

Study Report

Macarthur - CINI Macarthur Project

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EXECUTIVE SUMMARY

The national Family Planning programme (F.P) was started in 1951-52 as a purely demographic programme to check the rapid increase of the population in our country. The health status of the women in the reproductive age group and of under five children is of crucial importance for effectively tackling the problem of the growth of the population. Reproductive health programmes should focus on the needs of actual and potential clients, not only limiting the births but for healthy sexuality and child bearing. Reproductive health interventions would enable clients (1) to make informal choice, (2) to receive counseling and education for responsible and healthy sexual behavior, (3) to access user friendly services for preventing unwanted pregnancy and safe abortion, (4) maternity care and child survival and (5) management of reproductive tract infection (RTIs). At the end of the project in the third year the possible outcomes will include:

- All identified eligible couples will have to mutually discuss and decide the use of contraceptive methods, emphasis being put on male methods.
- Men's own reproductive health need will be adequately addressed in improving their pattern of sexual behavior.
- Men will be encouraged to become more aware of partners' Reproductive health issues and measure the male involvement in terms of Stress Management and cope with anger, sexual dysfunction, reproductive health problems, infertility etc.

The outputs, to be achieved from the project at the end of its three years duration are outlined as such:

- Reduction in the rate of unwanted pregnancies through the use of male methods viz.- vasectomy and condoms.
- Reduction of prevalence of STI among men and women and
- Reduction of RTI by men's support and care.

The study area is limited to 10,000 population each in the Blocks of Bishnupur-I (Sector-I) and Diamond Harbor (Sector-III) of CINI project area.1, 200 eligible couples from the first area (4 villages) and 800 couples from the second area (1 village) have been identified for the purpose. The four villages in Area-I are Abjakhali, Dakshin Bagi, Khariberia and Bhasa#14 and the only village in Area-II is Kamarpole. Both qualitative and quantitative methods have been used to collect data from the field. The results of both these surveys have been dealt separately in different chapters on the basis of the desired outputs of this project such as: (a) Background characteristics of the eligible couples under study, (b) Use of condoms (c) Acceptance of Vasectomy (d) Reduction of STDs /RTIs /HIV /AIDS and (e) Increasing male participation in RCH activities.

As observed from the fieldwork nearly 45% of the local population are land less. The area being a micro-cropped area has little access (20%) to irrigation. Mostly the illiterate young people get married earlier than the educated ones. In the illiterate category as well as in the primary level the area I shows a higher percentage than area II which more or less compensated by a lower percentage of secondary level education by the unmarried males. In area-I more people are engaged in daily labour or small business in both agricultural and trade sectors as the area is close to Calcutta. But in area-II people choose to do small businesses themselves or engaged in other business concerns. A good proportion of the married males, mostly Muslims in area- II is employed as tailors and masons. Nearly one fourth of the youth are mostly unemployed and school dropouts. Most of the wives are housewives and more than forty percent of them are illiterate in both the areas. In most of the Muslim families it has been marked that education of girl child gets least priority. More than ninety five percent of wives in both the areas are housewives. Occasionally they do help their husbands in their occupations and hardly work independently outside. . In area II more than 80% of the families live in poverty i.e. less than Rs.1500 per month. The general economic condition of area-I is little better than area-II. About one third of males in both the areas are married before attaining 21, the legal age of marriage. Only the educated, unemployed youths delay their marriage after 25 up to the time they get suitable job. Most of the girls after attaining puberty if not continuing with education are given marriage as soon as the parents get a suitable groom. Child marriages i.e. boys before 19 years and girls before 15 years of age are not uncommon in both the areas despite a majority of population know them as illegal.

When in area –I the legal age of marriage is known to 75% of the respondents, only half of them in area-II could give a suitable reply. In comparison to the married males the unmarried group is found to be more knowledgeable about the correct legal age at marriage for both the sexes. Almost all respondents (98%) in area (100%) & I in area-II were aware of physical changes in both boys and girls during adolescence. The young males prefer to have two children in maximum with one son and one daughter. Three to five years age gap is the ideal spacing of birth desired by the young respondents.

The condom is the most known and established method of birth control in India although it is ironical that the condom developed with sole objective of protecting sexually transmitted diseases was never means to be a mass product. The women were reluctant to this method due to lack of adequate privacy in Indian homes. They deemed it immodest to them, as it implied their active incitement to sex when social norms compels them to be its passive acceptors of sex.

In area-II use of condoms seems to be more popular than area-I which is distributed over four different villages with different ethnic composition. The use of oral pills as a temporary birth control measure is widely chosen in both the areas despite its side effects. This shows that women are held responsible for any family planning activity rather than the males in the area. People when asked about the cost factor involved for using condoms invariably answered in negative but stressed on the factor of its regular availability in the rural sector. Uninterrupted sexual pleasure is the main reason behind

the use of oral pills among the males of all age groups. The poverty and illiteracy play a major role in shaping the people's mind. The doctors and the medical practitioners of both the areas always form the major source of information with regards to issues concerning the reproductive health. In area -I where CINI is working since long, nearly 40% of the people have mentioned about the CINI health workers as their source of information for any family planning method; while in area-II the same is done by the government health workers. The Peer educators of this project who started functioning since the last few months have also started to educate the people in this regard. Apart from all these the elders in the family mostly parents or parents in law usually guide the younger generations which is very normal in any Indian set up with either nuclear or joint family structure in operation. Both condoms and oral pills scored all other methods though some natural methods as well as homeopathic medicines attract a significant proportion of the unmarried male respondents.

The qualitative study carried out along with the quantitative survey outlines the following findings on which the future strategy has to be drawn upon. They are as follows:

1. The use of condoms was somewhat preferred by the younger age-groups (<30years) to be followed up later by methods needing clinical interruptions temporarily initially and later on permanently.
2. Most of the couples use it as a birth control method rather than a barrier or check against STDs/RTIs/HIV/AIDS.
3. Condom use was more seen in affectionate and consistent relationships rather than occasional and commercial relationships.
4. Condom usage is hardly discussed by persons who play a key role in its prevention, namely doctors and other health care providers.
5. The specific barriers against acceptance of the condom use vary with different groups that need to be addressed separately.

Vasectomy as a technical procedure for a permanent method of birth control has a long and checkered history. Despite various efforts during the last decade men usually do not come forward to accept vasectomy due to many psychological, physical, economic and socio-cultural reasons. The health care providers' point of view also deserves a mention in this regard.

Most of the people interviewed have expressed their apprehension about losing sexual power after undergoing vasectomy. In many cases the women on their accord or persuaded by their husbands undergo Tubectomy. As most of the people of this area are either daily labourers or engaged in hard working professions, they never prefer to undergo vasectomy which also in most of the cases is agreed upon by their partners or family members. Although invariably the male members decide the size of the family, their wives take the burden of the family planning and undergo tubectomy without any objection. The respondents in area-II, opined that the tubectomy is a critical operation but does not hamper the physical health of the women as they stay indoors most of the time. The knowledge of the young unmarried males about the permanent birth control methods seems to be less in comparison to their knowledge of the temporary methods.

Tubectomy is more practiced in both the areas for which it is also known to the majority of the youths. But still a significant proportion of the youth either does not know any permanent birth control method or both of them at a time.

The qualitative survey conducted in both the areas reveals the following:

1. Men tend to refuse family planning practices for themselves and for their wives because they fear they will lose sexual power in the relationship they do not trust their partners' faithfulness and they also fear that they will lose sexual pleasure and virility by using condom or by having vasectomy.
2. Most of the males who are not better educated tend to believe in various myths in relation to virginity, pain, noise, the size of sexual organs etc.
3. Men perceive that family planning programmes are not men-friendly. Furthermore, men are not encouraged to attend the births of their children at their homes or in their institutions.

Both qualitative and quantitative surveys carried out in this area reveal the following factors that are responsible for causing STDs/RTIs in the area:

1. Irresponsible sexual behavior of the male partners,
2. No access to safe and adequate water supply,
3. No privacy while bathing/open defecation,
4. No proper hygienic toilet facilities,
5. Inadequate facilities available in the Primary Health Centres,
6. Rampant commercial sex activities in the area, and
7. Inadequate knowledge of the community.

Excluding that of AIDS in area-II and scabies in area-I, the male members of both the areas know no other sexually transmitted diseases. However, the male respondents know some of the common symptomatic elements, but they do not know their mode of transmission. About the mode of transmission of these diseases, man to woman or husband to wife response has never come significantly. The responses of woman to man and commercial sex worker to man are not much differentiated from one another and combiningly do not vary much area-wise. The more educated the population is the better is the response regarding the knowledge of spread of STD through commercial sex workers.

The location of the PHC for area-I is far away from the four studied villages, which make it difficult for the people to avail the required medical facilities on time. The treatment of different sexually transmitted diseases the poor and semi-literate people depend upon the village quacks, which treat them in confidence and take very nominal fees. When the diseases become serious and chronic the poor patients usually move to the government establishment and the well to do ones to the private practitioners. In area-II a few Homeopathic and Ayurvedic doctors make a brisk business by treating these diseases.

Most of the unmarried youths are very knowledgeable about the different sexually transmitted diseases, more specifically about syphilis, gonorrhoea etc. Like their married counterparts the young unmarried males are of the opinion that commercial sex workers are the major source of all sexually transmitted diseases. The young respondents prefer to seek the services of a registered practitioner or qualified physician, even a Homeopathic one rather than to treat themselves. Nearly half of the respondents agree that sexually transmitted diseases would definitely affect their marriage life if they suffer from it for a considerable period of time.

Although leucorrhoea or white discharge is known as one of the most commonly seen reproductive tract infections in the area, the male respondents seem to be less informed about it. Irregular menstruation in area –II and scabies in vagina in area-I are the two other different types of RTIs prevalent in these areas as reported by the respondents. In all age groups males have reported that their wives do inform them on time about the onset of the problems. In initial stages home remedy is mostly preferred with advice from seniors or friends in this regard. Only one fifth of the women go to the quacks for the treatment of their problems but most preferably avoid the local quacks of the same village. In later stages women go to the PHC or any registered practitioner for availing medical facilities. In most of the cases the husbands do not accompany their wives to the medical centres and women are under the control and subjugation of their husbands and in-laws. Unless the husband agrees to allow the wife to seek treatment, it is almost impossible for the woman to access services by herself. For the man to allow his wife to seek treatment, he has to first be made aware of the need to develop proper health-seeking behaviour. Along with CINI, the Rising Sun Club of Kamarpole also try to motivate the male members for taking a quick and appropriate decision regarding the treatment of RTIs by the authorized medical practitioners. Unlike the married males here both the mass media and the print media have got significant effect on the decision making process on the young adolescents.

The qualitative survey carried out in this area has brought out some interesting observations which affect the health seeking behavior of the population and subsequently the utilisation of health services by the eligible couples who suffer from different sexual health diseases.

In the phase of implementation from time to time Health & Family planning Counselors, Communication experts and Social Scientists were engaged in different project related works. The respective units of CINI did rest of the operational research, monitoring and evaluation works. At the field level help from different Govt. and non-Govt. agencies were solicited, as and when required. The future strategy of the project includes:

1. Training of Peer educators, health care providers, Panchayat members, project personnel etc.
2. Counseling centers for eligible couples by experts and CINI staff
3. Conducting Clinics for male members by Medical doctors
4. Social marketing of condoms by Peer Educators

5. Information, Education and Communication inputs by CINI and other Govt. and non-Govt. organizations.

Different units of CINI have been entrusted with supervision, monitoring, evaluation and operations research activities to achieve the set targets within the stipulated time period. Separate cells headed by efficient personnel have been given the specific responsibility in implementing the above strategy. They include policy development, regulation, reorienting organisational infrastructure, advocacy, capacity building, etc. to mobilise, empower and enable the community to make the programme sustainable.

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Chapter I

Introduction

Before discussing the role of male involvement / participation in the Reproductive and Child health programme(RCH) in the project area, it is necessary to discuss a little about the evolution and strategy of the programme in the national and international context. The national Family Planning programme (F.P) was started in 1951-52 as a purely demographic programme to check the rapid increase of the population in our country. Subsequently the element of public education and extension was included to facilitate the desired outcomes of the said programme. However, due to certain socio-cultural barriers the output was below expectation. But the experiences gained through this endeavor had amply established that the health status of the women in the reproductive age group and of under five children is of crucial importance for effectively tackling the problem of the growth of the population, which led to an effective change in the approach from family planning to family welfare with object to stabilise population at a level consistent with the needs of national development.

The Extended Programme of Immunisation (FPI) of 1978 followed by Universal Immunisation Programme(UIP)in 1985-86 aimed at reduction of mortality and morbidity among the infants and young children due to some major vaccine preventable diseases. The Oral Rehydration Therapy (ORI) and acute respiratory infection (ARI) control programme were also started in view of the fact that diarrhoea and ARI were two of the most dreaded causes of death among the young children. While these programmes did have a beneficial impact, the separate programmes caused problems in their effective management and coordination. Therefore, at the start of the 8th plan in 1992-93, all of these programmes were integrated under the Child Survival and Safe Motherhood (CSSM) programme from 1992-93. This led to further substantial improvement in the health of mothers and young children, though the position did not improve all over the country.

Moreover, the 1994 International Council for Population Development (ICPD), a growing international consensus on a new approach to policies to achieve population stabilisation. Fertility reduction concerns should be addressed at the level of broad social policy including the reduction of gender discrimination in education, health care and income generation. Reproductive health programmes should focus on the needs of actual and potential clients, not only limiting the births but for healthy sexuality and child bearing. In India the implications of the reproductive health approach would be to shift the focus from the use of family planning as a tool intended essentially for population stabilisation to using family planning as one among constellation of interventions that would enable women and men to achieve their personal reproductive goals without being subjected to the additional burdens of disease and health associated with their reproduction. Such a shift in emphasis is more likely to address the needs of women, who are at risk of unwanted births and in doing so assist the country to accelerate fertility decline. Reproductive health interventions would enable clients (1) to make

informal choice, (2) to receive counseling and education for responsible and healthy sexual behavior, (3) to access user friendly services for preventing unwanted pregnancy and safe abortion, (4) maternity care and child survival and (5) management of reproductive tract infection (RTIs).

The nation wide RCH programme based on well-defined strategies, health interventions and methodology has been officially announced by the honorable Prime Minister of India, on 15th October 1997. This ambitious RCH programme commencing in the 9th five year plan aims to effectively bring all the Reproductive and Child health services within easy reach of the community and most of its allocated resources will be for strengthening / improving facilities and services from peripheral to secondary and tertiary levels with well established referrals. The programme incorporates quality service provision with decentralised participatory planning while involving the community, panchayat, NGOs/ VOs and private sectors.

The programme of action strongly endorsed using ground breaking language, the concept of Reproductive and Child health and the services necessary to achieve needs. The adoption of notion of sexual health was in some ways, one of the most revolutionaries at ICPD. Thus the reproductive health framework extends beyond the narrow confines of family planning to encompass all aspects of human sexuality and reproductive health needs during the lifecycle.

A reproductive health approach means:

That the people have the ability to reproduction and regulate their fertility.

Women are able to go through pregnancy and childbirth safely.

The outcome of pregnancy is successful in terms of maternal and infant survival and well being.

Couples are able to have sexual relation free of the fear of pregnancy and of contracting disease.

The proponents of reproductive health framework believe that reproductive health is inextricably linked to the subject of reproductive rights.

The basic right of all the couples and individuals to decide freely and responsibly the number and spacing of their children and to have the ' information, education and communication means to do so;

The right to attain the highest standard of sexual and reproductive health;

The right to make decisions concerning reproduction free of discrimination, coercion and violence (UN-1994).

Male involvement in RCH

Up to the beginning of the IXth Five year plan all the programmes linked mother and child health were mostly focussed on women, as they had to bear the brunt of the burden. Therefore, the reproductive health has had a special emphasis on preventing unwanted pregnancy; and has largely dealt with women in the reproductive age period. This led to many areas of unmet reproductive and sexual health needs as well as several-neglected client groups, which included men and adolescents. As is evident, in many societies the gender inequalities favor men for taking many decisions regarding the sexual and reproductive health. So very lately during the last couple of years there is now a growing realisation evolved that unless men are reached with some special inputs the programme efforts will have limited impact. Besides men too have some pertinent reproductive health needs that should be addressed apart from encouraging men to take responsibility for family planning and reproductive health as sexual partners, husbands and fathers.

There are three reasons explaining why the issue of male involvement remained in the Bolivian to date and why this has come to the centre stage right now. They included:

1. As most of the contraceptives are designed for women, the policy planners which side lined men to take any initiation in this regard targeted them more.
2. As most of the societies are patriarchal, the economic burden is rested with the men which made women the soft targets for all other socio- cultural issues which included the needs for reproductive sexual health.
3. As in closed societies sex is not an open issue and seldom one can come across discussions on sex, sexuality, and sexual behavior etc. All the gaps became isolated from one another helped men to take a subdued role in these activities.

So near diverse perspectives on men's involvement in reproductive and sexual health has emerged with support of three implementing groups which include health sector personnel, development scientists and feminist and women activists. They have clearly identified four aspects on which all further programmes are to be initiated.

1. Men's involvement in decision regarding the family size and its effective achievement.
2. Men's involvement in the practice of fertility regulation.
3. Men's support for the reproductive health of women, and
4. Men's concerns for his own reproductive and sexual health needs.

Although there is more consensus on the first and some on the second, the third and fourth remain a contentious issue. Therefore, as decided by UNFPA in 1995 programmes to involve men more designed to address three major goals:-

Improve sexual and reproductive health of men and women.

To generate men's support for women's actions related to reproduction and respect for the women's reproductive and sexual rights; and

Promote responsible and healthy reproduction on sexual behaviour, the adolescents, the gender inequality as a major barrier will be overcome if these goals are met in coming year.

THE PRESENT PROJECT

Since 1997, funded by Mac Arthur Foundation, New Delhi, the present project deals with the male involvement in RCH programmes in two blocks of CINI project area. The present work is a part of the project that deals with the action research carried in the said areas at the start of the project. This phase of the action research covering the first year has three major objectives to fulfil. They are as such

To provide information on reproductive health problems of the communities and help to prepare action plan at different levels to encourage male involvement.

To give timely warning about reproductive health messages and initiate appropriate intervention programmes to prevent their occurrence.

To assist in management, monitoring and evaluation of reproductive health related programmes in the project area.

So at the end of the project in the third year the possible outcomes will include:

- All identified eligible couples will have to mutually discuss and decide the use of contraceptive methods, emphasis being put on male methods.
- Men's own reproductive health need will be adequately addressed in improving their pattern of sexual behavior.
- Men will be encouraged to become more aware of partners' Reproductive health issues and measure the male involvement in terms of:
 - a. Stress Management
 - b. Cope with anger
 - c. Cope with sexual dysfunction
 - d. Cope with Reproductive health problems
 - e. Cope with infertility.

Activities

The period of one year has been divided into two phases of six months each as Phase-I and Phase-II.

Phase-I [Through Participatory Rural Appraisal method]

1. Identification of major Reproductive health problems of the communities under study, which require future intervention.

2. Collection of the required information from the community and identification of the potential sources of data i.e. identification of 1,200 eligible couples in both the areas.

3. Determination of research questions/problems for the next phase of research.

4. Identification of Peer Educators through which all actions will be taken.

This phase has been already completed and different Reproductive Health problems of the communities have been identified. The project personnel with the help of the concerned Peer Educators have conducted the required PRAs.

The outputs, to be achieved from the project at the end of its three years period are outlined below:

1. Reduction in the rate of unwanted pregnancies through the use of male methods viz. - vasectomy and condoms.
2. Reduction of prevalence of STI among men and women.
3. Reduction of RTI by men's support and care.

Phase-II [Through Qualitative and Quantitative Data Collection methods]

1. Institutional arrangements for data collection for assessing the situation, analysis of causes and initiation of appropriate action on the above.
2. Determination of appropriate policies and inputs for programme interventions in the next phase of the project.

This report deals with the results of both these surveys conducted during the last six months of this phase.

Study area:

10,000 population each in the Blocks of Bishnupur-I (Sector-I) and Diamond Harbor (Sector-III) of CINI project area.

1,200 eligible couples from the first area (4 villages) and 800 couples from the second area (1 village) have been identified for the purpose.

The four villages in Area-I are Abjakhali, Dakshin Bagi, Khariberia and Bhasa#14 and the only village in Area-II is Kamarpole.

Sample size:

Age Group	Marital status	Number (Area-I +Area-II)
15-24	Unmarried male	100 + 100
15-24	Married Male	25 + 25
25-34	Married Male	150 + 150
35-44	Married Male	150 + 150
45 +	Married Male	75 + 75

Study methodology:

1.Quantitative methods:

- i. Format # 1: For all 400 + 400 married males of both the areas.
- i. Format # 2: For all 100 + 100 unmarried males of both the areas.

2.Qualitative methods:

(i) Key Informant Interviews: 8 from Area-I and 4 from Area-II.

(They were not necessarily from the identified 1,200 eligible couples)

(ii) In-depth Interviews:16 from Area-I and 8 from Area-II.

(They were necessarily from the identified 1,200 eligible couples)

(iii) Focus Group Discussions: 5 from Area-I and 5 from Area-II.

(They were necessarily from the identified 1,200 eligible couples and restricted to different specified age groups during FGDs. One FGD each was conducted with the Health Care Providers)

The study :

1. Data Collection: The Interviewers for quantitative data collection were all male and University Graduates. While some had previous experience in data collection, others

were new. All of them were given intensive field training for seven days at CINI before they have been sent to the field. Average age of the interviewers was 24 years and all of them are fluent in the local language, Bengali as well as Hindi and English. However, Senior Research Supervisors, appointed for this phase of Action Research, have collected the qualitative data. The Peer Educators of the respective areas assisted them in their fieldwork.

2.Supervision And Quality Control of Data Collection: Before the supervisors moved to the field with the team, tour programmes and their movements were finalised and made available to all. The project coordinator also made it a point to visit them for two days in a week in each area to check the methods and quality of data collection in the field as well as offering guidance and clarification of doubts, if any. Other Research personnel from CINI Research unit also invariably visited the field area during the survey work and extended all necessary help and advise to the field investigators.

3.Data Entry: The data entry was made in EPI INFO version 6, guided by the Research unit of CINI. Then they were analysed and monitored by the Monitoring unit of CINI.

4.Data Analysis: All completed questionnaires and recorded information sheets for the project were received at CINI office for data processing including editing, coding and data entry as per the tabulation plan and guidance offered by CINI.

5.Report writing: The data after analysis have been interpreted both by age group-wise and area-wise, which will be later taken up future intervention programmes. Although both qualitative and quantitative data were included in this report more emphasis has been given to the qualitative ones as this was a very sensitive issue on which the quantitative formats had their own limitations. People talked more freely in a group rather than individually. However, the in-depth interviews were conducted cautiously with the help of senior personnel of CINI. The results of both these surveys have been dealt separately in different chapters on the basis of the desired outputs of this project, such as

- (a) Background characteristics of the eligible couples under study,
- (b) Use of condoms
- (c) Acceptance of Vasectomy
- (d) Reduction of STD/RTI/HIV/AIDS
- (e) Increasing male participation in RCH activities.

The future plan of action with innovative strategy for the next two years has been included as the concluding chapter.

Chapter-II

Background characteristics

The beneficiaries of the programmes constitute the population that is spread over a cluster of villages in Bishnupur block II of the South Twenty-Four Pargonas district of West Bengal. They comprise mainly of Muslims and Hindus of scheduled constituencies and a majority of Christians. Nearly 45% of the local population are land less. The area being a micro-cropped area has little access (20%) to irrigation. The population is engaged in different kinds of occupation. They are mainly agricultural labourers while others are vegetable vendors, factory workers and daily labourers. As a result of low socio- economic conditions, inter alia relating to gender inequality, low education literacy and awareness levels prevalent, poor sanitation facilities and source of water, incidence of reproductive health related morbidities are frequent.

The different background characteristics of the respondents covered under the study, which is carried out, for 800 married in 4 different age groups and 200 unmarried males in 1 age group have been analysed below.

Quantitative Data Analysis

TABLE 1: Educational attainment of husband.

Category	Age Group I (15-24 years)		Age Group II (25-34 years)		Age Group III (35-44 years)		Age Group IV (45+ years)		Total	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1. Illiterate	24%	37%	17.8%	34.8%	28%	21.7%	25.6%	30.1%	23.5%	29.1%
2. Neo-literate	4%	7.4%	15.2%	10%	7.3%	8.5%	13.5%	9.5%	11.2%	9.2%
3. Primary	7.4%	24%	22.6%	14.0%	23.3%	14.4%	13.5%	15.0%	21.2%	13.9%
4. Secondary	44%	48.1%	39.7%	36.9%	38.6%	43.4%	39.1%	26.0%	39.5%	38.1%
5. Higher secondary	4%	0%	1.9%	0.6%	2.0%	2.6%	1.3%	6.8%	2.0%	2.4%
6. Graduate & above	0%	0%	2.6%	3.3%	0.6%	9.2%	6.7%	12.3%	2.5%	6.9%
TOTAL	25	27	151	149	150	152	74	73	400	401

Area wise

ANALYSIS:

The data on first age group of which comprises of married youth between 15- 24 years reveals that those who are mostly illiterate or school drop outs marry earlier than those who continue their study further. Apart from that no major differentiation has been marked between the educational composition of the groups excluding those of illiterates and graduates with a little higher percentage in area-II. During the collection of quantitative data it has been marked that most of the employed males remain outside the village during daytime for which they could not be included in this survey. One very pertinent observation has been marked from this table that mostly the illiterate young people get married earlier than the educated ones.

TABLE 2. Level of Education of unmarried youth

Category	Age Group (15-24 years)	
	Area I	Area II
1. Illiterate	13%	6%
2. Literate	3%	2%
3. primary	21%	13%
4. Secondary	53%	69%
5.Higher Secondary	5%	4%
6. Graduate	5%	6%

Analysis:

In the illiterate category as well as in the primary level the area I shows a higher percentage than area II which more or less compensated by a lower percentage of secondary level education by the unmarried males. Although facilities are limited to get better education in area II in no way the area lags behind. But the youth of area II do not get married early if they are educated beyond secondary level.

TABLE 3: Occupation of Husband

Category	Age Group I (15-24 years)		Age Group II (25-34 years)		Age Group III (35-44 years)		Age Group IV (45+ years)		Total Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
	1.Cultivation	4.0%	7.4%	13.2%	4.0%	7.3%	4.6%	5.4%	6.8%	9.0%
2.Daily Labour	68.0%	25.9%	55.6%	36.2%	54.6%	39.4%	54.0%	32.8%	55.7%	36.1%
3.Mason	0%	3.7%	0.6%	4.6%	1.3%	1.9%	0%	1.3%	0.7%	2.9%
4.Tailor	4.0%	37.0%	4.6%	13.4%	1.3%	5.2%	0%	6.8%	2.5%	10.7%
5.Service	8.0%	7.4%	9.9%	8.7%	6.0%	17.7%	8.1%	20.5%	8.0%	14.2%
6.Business	12.0%	11.1%	6.6%	18.1%	20.0%	24.3%	25.6%	23.2%	15.5%	20.9%
7.Vanrick puller	4.0%	3.7%	7.2%	11.4%	7.3%	5.9%	1.3%	5.4%	6.0%	7.7%
8.Others	0%	3.7%	1.9%	3.3%	2.0%	0.6%	5.4%	2.7%	2.5%	2.2%
TOTAL	25	27	151	149	150	152	74	73	400	401
Area wise										

ANALYSIS:

In area-I more people are engaged in daily labour or small business in both agricultural and trade sectors as the area is close to Calcutta. But in area-II people choose to do small businesses themselves or engaged in other business concerns. Both the areas are close to certain industrial units in which people prefer to do a variety of jobs either on contractual basis or permanently. A good proportion of the married males, mostly Muslims in area- II is employed as tailors and masons. As land owning is limited to some of the influential Hindu families less number of people take it as their main profession in the area.

TABLE 4: Pattern of Occupation of unmarried youth

Category	Age Group (15-24 years)	
	Area I	Area II
1. Student	28%	11%
2. Unemployed	23%	20%
3. Cultivator	-	3%
4.Daily Labour	30%	20%
5. Tailor	3%	23%
6. Service	4%	-
7. Business	6%	10%
8.VanRick Puller	2%	4%
9.Others	4%	9%

Analysis:

The unmarried youth of both the areas do some part time jobs along with their studies if they get any chance. Nearly one fourth of the youth are mostly unemployed and school dropouts. Some of them in area-I get jobs in other concerns because of its proximity to Calcutta where as in area II they usually help their parents in their professions or start doing small businesses themselves. As shown above, like the married males here also about one fifth of the unmarried males do the job of tailoring, carpentry etc.

TABLE 5: Educational Attainment of wife

Category	Age Group I		Age Group II		Age Group III		Age Group IV		Total	
	(15-24 years)		(25-34 years)		(35-44 years)		(45+ years)		Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1. Illiterate	36.0%	44.4%	32.4%	45.6%	52.0%	37.5%	48.6%	57.5%	43.0%	44.6%
2. Neo-literate	4.0%	3.7%	13.2%	8.7%	9.3%	5.9%	14.8%	6.8%	11.5%	6.9%
3. Primary	8.0%	11.1%	14.5%	10.0%	12.6%	13.1%	10.8%	4.1%	13.2%	10.2%
4. Secondary	52.0%	40.7%	39.0%	32.8%	24.0%	37.5%	22.9%	21.9%	31.2%	33.1%
5. Higher secondary	0%	0%	0.6%	1.3%	0.6%	2.6%	1.3%	1.3%	0.7%	1.7%
6. Graduate & above	0%	0%	0%	1.3%	0%	3.2%	1.3%	8.2%	0.2%	3.2%
TOTAL	25	27	151	149	150	152	74	73	400	401

Area wise

Analysis:

Most of the wives are housewives and more than forty percent of them are illiterate in both the areas. In area II like their male counter parts nearly 5% are seen to be educated beyond secondary level. No much differentiation has been marked in the composition of different age groups in both the areas apart from the fact that those who married early in life were either illiterate or educated up to primary level. In most of the Muslim families it has been marked that education of girl child gets least priority. However some of the women have got some elementary education through special literacy programmes of the government.

TABLE 6: Occupation of wife

Category	Age Group (15-24 years)		I Age Group (25-34 years)		II Age Group (35-44 years)		III Age Group (45+ years)		IV Total Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1. House wife	100%	100%	97.3%	97.9%	94%	95.3%	89.1%	95.8%	94.7%	96.7%
2. Cultivation	0%	0%	0%	0%	0.6%	0.6%	2.7%	1.3%	0.7%	0.4%
3. Daily labour	0%	0%	0%	0%	2.0%	0.6%	1.3%	0%	1.0%	0.2%
4. Semester	0%	0%	1.2%	0.6%	0%	1.2%	0%	0%	0.5%	0.7%
5. Service	0%	0%	0%	0%	0.6%	0%	1.3%	1.3%	0.5%	0.4%
6. Business	0%	0%	1.2%	0%	2.0%	0%	5.4%	1.3%	2.2%	0.2%
7. others	0%	0%	0%	1.2%	0.6%	2.4%	0%	0%	0.2%	0.9%
TOTAL	25	27	151	149	150	152	74	73	400	401

Analysis:

More than ninety five percent of wives in both the areas are housewives. Occasionally they do help their husbands in their occupations and hardly work independently outside. In younger age groups the married women are confined to their homes, busy in rearing up children. Once the children are grown up they keep themselves busy in jobs, not very far away from their houses. In area-I a few women are seen to be doing their individual business. The women who work outside in the field often get less remuneration in comparison to their male counterparts. Some of the agricultural activities are only limited to women. In area-I, because of its proximity to the city of Calcutta, some women serve as maid-servants in near by localities. As women do not significantly substantiate the family income they do have lesser control over the family decisions, which are mostly taken by their husbands or any other elder member of the family.

TABLE : 7 Family monthly income.

Category	Age Group (15-24 years)		I Age Group (25-34 years)		II Age Group (35-44 years)		III Age Group (45+ years)		IV Total Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1. Below-Rs1000	32.0%	81.4%	29.1%	71.8%	32.6%	61.1%	14.8%	49.3%	28%	
2. Rs.1001-1500	24.0%	18.5%	32.4%	18.1%	26.6%	20.3%	20.2%	16.4%	27.5%	
3. Rs.1501-2000	20.0%	0%	11.2%	8.0%	17.3%	10.5%	20.2%	15.0%	15.7%	
4. Rs.2001-2500	8.0%	0%	3.9%	0%	6.6%	2.6%	13.5%	2.7%	7.0%	
5. Rs.2501-3000	4.0%	0%	9.2%	1.3%	8.6%	1.9%	8.1%	4.1%	8.5%	
6. Rs.3001-above	12.0%	0%	13.9%	0.6%	8.0%	3.2%	22.9%	12.3%	13.2%	
TOTAL	25	27	151	149	150	152	74	73	400	

Area wise

ANALYSIS:

The general economic conditions of the families become better with advancement of age of the male earning member. In area II more than 80% of the families live in poverty i.e. less than Rs.1500 per month. The general economic condition of area-I is little better than area-II. As women seldom do a paid job, the total responsibility of the family lies with male members who find themselves very busy in earning their livelihoods. So they are quite indifferent to various other matters of the family including health and family welfare. However, the data on family income was not very reliable due to the fact that the respondents did not give actual figures during interview and calculating them did go wrong at places.

TABLE 8: Family category

Category	Age Group I (15-24 years)		Age Group II (25-34 years)		Age Group III (35-44 years)		Age Group IV (45+ years)		Total Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1.Nuclear	40%	70%	54%	84%	70%	85%	64%	76%	62%	82%
2. Joint	60%	30%	46%	16%	30%	15%	36%	24%	38%	18%
TOTAL	25	27	151	149	150	152	74	73	400	401
Area wise										

ANALYSIS:

In younger age group in area-I more families are joint families, which means at a younger age parents get their children married irrespective of their capability of earning their own livelihood. When they become self-sufficient they are allowed to lead their nuclear families and in course of time the cycle is again repeated. But due to urbanization and industrialization the past traditions are changing, as more families become nuclear just after marriage. Although these interpretations are well shown in the above table, another additional fact which deserves due mention here in this context is that the poorer the families in economic conditions more inclined they become to opt for a joint family system. Most of the Muslim families do not prefer to remain nuclear, as

also the Hindus with landed properties. In all these cases, males become less supportive to their partners as the joint families often take care of the responsibilities. Extended families are often seen who are mostly migrated from other places.

TABLE 9: Age of marriage by husband age group.

Category	Age Group I (15-24 years)		Age Group II (25-34 years)		Age Group III (35-44 years)		Age Group IV (45+ years)		Total Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
	1.10-15 years	0%	3.7%	2.6%	0%	0.6%	1.3%	0%	1.3%	1.2%
2.16-20 years	40.0%	66.6%	39.0%	32.2%	26.1%	26.0%	32.4%	19.1%	33.0%	30.1%
3.21-25 years	60.0%	29.6%	46.3%	59.7%	47.6%	45.0%	36.4%	35.6%	45.7%	47.3%
4.26-30 years	0%	0%	11.2%	8.0%	21.4%	21.0%	24.3%	28.7%	16.7%	16.2%
5.31-35 years	0%	0%	0.6%	0%	4.6%	6.5%	6.7%	15.0%	3.2%	5.2%
TOTAL	25	27	151	149	150	152	74	73	400	401

Area wise

Analysis:

About one third of males in both the areas are married before attaining 21, the legal age of marriage. Only the educated, unemployed youths delay their marriage after 25 up to the time they get suitable job. In joint family system the sons after attaining 19 to 21 years of age are compelled to get married even if they are not economically self sufficient. As evident from the above table it is a fact to reckon with that the age barrier is coming down in the younger age groups in area –I, where as the reverse is true for area-II. As observed from the field, the child marriage is a common phenomenon among the Muslims of area –II. But now-a-days more and more young people, if educated prefer to delay their marriage up to they become economically independent.

TABLE 10: Age of marriage of wife by husband age group

Category	Age Group I		Age Group II		Age Group III		Age Group IV		Total	
	(15-24 years)		(25-34 years)		(35-44 years)		(45+ years)		Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1. 10- 15 years	4.0%	29.6%	50.3%	26.1%	53.3%	26.8%	63.5%	39.7%	50.5%	28.9%
2. 16- 20 years	92.0%	70.3%	39.0%	69.1%	36.6%	63.8%	31.0%	42.4%	40.0%	62.3%
3 21- 25 years	4.0%	0%	9.9%	4.6%	10.0%	7.8%	5.4%	16.4%	8.7%	7.7%
4. 26 –30 years	0%	0%	0.6%	0%	0%	1.9%	0%	1.3%	0.2%	0.9%
TOTAL	25	27	151	149	150	152	74	73	400	401

Area wise

ANALYSIS:

Most of the girls after attaining puberty if not continuing with education are given marriage as soon as the parents get a suitable groom. Child marriages i.e. boys before 19 years and girls before 15 years of age are not uncommon in both the areas despite a majority of population know them as illegal. Women are hardly left unmarried after 25 years of age. As very much evident from the above table, in area-I where CINI is working for nearly 20 years a significant behavior change has been marked in increasing of the marriageable age of both the sexes. Very interestingly in area II some women of the older age groups got married at later age, which can be correlated of their attainment of higher education.

TABLE 11: Knowledge of legal marriage age

Category	Age Group I		Age Group II		Age Group III		Age Group IV		Total	
	(15-24 years)		(25-34 years)		(35-44 years)		(45+ years)		Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1. Correct	76%	37%	74.1%	45.6%	74%	55.2%	72.9%	47.9%	74%	49.1%
2. Incorrect	4%	14.8%	8.6%	15.4%	8.6%	13.1%	5.4%	12.3%	7.8%	13.9%
3.No response	20%	48.1%	17.2%	38.9%	17.2%	31.5%	21.6%	39.7%	18.2%	36.9%
TOTAL	25	27	151	149	150	152	74	73	400	401

Area wise

ANALYSIS:

When in area –I the legal age of marriage is known to 75% of the respondents, only half of them in area-II could give a suitable reply. As legal age at marriage seldom creates any legal hurdles for the population they are not very much bothered about it. CINI's awareness programmes in recent years in area-II have only made the people more knowledgeable. Only further education in this regard can bring about a behavior change in coming years.

TABLE 12: Knowledge of unmarried youth about Legal Marriage Age

Category	Age Group (15-24 years)	
	Area I	Area II
1. Yes	88%	95%
2. No	12%	5%
3. Actual Age(boy)	61%	82%

Analysis:

In comparison to the married males the unmarried group is found to be more knowledgeable about the correct legal age at marriage for both the sexes. CINI's recent awareness programmes have clearly affected the swing in favour of a better response for area-II. When met, most of the young people cited this cause as their main reason for not getting married.

Apart from the above quantitative formats administered to married and unmarried males, another twelve key-informants have also been interviewed in-depth to collect data on people and their pattern of sexual behaviour in these areas. Both the areas, since long have remained underdeveloped due to poor communication network and indifferent attitudes of both the Government and people. Backward castes and Muslims are in a majority who despite all efforts are very poorly educated and live in very unhygienic conditions. During the last decade a number of resorts have come up in the area that serve as den of all vices. The unsociable elements cause a great deal of trouble to the local people and also, the commercial sex workers are very active in the area. Both extramarital and premarital relationships are very common in these areas also. The various sexual diseases are quite prevalent in these areas but up to date no reported case of HIV/AIDS has been cited yet.

TABLE 13: Knowledge of unmarried youth about physical Changes

Category	<u>Age Group (15-24 years)</u>	
	Area I	Area II
1. Change of Boy Yes	98%	100%
2. No	2%	-
3. Change of girl Yes	98%	100%
4. No	2%	-
5. Boys:- Beard	93%	98%
6. Voice Change	56%	93%
7. Grow in Height	67%	98%
8. Girls:- Breast	87%	92%
9. Hand pit Hair	40%	64%
10. Menstruation	77%	63%
11. Height	72%	97%

Analysis:

Almost all respondents were aware of physical changes in both boys and girls during adolescence. But comparing their knowledge on both the sexes it has been found out beard for boys and breast for girls are the most known and visible sign of maturity as reported by the respondents.

As today's youth is tomorrow's parents, emphasis is given to find out their preference of the maximum number of children that they would like to have after marriage.

TABLE 14 : Preference of Children of unmarried youth.

Category	<u>Age Group (15-24 years)</u>	
	Area I	Area II
1. One Son	5%	--
2. One Daughter	1%	6%
3. One Son & One Daughter	70%	86%
4. Two Sons & One Daughter	19%	7%
5. Two Sons & Two Daughter	5%	1%

Analysis:

As seen from the above table most of the young males prefer to have two children in maximum with one son and one daughter. Even some of them have opted for a single child family with preference for son in area-I and daughter in area –II. Nearly one fourth of the respondents in area-I replied to have more than two children, as they are very concerned about longevity of the children. This clearly shows that today's youth is more concerned about limiting the family size, which may be the outcome of correct strategy of family welfare programmes in this area.

TABLE 15 : Preference of age gap of children of unmarried youth.

Category	<u>Age Group (15-24 years)</u>	
	Area I	Area II
1. 1 year	--	1%
2 2 year.	7%	17%
3. 3 year	45%	30%
4. 4 year	25%	16%
5. 5 year	22%	33%
6. 6 year	--	3%

Analysis:

As shown in this table three to five years age gap is the ideal spacing desired by the young respondents although a very few of them have said in favor of either less than three and more than five years also.

CHAPTER-III

USE OF CONDOMS

This is the most known and established method of birth control in India although it is ironical that the condom developed with sole objective of protecting sexually transmitted diseases was never means to be a mass product. In the early years of the family planning programme in India, the government favoured the diaphragm and jelly over other spacing methods. However, women were reluctant to this method due to lack of adequate privacy in Indian homes. They deemed it immodest to them, as it implied their active incitement to sex when social norms compels them to be its passive acceptors of sex. Interest in sex and initiation of it was viewed as the male prerogative. Hence, the use of condom was the most acceptable method, which is the only and directly male-controlled one. In this respect the current study is designed to study the use of condoms in the area against all other temporary methods and its reasons of it.

Quantitative Data Analysis

TABLE 16 : Use of temporary methods.

Category	Age Group I		Age Group II		Age Group III		Age Group IV		Total	
	(15-24 years)		(25-34 years)		(35-44 years)		(45+ years)		Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1. Condom	15%	26%	10%	24.8%	7.2%	25.6%	0%	15.7%	7.8%	24.6%
2. Abstinence	0%	0%	0%	0.6%	0%	0%	0%	0%	0%	0.3%
3. Withdrawal	0%	0%	1.8%	1.3%	1.3%	0%	0%	0%	1.3%	0.6%
4. O.P.	31.5%	60.8%	39.3%	55.5%	37.3%	45.6%	27.0%	34.2%	36.6%	48.9%
5. Homeopath	0%	0%	4.3%	0.6%	2.1%	0.8%	4.1%	2.6%	3.5%	0.9%
6. C.T.	0%	0%	3.7%	0%	2.1%	0%	2.0%	0%	2.7%	0%
7. Rhythm	47.3%	13.0%	40.6%	16.9%	50.0%	28.0%	66.6%	63.1%	48.0%	24.6%
TOTAL	25	27	151	149	150	152(125)	74(48)	73(38)	400	401
Area wise	(19)	(23)	(160)	(153)	(142)	(82.2%)	(51.3%)	(52%)	(368)	(333)
	(76%)	(85.1%)	(105%)	(102.6%)	(94.6%)					

ANALYSIS:

In area-II use of condoms seems to be more popular than area-I which is distributed over four different villages with different ethnic composition. The use of oral pills as a temporary birth control measure is widely chosen in both the areas despite its side effects. This shows that women are held responsible for any family planning activity

rather than the males in the area. Even the condoms used by some male members are either purchased or collected by their female partners. Couples using any natural method are not very consistent and their knowledge about the safe period is found to be wanting. Although people spend some money on homeopathic and ayurvedic methods, they are not very effective. The use of IUD was very limited and some times does not tally with the government figures. Those who do not use any method some times respond with more than one method, which seems to be a big exaggerated. The free supply of condoms and subsidised rate of oral pills do not affect their use in any significant manner.

TABLE 17 : Why condom is used.

Category	Age Group I (15-24 years)		Age Group II (25-34 years)		Age Group III (35-44 years)		Age Group IV (45+ years)		Total Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1. No cost	0%	0%	11.1%	2.6%	0%	0%	0%	0%	6.4%	1.2%
2. Less costly	66.6%	50%	22.2%	15.7%	50%	9.3%	0%	33.3%	35.4%	17.1%
3. Easily available	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
4. Easy use	0%	50%	50%	68.4%	0%	56.2%	0%	50%	22.5%	61.3%
5. Good for health	33.3%	0%	16.6%	13.1%	45%	30.0%	0%	16.3%	35.4%	20.2%
6. protection from diseases	0%	0%	0%	0%	5%	4.3%	0%	0%	3.2%	2.4%
TOTAL Area wise	25 (3)	27(6)	151(18)	149(38)	150(10)	152(32)	74(0)	73(6)	400(31)	401(81)

ANALYSIS:

People when asked about the cost factor involved for using condoms invariably answered in negative but stressed on the factor of its regular availability in the rural sector. The young and the newly married couples mostly use it either for delaying the first pregnancy or for spacing after the first child. They were not very conscious about its added advantage of giving protection against different sexual diseases. In both the areas the drug stores are not very well equipped and hardly store quality condoms. The government supply is not very regular and the quality of the condoms is poor. Most of the supplied condoms are distributed to the eligible couples by the concerned ANMs in their areas. Some of the respondents during the field survey told the investigators that condom use good for health and further inquiry opined that unlike oral pills condoms do not have any known side effect. The misconception about the condoms reducing sexual pleasure are so binding in the minds of the people that men often mentioned their wives do often disagree for using condoms. So in spite of the side effects and irregularity in use, oral pills always scored over condoms. However, some of the aged males often

used condoms while visiting sex workers, either of their own or provoked by the sex worker.

TABLE 18 : Why oral pill is consumed

Category	Age Group I		Age Group II		Age Group III		Age Group IV		Total		
	(15-24 years)		(25-34 years)		(35-44 years)		(45+ years)		Category wise		
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	
1.No cost	0%	0%	4.6%	0%	13.2%	1.7%	7.6%	0%	8.0%	0.6%	
2.Less costly	33.3%	21.4%	24.6%	22.4%	35.6%	22.8%	38.4%	0%	30.6%	21.4%	
3.Easy to use	0%	71.4%	46.1%	69.4%	26.4%	57.8%	38.4%	85.7%	38.6%	66.2%	
4.Good for health	66.6%	7.1%	24.6%	8.2%	24.5%	17.5%	15.3%	14.3%	22.6%	11.6%	
TOTAL	25(6)	27(14)	151(65)	149(85)	150(53)	152	74	73(7)	400	401	
Area wise						(57)	(13)			(137)	(163)

ANALYSIS:

Most of the women consuming oral pills get it from the nearest PHC through the ANMs. Although the quantitative survey is limited to the male respondents, their responses were directed to its cost factor and easy to use approach that always overrides the cause of side effects. Uninterrupted sexual pleasure is the main reason behind the use of oral pills among the males of all age groups. Even some of the Muslim eligible couples use oral pills as a permanent method for birth control, as often they cited religious strictures for getting operated. The drug stores of both the areas hardly store any oral pills of better quality for which the women have to depend mostly on the government supply. When asked about the preference of oral pills to condoms the respondents cited many reasons that have been discussed in detail during qualitative survey.

TABLE 19: Sources of information about temporary method

Category	Age Group I		Age Group II		Age Group III		Age Group IV		Total	
	(15-24 years)		(25-34 years)		(35-44 years)		(45+ years)		Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1.Govt.health worker	0%	30%	1.8%	34.1%	4.1%	28.2%	6.6%	29.3%	3.3%	30.7%
2.CINI health worker	45%	20%	44.3%	7.7%	42.4%	8.9%	36.6%	6.8%	42.5%	9.2%
3.Pear educator	10%	10%	3.1%	3.5%	4.1%	1.5%	1.6%	1.7%	3.6%	3.0%
4.Doctor	30%	20%	40.5%	40.7%	37.6%	31.9%	30%	34.4%	37.3%	34.4%
5.Elders in the family	10%	17.5%	2.5%	11.3%	2.7%	17.2%	11.6%	25.8%	4.4%	16.2%
6.Radio	0%	2.5%	1.2%	1.1%	4.1%	3.0%	5.0%	0%	2.8%	1.9%
7.T.V.	5%	0%	1.8%	0.5%	0%	3.0%	5.0%	0%	1.8%	1.5%
8. Books	0%	0%	3.7%	0%	4.1%	3.6%	3.2%	0%	3.6%	1.5%
9.News paper	0%	0%	0%	0%	0%	1.0%	0%	1.7%	0%	0.6%
10.Advertisement	0%	0%	0.6%	0.5%	0.6%	1.0%	0%	0%	0.2%	0.6%
TOTAL	Area wise								383	456

ANALYSIS:

Analysing the above table it is being observed clearly that both print media and mass media did not significantly influence the knowledge base of the population which is mainly due to the fact that poverty and illiteracy play a major role in shaping the people's mind. But the doctors and the medical practitioners of both the areas always form the major source of information with regards to issues concerning the reproductive health. In area -I where CINI is working since long, nearly 40% of the people have mentioned about the CINI health workers as their source of information for any family planning method; while in area-II the same is done by the government health workers. The Peer educators of this project who started functioning since the last few months have also started to educate the people in this regard. Apart from all these the elders in the family mostly parents or parents in law usually guide the younger generations which is very normal in any Indian set up with either nuclear or joint family structure in operation.

TABLE 20 : Knowledge of unmarried youth about temporary methods.

Category	<u>Age Group (15-24 years)</u>	
	Area I	Area II
1.Male: condom	94%	88%
2. Abstinence	3%	5%
3.Withdrawal	--	10%
4. Female:- O.P.	92%	91%
5.Homeopath	17%	7%
6. C.T.	3%	21%
7. Rhythm	7%	18%
8.Not known any temporary method.	2%	7%

Analysis:

Due to recent awareness generation camps by CINI in both the areas the knowledge about the temporary methods has shown better results in comparison to the situation before two years in the area. Both condoms and oral pills scored all other methods though some natural methods as well as homeopathic medicines attract a significant proportion of the unmarried male respondents. However they are of the opinion that any temporary method when used correctly and consistently brings the desired results. But still there remains some that are still not aware of any temporary birth control device.

The qualitative study carried out along with the quantitative survey outlines the following findings on which the future strategy has to be drawn upon. They are as follows.

- The use of condoms was somewhat preferred by the younger age-groups (<30years) to be followed up later by methods needing clinical interruptions temporarily initially and later on permanently.
- Most of the couples use it as a birth control method rather than a barrier or check against STDs/RTIs/HIV/AIDS.
- The use of condoms was found to be preferred in marital sex to either extra-marital or premarital sex. Previously in commercial sex activities condoms were hardly used. But in recent months due to various intervention programmes by CINI the situation has been considerably changed.
- Condom use was more seen in affectionate and consistent relationships rather than occasional and commercial relationships.

- Physical pleasure, which is reported to be the main reason for seeking commercial sex and multiple partners, is thwarted by the use of condoms. Thus it is avoided in most instances and they had to be paid more for the purpose. Hence, the transmission of sexual diseases became a very normal and costly proposition.
- Condom usage is hardly discussed by persons who play a key role in its prevention, namely doctors and other health care providers.
- The specific barriers against acceptance of the condom use vary with different groups that need to be addressed separately.
- Apart from the above, the use of condoms raises many pertinent issues in the minds of its users which also significantly affects its correct and consistent use. They include:
 - Availability of condoms
 - Quality of the product
 - Effectiveness as viewed by the consumer
 - Correct procedure of its use
 - Lubrication
 - Storage facilities at home
 - Disposal of condoms after use
 - Consistency/Periodicity of use
 - Reusing of condom
 - The reversibility of the method
 - Social / Cultural / Psychological attitudes, and
 - Social marketing

CHAPTER-IV

ACCEPTANCE OF VASECTOMY

Vasectomy as a technical procedure for a permanent method of birth control has a long and checkered history. Although it is a controversial matter enough pointers are there in the history to show why men do not accept vasectomy. Besides, the off-quoted male chauvinism, gender issues are also reasons for rejecting vasectomy. Despite various efforts during the last decade men usually do not come forward to accept vasectomy due to many psychological, physical, economic and socio-cultural reasons. The health care providers' point of view also deserves a mention in this regard. They include:

1. Psychological fears
2. Fear about loss of strength
3. Loss of sexual satisfaction
4. Social ostracism
5. Provider bias
6. Fear of complications
7. Fear of conception due to failure
8. Loss of wages
9. Different social mores
10. Gender and other convenience issue

TABLE 21: Reasons for accepting /non-accepting vasectomy

Category	Age Group I		Age Group II		Age Group III		Age Group IV		Total	
	(15-24 years)		(25-34 years)		(35-44 years)		(45+ years)		Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1.Easy operation	100%	0%	50%	66.6%	20%	75%	0%	75%	83.3%	47.0%
2.No side affect	0%	0%	0%	0%	10%	0%	0%	0%	0%	2.9%
3.Revertto normalcy	0%	100%	50%	33.4%	70%	25 %	0%	25%	16.7%	44.1%
4.Office rule	0%	0%	0%	0%	0%	0%	0%	100%	0%	5.8%
1. Loss of sexual power	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

ANALYSIS:

Most of the people interviewed have expressed their apprehension about loosing sexual power after undergoing vasectomy. As per their opinion, women lose neither sexual power nor interest after Tubectomy. So in many cases the women on their accord or

persuaded by their husbands undergo Tubectomy. It has been come to the notice of the investigators that their wives before going for the operation also not earlier informed some times husbands. The health care providers never highlight two major factors, which should have been made vasectomy more popular among the eligible couples. They are easy operation and the reversibility of the method. In this area, two to three deaths occurred before some years after undergoing vasectomy, which created a negative impact in the minds of the people. Also, the Muslims have their own apprehension for any kind of operation which definitely leaves a very different feeling in the minds of the Hindu population of the locality as if all these methods are directed towards Hindus for limiting their growth. However, all the male respondents agreed that vasectomy has got no major side effects except that of losing sexual power in the long run which also hampers their physical strength. As most of the people of this area are either daily labourers or engaged in hard working professions, they never prefer to undergo vasectomy which also in most of the cases is agreed upon by their partners or family members.

TABLE 22: Reasons for accepting / non- accepting tubectomy

Category	Age Group I (15-24 years)		Age Group II (25-34 years)		Age Group III (35-44 years)		Age Group IV (45+ years)		Total Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1.Easy operation	95%	12.5%	92.6%	25.5%	91.3%	10.5%	94.3%	10%	92.6%	16.8%
2.Scope of 2 nd marriage	0%	0%	1.6%	1%	1.7%	1.1%	0%	3.3%	1.2%	1.3%
3.Avoid husband's trouble	5%	87.5%	5.6%	73.6%	7.0%	88.4%	5.7%	86.7%	6.1%	81.8%
1..Side affect	0%	0%	33.3%	26.6%	75.0%	0%	0%	10.0%	57.1%	10.6%
2.Critical operation	0%	42.8%	33.3%	40.0%	0%	40.0%	0%	20.0%	0%	36.1%
3.Not cause trouble to wife	to 100%	57.2%	33.3%	33.3%	25%	60%	0%	70.0%	52.9%	53.1%

ANALYSIS:

Most of the women folk of both the areas are housewives while their husbands go out to earn the livelihoods. As per the Indian traditions the males are always dominant and make all family decisions. So the women in the society feel it improper to load the male mind with issues like household chores, family planning etc. Although invariably the male members decide the size of the family, their wives take the burden of the family

planning and undergo tubectomy without any objection. The males believe that tubectomy is an easy operation like vasectomy and has got no major side effects. Of course, this view is deferred by half of the male respondents in area-I. In contrast about one third of the respondents in area-II, opined that the tubectomy is a critical operation but does not hamper the physical health of the women as they stay indoors most of the time. Confined to the four walls of their homes women of both the areas do not have any other alternative than to go for tubectomy if they want to limit their family size permanently.

TABLE 23 : Knowledge of unmarried youth about permanent birth control methods

Category	Age Group (15-24 years)	
	Area I	Area II
1. Vasectomy	54%	62%
2. Tubectomy	67%	83%
3. Not known any permanent method	18%	8%

Analysis:

The knowledge of the young unmarried males about the permanent birth control methods seems to be less in comparison to their knowledge of the temporary methods. Tubectomy is more practiced in both the areas for which it is also known to the majority of the youths. But still a significant proportion of the youth either does not know any permanent birth control method or both of them at a time. This may be due to the fact that in the area the health care providers at the grass root level are not seriously promoting vasectomy.

TABLE 24: Consultation with wife for selecting method

Category	Age Group I		Age Group II		Age Group III		Age Group IV		Total	
	(15-24 years)		(25-34 years)		(35-44 years)		(45+ years)		Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1. Yes	84%	77.7%	88.7%	87.2%	85.3%	77.6%	68.9%	60.2%	81%	78%
2. No	16%	22.3%	11.3%	12.8%	14.7%	22.4%	31.1%	39.8%	19%	22%

ANALYSIS:

Although in both of the areas the male members answered in affirmative regarding prior consultation with their wives regarding the choice of any permanent method, hardly the

male decision is altered after such a consultation. In contrary, the choice of any temporary method is taken jointly by both the partners. From the field observations it has been found that women being motivated by the health care providers often undergo tubectomy without the knowledge of their husbands. But seldom it leads to any serious family conflict. Hence, it becomes very clear that either persuaded or not women take the whole responsibility of family control with or without the support of their partners.

The qualitative survey conducted in both the areas reveals the following.

- Men tend to refuse family planning practices for themselves and for their wives because they fear they will lose sexual power in the relationship they do not trust their partners' faithfulness and they also fear that they will lose sexual pleasure and virility by using condom or by having vasectomy.
- The male respondents interviewed know very little about their own bodies and far less about women's bodies. Many men are unconcerned about total sexual health as long as they feel potent.
- Most of the educated men fear that family planning is a plot to throw them away because it was initially introduced in developing countries as women's issue. This fear leads them to refuse to allow their partners to use contraception.
- Most of the males who are not better educated tend to believe in various myths in relation to virginity, pain, noise, the size of sexual organs etc.
- Men perceive that family planning programmes are not men-friendly. Furthermore, men are not encouraged to attend the births of their children at their homes or in their institutions.

Women of the area feel that they are the passive partners in all matters of sex and have to fulfil the wishes of their husband, as they are breadwinners of the family.

CHAPTER-V

Sexual Health Diseases

Analysing the clinical data available from earlier surveys carried out in the area it has been seen that three major types of STDs / RTIs are prevalent. But no confirmed case of HIV/AIDS has been yet reported. The three major types of Reproductive tract infections seen in these areas can be categorised as follows:

1. Diseases that are sexually transmitted such as gonorrhoea. Syphilis, trichomonas, chlamydia etc.
2. Diseases that are endogenous due to over growth of existing bacteria as for example candidiasis during pregnancy etc.
3. Diseases that are caused by infection of instrumentation such as sepsis following a pelvic examination, septic abortion etc.

As studied previously the factors responsible for causing the above diseases in the area are as follows:

- Irresponsible sexual behavior of the male partners,
- No access to safe and adequate water supply,
- No privacy while bathing/open defecation,
- No proper hygienic toilet facilities,
- Inadequate facilities available in the Primary Health Centres,
- Rampant commercial sex activities in the area, and
- Inadequate knowledge of the community

The data from the quantitative survey carried out in this area are tabulated below.

TABLE 25 : Knowledge of STDs/AIDS

Category	Age Group I		Age Group II		Age Group III		Age Group IV		Total	
	(15-24 years)		(25-34 years)		(35-44 years)		(45+ years)		Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1.Syphilis	0%	15%	0%	11.8%	0%	10.7%	0%	2.2%	0%	10%
2.Gonorrhoea	8.3%	30%	6.4%	24.7%	6.4%	21.4%	14.9%	20%	8.1%	23%
3. AIDS	25%	55%	20.8%	62.3%	24.2%	64.7%	34.3%	77.7%	21.8%	65.3%
4.Scabies	66.6%	0%	72.6%	1.0%	69.2%	2.9%	50.7%	0%	70.0%	1.5%
Total area wise	24	20	139	93	140	102	67	45	370	260

ANALYSIS:

Excluding that of AIDS in area-II and scabies in area-I, the male members of both the areas know no other sexually transmitted diseases. Due to recent awareness programmes by CINI in area –II regarding AIDS a higher frequency is observed to that regard. Even the respondents who know some of the names of the diseases do not have any clear concept of their signs and symptoms. However, the male respondents know some of the common symptomatic elements, but they do not know their mode of transmission. Unsanitary conditions, excessive masturbation, nightfall and taking of hot and spicy foods are often mentioned as the major causes of these diseases. However all of them agreed that AIDS is one of the major fatal disease that is mostly spread by the commercial sex workers.

TABLE 26 : How the STDs spread

Category	Age Group I		Age Group II		Age Group III		Age Group IV		Total	
	(15-24 years)		(25-34 years)		(35-44 years)		(45+ years)		Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1.Man to women	0%	0%	6.0%	1.2%	1.5%	1.1%	2.1%	0%	1.0%	0.9%
2.Woman to man	0%	35.7%	2.0%	22.5%	2.7%	30.6%	2.1%	26.4%	3.0%	27.3%
3.Man to man	0%	0%	0%	7.5%	0.6%	2.2%	1.3%	2.9%	0.5%	4.1%
4.Commercial sex worker to man	91.3%	42.8%	72.6%	51.2%	74.7%	53.4%	76.7%	61.7%	75.0%	53.2%
5.others	8.7%	21.4%	24.6%	13.7%	19.7%	12.5%	17.8%	5.8%	20.5%	12.5%
6.not know	0%	0%	0%	3.7%	0%	0%	0%	2.9%	0%	1.8%

ANALYSIS:

During the last couple of years the areas have seen a mushrooming growth of commercial sex activities in and around the road leading to Diamond Harbor. Both pre-marital and extra-marital relationships are very frequent which often lead to serious family conflicts. When asked about the mode of transmission of these diseases, man to woman or husband to wife response has never come significantly during the interviews that shows the male bias regarding both the source and the medium. Even educated and well to do male members told that AIDS spread through viruses present in air. Conceptually, there remain some significant variations in this regard among the members of different age groups of both the areas. The above two responses of woman to man and commercial sex worker to man are not much differentiated from one another and combiningly do not vary much area-wise.

ANALYSIS:

The location of the PHC for area-I is far away from the four studied villages, which make it difficult for the people to avail the required medical facilities on time. As CINI's health workers visit the area quite regularly, they take care of most of the childhood diseases. But for the treatment of different sexually transmitted diseases the poor and semi-literate people depend upon the village quacks, which treat them in confidence and take very limited fees. When the diseases become serious and chronic the poor patients usually move to the government establishment and the well to do ones to the private practitioners. In area-II a few Homeopathic and Ayurvedic doctors make a brisk business by treating these diseases. A very insignificant proportion of the population either does nothing or practices any other method other than these. But what is most important of all is that the people suffering from these diseases delay the start of the treatment and later on spend a fortune to cure it completely. The recently started clinic for men by CINI is well attended by the people of these areas with several types of sexual diseases.

TABLE 29 : Knowledge of unmarried youth about STDs.

Category	<u>Age Group (15-24 years)</u>	
	Area I	Area II
1. Known STD	83%	96%
2. Not known STD	9%	3%
3. Known HIV/AIDS	74%	88%

Analysis:

Most of the respondents are very knowledgeable about the different sexually transmitted diseases, more specifically about syphilis, gonorrhoea etc. Some of the young people even consider nightfall, early ejaculation etc. as serious sexual disorders resulting from excessive masturbation.

TABLE 30 : Knowledge of unmarried youth on how STD spreads

Category	<u>Age Group (15-24 years)</u>	
	Area I	Area II
1. Male to Female	26%	25%
2. Female to Male	44%	46%
3. Male to Male	11%	25%
4. Sex worker to male	50%	69%
5. Does not know	17%	9%

Analysis:

Like their married counter parts the young unmarried males are of the opinion that commercial sex workers are the major source of all sexually transmitted diseases. The educated young people are more concerned about HIV/AIDS than all other STDs. As shown above, unlike the married males the unmarried ones believe that homosexuality is also a cause for transmission of these diseases. Some of the respondents even do not know the exact mode of transmission of these diseases.

TABLE 31 : Knowledge of unmarried youth about sources of treatment of STDs

Category	<u>Age Group (15-24 years)</u>	
	Area I	Area II
1. Sub-centre	1%	3%
2. Govt. Hospital	43%	3%
3. Quack Doctor	31%	61%
4. Qualified Doctor	43%	30%
5. Homeopath	35%	53%
6. Ayurved	--	1%
7. Magico-religious	--	14%
8. Herbs & Leaves	3%	14%
9. Others	4%	--
10. Not known	14%	5%

Analysis:

The young respondents prefer to seek the services of a registered practitioner or qualified physician, even a Homeopathic one rather than to treat themselves. Although the married males prefer to go to the nearest government dispensary, the unmarried youth prefer the private establishment in stead. It is very interesting to note here that in area II the respondents still believe that STDs can be cured with different magico-religious methods as well as different herbs and leaves. Some of them also believe that the diseases do not require any treatment and can be cured automatically with the pass of time.

TABLE 32 : Knowledge of unmarried youth about affect of STDs on marriage life

Category	<u>Age Group (15-24 years)</u>	
	Area I	Area II
1. Yes	49%	56%
2. No	4%	9%
3. Does not know	45%	35%

Analysis

Nearly half of the respondents agree that sexually transmitted diseases would definitely affect their marriage life if they suffer from it for a considerable period of time. Therefore, most of them seek better treatment before getting married. But still a majority of them are ignorant of such a thing to happen and are not very sure what to do in future if at all they suffer from such a disease.

TABLE 33 : Knowledge of RTIs

Category	Age Group I (15-24 years)		Age Group II (25-34 years)		Age Group III (35-44 years)		Age Group IV (45+ years)		Total Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1.White discharge	0%	13.0%	2.8%	10.4%	3.5%	7.8%	1.4%	11.7%	2.7%	9.8%
2.Irregular menstruation	14.2%	56.5%	9.3%	47.2%	8.5%	45.7%	13.4%	52.9%	10.1%	48.3%
3.Lower abdominal pain	19.4%	26.0%	27.3%	20.8%	22.8%	23.5%	17.9%	22.0%	23.4%	22.4%
4.Pain during intercourse	9.5%	4.3%	15.1%	5.6%	14.2%	9.2%	17.9%	4.4%	14.9%	6.7%
5.Scabies in vagina	57.1%	0%	45.3%	16.0%	50.7%	12.8%	49.2%	8.8%	48.7%	12.3%
6.Others	0%	0%	0%	0%	0%	0.7%	0%	0%	0%	0.25
TOTAL	21	23	139	125	140	140	67	68	367	356
Area wise										

ANALYSIS:

Both the age group and area variations marked in this table are due to recent awareness generation camps of CINI under different RCH programmes in these villages. The better showing in area- II is because of the good work done by the Rising Sun Club in this regard. Although leucorrhoea or white discharge is known as one of the most commonly seen reproductive tract infections in the area, the male respondents seem to be less informed about it. Irregular menstruation in area –II and scabies in vagina in area-I is the two other different types of RTIs prevalent in these areas as reported by the respondents. In this regard it can be said here that the earlier conception of the researchers about the males not knowing much of the RTIs do not hold good here.

TABLE 34 : Whether RTIs suffering wife informs husband.

Category	Age Group I (15-24 years)		Age Group II (25-34 years)		Age Group III (35-44 years)		Age Group IV (45+ years)		Total Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1. Yes	92%	96.2%	98.6%	98.6%	94.6%	96.0%	93.2%	98.6%	95.7%	97.2%
2. No	8.0%	3.8%	1.4%	1.4%	5.4%	4.0%	6.8%	1.4%	4.3%	2.8%

ANALYSIS:

In both the areas and almost in all age groups males have reported that their wives do inform them on time about the onset of the problems, but due to different other socio-economic reasons they could not attach much significance to it as they are not serious diseases. According to them these can be treated without much of their intervention.

TABLE 35 : Steps taken by women for RTIs treatment.

Category	Age Group I (15-24 years)		Age Group II (25-34 years)		Age Group III (35-44 years)		Age Group IV (45+ years)		Total Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1. PHC	16.1%	21.7%	39.6%	35.8%	36.6%	36.0%	30.3%	33.3%	35.5%	34.4%
2. Doctor	54.8%	34.7%	35.8%	27.4%	33.5%	32.0%	37.0%	30.7%	36.7%	30.2%
3. Quack	29.0%	28.2%	22.8%	19.7%	27.2%	19.6%	28.0%	24.7%	26.0%	21.1%
4. Herbs & leaves	0%	8.5%	0.5%	11.2%	0.5%	8.0%	2.2%	6.8%	0.4%	8.9%
5. Homeopath	0%	6.9%	0.5%	5.2%	0.5%	4.4%	1.1%	3.4%	0.6%	4.8%
6. magico-religious	0%	0%	0.5%	0.4%	1.5%	0%	1.1%	0.8%	0.8%	0.3%
7. Others										
Total wise	area 31	46	184	248	191	250	89	117	492	662

ANALYSIS:

Most of the women avail multiple treatments at a time to treat their reproductive tract problems. In initial stages home remedy is mostly preferred with advice from seniors or friends in this regard. Only one fifth of the women go to the quacks for the treatment of their problems but most preferably avoid the local quacks of the same village. In later stages women go to the PHC or any registered practitioner for availing medical facilities. The younger and educated the group is better is the understanding of the signs and symptoms of these diseases as well as available facilities for its proper cure. In most of the cases the husbands do not accompany their wives to the medical centres. Within

the private establishment the CINI's RCH clinic get a sizable proportion of the women patients in both the areas, who are mostly motivated by the health workers of the organisation. Only in area-II a few eligible couples prefer to go the Homeopathic and Ayurvedic practitioners but seldom get them fully cured.

Chapter-VI

Male Involvement in RCH

CINI's long and vast experience of working in this region has manifested one very important fact, that to carry out any interventions benefiting women, the involvement and the cooperation of men is essential. In these areas, women are under the control and subjugation of their husbands and in-laws. Unless the husband agrees to allow the wife to seek treatment, it is almost impossible for the woman to access services by herself. Women are not economically independent, if the husband does not give her the money, it is not possible for her to come to the clinic and get herself treated. However, for the man to allow his wife to seek treatment, he has to first be made aware of the need to develop proper health-seeking behaviour. He also needs to understand that his wife needs proper diagnosis and treatment for her RTI. This is where the question of his involvement and his roles and responsibilities in sexual and reproductive health come in.

In trying to understand the gaps in women's health at a conceptual level, we explored the underlying cultural and social issues. Clearly, women bear greater health hazards associated with reproduction than men, even though it is men who are largely responsible for originating them- for example, in a situation where an unwanted pregnancy is followed by an unsafe induced abortion. Furthermore, men are often responsible for the transmission of sexually transmitted diseases (STDs) to their partners. Men in many cultures, including India, are more likely to initiate or be involved in sexual relationships that include more than one partner, and consequently, increase their chances of exposure to STDs as well as those of their partners.

In majority of the cases, women have been responsible for fertility regulation and birth control. Family planning programs and services programs traditionally women – centered, have also tended to ignore men. To this end, we realised that increasing male responsibility in decisions and behaviour concerning sexual practices, including a greater participation in family planning, is a key to improving reproductive health and curtailing the spread of STDs.

Other reasons for the lack of male involvement in women's health can be located in the cultural context of Indian society. Social roles prescribing to patriarchal norms, largely dictate male and female behaviour and identity. Accordingly, the men assume superior positions in the family largely due to their earning capabilities. Men also dominate decision making in all spheres of life, including home management, family planning decisions and giving permission to access health care and education. In the rural areas of West Bengal, men also control the movement of their wives in and out of the home. In the traditional role, the husband was responsible for the economic well being of the family, while the wife was in charge of everything else, including reproduction, child rearing and home care. Likewise, if an unmarried girl becomes pregnant, she is held

responsible for not taking the necessary precautions to avoid pregnancy- a man for impregnating her.

Keeping in view of all these, the current study has focussed its attention on some key issues of male participation and hence, through its quantitative and qualitative surveys has been able to find some areas of future intervention.

TABLE 36 : Influences in decision making.

Category	Age Group I (15-24 years)		Age Group II (25-34 years)		Age Group III (35-44 years)		Age Group IV (45+ years)		Total Category wise	
	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II	Area I	Area II
1.Govt.health worker	0%	18.8%	0.9%	27.2%	1.9%	34.5%	4.4%	33.8%	1.4%	30.7%
2.CINIhealth worker	15.7%	0%	46.7%	1.5%	33.6%	0.7%	40%	0%	38.8%	0.8%
3.Pear educator	5.2%	13.5%	0%	18.1%	0%	19.1%	0%	6.1%	0.3%	16.0%
4.Elders in the family	10.4%	22.7%	15.5%	21.9%	23.7%	10.2%	11.1%	15.3%	17.5%	16.3%
5.Doctor	63.1%	45.0%	29.9%	28.0%	34.6%	33.0%	35.5%	35.3%	34.7%	32.3%
6.Friends	5.2%	0%	7.05	3.0%	5.9%	2.2%	8.8%	9.2%	6.9%	3.6%
10.	19	22	109	132	101	136	45	65	273	355

Analysis:

As CINI is working in area –I since long the people of the concerned have complete faith and trust on its workers and their suggestions count much in making of a decision regarding the treatment of sexual diseases. Along with CINI, the Rising Sun Club of Kamarpole also try to motivate the male members for taking a quick and appropriate decision regarding the treatment of RTIs by the authorized medical practitioners. Unlike in area –I the government health workers of area-II seem to be very active in delivering the health care services in their locality; which however, is done by the CINI health workers in area-I. Other people who count much in this regard are the elders, friends and the neighbours who often guide the female members in this regard.

TABLE 37 : Influences in decision making among the unmarried group

Category	<u>Age Group (15-24 years)</u>	
	Area I	Area II
1. From:- Books	14%	27%
2. Radio	9%	18%
3. T.V.	28%	32%
4. Cinema	2%	19%
5. Friends.	64%	47%
6. Doctor	8%	5%
7.CINI Health worker	20%	9%
8.Govt.Health worker	2%	1%
9. Elders in family/ neighborhood	17%	1%

Analysis:

Unlike the married males here both the mass media and the print media have got significant effect on the decision making process on the young adolescents. This means that any future IEC inputs will work better among them. Also the person to person approach is more limited to their friends to whom they believe more than any body else. That gives a clear indication that the peer educator approach is more appropriate in educating the younger generation on which the future can rely upon. The recent efforts carried out by the CINI health workers started to leave its own impression on the young minds.

The qualitative survey carried out in this area has brought out some interesting observations which affect the health seeking behavior of the population and subsequently the utilisation of health services by the eligible couples who suffer from different sexual health diseases. These observations include the followings:

- The visibility, recognition and perceptual silence on deviant signs and symptoms of these diseases are clearly marked among the population of both the areas.
- The extents to which the symptoms are perceived as serious or severe vary on the basis of age, education and socio- economic status.
- The frequency, persistence and recurrence of the symptoms do not always agree to the spread of infection.
- The tolerance attitude of the couples during the initial stages of these diseases prohibits them to avail the necessary health care facilities.
- The available information, knowledge, cultural assumptions and understanding do vary according to caste, religion, education and other localized factors, which sometimes mislead the health care providers.
- Certain basic needs and requirement of the family often lead to the denial of the symptoms by the suffering couples that delay the process of treatment.

- More often it has been seen that the illness in its initial stages is not revealed by the partners which help in spread of these diseases.
- Most of the people do not avail the necessary medical assistance on time which make them to spend more during later stages.
- Although women prefer to get themselves cured through government functionaries men go to the private establishments. This is due to their closeness with ANMs and AWWs of the area, as well as the health workers of CINI.
- When decisions regarding temporary methods for birth control, unsafe abortion etc. are taken jointly by both the partners, the decisions regarding the permanent methods and sexual diseases are taken unilaterally.

The mutual support and care of one partner to another is always missing, partly due to unawareness and rest due to other socio-economic constraints.

Chapter-VII

Future Strategy

The next phase of the project has started with three major outcomes in mind, set to be achieved during the remaining duration of the project. These outcomes are:

- 1.Reduction in the rate of unwanted pregnancies through the use of male methods viz. - vasectomy and condoms.
- 2.Reduction of prevalence of STI among men and women.
- 3.Reduction of RTI by men's support and care.

The major activities, which have already been taken up in the project area, include the following:

- Identifying a group of influential male peer educators in the project area to work exclusively on male members of the community.
- Registration of all the eligible couples in the project area on the basis of their acceptance and non-acceptance of any family planning method.
- The potential and unprotected couples have been identified and studied for motivational support to accept any temporary or permanent method for family planning - more emphasis being put on male methods like condoms and vasectomy respectively.
- Better IEC inputs through peer educators, further training to health care providers, proper counseling to the eligible couples, and conducting male clinics at a suitable time were some of the applied methods, focussing more on STD/RTI/HIV/AIDS.
- Once the population was thoroughly sensitized on using condoms for protection against sexual diseases, their attention was diverted to family spacing or birth control using nothing extra for the purpose.
- The social marketing of condoms was started along with as a separate channel, but later on, handed over to the peer educators for allowing a little bit of incentive to continue their work uninterruptedly.
- Involving the ICDS workers, health care providers and the Gram Panchayat members at the grass root level to help the implementation of the project work.

- Collection of regular feedback from the field through project personnel and modifying the strategies, if required.

Besides the above, from time to time Health & Family planning Counselors, Communication experts and Social Scientists were engaged in different project related works. The respective units of CINI did rest of the operational research, monitoring and evaluation works. At the field level help from different Govt. and non-Govt. agencies were solicited, as and when required.

The five major inputs given during the project operation includes:

1. Training of Peer educators, health care providers, Panchayat members, project personnel etc.
2. Counseling centers for eligible couples by experts and CINI staff
3. Conducting Clinics for male members by Medical doctors
4. Social marketing of condoms by Peer Educators
5. Information, Education and Communication inputs by CINI and other Govt. and non-Govt. organizations.

The strategies adopted for the three different outcomes are outlined below.

I. Use of condoms:

- The promotion of condoms has been done to as many diverse groups as possible but not at a time to all of them. Different groups have been allotted different peer educators for the purpose.
- Educating people about their regular procurement, correct and consistent use, disposal etc. have been given special emphasis with live-in demonstrations.
- Making condoms available in ample quantities at low prices through different outlets as well as social marketing through peer educators was taken up in consultation with different concerned agencies.
- The health care providers have been asked to sensitise the couples on the added advantage of condoms to be used as a protective device against sexually transmitted diseases in addition to its use as a birth control measure.

(II) Use of Vasectomy:

- As the health care providers at the grass root level are currently engaged in promoting tubectomy only, they are given instructions to promote vasectomy as well.
- The doctors in government and private establishments are requested to opt for no-scalpel technique to attract new acceptors.
- The persons in both the areas who have already undergone vasectomy have been requested to act as role models in the community propagating the advantages of the method.

- The community mobilisation process with added incentives have to be introduced before conducting special camps in both the areas.

(III) Increasing male support and care in RCH:

- Interpersonal communication with specific members of the community has been identified as the main key to intervene in this area on a case to case basis.
- The EC inputs to be developed has been designed to address the needs of both the partners in stead of making it more women focussed.
- The counseling centres are combined with male clinics at a suitable time for the community to participate in it.
- Joint sessions with both male and female members of the community have been planned to be held subsequently.
- The community is made aware of STDs /RTIs /HIV / AIDS through the health care providers, CINI health workers and the peer educators.
- The medical facilities for them have been upgraded to provide the following:
 1. Respond to local needs and requests.
 2. Maintain an on going dialogue with individuals, families and communities.
 3. Provide promotive, preventive, curative, rehabilitative activities.
 4. Work with other sectors in promoting and initiating these activities.
 5. Function as an integrated health development unit and not as a clinical service point only.
 6. Provide equitable and quality health care to all in the catchment area.

Some of the other issues which have been given priority to increase the participation of the male in all RCH activities include :

1. Improve men's behavior for the prevention of STDs and most specifically to check its reoccurrence.
2. To encourage men to overcome a number of biases regarding different issues on sex, sexuality, sexual behavior and sexual illnesses.
3. To make the men aware of the incoming threats to men's fertility and reproductive health including sexually transmitted diseases, cancer and other infections and exposure to toxins.
4. To help and substantiate the new users and acceptors of different male methods to cope with family and community oppositions.
5. To minimise the differences in use of different family planning methods by different age groups.

Different units of CINI have been entrusted with supervision, monitoring, evaluation and operations research activities to achieve the set targets within the stipulated time period. Separate cells headed by efficient personnel have been given the specific responsibility in implementing the above strategy. They include policy development, regulation, reorienting organisational infrastructure, advocacy, capacity building, etc. to mobilise, empower and enable the community to make the programme sustainable.

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