want to demonstrate that they are very concerned about the wife and do not leave any stone unturned when the wife is sick (Jejeebhoy, 2002:307). Women in villages with low urban characteristics reported that the husbands generally take them to the doctor, while women from villages with high urban characteristics informed that husbands saw that the wife was recovering. However, larger percentages of men from villages with high urban characteristics stated that they took the wife to the doctor and confirmed whether the wife was recovering from the sickness as compared to men from villages with low urban characteristics. Furthermore, analysis based on the secondary sources such as NFHS-3 for the state of Uttar Pradesh revealed that women from urban areas have a final say on decisions pertaining to their own health, demonstrating that urban women are less dependent on their husbands and other family members either to decide about their health or assist them to the health centre.

In addition to this, responses from women and men from the field survey are analysed at the individual level to look at the net effects of various socio-economic and demographic factors that impact men's participation in women's reproductive health at the time of pre-natal, natal and post-natal period or at the time of wife's sickness using the technique of logistic regression.

Involvement of husband in providing pregnancy care

A husband takes care of his wife during pregnancy in several ways, by taking her to the health centre for check-ups, following the advice of the health workers on taking proper care of her diet, giving rest and keeping a check on vaccinations etc. Women's responses indicated that 69% of the husbands are involved in taking care of the wife during pregnancy. Furthermore, wife's age, education of wife, standard of living, husband's nature of work, media exposure and women's empowerment seem to significantly affect husbands' involvement in providing pregnancy care to the wife. None of the urban characteristics showed significant influence on husbands' involvement. But when wife's education was replaced by husband's education, and the analysis was re-run, most of the results are identical and in addition to that, husband's place of work also showed significant effect on

involvement of husbands in pregnancy care. The odds ratio for husbands working outside the village are twice as high compared to those working within the village. However, responses from men depicted a little lower involvement of husbands, i.e., 66% of them involved in providing pregnancy care to the wife. The results again indicated significant effect of wife's age, education and women's empowerment on husbands' involvement in pregnancy care. When analysis was re-run after replacing wife's education with husband's education as an explanatory variable, the results did not differ much.

From both the analysis based on women's and men's responses, urban characteristics (except for husband's place of work) do not show influence on involvement of husbands in pregnancy care. Many health-workers more from villages with high urban characteristics than other villages have reported that they have seen young husbands accompanying the wife for the check-ups and those couples who now live in nuclear families take interest in asking about progress of the wife's pregnancy and their concerns on health from them. As Jennings et al. argued that "increased male involvement in ANC can spur changes in social norms for women and men" in a context where women's empowerment is low (Jennings et al., 2014:9), in the current research women and men respondents affirmed that some husbands even make sure that a member from the family also accompanies the wife to the health centre when they are not around which is an indication of some change in the social norm where husbands make sure that the wife does not go alone to the health centre in a pregnant state. Many women also stated that due to increase in facilities within the villages over the past few years, it is easier to commute to the health centre and that is why many husbands accompany the wife for the antenatal check-ups. While most men feel that due to increase in awareness, their understanding of women's reproductive health issues have improved and husbands feel more concerned about the wife's health these days than in the past.

Involvement of husband in delivery care

Since delivery is an important event both for the wife and husband, arranging resources to ensure safe delivery becomes imperative. This is done by engaging members of the household with support from husband. So understanding how husbands are engaged at this crucial stage in women's life become important. Results from women respondents on husband's involvement in providing delivery care to his wife showed that around 85% of the husbands are involved during delivery time. The results showed significant effect of wife's

age, standard of living, husband's nature of work and media exposure on husband's involvement in pregnancy care. One of the urban characteristics, i.e., visiting relatives in urban areas also has significant influence on husband's involvement. Odds ratio for women who visited relatives living in urban areas is twice as compared to those who do not visit relatives from urban areas. When the results were re-analysed using husband's education in place of wife's education, women's empowerment and husband's place of work also showed significant effect on husband's involvement in providing pregnancy care to the wife. Results depicted that urban aspects significantly impact men's engagement and participation during delivery phase of a woman's life. In case of results based on men's responses, it is observed that universally men reported to have been involved during the wife's delivery (almost 98% of them). The differences in women's and men's reporting regarding level of husband's involvement in extending delivery care are relatively large and very prominent. The major reason behind this is the difference in women's and men's perception towards involvement. While women considered emotional support and physical presence of husband as key indicators of involvement at the time of delivery, men regarded providing any kind of support such as logistic support or financial support (transportation, medical supervision, arranging some relative to accompany wife) as important aspects of their involvement during the wife's delivery. So husbands reported higher levels of their involvement as compared to women respondents.

Moreover, insights from the field also suggested that many mothers-in-law who adhere to the traditional belief of childbirth, do not believe in the efficacy of "institutional care as necessary or even detrimental, such that they discouraged their daughters-in-law seeking care from trained providers." They draw such conclusions from their own maternal health-care experiences, they did not receive modern health-care and thus they may be viewing it unimportant for their daughters-in-law (White et al., 2013:64). Nonetheless, as Furuta and Salway pointed out that people's utilization of health services depends on demand "(perceived need and recognition that available services are valuable and appropriate)" and ability to act on that demand (Furuta and Salway, 2006:24), women's and men's own perceptions toward the health centre services are also informed by their experiences and little preference for institutional delivery. Usually they utilize and opt for institutional services in cases of some complication or emergency. The reasons cited by them is that hospital environment creates 'panic and anxiety' at the time of delivery, but home delivery among the

family members provide a 'secure surrounding' which is not emotionally draining. So the quality of care also determines what choices people make when deciding about the place of delivery.

Involvement of husband in post-natal care

Post-natal care forms an essential part of mother and child care which ensures survival of both. This care is generally taken less seriously and many a times neglected. In this study, factors affecting husbands' engagement in post-natal care are explored. Involvement in post-natal care seems to attract little attention of husbands as merely 26 percent of the husbands are involved in post-natal care as reported by women respondents while men reported just 10 percent which represented very low levels of involvement in post-natal care. The results based on women's responses showed significant effect of education, wife's work status, exposure to mass media and women's empowerment on husbands' involvement in post-natal care. Here again husband's place of work significantly affects husband's involvement, odds ratio for women whose husbands work outside the village are twice as high as those who work within the village. Results do not vary much when wife's education was replaced by husband's education as an explanatory variable and data were re-examined. However, results from men respondents revealed that only women's empowerment has a significant influence on husbands' involvement in post-natal care. Odds ratio for women with high empowerment was 14 times higher than those with some empowerment. Again, when the analysis was re-done after replacing wife's education by husband's education, standard of living and women's empowerment appeared to significantly affect husbands' involvement in post-natal care. There are wide differences in the reporting levels among women and men mainly because husbands tried to avoid going to the hospital after birth of a baby unless there was a requirement to do so. Very few men understood the importance of post-natal care and got involved in it. Once the delivery is normal, they resume their work and have little knowledge whether a health worker visited their home within first week of birth to check the wife or the baby. Many men opined that post-natal care is not even necessary as it did not qualify as an important health-care practice. They considered it a "hassle" if they have to go for a follow up to a clinic even though there are no observable complications or complaints on the part of wife or the baby.

Involvement of husband in care during wife's sickness

Husbands' involvement is explored for wife's general sickness or when she had RTI infection. Results from the analysis revealed that 85% of the husbands were engaged as stated by women respondents, while men universally (98%) agreed that they were involved when the wife was sick. Caste and women's empowerment are the only two indicators that appeared to affect husbands' involvement at the time of wife's sickness. The differences in the reporting levels could have arisen due to the fact that most men gave socially "acceptable responses" during the survey to convey that they are very concerned about the wife's situation and make every possible effort to help treat their sick wife (Jejeebhoy, 2002:307). Moreover, further understanding of the differences in responses of women and men are attributed to the role of the government's health-care services and women's empowerment. Women who are independent and are informed about health-facilities in their area took little or no help from their husbands and visited the health-centre on their own. Also women gained information from health workers working in their community and consulted them during sickness and requested medicines from them such as from ANM. It is interesting to note that many husbands "voiced a sense of responsibility" when it is a matter of accompanying wife to the clinic or paying for health-care regardless of their knowledge levels (Barua et al., 2004:5666). Men during the survey informed that they take the wife to the doctor the moment they get to know about the condition of their ailing wife. However, some argued that the wife did not inform when she fell sick until the situation deteriorated. Even the health-workers brought up this issue during the discussion that many women procrastinate seeking medical help from the doctor and usually informed their husbands when the emergency arrived. So the husbands and the health-workers believed that women should take care of their health and communicate immediately when they fall sick rather than wait till the situation worsened.

Thus it is evident from the above findings that various aspects of urbanization significantly affect husband's involvement in pregnancy, delivery, and post-natal care as reported by women and men. Other socio-economic and demographic factors such as woman's age, education, and women's empowerment are more profound and have a strong bearing on husband's involvement, although place of residence which is the variable of interest does not show any significant influence over husband's involvement in pregnancy, delivery, post-natal care, or during wife's sickness. Mostly changes in husband's nature and type of work i.e.,

changes in the primary occupation and lifestyle, contact with relatives in urban areas along with high women's empowerment have a direct effect on husband's participation levels in the two sets of villages. An explanation to this is that, clearly villages with high urban characteristics demonstrate more urban aspects like educated women, men engaged in non-manual jobs and working outside the village, better housing conditions compared to their counterparts in villages with low urban characteristics, but due to their proximity to the National Capital Region both sets of villages have nearly equal exposure to information and mass media. Thus the difference basically lies at the behavioural level, practice and perceptions and also the quality of care for utilization of services available to them. Additionally, the differences in the levels of involvement also arise due to husband's perception towards wife's reproductive needs and women's own understanding of their reproductive health requirements.

7.2.3 Men as supportive partners in fertility regulation and contraceptive use

In order to study how men act as supportive partners with regards to fertility regulation and the use of contraceptives, information at various levels was collected during the field survey both from women and men.

Contraceptive use and preference

The field survey had a series of questions pertaining to first time use, ever use, current use and future use of contraceptives that were asked from both women and men from two different sets of villages. Results on the first time use of contraception suggested that most common methods reported by women and men are female sterilization and condom. Women reported mostly female sterilization (female method), while men reported condom (male method) which were used by them for the first time. Moreover, women reported that one in four did not use any contraceptive method, and men reported that half of them have never used any family planning methods. This difference in the reporting suggested that mainly male methods are preferred over female methods when method is used for the first time.

Information on ever use of contraception revealed that women who have ever used a method preferred to use either terminal method like female sterilization or male method-condoms. Third method which is widely preferred was IUD/loop. However, women in low urban

characteristics villages have a greater preference for female sterilization, while those in high urban characteristics villages have preference to use condoms as a spacing method. This pattern holds true for women who are currently using any contraceptive method also. Women who expressed their desire for future use of contraception also suggested that they either will prefer female sterilization or reversible method, i.e., condom use. The preference among men did not vary much across the two sets of villages, most men reported to use condoms followed by female sterilization as ever users and current users. Even for future use, most of them informed to choose between female sterilization and condom use. Very few men reported about the use of pills and IUDs, one of the reasons behind low reporting of these methods became evident during the fieldwork, women covertly use these two methods without bringing it to the knowledge of their husbands, so husbands did not have much information on the use of IUDs and pills. This finding also suggested that there existed power relations that are expressed not only by exercising agency and choice, but also what kind of choices people make (Kabeer, 1999: 441). So when women make a choice to use IUDs and pills without informing their husbands, they are making this choice independently. Nevertheless, the practice of choosing terminal methods of contraception by women and men has been well documented by various national health surveys also. These surveys show that female sterilization is widely known and has been adopted by women without any resistance. Moreover, both women and men supported female sterilization over other methods and felt delighted and expressed their pride when disclosing that the wife has undergone an operation *"hamne tau katwa di"*- meaning that "I got myself/ wife operated" while discussing contraception during the survey.

Involvement of husbands in fertility regulation

Desire for additional child

"A better grasp of what children mean to men and women separately, and how this meaning has changed over time, will improve our understanding of men's and women's reproductive strategies" (Green and Biddlecom, 2000:106). Fertility regulation depends on desire to have additional children, so women and men were asked if they want an additional child. Women with one child from villages with low urban characteristics reported that their husbands have a strong desire to have another child, and the desire lowered once they have two children. However, women with two children from villages with high urban characteristics reported that their husbands still want to have an additional child, though their own desire to have a

third child was lesser than their husband's desire. Men with two children from villages with high urban characteristics desired to have an additional child and have similar opinion about the wife. Findings suggested that men at least wanted two to three children whether from villages with low urban or high urban characteristics as they wish to have two sons and a daughter in their family due to cultural notions attached to sons and daughters.

Furthermore, an analysis is carried out using NFHS-3 data on women for the state of Uttar Pradesh to explore whether place of residence influences desire for an additional child. The desire for an additional child is only accessed for women who have living children; those with no child are dropped from the analysis as their desire to have a child is nearly universal. The results showed that a woman's desire to have another child is lower in urban residences. This supports the evidence obtained from the field survey also. A similar analysis has been carried out on match between desires of spouses (dependent variable), with three categories, 'both have the same desire' (reference), 'desires differ' and 'do not know.' The results depict that urban couples have more agreement in their desire to have an additional child as compared to rural couples. This showed that there is some kind of communication that exist among urban couples which is reflected through their match in agreement level while making decisions on an additional child.

In order to understand the role of socio-economic and demographic factors affecting husband's desire for additional child, logit analysis was done. According to women respondents, nearly 16% of the husbands have the desire for an additional child. The desire lowered with age of a woman, number of living children, work status of a woman and women's empowerment. These factors also appeared to significantly influence husband's desire for an additional child.

When the results are re-run after replacing wife's education with husband's education as an explanatory variable, results were almost identical except for the role of family type which depicted that with nuclear family, husband's desire to have an additional child decreases. However, men reported an overall higher desire for an additional child which is 27% as compared to women. Again, wife's age and number of living children significantly affect husband's desire for an additional child. One of the urban characteristic, i.e., husband's place

of work also has shown to affect husband's desire significantly. Men who are working outside the village were less likely to have desire for an additional child as compared to men who worked within the village. Results did not change when they were re-analysed after replacing wife's education by husband's education.

The differences in the reporting level of women and men indicated that women generally did not want to have more than two or three children, while men wanted at least two sons (where one could go out for work and the other could stay back with the parents) and a daughter to complete the family and have expressed strong son preference. Studies have shown that traditionally a son lights his funeral pyres and is also responsible for supporting parents in old age, while daughter is important to do '*kanyadaan*' (gifting daughter through marriage), so that the parents get liberated after death (Khan and Patel, 1997:7).

Husband's involvement in getting contraceptive for wife

Husband's involvement in arranging contraceptive for wife could be a huge favour to a woman who wants to use contraception to space children and limit family size but faces difficulties in procuring it. Results from women's reporting indicated a little lower than 50% involvement of husbands in getting contraceptives for the wife. Findings from the logit analysis suggested that there is significantly more likelihood of husbands' involvement in getting contraceptives for the wife with increase in number of living children, education, work status of a woman, and women's empowerment. Women with two or three or more number of children demonstrated greater involvement of husbands in getting contraceptives for them as compared to women with one child. The odds ratio for women with two children is 8 times higher than women with just one child. Women's empowerment further enhanced the chances of husbands' involvement as odds ratio was high. When the analysis was re-run by replacing wife's education with husband's education, results did not change much except for the media exposure that increased the likelihood of husbands' involvement in getting contraceptive for the wife.

Furthermore, results based on men's responses indicated around 13 percent of the husbands were involvement in getting contraceptives for the wife. With increase in number of living children and women's empowerment, likelihood of husband's involvement in getting

contraceptives for wife increased. However, exposure to mass media has shown to lower husband's involvement in arranging contraceptive for wife. Re-analysis of the indicators after replacing wife's education with husband's education did not alter the results much; standard of living appeared to be significantly affecting husband's involvement and with high standard of living there was more likelihood of husbands in getting contraceptive for the wife.

There is a wide difference in the reporting between women and men. Women have stated three times higher involvement of husband as compared to men themselves. When their husbands encouraged them, women easily got male contraceptives on request from the health workers. Moreover, women did not go out to buy contraceptives on their own and required husband to get it for them. In all such cases, women considered that their husbands were involved in arranging contraceptives for them. Furthermore, these findings also reflect that women have a better understanding of the "benefit of spacing their children" and the danger associated with having "births in quick succession" (Bankole and Singh, 1998:22). Reporting from men indicated that they only considered their involvement when they used male methods or buy contraceptives from a medical store. Moreover, men's reporting also has shown that exposure to mass media has decreased the likelihood of husbands' involvement in getting contraceptive for wife because most men were well aware of the government run programmes that provide free supplies of family planning alternatives to the wife, so men think that wife can have easy access to contraceptives from the health workers.

Husband's involvement in decision-making on contraceptive use

Role of husbands in decision-making to encourage or discourage wife to use contraception is very crucial as in India and many other countries more women tend to use contraception than men. Responses from the field survey are analysed based on reporting by both women and men. Results at the gross level depicted husbands from villages with high urban characteristics wanted the wife to use contraception especially after the first and the third child to promote spacing among the children. Women from villages with high urban characteristics again documented that their husbands discouraged them to use contraception after two children due to husband's preference to have at least three children which is considered as an ideal family size by many husbands from villages with more urban characteristics. Moreover, the NFHS-3 data also has information on the role of spouses in

making decisions on use of contraceptives. Regression analysis was done for the state of Uttar Pradesh to gauge the effect of urbanization (place of residence-rural/ urban). The results depicted that place of residence did not show any significant influence over decision-making for using contraceptives when controlled for other socio-economic factors.

The data collected from the field survey based on women's reporting suggested that around 42% of the husbands were involved in making decisions on contraceptive use. Logit results indicated that husbands' contraceptive behaviour (whether the husband encouraged or discouraged use of contraception) was influenced by the number of living children, family type, media exposure, and women's empowerment. Husbands' involvement in decision-making on contraceptive use was more likely to get influenced by increase in number of living children, media exposure and women's empowerment, however, nuclear family was less likely to affect husbands' decision-making on contraceptive use. Results were identical when wife's education was replaced by husband's education.

Men reported that around 36% of them were involved in making decisions on contraceptive use. Number of living children, caste, wife's education, standard of living, and women's empowerment significantly affect contraceptive behaviour of husbands (whether the husband encouraged or discouraged use of contraception), while wife's age and media exposure have lower influence on husbands' contraceptive behaviour. One of the urban characteristics, i.e., the place of residence also influenced husbands' decision-making on the use of contraception. Men in villages with high urban characteristics tend to get more involved in encouraging or discouraging wife to use contraception. When the analysis was re-run after replacing wife's education with husband's education, results were mostly identical and again place of residence significantly affect husbands' contraceptive behaviour.

There is little difference in the reporting level among women and men. Insights from the field survey indicate a "multifaceted decision-making process" where a wife accepts the responsibility of obtaining contraceptive (male methods) from the health workers on the demand of her husband and reported this as husband's involvement. At other times, a husband appears to dominate the decision when he himself buys it from the medical store and encourages wife to use contraceptive (Biddlecom et al., 1997:114). To complicate the

situation, women also informed that they covertly use contraceptives without informing their husbands and do not talk about it publicly. Moreover, health workers also testified that husbands mainly make the decision on the use of contraceptive, but in some cases they discuss it with the wife and take into consideration the wife's will also.

Husbands' involvement in getting sterilization services

The results from the field survey have shown that sterilization is the most common type of non-reversible method preferred and used by couples. Very few men opt for vasectomy these days as they consider it "death of maleness" because they feel that once they get sterilized they lose manhood (John et al., 2015:103). Women usually undergo sterilization, so it is important to explore the possibilities of how their husbands are involved in securing sterilization for them. Based on women's responses, a little over 70% reported that their husbands provided some type of care to them, however, men universally reported that they provided support to the wife after the operation was performed. Majority of women and men reported that they gave rest to the wife or did not allow her to lift heavy objects. However, women from villages with low urban characteristics reported that their husbands did not let them work with water to wash clothes or utensils, though this particular care was missed out in reports by men from both sets of villages in the district Gautam Buddha Nagar.

Results from the field suggested there is a huge gap in women's and men's reporting on husband's involvement in sterilization. Analysis of women's reporting indicated that overall 38% of their husbands were involvement in getting services for sterilization, while men reported only 17% of them were involved. Results from the logistic regression suggested that demographic factors influence husbands' involvement significantly in sterilization services. Wife's age and number of living children were both significant in determining husbands' involvement in sterilization. Other factors included caste and education of a woman that affect husband's involvement significantly. However, in case of women with higher education, husbands' involvement was significantly lower. Urban characteristics showed a significant effect on husband's involvement. Husbands living in villages with high urban characteristics were less likely to get involved as compared to those from villages with low urban characteristics. In addition, husbands who worked outside the village tend to get more involved in getting services for the wife's sterilization as compared to other husbands. When

the analysis was re-run by using husband's education in place of wife's education, results were nearly alike except that husband's place of work did not show any significant impact on their involvement in sterilization.

Furthermore, results based on men's reporting demonstrated significant effect of number of living children, wife's work status and women's empowerment on involvement of husbands in sterilization. This suggested that indicators of women's autonomy determined husband's involvement and likelihood of husbands' involvement increased if the wife was working or has more empowerment as compared to those who were non-working and were less empowered. Thus the differences in the reporting levels of women and men illustrated that women's autonomy is very crucial in determining whether her husband gets involved in sterilization or not. This is due to the fact that most men considered sterilization a 'routine operation' and do not pay attention to various measures to be taken once the operation is performed. Moreover, women are generally informed about what precautions to take as they have had such cases within their family also. As informed by men respondents, when the wife who is more informed and knowledgeable requested their involvement after getting sterilized, then the men took care of the wife and took advice from the medical practitioners on necessary precautions to be followed after the operation.

Decision-making and equity in contraceptive use

Furthermore, an attempt was made during the field work to get a sense of who makes the decision about issues related to use and type of contraceptive to space children. This information revealed how women operate in the patriarchal system which is always perceived as a very rigid system that subjugates and controls women. Additionally, the information also helps to unfold the factors that affect women's decisions and choices and whether they are able to get the support from their husbands at the village level. In other words, it explores whether there is an existence of gender-equity and whether it varies across the two sets of villages.

Nearly one in every two women from villages with high urban characteristics perceived their status as very important in their households, while women from low urban characteristics villages thought that their status was somewhat important in their houses. Regarding

importance of communication on family planning decisions, majority of women and men agreed that it was extremely important to discuss about birth control methods. Furthermore, nearly half of women from villages with high urban characteristics informed that their husband was the important source of support to them along with other members of the family and friends when they used contraceptives as compared to men from same villages who considered themselves as the 'only important support' to the wife when using contraceptives. For women in villages with low urban characteristics, after husband health-workers were the second major source of support who encouraged them to use contraception.

Moreover, men's responses did not vary much across villages, only one-third men from villages with high characteristics felt that there wife enjoyed 'very important status' as a decision-maker in the household, while most men from villages with low characteristics thought that the wife's contribution is 'somewhat important' as a decision-maker at home. Under such a situation where women's own perception about self holds more importance as compared to men, "husbands' perceptions of the extent to which their wives have a say in their own lives play a more important role than women's own perceptions in shaping aspects of reproductive choice" (Jejeebhoy, 2002:307).

Additionally questions were asked from both women and men who were currently using some kind of contraceptives and were not sterilized to get a sense of equity among them while making decisions on contraception. Results suggested that higher percentages of women in villages with high urban characteristics indulged in discussing about the use of contraception, type of contraception and when to use contraception with their husbands compared to their counterparts from villages with low urban characteristics. Men's reporting did not show much differential at the residence level; majority of men from villages with low urban characteristics seldom discussed with the wife on the use and type of contraception, while men from villages with high urban characteristics never discussed about contraception with the wife. Results indicated that more women from high urban characteristics discussed regarding contraceptives and might have more say while making decisions on contraception as they were actively involved in the discussion. Thus according to women, some kind of equity existed among couples from villages with high urban characteristics, although it is at a very preliminary level.

7.3 Discussion

Various socio-economic and demographic factors such as wife's age, number of living children and education significantly affect husband's involvement in the wife's reproductive health. With the increase in age of the wife, education level, number of children, and women's empowerment, husbands tend to get more involved and make decisions to ensure proper pregnancy care, delivery care and post-natal care. However, the level of involvement of husbands varies; husbands tend to be more actively involved at the time of delivery, and less during the period of pregnancy. In villages with low urban characteristics, men usually decide to which health centre the wife goes to because they are mainly responsible to accompany them and support them financially besides the mother-in-law. However, in villages with more urban characteristics, women have more ability to act and access resources and services meant for them on their own as they are more confident and knowledgeable about them. More involvement of husband in delivery and less in pregnancy is perhaps at their attitude level, because men who have "egalitarian gender role attitudes" are more likely to assist the wife during pregnancy than men who have "traditional gender role attitudes" (Singh and Ram, 2009:97). Furthermore, as pointed out by many health workers that a "loving husband" prefers that his wife receives antenatal care although he is not available to accompany her, he ensures that she receives care by travelling on her own to the health centre, or accompanied by a family member (Allendorf, 2010: 266).

Furthermore, husbands are least involved when it comes to post-natal care. Wife's education, work status, husband's workplace and women's empowerment greatly influence husbands' involvement in post-natal care. The results indicate women's education and work status (which are important elements of empowerment) increase the likelihood of husbands' involvement in post-natal care. With rise in education, feeling of self-worth and self-confidence increases, so some researchers have argued that education plays an important role in bringing about change in health-related behaviour compared to exposure to relevant information as it leads to receptiveness of new ideas, and strengthen women's ability to act to access quality of care (Furuta and Salway, 2006: 25). It is also found during the research that educated women and men relate them to modern ideas of urban life. People openly commented that *"now days, nobody veils even in the villages, we also get married like people in the cities where one could see the bride's face. Husbands now run to the doctors first when the wife complaints of any sickness and when they come back after consulting the doctor,*

only then they inform other family members the reason for visiting the doctor." Involvement of husbands in wife's sickness is basically determined by caste status and women's empowerment. These are the two factors that significantly affect husbands' involvement in wife's sickness. Thus women's empowerment is one such social determinant that greatly influences husband's involvement in various aspects of the wife's reproductive health. Women who enjoy an important status in decision-making at home regarding spending family's income and making family planning decisions jointly with the husbands show more involvement of husbands in almost every kind of health-care they receive from them.

Number of living children critically affects fertility preferences and fertility regulation through the use of contraception. It also determines various contraceptive decisions and husband's involvement in those decisions. The results on husbands' desire to have an additional child revealed that wife's age, wife's work status, and husband working outside the village have a bearing on husbands' desire as these factors significantly lowers husbands' desire for an additional child. While number of living children, wife's work status, and women's empowerment largely affect husbands' involvement in getting contraceptive for wife. In addition, number of living children, caste, and standard of living influence husbands' involvement in decision-making on contraceptive use.

Urban characteristics such as place of residence and husband's place of work affect husbands' involvement in getting sterilization services. The results have shown that place of residence, which is also a variable of interest, significantly increases husbands' involvement and participation of those who work outside the village in getting sterilization services for wife.

Other factors that contribute significantly towards husband's involvement are exposure to mass media (which is nearly universal in all these villages), and contact with relatives who are living in urban areas. Visiting relatives in urban areas also significantly affect husband's involvement in delivery care while mass media has a significant impact on husbands' involvement in providing pregnancy care, delivery care and post-natal care to the wife.

7.4 Strengths and limitations of the study

The current study has made an attempt to ask the same set of very sensitive and personal questions on reproductive health from both women and men separately in the field survey along with interviewing the health workers. The strength of the study lies in the mixed method approach which is utilized by the researcher to collect information both quantitatively and qualitatively from women and men separately. The qualitative data are used to substantiate and support quantitative data in order to provide a richer understanding of the cultural context and involvement of husbands in reproductive health (Barua et al, 2004). Furthermore, questions were not asked to the couples due to ethical issues and to avoid any conflict which might arise between a husband and a wife due to differences in their responses and perceptions on husband's involvement in reproductive health issues.

The study's limitations should also be considered which largely influence the results of the study. Researcher's positionality is one such factor which is crucial while conducting field work in a context where the researcher comes from a different socio-economic background. It is observed during the survey that many respondents tried to provide a 'modern image' to the researcher and gave 'socially desirable answers' (Green and Biddlecom, 2000:92).

Since, all the data is self-reported, so there are possibilities of recall and social desirability biases (White, 2013:65). Most men accurately reported about the number of births and the succession of births, but their responses are less reliable on issues like post-natal care, their involvement in delivery and wife's sickness. They reflected some ambiguity in sharing information on these issues, may be due to problem in recalling information or due to their intension to give acceptable responses which resulted in their involvement in delivery and wife's sickness nearly universal as compared to women's reporting which are far less than them.

Due to constraints of resources, this study is conducted at a small scale, thus has sample size limitations. A small sample does not allow the researcher to detect small differences or effects statistically. It is desirable to conduct this study at a large scale to collect detailed information on each type of care women receives and husbands' involvement in those type of care. Moreover, the impact of husbands' involvement on women's health outcomes is not

captured in the present study, so this study can be extended further to assess the impact of husband's involvement on women's reproductive health.

Moreover, this exploratory analysis gives the reflections of attitudes and perceptions of women and men in a context which is experiencing transition from rural life to urban mode of living under the wake of urbanization. So it cannot be generalized for other contexts that are either totally rural or totally urban. But then, understanding changes during the process of transition to urbanization was the purpose of the study. More culturally specific research on reproductive health in different contexts should be encouraged to understand varied perceptions, attitudes and practices of women and men that have a bearing on reproductive health of women.

7.5 Conclusions

Even though there are many challenges that husbands face when the wife seek health-care, the research shows that, echoing Barua, "men were eager to be involved when there were problems, and in fact they did participate more than for routine care" (Barua et al., 2004:5666). Several common findings emerge from the study. The analysis showed that men are aware about women's requirements during pregnancy and delivery and they are also aware of the problems and complications that could occur during these periods. Data suggested that men's knowledge centered on providing nutritious food to the wife along with giving her rest during pregnancy and taking care of antenatal check-ups. However, only a very few men think that institutional delivery and post-natal care are important for the wife and the new born baby, so less men are involved in taking the wife for institutional delivery or for post-natal check-ups.

Other factor that affects husbands' involvement in pregnancy and delivery care is age of the wife. Women of older ages who have grown in knowledge and exposure feel more confident in taking care of them during pregnancy and delivery which lessens husband's involvement during these phases, however, young women are more dependent on their husbands or in-laws to seek health-care due to lack of experience and confidence. Moreover, quality of care for institutional delivery matters a lot. As shown by AHS data (2011-12) only 17% of the institutional deliveries are conducted in government facilities vs 36% in the private facilities (Registrar General and Census Commissioner, 2011-12: 122). Furthermore, involvement of

husband when wife is sick indicates that empowerment has dual aspect, in one aspect it shows higher dependency of less empowered women on their husbands for seeking health-care, while in other aspect more empowered women are "more likely to voice and achieve their preferences" to seek medical help for self (Jennings et al., 2014:9).

While number of living children significantly affects fertility preferences and fertility regulation through the use of contraception. It also influences various decisions around contraceptive use and husband's involvement in those decisions. Wife's education also plays an essential role which in particular improves women's ability to make decisions by providing a wider array of information to them on access to modern and effective contraceptive methods (Hogan et al., 1999:304).

However, regarding the variable of interest, i.e., the effect of place of residence on indicators of husband's involvement, the results have shown that place of residence significantly affects only husbands' involvement in obtaining sterilization services and also husband's involvement in decision-making on contraceptive use. Husbands from villages with high urban characteristics are less likely to participate in the wife's sterilization. Place of residence significantly affects husband's involvement in decision-making on contraceptive use. This suggests that place of residence does not influence many aspects of husband's involvement in villages that are situated near to the national capital region. This is so because almost all the villages have access to health information, but the perspective to utilize health services differ. In those villages that demonstrate more urban characteristics and men are engaged in non-agricultural activities, people tend to accept and value health-care services and their perceptions towards utilization of health-services is more positive. On the other hand, in villages that demonstrate low urban characteristics, people are still apprehensive about modern health-care and tend to utilize it only in emergency cases and neglect when things are normal.

There are other factors that have a profound effect on husband's involvement besides socio-economic and demographic factors. Villages that show high urban characteristics depict that communications among the couples have improved with more couples making their own decisions on family planning and use of contraception with less parental involvement. New aspirations along with changes in surrounding due to settlement of migrants in these villages

have given rise to a new value system. Couples now relate small family size as a way to achieving prosperity and better standard of living in these villages. Husbands from villages with high urban characteristics have started engaging themselves in the wife's reproductive health mainly because now they follow modern health practices like their relatives who live in nearby urban areas, and also because by virtue of their work outside the village they come in contact with new information on health-care. This is not to say that husbands from villages with low urban characteristic do not involve in providing better health conditions to the wife, the difference lies in what stage of reproductive life husbands consider it important. Mainly husbands from low urban areas provide rest to the wife at the time of pregnancy and delivery, but they resist going for the institutional deliveries and seeking post-natal care unless it is an emergency situation. Therefore, the research has brought up various issues that influence husband's involvement in various aspects of women's reproductive health.

Thus, the present study shows that at least in the urbanizing villages studied, husbands are becoming more sensitive towards the wife's needs. They are quite involved in pregnancy care, delivery care and in treatment for wife's sickness but less involved in post-natal care which they feel is essentially the mother's domain. Anecdotes from the field survey suggest that wife and husband have different perspectives and attitudes toward reproductive health. The differentials in their expectations are observed in the research where the wife may consider certain aspect of husband's involvement more important over other, while the husband may have an entirely different concern in mind. Husband's and wife's opinions on the nature of involvement do not seem to converge. This should not be interpreted as 'no involvement' or 'lack of concern' on the husband's part. Moreover, the place of residence (villages with high or low urban characteristics) does not seem to affect husband's involvement except in getting sterilization services and husband's involvement in decision-making on contraceptive use. The other aspects of urbanization are more likely to affect husband's involvement besides women's empowerment which has emerged as an important indicator of promoting husband's involvement in most types of care. This suggests that more research in the future should be done especially in the context of populations undergoing transition to reveal their apprehensions, conflicts and coping mechanisms while making a shift from rural to urban lifestyle.

Furthermore, a wife has to understand that her health is a priority and she has to take care of it. She has to effectively communicate health concerns to her husband before it worsens and should discontinue being a 'mute spectator.' Also as researchers we should not neglect the role of changing times that have a strong influence on the mindset of people undergoing that change. There are temporal changes in the aspirations, expectations, and role as a decision-maker which have a bearing on husband's involvement in reproductive health matters. Moreover, health workers should continue to take motivational approach besides informing, educating and spreading awareness within the community by promoting good practices of actively engaging husbands in the wife's reproductive health and setting up examples which will ensure positive health outcomes.

REFERENCES

REFERENCES

Allendorf, K. 2010. "The quality of family relationships and use of maternal health-care services in India," *Studies in Family Planning* 41(4): 263-276.

Allendorf, K. 2013. "Going nuclear ? Family structure and young women's health in India, 1992–2006," *Prisms of Globlization Lecture Series and the Global Health Initiative, 2013*. USA: University of Illinois.

Anandhi, S., J. Jeyaranjan and R. Krishnan. 2002. "Work, caste and competing masculinities: Notes from a Tamil village," *Economic and Political Weekly* 37(24): 4403-4414.

ARCH Team. 2000. "Perceptions of male members about reproductive health matters: Preliminary evidence from a tribal area of Gujarat," in S. Raju and A. Leonard (eds.), *Men as Supportive Partners in Reproductive Health (Moving from Rheotoric to Reality)*. South and East Asia Regional Office, New Delhi: Population Council, pp. 14-15.

Arnold, F., S. Kishor and T.K. Roy. 2002. "Sex-selective abortions in India," *Population and Development Review* 28 (4), 759-785.

Banerji, D. 2005. "Politics of rural health in India," *Indian Journal of Public Health* 49(3):113-122.

Bankole, A., and S. Singh. 1998. "Couples' fertility and contraceptive decision-making in developing countries: Hearing the man's voice," *International Family Planning Perspectives* 24(1): 15-24.

Barua, A. 2000. "Young husbands' involvement in reproductive health in rural Maharashtra," in S. Raju and A. Leonard (eds.), *Men as Supportive Partners in Reproductive Health (Moving from Rheotoric to Reality)*. South and East Asia Regional Office, New Delhi: Population Council, pp. 6-8.

Barua, A., R. P. Pande, K. MacQuarrie and S. Walia. 2004. "Caring men? Husbands' involvement in maternal care of young wives," *Economic and Political Weekly* 39(52): 5661-5668.

Beck, U. and E. Beck-Gernsheim. 2002. *Individualization: Institutionalized Individualism and its Social and Political Consequences*. London: Sage publishing.

Bhende, A.A. and T. Kanitkar. 2006. *Principles of Population Studies*. New Delhi: Himalaya Publishing House, (18th Edition).

Bhende, A.A. and T. Kanitkar. 2002. *Principles of Population Studies*. New Delhi: Himalaya Publishing House, (Reprint Edition).

Biddlecom, A. E., J. B. Caterline and A. E. Perez. 1997. "Spouses' views of contraception in the Philippines," *International Family Planning Perspectives* 23(3): 108-115.

Blanc, A.K. 2001. "The effect of power in sexual relationships on sexual and reproductive health: An examination of the evidence," *Studies in Family Planning* 32(3): 189-213.

Caldwell, J. C., P.H. Reddy and P. Caldwell. 1988. *The Causes of Demography Change: Experimental research in South India*. Wisconsin: The University of Wisconsin Press.

Chacko, E. 2001. "Women's use of contraception in rural India: A village-level study," *Health and Place* 7: 197-208.

Char, A., M. Saavala and T. Kulmala. 2009. "Male perceptions on female sterilization: A community-based study in rural central India," *International Perspectives on Sexual and Reproductive Health* 35(3): 131-138.

Dahal, G. P., S. S. Padmadas and P. R. A. Hinde. 2008. "Fertility-limiting behavior and contraceptive choice among men in Nepal," *International Family Planning Perspectives* 34(1): 6-14.

Datta, R. 2004. "Territorial integration: An approach to address urbanizing villages in the planning for Delhi metropolitan area, India," 40th ISoCaRP Congress 2004. http://www.isocarp.net/Data/case_studies/427.pdf. Accessed on 20/3/2008.

Das Gupta, M. and P. N. Mari Bhat. 1997. "Fertility decline and increased manifestation of sex bias in India," *Population Studies* 51(3): 307-315.

DeRose, L. F. and A. C. Ezeh. 2010. "Decision-making patters and contraceptive use: Evidence from Uganda," *Population Research and Policy Review* 29(3): 423-439.

Donner, H. 2003. "The place of birth: Childbearing and kinship in Calcutta middle-class families," *Medical Anthropology* (22): 303-341.

Dube, L. 1986. Seed and Earth: "The symbolism of biological reproduction and sexual relations of reproduction," in L. Dube, E. Leacock and S. Ardener (eds.), *Visibility and Power: Essays on Women in Society and Development*. USA: Oxford University Press, pp. 22-53.

Dube, S. 1998. *In the Land of Poverty: Memoirs of an Indian Family, 1947-1997*. London: Zed Publications.

Dudgeon, M. R. and M. C. Inhorn. 2004. "Men's influences on women's reproductive health: Medical anthropological perspectives," *Social Science Medicine* (59): 1379-1395.

Dyson, T. and M. Moore. 1983. "On kinship structure, female autonomy, and demographic behaviour in India," *Population and Development Review* 9(1): 35-60.

Furlong, A. and F. Cartmel. 1997. *Young People and Social Change: Individualization and Risk in the Age of High Modernity*. Buckingham: Open University Press.

Furuta, M. and S. Salway. 2006. "Women's position within the household as a determinant of maternal health care use in Nepal," *International Family Planning Perspectives* 32(1): 17-27.

Goldie, J. (2007). "Men as partners in reproductive health, Australian reproductive health alliance," http://pandora.nla.gov.au/pan/24227/20070404-0000/www.arha.org.au/submissions/Men%20as%20partners%20in%20RH.pdf. Accessed on 17/04/2014.

Government of Uttar Pradesh. 2006. "Greater Noida Industrial Development Authority" www.greaternoida.com. Accessed on 20/10/2006.

Green, C.P., S. I. Cohen and H. H. B. Ghouayel. 1995. *Male Involvement in Reproductive Health, Including Family Planning and Sexual Health. Technical Report, No. 28*. New York: United Nations Population Fund.

Greene, M. E. and A. E. Biddlecom. 2000. "Absent and problematic men: Demographic accounts of male reproductive roles," *Population and Development Review* 26(1): 81-115.

Greene, M. E., M. Mehta, J. Pulerwitz, D. Wulf, A. Bankole and S. Singh. 2006. "Involving men in reproductive health: Contributions to development," *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals*. New York: Millennium Development Project.

Helzner, J. H. 1996. "Men's involvement in family planning," *Reproductive Health Matters* 4(7): 146-154.

Hogan, D. P., B. Berhanu and A. Hailemariam. 1999. "Household organization, women's autonomy, and contraceptive behavior in Southern Ethiopia," *Studies in Family Planning* 30(4): 302-314.

International Institute for Population Sciences (IIPS) and ORC Macro. 2007. *National Family Health Survey (NFHS-3), India, 2005-06*. Mumbai: IIPS.

International Institute for Population Sciences (IIPS). 2010. *District Level Household and Facility Survey (DLHS-3), 2007-08: India. Uttar Pradesh*. Mumbai: IIPS.

Jeffery, P., R. Jeffery and A. Lyon. 1988. *Labour Pains and Labour Power: Women and Child Bearing in India*. London and New Jersey: Zed Books Ltd.

Jejeebhoy, S. J. 1997. "Addressing women's reproductive health needs: Priorities for the Family Welfare Programme," *Economic and Political Weekly* 32(9/10): 475-484.

Jejeebhoy, S. J. 2002. "Convergence and divergence in spouses' perspectives on women's autonomy in rural India," *Studies in Family Planning* 33(4): 299-308.

Jejeebhoy, S. J., R. Prakash, R. Acharya, S. K. Singh and E. Daniel. 2015. "Meeting contraceptive needs: Long-term associations of the PRACHAR project with married women's awareness and behavior in Bihar," *International Perspectives on Sexual and Reproductive Health* 41(3): 115-125.

Jennings, L., N. Muzi, M. Cherewick, M. Hindin, B. Mullany and S. Ahmed. 2014. "Women's empowerment and male involvement in antenatal care: analyses of demographic and health surveys (DHS) in selected African countries," *Bio Med Central: Pregnancy and Childbirth* 14: 297-307.

John, N. A., S. Babalola and E. Chipeta. 2015. "Sexual pleasure, partner dynamics and contraceptive use in Malawi," *International Perspectives on Sexual and Reproductive Health* 41(2): 99-107.

Kabeer, N. 1999. "Resources, agency, achievements: Reflections on the measurement of women's empowerment," *Development and Change* 30:435-464.

Khan, M.E. and B. C. Patel. 1997. *Male Involvement in Family Planning. A KABP study of Agra District, India. Final Report.* New Delhi: Population Council.

Khanna, S. K. 2001. "Shahri Jat and Dehati Jatni: the Indian peasant community transition," *Contemporary South Asia* 10(1): 37-53.

Kishor, S. and K. Gupta. 2009. *Gender Equality and Women's Empowerment in India*. National Family Health Survey (NFHS-3), India, 2005-06. Mumbai: International Institute for Population Sciences; Calverton, Maryland, USA: ICF Macro.

Kulkani, P.M. 2009. "Shaping India's population policy and programme: Internal factors and external influences," *Artha Vijnana* LI(1): 12-38.

Lambert, H. and K. Wood. 2005. "A comparative analysis of communication about sex, health and sexual health in India and South Africa: implications for HIV prevention," *Culture, Health and Sexuality* 7(6): 527-541.

Mahler, K. 2000. "Indian men with higher socioeconomic status are more likely to be knowledgeable about reproductive health," *International Family Planning Perspectives* 26(3): 143-144.

Masih, A.M.M. and R. Masih. 1999. "Is a significant socio-economic structural change a pre-requisite for 'Initial' fertility decline in the LDCs? Evidence from Thailand based on a multivariate cointegration/vector error correction modelling approach," *Journal of Population Economics, Springer* 12(3): 463-487.

Moore, M. 1999. "Men in Uttar Pradesh, India know little about women's reproductive health needs," *International Family Planning Perspectives* 25(2): 107.

Miller, B.D. 1989. "Son preference, the household and a public health programme in North India," in M. Krishnaraj and K. Chanana (eds.), *Gender and the Household Domain*. New Delhi: Sage Publications Ltd., pp. 191-208.

Ministry of Health and Family Welfare. 2000. *National Population Policy 2000*. New Delhi: Government of India.

Ministry of Health and Family Welfare. 2009. *Four years of NRHM 2005-2009: Making a Difference Everywhere.* New Delhi: Government of India.

Ministry of Health and Family Welfare. 2012. "National Rural Health Mission: Meeting people's health needs in rural areas. Framework for Implementation," http://nrhm.gov.in/images/pdf/about-nrhm/nrhm-framework-implementation/nrhm-framework-latest.pdf . Accessed on October 19, 2015.

Mistik, S., M. Nascar, M. Mazicioglu and F. Cetinkaya. 2003. "Married men's opinions and involvement regarding family planning in rural areas," *Contraception* 67: 133-137.

Mitchell, R. B. 1971. "Changes in fertility rates and family size in response to changes in age at marriage, the trend away from arranged marriages, and increasing urbanization," *Population Studies* 25(3): 481-489.

Mutharayappa, R., M. K. Choe., F. Arnold and T. K. Roy. 1997. "Son preference and its effect on fertility in India," *India: National Family Health Survey Subject Reports Number 3. March 1997*. Mumbai: IIPS and Hawaii: East West Center.

Pachauri, S. 2014. "Priority strategies for India's family planning programme," *The Indian Journal of Medical Research* 140 (Supplement) 2014: 137-146.

Patel, T. 1994. *Fertility Behaviour: Population and Society in a Rajasthan Village*. Delhi: Oxford University Press.

Petro-Nustas, W. 1999. "Men's knowledge of and attitudes toward birthspacing and contraceptive use in Jordan," *International Family Planning Perspectives* 25(4): 181-185.

Planning Commission Report. 2006. "9th Five Year Plan," http://planningcommission.nic.in/plans/planrel/fiveyr/9th/default.htm . Accessed on 12/8/07.

Ramachandran, R. 2006. *Urbanization and Urban Systems in India*. Sixteenth Edition. New Delhi: Oxford University Press.

Ramachandrudu, G. and G. Kamalamma. 1997. "Health planning in India- A critical evaluation," in G. Ramachandrudu (eds.), *Health Planning in India*. New Delhi: A.P.H. Publishing Corporation.

Raju, S. 2001. "Negotiating with patriarchy: Addressing men in reproductive and child health," *Economic and Political Weekly* 36(49): 4589-4592.

Raju, S. 2006. "Contextualising gender empowerment at the grassroots: A tale of two policy initiatives," *GeoJournal, Springer* 65(4): 287-300.

Ram, K. 1994. "Medical Management and Giving Birth: Responses of Coastal Women in Tamil Nadu," *Reproductive Health Matters* (4): 20-26.

Ram, K. 1998. "Maternity and the story of enlightenment in the colonies: Tamil coastal women, south India," in K. Ram and M. Jolly (eds.), *Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific*. U.K. Cambridge University Press, pp. 114-143.

Rao, M.S.A. 1970. *Urbanization and Social Change: A Study of a Rural Community on a Metropolitan Fringe*. New Delhi: Orient Longmans Ltd.

Registrar General and Census Commissioner. 2001. CD. *Census of India 2001: Primary Census Abstract*. New Delhi.

Registrar General. 2006. *Maternal Mortality in India: 1997-2003. Trends, Causes and Risk Factors. Based on Sample Registration System*. New Delhi: Office of the Registrar General and University of Toronto, Canada: Center for Global Health Research.

Registrar General. 2010. *Chapter-3: Estimates of Fertility Indicators. Based on SRS Statistical Reports*. http://www.censusindia.gov.in/vital_statistics/srs/Chap_3_-_2010.pdf. Accessed on 14/01/2016.

Registrar General. 2010. *Compendium of India's Fertility and Mortality Indicators 1971-2007: Based on the Sample Registration System (SRS)*. New Delhi: Office of the Registrar General.

Registrar General and Census Commissioner. 2011. *Census of India 2011: Primary Census Abstract*. New Delhi.

Registrar General and Census Commissioner. 2011. *Primary Census Abstract. Uttar Pradesh: Figures at a Glance*. http://www.censusindia.gov.in/2011census/PCA/PCA_Highlights/pca_highlights_file/UP/5PCA-Figures_at_Glance.pdf. Accessed on 5/10/2015.

Registrar General. *MMR Bulletin 2011-2013. Based on SRS Statistical Reports*. http://www.censusindia.gov.in/vital_statistics/mmr_bulletin_2011-13.pdf. Accessed 14/01/2016.

Registrar General and Census Commissioner. 2011-12. *Annual Health Survey: Factsheet, Uttar Pradesh*. New Delhi.

Registrar General and Census Commissioner. 2012-13. *Annual Health Survey: Factsheet, Uttar Pradesh*. New Delhi.

Registrar General. 2013. *Chapter-3: Estimates of Fertility Indicators. Based on SRS Statistical Reports*. http://www.censusindia.gov.in/vital_statistics/SRS_Reports_2013.html. Accessed on 14/01/2016.

Retherford, R. D. and M. K. Choe. 1993. *Statistical Model for Causal Analysis*. New York: Wiley-Interscience Publication and John Willey and Sons, Ins.

Retherford, R.D. and T. K. Roy. 2003. "Factors affecting sex-selective abortion in India and 17 major states," *India: National Family Health Survey subject Reports Number 21. January 2003.* Mumbai: IIPS and Hawaii: EWC.

Robinson, W.C. 1963. "Urbanization and fertility: The non-western experience," *The Milbank Memorial Fund Quarterly* 41(3): 291-308.

Ruth, D.M. and M. T. Mbizvo. 2001. "Promoting safe motherhood in the community: The case for strategies that include men," *African Journal of Reproductive Health* 5(2):10-21.

Sandhyarani, M. C. and C. U. Rao. 2013. "Role and responsibilities of anganwadi workers, with special reference to Mysore district," *International Journal of Science, Environment and Technology* 2(6): 1277-1296.

Seymour, S.C. 1999. *Women, Family, and Child Care in India: A World in Transition*. U.K: Cambridge University Press.

Singh, K. K., S. S. Bloom and A. O. Tsui. 1998. "Husband's reproductive health knowledge, attitudes, and behaviour in Uttar Pradesh, India," *Studies in Family Planning* 29(4): 388-399.

Singh, A. and F. Ram. 2009. "Men's involvement during pregnancy and childbirth: evidence from rural Ahmadnagar, India," *Population Review* 48(1): 83-102.

Speare, A. Jr., M. C. Speare and L. Hui-Sheng. 1973. "Urbanization, non-familial work, education and fertility in Taiwan," *Population Studies, Population Investigation Committee* 27(2): 323-334.

Speizer, I. S., L. Whittle and M. Carter. 2005. "Gender relations and reproductive decision making in Honduras," *International Family Planning Perspectives* 31(3): 131-139.

Srivastava, S. 2001. "Introduction: Semen, history, desire, and theory," in S. Srivastava (eds.) *South Asia: Journal of South Asian Studies*. XXIV: 1-24.

Thapan, M. 2003. "Marriage, well being, and agency among women," in C. Sweetman (eds.), *Gender, Development and Marriage*. An Oxam Publication, pp. 77-84.

Tripathi, V. and D. Nandan. 2006. "Reproductive health: An introduction to IUCD in India," *International Electronic Journal of Health Education* (9):1-12.

United Nations Population Fund. 1996. *Programme of Action*, adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994. USA.

Van Hollen, C. 2003. *Birth on the Threshold: Childbirth and Modernity in South India*. Berkeley, California: University of California Press.

Wadley, S.S. and B. W. Derr. 1993. "Karimpur families over sixty years in P. Oberoi, P. (eds.) *Family, Kinship And Marriage in India*. Delhi: Oxford University Press, pp. 393-415.

Wadley, S.S. 1994. *Struggling with Destiny in Karimpur*. Berkeley: University of California Press.

Wegner, M. N., E. Landry, D. Wilkinson and J. Tzanis.1998. "Men as partners in reproductive health: From issues to Action," *International Family Planning Perspective, Special report* 24: 38-42.

White, D., M. Dynes, M. Rubardt, K. Sissoko and R. Stephenson. 2013. "The influence of intrafamilial power on maternal health care in Mali: Perspectives of women, men and mothers-in-law," *International Perspectives on Sexual and Reproductive Health* 39(2): 58-68.

APPENDICES

TABLE-1: Involvement of husbands in pregnancy care (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in pregnancy care	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	159			77	77
36 and above	79	-1.293	**0.275*** **	53	48
No. of living children					
1 Child ®	25			92	88
2 Children	58	-1.260	0.284	78	68
3 and above children	155	-1.396	0.248	62	65
Family Type					
Joint Family ®	86			77	74
Nuclear Family	152	-0.363	0.695	64	66
Caste					
Others ®	100			72	69
OBC	98	-0.188	0.828	69	65
SC/ST	40	0.332	1.394	60	76
Education of a man/husband					
No Education ®	32			31	45
Up to 8th level	59	1.263	**3.536****	66	75
Above 8th level	147	1.087	**2.964***	78	71
Standard of living					
Low ®	51			49	59
Medium	118	-0.236	0.790	63	53
High	69	1.929	**6.881*****	94	91
Woman's/Wife's work status					
Not working ®	188			70	71
Working	50	-0.451	0.637	64	61
Husband's nature of work					
Manual job ®	130			56	58
Non-manual job	108	1.019	**2.770****	84	79
Media exposure					
No exposure to mass media ®	32			44	45
Exposed to mass media	206	1.169	**3.220****	73	72
Women's empowerment					
Low empowerment ®	101			53	51
High empowerment	137	1.301	**3.672*****	80	79
Residence					
Villages with low urban characteristics ®	120			60	63
Villages with high urban characteristics	118	0.492	1.636	78	74
Husband's workplace					
Within the village ®	129			60	62
Outside the village	109	0.710	**2.034***	80	77
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			40	56
Visit relatives in urban areas	195	0.684	1.982	75	71
Constant		-1.410	0.244		
% of husband's involvement	**69**				

®- Reference Category, -2 log likelihood = 186.039, Nagelkerke R Square = 0.517, Significance level- *** at 1%, ** at 5%, * at 10%; N= 238. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

TABLE-2: Involvement of husbands in pregnancy care (Responses from men)

Background Characteristics	Total no. of men	B	Exp (B)	Percentage husbands involved in pregnancy care	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	181			73	72
36 and above	50	-1.304	**0.271*** **	40	41
No. of living children					
1 Child ®	33			82	76
2 Children	77	-0.704	0.495	73	61
3 and above children	121	-0.494	0.610	58	66
Family Type					
Joint Family ®	133			71	72
Nuclear Family	98	-0.601	**0.548***	59	58
Caste					
Others ®	71			76	69
OBC	110	-0.119	0.888	65	67
SC/ST	50	-0.404	0.668	54	60
Education of a man/husband					
No Education ®	41			46	56
Up to 8th level	66	0.515	1.673	64	68
Above 8th level	124	0.539	1.714	74	68
Standard of living					
Low ®	59			53	56
Medium	81	0.558	1.746	68	69
High	91	0.643	1.902	74	70
Woman's/Wife's work status					
Not working ®	194			64	63
Working	37	0.971	**2.642***	78	82
Husband's nature of work					
Manual job ®	178			62	66
Non-manual job	53	0.091	1.095	79	68
Media exposure					
No exposure to mass media ®	21			52	76
Exposed to mass media	210	-0.539	0.584	68	65
Women's empowerment					
Low empowerment ®	165			57	57
High empowerment	66	1.397	**4.041*** **	89	84
Residence					
Villages with low urban characteristics ®	116			60	63
Villages with high urban characteristics	115	0.315	1.370	72	70
Husband's workplace					
Within the village ®	139			58	61
Outside the village	92	0.569	1.766	79	73
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	49			65	70
Visit relatives in urban areas	182	-0.245	0.783	66	65
Constant		0.956	2.601		
% of husband's involvement	**66**				

®- Reference Category, -2 log likelihood = 236.684, Nagelkerke R Square = 0.311, Significance level- *** at 1%, ** at 5%, * at 10%; N= 231. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

TABLE-3: Involvement of husbands in delivery care (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in delivery care	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	159			91	91
36 and above	79	-1.705	**0.182*** **	75	65
No. of living children					
1 Child ®	25			92	89
2 Children	58	-0.424	0.655	88	85
3 and above children	155	-0.398	0.671	83	85
Family Type					
Joint Family ®	86			85	82
Nuclear Family	152	0.382	1.465	86	87
Caste					
Others ®	100			82	81
OBC	98	0.285	1.330	88	85
SC/ST	40	1.010	2.747	88	92
Education of a man/husband					
No Education ®	32			84	96
Up to 8th level	59	-0.702	0.496	88	92
Above 8th level	147	-1.897	**0.150** **	84	77
Standard of living					
Low ®	51			76	73
Medium	118	0.259	1.296	82	78
High	69	2.178	**8.828** **	97	96
Woman's/Wife's work status					
Not working ®	188			85	86
Working	50	-0.318	0.728	88	82
Husband's nature of work					
Manual job ®	130			80	79
Non-manual job	108	1.016	**2.761***	92	91
Media exposure					
No exposure to mass media ®	32			63	59
Exposed to mass media	206	1.598	**4.944*** **	89	88
Women's empowerment					
Low empowerment ®	101			79	78
High empowerment	137	0.871	**2.390***	90	89
Residence					
Villages with low urban characteristics ®	120			82	86
Villages with high urban characteristics	118	-0.054	0.947	89	85
Husband's workplace					
Within the village ®	129			81	79
Outside the village	109	0.907	**2.476***	91	90
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			65	70
Visit relatives in urban areas	195	1.120	**3.064** **	90	88
Constant		0.055	1.056		
% of husband's involvement	**85**				

®- Reference Category, -2 log likelihood = 138.678, Nagelkerke R Square = 0.394, Significance level- *** at 1%,

***** at 5%, * at 10%; N= 238. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).***

TABLE-4: Involvement of husbands in post-natal care (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in post-natal care	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	159			31	32
36 and above	79	-0.792	**0.453***	16	17
No. of living children					
1 Child ®	25			48	44
2 Children	58	-0.890	0.411	31	25
3 and above children	155	-0.881	0.415	21	25
Family Type					
Joint Family ®	86			43	31
Nuclear Family	152	-0.334	0.716	17	24
Caste					
Others ®	100			30	29
OBC	98	-0.121	0.886	27	27
SC/ST	40	-0.454	0.635	18	21
Education of a man/husband					
No Education ®	32			6	11
Up to 8th level	59	0.922	2.514	19	23
Above 8th level	147	1.417	**4.124***	34	33
Standard of living					
Low ®	51			16	23
Medium	118	0.110	1.116	25	25
High	69	0.398	1.489	38	31
Woman's/Wife's work status					
Not working ®	188			28	29
Working	50	-0.608	0.545	22	18
Husband's nature of work					
Manual job ®	130			20	23
Non-manual job	108	0.372	1.450	34	31
Media exposure					
No exposure to mass media ®	32			3	3
Exposed to mass media	206	2.712	**15.065*****	30	34
Women's empowerment					
Low empowerment ®	101			13	13
High empowerment	137	1.592	**4.912*****	36	41
Residence					
Villages with low urban characteristics ®	120			23	27
Villages with high urban characteristics	118	-0.058	0.943	31	26
Husband's workplace					
Within the village ®	129			19	20
Outside the village	109	0.773	**2.167****	35	35
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			19	36
Visit relatives in urban areas	195	-0.527	0.590	28	25
Constant		-4.658	0.009		
% of husband's involvement	**26**				

®- Reference Category, -2 log likelihood = 213.001, Nagelkerke R Square = 0.335, Significance level- *** at 1%, ** at 5%, * at 10%; N= 238. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

TABLE-5: Involvement of husbands in post-natal care (Responses from men)

Background Characteristics	Total no. of men	B	Exp (B)	Percentage husbands involved in post-natal care	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	-	-	-	-	-
36 and above	-	-	-	-	-
No. of living children					
1 Child ®	33			18	12
2 Children	77	0.267	1.306	13	15
3 and above children	121	-0.489	0.613	6	7
Family Type					
Joint Family ®	133			10	8
Nuclear Family	98	0.483	1.621	10	13
Caste					
Others ®	71			14	7
OBC	110	0.447	1.564	7	10
SC/ST	50	1.044	2.840	10	17
Education of a man/husband					
No Education ®	41			2	9
Up to 8th level	66	0.596	1.814	11	15
Above 8th level	124	-0.110	0.896	12	8
Standard of living					
Low ®	59			3	4
Medium	81	0.613	1.846	6	8
High	91	1.791	**5.998***	18	21
Woman's/Wife's work status					
Not working ®	194			8	9
Working	37	0.485	1.625	19	14
Husband's nature of work					
Manual job ®	178			7	10
Non-manual job	53	0.211	1.235	21	12
Media exposure					
No exposure to mass media ®	21			5	9
Exposed to mass media	210	0.096	1.101	10	10
Women's empowerment					
Low empowerment ®	165			2	5
High empowerment	66	2.719	**15.159*****	29	44
Residence					
Villages with low urban characteristics ®	116			6	9
Villages with high urban characteristics	115	0.333	1.396	14	12
Husband's workplace					
Within the village ®	139			5	8
Outside the village	92	0.625	1.869	17	14
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	49			4	7
Visit relatives in urban areas	182	0.585	1.795	12	11
Constant		-6.724	0.001		
% of husband's involvement	**10**				

®- Reference Category, -2 log likelihood = 100.377, Nagelkerke R Square = 0.403, Significance level- *** at 1%, ** at 5%,

**** at 10%; N= 231. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12), Note: Wife's age is dropped from the analysis.***

TABLE-6: Husbands desire for additional child (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands' desire for additional child	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	159			23	30
36 and above	79	-2.393	**0.091****	3	4
No. of living children					
1 Child ®	25			88	97
2 Children	58	-4.832	**0.008*****	17	23
3 and above children	155	-6.290	**0.002*****	5	7
Family Type					
Joint Family ®	86			28	29
Nuclear Family	152	-1.151	**0.316***	10	11
Caste					
Others ®	100			17	15
OBC	98	-0.001	0.999	11	15
SC/ST	40	0.715	2.045	28	26
Education of a man/husband					
No Education ®	32			6	26
Up to 8th level	59	-0.134	0.875	17	24
Above 8th level	147	-0.916	0.400	18	12
Standard of living					
Low ®	51			8	11
Medium	118	0.467	1.595	19	17
High	69	0.668	1.990	17	20
Woman's/Wife's work status					
Not working ®	188			19	21
Working	50	-1.558	**0.210***	6	5
Husband's nature of work					
Manual job ®	130			16	20
Non-manual job	108	-0.491	0.612	17	13
Media exposure					
No exposure to mass media ®	32			13	30
Exposed to mass media	206	-0.890	0.411	17	15
Women's empowerment					
Low empowerment ®	101			24	27
High empowerment	137	-1.121	**0.326***	11	11
Residence					
Villages with low urban characteristics ®	120			15	16
Villages with high urban characteristics	118	0.129	1.138	18	17
Husband's workplace					
Within the village ®	129			18	23
Outside the village	109	-0.920	0.399	15	11
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			12	8
Visit relatives in urban areas	195	0.990	209.095	17	19
Constant		5.343			
% of husband's involvement		**16**			

®- Reference Category, -2 log likelihood = 94.058, Nagelkerke R Square = 0.663, Significance level- *** at 1%, ** at 5%, * at 10%; N= 238. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

TABLE-7: Husbands desire for additional child (Responses from men)

Background Characteristics	Total no. of men	B	Exp (B)	Percentage husbands' desire for additional child	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	181			34	45
36 and above	50	-3.574	**0.028***	4	2
No. of living children					
1 Child ®	33			94	98
2 Children	77	-4.731	**0.009*****	27	31
3 and above children	121	-6.340	**0.002*****	9	8
Family Type					
Joint Family ®	133			30	25
Nuclear Family	98	0.263	1.301	23	30
Caste					
Others ®	71			24	29
OBC	110	-0.255	0.775	26	24
SC/ST	50	0.093	1.098	34	31
Education of a man/husband					
No Education ®	41			27	35
Up to 8th level	66	0.204	1.227	29	40
Above 8th level	124	-0.775	0.461	27	20
Standard of living					
Low ®	59			25	24
Medium	81	0.720	2.054	32	40
High	91	-0.253	0.777	24	20
Woman's/Wife's work status					
Not working ®	194			28	28
Working	37	-0.108	0.898	22	26
Husband's nature of work					
Manual job ®	178			28	31
Non-manual job	53	-0.773	0.461	25	17
Media exposure					
No exposure to mass media ®	21			14	15
Exposed to mass media	210	0.801	2.228	29	29
Women's empowerment					
Low empowerment ®	165			27	30
High empowerment	66	-0.440	0.644	29	21
Residence					
Villages with low urban characteristics ®	116			23	22
Villages with high urban characteristics	115	0.555	1.742	31	33
Husband's workplace					
Within the village ®	139			27	38
Outside the village	92	-1.285	**0.277****	27	15
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	49			24	26
Visit relatives in urban areas	182	0.112	1.118	28	28
Constant		3.897	49.250		
% of husband's involvement	**27**				

®- Reference Category, -2 log likelihood = 144.736, Nagelkerke R Square = 0.609, Significance level- *** at 1%, ** at 5%, * at 10%; N= 231. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

TABLE-8: Involvement of husbands in getting contraceptive for wife (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in getting contraceptive	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	159			45	44
36 and above	79	0.190	1.210	48	49
No. of living children					
1 Child	25			20	15
2 Children ®	58	1.924	**6.850*** **	57	54
3 and above children	155	1.717	**5.565*** **	46	49
Family Type					
Joint Family ®	86			42	44
Nuclear Family	152	0.100	1.105	48	47
Caste					
Others ®	100			49	50
OBC	98	-0.412	0.663	45	39
SC/ST	40	0.100	1.105	40	52
Education of a man/husband					
No Education ®	32			44	48
Up to 8th level	59	-0.626	0.535	31	33
Above 8th level	147	0.105	1.111	52	51
Standard of living					
Low ®	51			37	42
Medium	118	0.221	1.247	45	48
High	69	0.105	1.110	54	45
Woman's/Wife's work status					
Not working ®	188			41	41
Working	50	0.835	**2.305** **	64	62
Husband's nature of work					
Manual job ®	130			42	42
Non-manual job	108	0.354	1.425	50	51
Media exposure					
No exposure to mass media ®	32			28	26
Exposed to mass media	206	1.026	**2.791** **	49	49
Women's empowerment					
Low empowerment ®	101			33	35
High empowerment	137	0.756	**2.130** **	55	54
Residence					
Villages with low urban characteristics ®	120			42	44
Villages with high urban characteristics	118	0.177	1.194	50	48
Husband's workplace					
Within the village ®	129			38	40
Outside the village	109	0.480	1.616	55	52
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			30	38
Visit relatives in urban areas	195	0.387	1.472	49	48
Constant		-4.130	0.016		
% of husband's involvement	**46**				

®- Reference Category -2 log likelihood = 280.070, Nagelkerke R Square = 0.245, Significance level- *** at 1%, ** at 5%, * at 10%; N= 238. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

TABLE-9: Involvement of husbands in getting contraceptive for wife (Responses from men)

Background Characteristics	Total no. of men	B	Exp (B)	Percentage husbands involved in getting contraceptive	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	150			13	15
36 and above	48	-0.546	0.579	13	9
No. of living children					
1 Child	-	-	-	-	-
2 Children ®	77			5	4
3 and above children	121	2.155	**8.629*** **	18	26
Family Type					
Joint Family ®	110			11	13
Nuclear Family	88	0.075	1.077	16	14
Caste					
Others ®	61			13	9
OBC	98	0.729	2.073	14	16
SC/ST	39	0.518	1.678	10	14
Education of a man/husband					
No Education ®	35			17	23
Up to 8th level	58	-0.762	0.467	14	12
Above 8th level	105	-0.871	0.419	11	11
Standard of living					
Low ®	53			11	6
Medium	69	0.653	1.920	13	11
High	76	1.577	**4.839***	14	24
Woman's/Wife's work status					
Not working ®	166			12	12
Working	32	0.690	1.994	19	21
Husband's nature of work					
Manual job ®	155			12	11
Non-manual job	43	0.855	2.352	19	23
Media exposure					
No exposure to mass media ®	19			21	29
Exposed to mass media	179	-1.125	0.325	12	12
Women's empowerment					
Low empowerment ®	145			8	9
High empowerment	53	1.563	**4.771*** **	26	32
Residence					
Villages with low urban characteristics ®	126			11	12
Villages with high urban characteristics	72	0.212	1.236	16	14
Husband's workplace					
Within the village ®	126			9	11
Outside the village	72	0.642	1.901	21	19
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			16	20
Visit relatives in urban areas	155	-0.641	0.527	12	12
Constant		-3.891	0.020		
% of husband's involvement	**13**				

®- Reference Category -2 log likelihood = 120.615, Nagelkerke R Square = 0.287, Significance level- *** at 1%, ** at 5%, * at 10%;

N= 198. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12), Note: Men with 1 child are dropped from the analysis.

TABLE-10: Husbands' involvement in decision-making on contraceptive use (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in decision-making on contraceptive use	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	159			42	41
36 and above	79	0.078	1.081	42	43
No. of living children					
1 Child ®	25			24	19
2 Children	58	1.224	**3.400****	48	44
3 and above children	155	1.272	**3.566****	42	45
Family Type					
Joint Family ®	86			47	52
Nuclear Family	152	-0.670	**0.512****	39	36
Caste					
Others ®	100			39	38
OBC	98	0.150	1.161	46	42
SC/ST	40	0.416	1.515	38	49
Education of a man/husband					
No Education ®	32			41	51
Up to 8th level	59	-0.633	0.531	34	35
Above 8th level	147	-0.339	0.712	45	42
Standard of living					
Low ®	51			29	34
Medium	118	0.517	1.676	43	46
High	69	0.267	1.306	48	40
Woman's/Wife's work status					
Not working ®	188			38	39
Working	50	0.513	1.670	54	52
Husband's nature of work					
Manual job ®	130			38	39
Non-manual job	108	0.268	1.308	45	45
Media exposure					
No exposure to mass media ®	32			22	23
Exposed to mass media	206	1.035	**2.816****	45	45
Women's empowerment					
Low empowerment ®	101			31	31
High empowerment	137	0.839	**2.314*****	50	50
Residence					
Villages with low urban characteristics ®	120			38	41
Villages with high urban characteristics	118	0.075	1.078	45	43
Husband's workplace					
Within the village ®	129			37	39
Outside the village	109	0.265	1.303	47	45
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			26	30
Visit relatives in urban areas	195	0.623	1.864	45	44
Constant		-3.528	0.029		
% of husband's involvement	**42**				

®- Reference Category, -2 log likelihood = 289.257, Nagelkerke R Square = 0.179, Significance level- *** at 1%, ** at 5%, * at 10%; N= 238. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

TABLE-11: Husbands' involvement in decision-making on contraceptive use (Responses from men)

Background Characteristics	Total no. of men	B	Exp (B)	Percentage husbands involved in decision-making on contraceptive use	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	181			40	42
36 and above	50	-1.262	**0.283****	20	17
No. of living children					
1 Child ®	33			27	16
2 Children	77	0.871	2.389	39	31
3 and above children	121	1.536	**4.647*****	36	46
Family Type					
Joint Family ®	133			34	32
Nuclear Family	98	0.389	1.476	38	41
Caste					
Others ®	71			38	28
OBC	110	0.662	**1.938***	41	43
SC/ST	50	0.080	1.083	20	30
Education of a man/husband					
No Education ®	41			27	38
Up to 8th level	66	-0.270	0.763	30	31
Above 8th level	124	-0.020	0.980	41	37
Standard of living					
Low ®	59			24	19
Medium	81	0.761	2.140	32	33
High	91	1.537	**4.653*****	46	52
Woman's/Wife's work status					
Not working ®	194			35	35
Working	37	0.163	1.177	41	39
Husband's nature of work					
Manual job ®	178			31	34
Non-manual job	53	0.355	1.426	49	42
Media exposure					
No exposure to mass media ®	21			33	57
Exposed to mass media	210	-0.962	0.382	36	34
Women's empowerment					
Low empowerment ®	165			25	27
High empowerment	66	1.418	**4.127*****	61	60
Residence					
Villages with low urban characteristics ®	116			23	25
Villages with high urban characteristics	115	1.028	**2.796*****	48	48
Husband's workplace					
Within the village ®	139			29	35
Outside the village	92	0.108	1.114	45	37
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	49			31	40
Visit relatives in urban areas	182	-0.235	0.791	37	34
Constant		-2.923	0.054		
% of husband's involvement	**36**				

®- Reference Category, -2 log likelihood = 238.691, Nagelkerke R Square = 0.323, Significance level- *** at 1%, ** at 5%, * at 10%; N= 231. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).

TABLE-12: Involvement of husbands in getting sterilization services (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in getting sterilization services	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	137			22	23
36 and above	76	2.025	**7.575*** **	67	69
No. of living children					
1 Child	-	-	-	-	-
2 Children ®	58			14	15
3 and above children	155	1.712	**5.540*** **	47	49
Family Type					
Joint Family ®	73			33	42
Nuclear Family	140	-0.245	0.783	41	36
Caste					
Others ®	87			29	32
OBC	93	0.907	**2.476** **	44	54
SC/ST	33	-0.986	0.373	8	15
Education of a man/husband					
No Education ®	32			56	60
Up to 8th level	55	-1.22	**0.295** **	33	30
Above 8th level	126	-0.946	**0.388***	36	36
Standard of living					
Low ®	50			20	45
Medium	102	-0.245	0.783	40	39
High	61	-0.547	0.579	21	32
Woman's/Wife's work status					
Not working ®	166			40	40
Working	47	-0.379	0.685	32	31
Husband's nature of work					
Manual job ®	121			36	39
Non-manual job	92	-0.104	0.901	40	37
Media exposure					
No exposure to mass media ®	31			42	35
Exposed to mass media	182	0.161	1.174	37	39
Women's empowerment					
Low empowerment ®	88			36	33
High empowerment	125	0.359	1.432	39	42
Residence					
Villages with low urban characteristics ®	110			45	48
Villages with high urban characteristics	103	-0.855	**0.425** **	31	28
Husband's workplace					
Within the village ®	116			40	32
Outside the village	97	0.593	1.809	36	46
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	40			45	40
Visit relatives in urban areas	173	-0.110	0.896	36	38
Constant		-1.644	0.193		
% of husband's involvement	**38**				

®- Reference Category -2 log likelihood = 205.166, Nagelkerke R Square = 0.416, Significance level- *** at 1%, ** at 5%, * at 10%; N= 213. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12), Note: Women with 1 child are dropped from the analysis.

TABLE-13: Involvement of husbands in getting sterilization services (Responses from men)

Background Characteristics	Total no. of men	B	Exp (B)	Percentage husbands involved in getting sterilization services	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	150			18	20
36 and above	48	-0.697	0.498	15	11
No. of living children					
1 Child	-	-	-	-	-
2 Children ®	77			9	8
3 and above children	121	1.495	**4.458*** **	22	27
Family Type					
Joint Family ®	110			14	15
Nuclear Family	88	0.277	1.320	22	19
Caste					
Others ®	61			18	16
OBC	98	0.370	1.447	19	21
SC/ST	39	-0.374	0.688	10	11
Education of a man/husband					
No Education ®	35			23	23
Up to 8th level	58	-0.713	0.490	16	13
Above 8th level	105	-0.332	0.718	16	18
Standard of living					
Low ®	53			15	12
Medium	69	0.658	1.930	13	20
High	76	0.578	1.783	22	19
Woman's/Wife's work status					
Not working ®	166			14	15
Working	32	1.225	**3.406** **	31	37
Husband's nature of work					
Manual job ®	155			17	17
Non-manual job	43	0.064	1.066	19	18
Media exposure					
No exposure to mass media ®	19			26	36
Exposed to mass media	179	-1.098	0.334	16	16
Women's empowerment					
Low empowerment ®	145			12	14
High empowerment	53	0.952	**2.592** **	30	29
Residence					
Villages with low urban characteristics ®	126			14	14
Villages with high urban characteristics	72	0.420	1.522	21	20
Husband's workplace					
Within the village ®	126			13	14
Outside the village	72	0.664	1.942	25	24
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	43			21	22
Visit relatives in urban areas	155	-0.375	0.687	16	16
Constant		-2.631	0.072		
% of husband's involvement	**17**				

®- ***Reference Category -2 log likelihood = 149.859, Nagelkerke R Square = 0.247, Significance level- *** at 1%, ** at 5%,***

**** at 10%; N= 198. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12), Note: Men with 1 child are***

dropped from the analysis.

TABLE-14: Involvement of husbands in wife's sickness (Responses from women)

Background Characteristics	Total no. of women	B	Exp (B)	Percentage husbands involved in wife's sickness	
				Unadjusted	Adjusted
Wife's age					
Up to 35 years ®	114			87	86
36 and above	55	-0.200	0.819	82	83
No. of living children					
1 Child	17			88	78
2 Children ®	37	0.913	2.493	89	90
3 and above children	115	0.441	1.555	83	84
Family Type					
Joint Family ®	116			86	82
Nuclear Family	53	0.733	2.081	83	91
Caste					
Others ®	60			77	68
OBC	72	1.254	**3.504****	90	88
SC/ST	37	2.080	**8.005****	89	94
Education of a man/husband					
No Education ®	28			68	74
Up to 8th level	46	0.216	1.241	83	78
Above 8th level	95	1.134	3.108	92	90
Standard of living					
Low ®	51			76	78
Medium	118	0.719	2.052	89	88
High	-	-	-	-	-
Woman's/Wife's work status					
Not working ®	136			85	86
Working	33	-0.518	0.596	85	79
Husband's nature of work					
Manual job ®	109			82	81
Non-manual job	60	0.757	2.133	92	90
Media exposure					
No exposure to mass media ®	27			70	79
Exposed to mass media	142	0.487	1.628	88	86
Women's empowerment					
Low empowerment ®	81			77	73
High empowerment	88	1.408	**4.088****	93	92
Residence					
Villages with low urban characteristics ®	88			84	88
Villages with high urban characteristics	81	-0.477	0.621	86	82
Husband's workplace					
Within the village ®	94			80	79
Outside the village	75	0.959	2.609	92	91
Visit relatives in urban areas					
Do not visit relatives in urban areas ®	42			71	77
Visit relatives in urban areas	127	0.689	1.992	90	87
Constant		-2.669	0.069		
% of husband's involvement	**85**				

®- Reference Category -2 log likelihood = 105.042, Nagelkerke R Square = 0.343, Significance level- *** at 1%,

***** at 5%, * at 10%; N= 169. Source:- Survey conducted in Gautam Buddha Nagar District (2011-12).***

Note: Women from high standard of living are dropped from the analysis.

SOME PHOTOGRAPHS FROM THE FIELD SURVEY

Grassroots Health workers actively involved at the village level

A mud and dung wall painting of goddess during Dussehra

Researcher interviewing a woman

Example of industrial development in the village