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**REACHING WOMEN:
A STUDY OF UNMET NEED
IN UTTAR PRADESH, INDIA**

by

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1 INTRODUCTION

The concept of unmet need, which refers to a discrepancy between women's expressed fertility preferences and their contraceptive practices (Casterline et al 1995), is an important indicator of how well family planning programs are serving women's needs. Currently, the most common measure of unmet need is the one used by the Demographic and Health Surveys (DHS) project (Westoff and Bankole 1995). It includes fecund, married women who say they would prefer not to have any more children or to postpone the birth of their next child for at least two years but are not using any method of family planning. It also includes pregnant or amenorrheic women whose current or last pregnancy was unintended but who were not using a contraceptive method at the time of conception. There is considerable debate and discussion regarding this definition of unmet need. It is a definitional construct calculated from large scale surveys and may not include the full range of women at risk of an unintended pregnancy (Dixon-Mueller and Germain 1992, Bongaarts and Bruce 1995).

It is often assumed that unmet need represents a latent demand for contraception that a woman is not acting on either because she does not know what she needs is a contraceptive or because she has lack of access to family planning services. It is assumed, therefore, that if family planning information and supplies were made more easily available to such a woman, she would become a willing user. Yet, there is little evidence that lack of access is the main cause of unmet need. On the contrary, a range of socio-cultural barriers, including lack of understanding of how contraceptives work, gender subordination, and fear of innovative behavior have been found to be the most common barriers to use of family planning (Bongaarts and Bruce 1995, Casterline et al 1997, Biddlecom et al 1997, Stash 1995). Thus, to be able to address unmet need and help women achieve their stated fertility preferences, it is necessary to examine this definition of unmet need and its determinants from the perspective of the women and men.

To this end, the International Center for Research on Women (ICRW) in collaboration with the Social and Rural Research Institute (SRI) conducted a study in Uttar Pradesh.¹ The objectives of the study were

- to evaluate the current definition and measurement of the unmet need from the perspective of women and men,
- to understand the barriers that men and women face in using reproductive health services and regulating their fertility, and
- to propose recommendations for reducing the barriers men and women face in regulating their fertility and improving the measurement of unmet need for family planning

Two districts in Uttar Pradesh, Agra and Sitapur, were selected for the study. Data were collected using a combination of qualitative and quantitative methods to provide both a more textured and detailed understanding of reproductive behavior patterns as well as their distribution and importance within the study population (see table 1.1). The study was carried out in four sequential phases.

¹ This is one of three studies in a research program conducted by ICRW. The other two sites were in Guatemala and Zambia.

- 1. Site Selection, Introduction of the Study to the Community, and the Formation of the Technical advisory Group (TAG)** The research team in collaboration with USAID selected the villages and towns within each district according to their suitability to the study. The research team visited the selected villages and spoke to women as well as opinion leaders to understand the social context. The team also took this opportunity to introduce the study to the villagers.

During this phase, a Technical Advisory Group (TAG) was formed, including one representative each from SIFPSA, USAID/India, and the Population Council, as well as four other individuals from local research institutions, women's groups, and donor agencies with expertise in the area of sexuality and reproductive health in India. The TAG met thrice during the course of the study and was actively involved at every stage.

- 2. Identification of Respondents for In-depth Interviews** The next phase comprised a screening survey of 287 married women to identify women who would be classified as having unmet need for family planning according to the DHS definition as well as those who would be classified as having met need and no need. A survey was also conducted with 104 married men. The sample was stratified by age within each district, with roughly equal numbers selected from each of four age groups: 15 to 19 years, 20 to 24 years, 25 to 29 years, and 30 years or older. The final sample from each district was checked to ensure that Muslims, Hindus, and scheduled castes and tribes are represented.

The survey instrument for this exercise collected information on fecundity, exposure to risk of pregnancy, current contraceptive use, the desire to space or limit births, and details of the last pregnancy. All respondents were also asked for information on their husbands' use of family planning, including vasectomy, in order to identify men for the in-depth interview sample.

Within each district, 6 villages and 2 urban wards were selected to administer the survey. Thus, a total of 12 villages and 4 urban wards were covered through this exercise.

- 3. In-depth Interviews** Based on the data gathered through the screening survey, the following groups of women were identified to form the sample for the in-depth interviews: women with unmet need for spacing, women with unmet need for limiting, women who were currently using family planning, and mothers-in-law. The sample of men comprised those whose wives had unmet need for family planning and those who were using a family planning method. Ninety women and 30 men were interviewed in this phase.

The in-depth interviews were designed to assess the dynamics of reproductive decisionmaking and the roles that women, their partners, and other family members play in that process, to gain a better understanding of the nature and determinants of unmet need for family planning from the perspective of women and men, and to develop an in-depth understanding of the ways in which different factors interact to determine women's use or non-use of family planning.

4 Follow-up Survey The findings of the qualitative phase of the study were reviewed and based on a set of hypotheses deriving from those findings, a survey was carried out to quantify the various determinants of unmet need. For example, the in-depth interviews highlighted a series of socio-cultural barriers, such as low decisionmaking authority and low motivation, that appeared to have played a role in women's apparently contradictory family planning non-behavior. The survey was designed to examine those barriers in more depth.

This phase of the study was conducted only in Sitapur and included a sample of 799 women and 199 men. The sample was drawn from 40 urban and 10 rural sites.

Table 1.1 Overview of the Research Sites and Sample Sizes: Uttar Pradesh, India

Sites	Sample for screening survey	Sample for In-depth interviews: women with met and unmet need, and significant others	Sample for follow-up Survey
Agra District	108 married women and 45 married men from 6 rural villages, 2 urban wards (done 8/96)	35 married women, 15 married men, 10 mothers-in-law (done 9-10/1996)	(not done in Agra)
Sitapur District	179 married women and 59 married men from 6 rural villages, 2 urban wards (done 8/96)	35 married women, 15 married men, 10 mothers-in-law (done 9-10/1996)	799 married women and 200 married men from 40 rural sites and 10 urban sites (done 3/97)

The data will be presented in an integrated fashion as follows:

- Discussion of an alternative, more inclusive definition of unmet need
- Family size, including fertility and child loss, fertility preferences, including son preference, and motivation to avoid a pregnancy
- Barriers to the use of family planning including poor knowledge and fears concerning family planning, poor reproductive health, lack of autonomy and poor intra-family communication, and violence against women
- Multivariate analysis of the determinants of unmet need
- Conclusions and recommendations

2 DEFINITIONS OF UNMET NEED

The standard definition of unmet need used by the Demographic and Health Surveys (DHS) evolved primarily from the work of Charles Westoff (Westoff and Ochoa 1991, Westoff and Bankole 1995) According to the DHS definition, unmet need includes

- currently married or in union women who say they would prefer to avoid any more pregnancies or to postpone their next birth by at least two years, but are not using any contraceptive method, and
- pregnant or post-partum amenorrheic women whose current /last pregnancy was unintended and who were not using any contraceptive method at the time of conception

Using that definition, 31.7 percent of the women interviewed in the survey in Sitapur (n=799) can be classified as having unmet need for family planning (refer Figure 1.1), 16.6 percent have unmet need for spacing, and 15 percent have unmet need for limiting²

Over the years, researchers and analysts have pointed out limitations in the DHS definition of unmet need (Dixon-Mueller and Germain 1992, Bongaarts and Bruce 1995) Different categories or sub-groups of women who are at substantial risk of unintended pregnancy are excluded from the standard formulation, for example

- DHS excludes women who are using highly ineffective methods (folk methods), effective methods ineffectively, or inappropriate or unsuitable methods,
- DHS does not consider unmet need among unmarried women who are sexually active and at risk of unintended pregnancy³,
- The standard formulation considers only the wantedness of the current/last pregnancy of the pregnant women or those who are amenorrheic post-partum. It is possible that even those who had desired that pregnancy would have need for contraception to avoid future pregnancies

The standard definition focuses only on use of family planning per se, not on the results of family planning behavior, i.e. avoiding or having unintended pregnancies. Unintended pregnancies result both from nonuse of contraception and method failure. An improved definition of unmet need would, therefore, provide a more accurate estimate of the number of women at risk of unintended pregnancy – for both reasons. In addition, the measure would contribute to a better understanding of the underlying causes of unmet need, and thus to identifying different categories of women for whom services need to be better tailored.

The study findings reveal that there is more to unmet need than a simple “yes/no” situation. There was a clear relationship between unmet need and the socio-cultural situation of the women interviewed. In tandem with other factors that functioned as direct barriers to the use of

² This compares favorably with analysis of unmet need in UP from the National Family Health Survey, which estimated that 30 percent of the women throughout the state have unmet need (Devi et al 1996)

³ This study also focuses only on married women, as the research team considered that the appropriate population to include in the UP sites. The other ICRW sites, Guatemala and Zambia, included the unmarried.

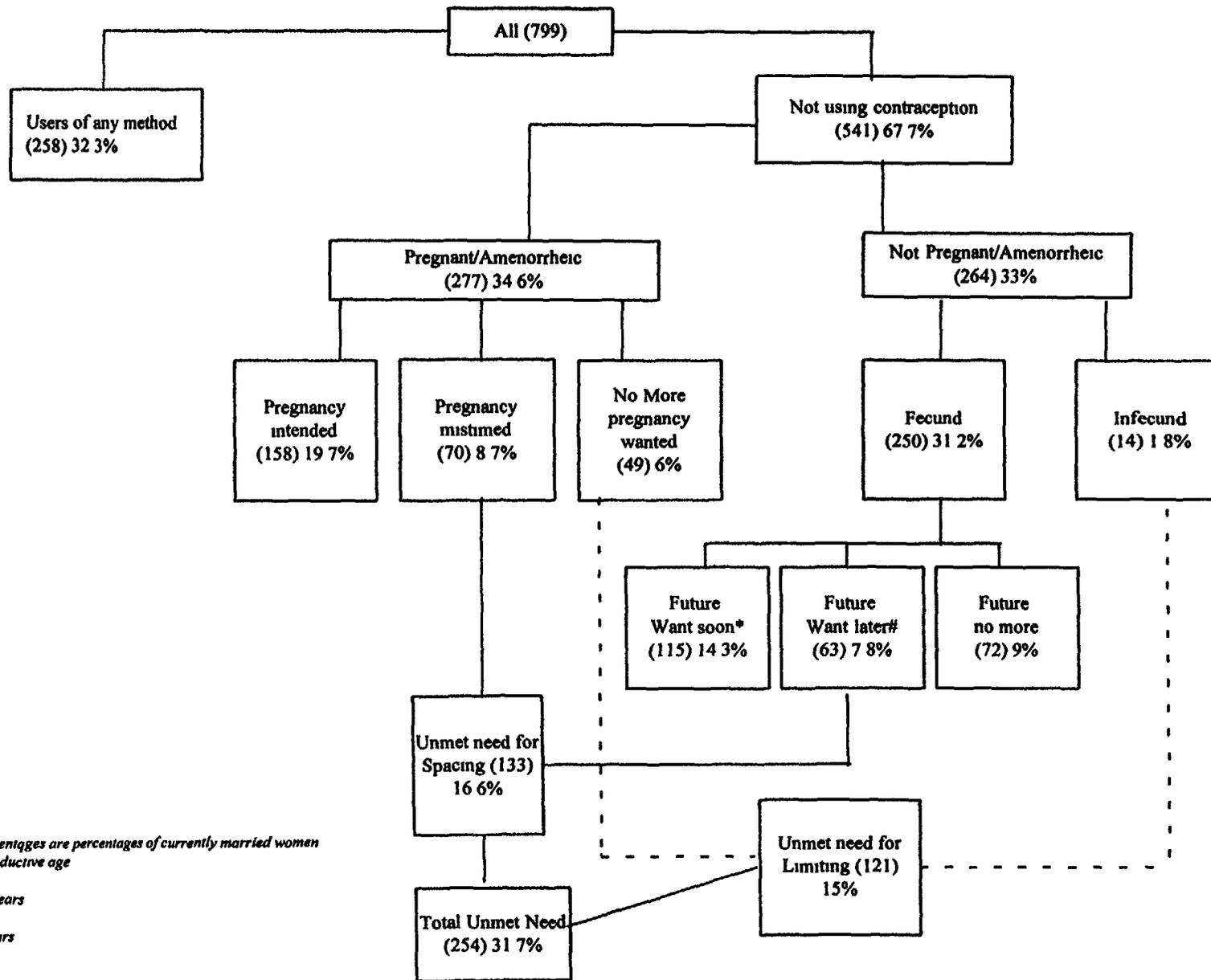
contraception, the socio-cultural situation compounds the lack of control women have over their reproductive health and fertility

To utilize the full potential of the concept of unmet need, it needs moves from being a definitional construct to an operational concept that focuses on the risk of unintended pregnancy, not just the use or non-use of family planning. The data from the qualitative and quantitative phases of this study revealed that a large number of women -- including many who were trying to control their fertility -- mainly through use of traditional methods -- were unable to achieve their fertility preferences. This led the research team to propose the following modified definition:

1. **Users of traditional methods** The DHS definition excludes users of **any** method of contraception in the calculation of unmet need. However, the research team found that the majority of the women using traditional methods of contraception such as periodic abstinence were using the method incorrectly. These women were thus at the risk of unintended pregnancy. Therefore, the team decided to include users of traditional methods among non-users for arriving at unmet need. However, a small proportion of the women who were practicing periodic abstinence did so correctly. To prevent an over-estimation of the extent of unmet need, they were included in the met-need category. Couples using withdrawal were also included in met need. This modification added 9 percent to unmet need.
2. **Dissatisfied users** Dissatisfaction with the method currently being used can lead to discontinuation of that method. In addition, a dissatisfied user can talk to others about the reasons for her/his dissatisfaction, potentially adding to the large pool of fears and rumors. Thus, dissatisfied users of temporary family planning methods, including traditional methods, were included in the unmet need group. Since nothing much can be done about the dissatisfied users of permanent methods, the research team excluded them from the calculation of unmet need. Although the proportion of dissatisfied users of temporary methods was very small (it only adds 1.1 percent), it brings to the fore an important category to be addressed through the family planning program.
3. **Future intention of pregnant/amenorrheic women** The DHS definition asks the currently pregnant and post-partum amenorrheic women if their current or recent pregnancy was intended, mistimed, or unwanted. Depending on a woman's response, and her contraceptive status at the time the pregnancy occurred, the definition classifies women as having unmet need or no need. (Note: pregnancies resulting from method failure are not classified as unmet need.) However, the study data showed that the intention at the time this pregnancy occurred was not enough. The future intention of the woman was also important. It could sometimes present a picture quite different from the one obtained by just asking for her past intention. In this study, there were a few women whose current or most recent pregnancy was desired but, when asked about their future intention did not desire one. Thus, need status of these women would shift from no need to unmet need in a future frame of reference. Future intention could be a function of different factors such as the gender of the last child, child/infant mortality, an improvement in the life situation (socio-economic), family pressure, and so on and so forth. Counting past or future fertility intentions adds 8.3 percent.

- 4 Limit the period of amenorrhea In the standard DHS definition, there is no restriction placed on the length of post-partum amenorrhea Yet after six months, even women who are still breastfeeding are at increasing risk of pregnancy The research team therefore suggest restricting the period of post-partum amenorrhea to six months After that time, amenorrheic women would be grouped with non-pregnant, non-amenorrheic women This change would add 4.6 percent
- 5 Different levels of motivation The qualitative phase of the study revealed women with an expressed preference to control their fertility had varying degrees of motivation, ranging from very high levels to almost a total lack of motivation Initially the research team had decided to exclude those with the lowest motivation from the unmet need category (it would have reduced unmet need by 14 percent) However, the research team realized that this lack of motivation in itself could be the function of the barriers to the use of contraception, particularly the socio-cultural ones Although the research team does not recommend including this as a modification to the definition of unmet need, details on motivation are presented below, and it is included in the multivariate analysis

As a corollary to the inclusion of more categories under the umbrella of unmet need, the percentage of women defined to have unmet need jumped dramatically The unmet need among the sample population according to the modified definition is 54.8 percent (refer to figure 2.2) While this definition more accurately captures the group of women at risk of unintended pregnancy, by expanding the criteria for unmet need, the women included in the definition are also more heterogeneous This underlines the need to use a carefully crafted, client-centered approach to programs to address unmet need



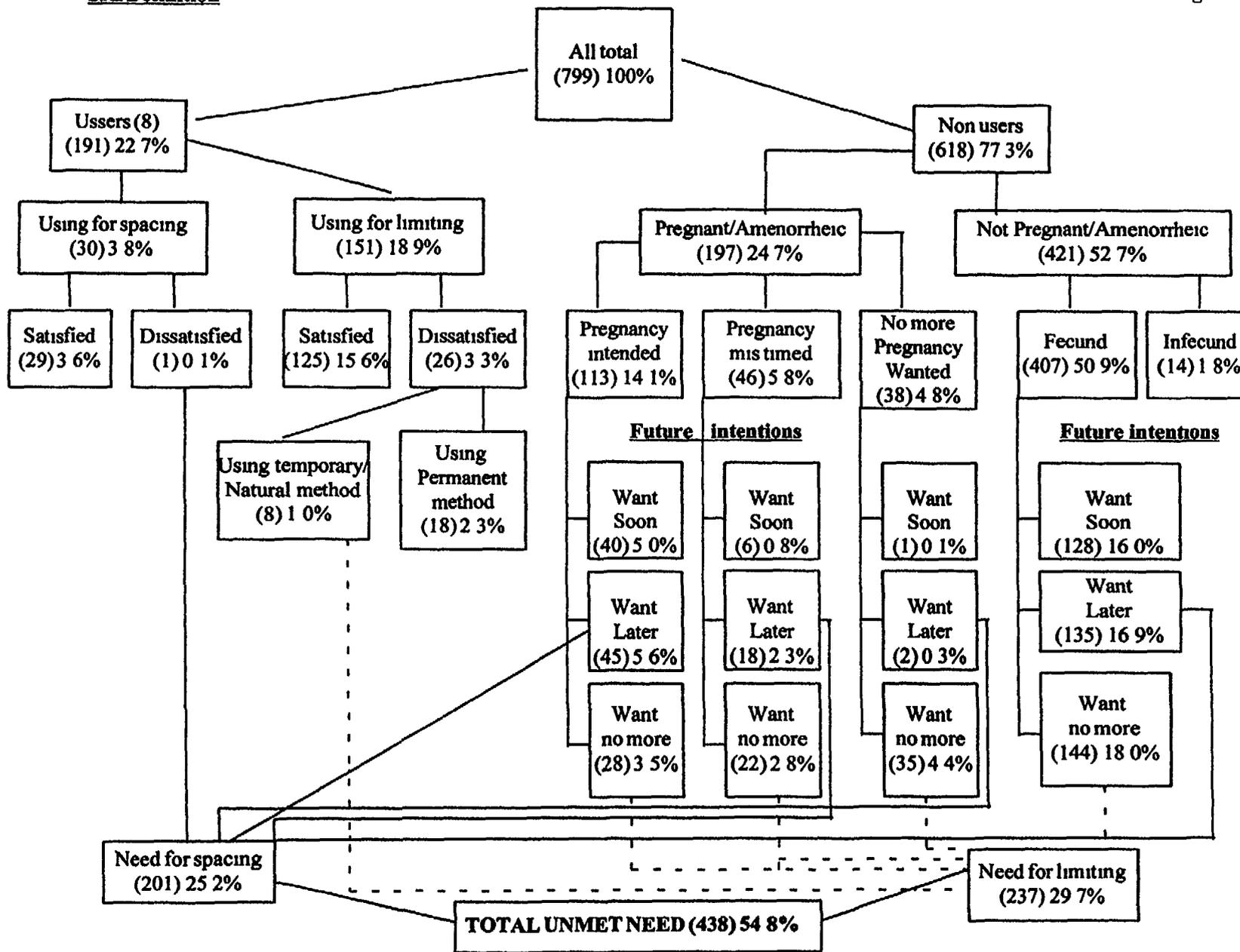
Note: All percentages are percentages of currently married women of reproductive age

*Within two years

#After two years

SRI Definition

Figure 2.2



3. FERTILITY PREFERENCES

The next five chapters will take an in-depth look at the determinants of unmet need and the barriers women face achieving their reproductive preferences. Any discussion of unmet need has to be in the context of fertility preferences and risk of pregnancy, those data will be presented in this chapter. First, however, basic demographic factors that influence those preferences, including number of children, number of pregnancies and child loss, are discussed.

NUMBER OF CHILDREN

The women in the sample had an average of 2.8 children, ranging from 1.4 in the youngest age group to 4.9 in the oldest group (see table 3.1). If the fertility of the oldest group is taken as an indicator of the sample population's fertility rate, the data show this to be a fairly high-fertility population. About a quarter of the overall sample had three children, three children appears as a threshold for several variables discussed below including desire to space or limit births. The data showed little variation in fertility with socioeconomic classification (SEC)⁴.

**Table 3.1 Number of Children Reported by Female Respondents
(in percent)**

	N	Number of children							Mean
		0	1	2	3	4	5	6+	
Total	799	10%	15%	20%	23%	14%	10%	9%	2.8
Age									
15-24	256	25	33	26	14	1	1	-	1.4
25-34	351	5	8	21	32	19	10	7	3.1
35-44	192	0	3	9	18	25	23	23	4.9
SEC									
1 (least poor)	107	5	17	26	25	12	10	7	2.8
2	188	9	13	26	28	12	10	3	2.7
3	275	13	15	18	19	17	10	10	2.9
4 (poorest)	229	11	15	14	22	14	11	13	3.0

Forty-two percent of the 199 men interviewed for the study had 2-3 children (see table 3.2). Unlike the women respondents, the majority of the men in the youngest age group had no children, which basically reflects a higher age at marriage than women. Again, there was little variation by SEC.

⁴ SEC was calculated using a scale. Details are in the annex.

**Table 3 2 Number of Children Reported by Male Respondents
(in percent)**

	N	Number of children							Mean
		0	1	2	3	4	5	6+	
Total	199	14%	13%	21%	21%	17%	7%	7%	2.6
Age									
15-24	27	59	19	19	4	-	-	-	7
25-34	82	10	20	30	23	13	2	1	1.7
35-44	90	3	6	13	24	26	13	15	3.6
SEC									
1 (least poor)	19	11	11	32	16	26	5	-	2.5
2	37	8	14	22	11	27	14	5	3.0
3	81	16	15	14	31	12	3	10	2.6
4 (poorest)	62	15	11	27	16	15	10	6	2.6

CHILD LOSS

Eight percent of the women in the study had had at least one still birth. And 43 percent had lost at least one child who had been born alive, about half had lost one child, a fourth had lost two children, and a fourth more than two. Not surprisingly, older women, those with more than four children and those in the lower half of the socio-economic scale are more likely to have lost a child (see table 3.3). Among these groups at least half had experienced child loss. Having lost a child, or fear of child loss, may contribute to unmet need and low contraceptive prevalence, even couples who would prefer to limit their fertility may have more children than they say is ideal as a kind of insurance policy against child loss.

**Table 3 3 Child Mortality
% down**

	Total	Age			No of children			SEC			
		15-24	25-34	35-44	None	1-3	4+	1	2	3	4
N=	751*	218	341	192	33	454	264	103	177	257	214
Lost at least one child	43%	24	45	62	45	36	56	34	33	49	50
Never lost a child	57%	76	55	38	55	64	44	66	67	51	50

* All ever got pregnant

All women who had had at least one pregnancy (n=751) were asked whether they had had any pregnancy that did not result in a birth. Twenty-two percent reported that they had had such a pregnancy. Of those, 14 percent had been a result of a medical termination of pregnancy (abortion). The rest (86 percent) had been natural miscarriages.

FERTILITY PREFERENCES

Respondents⁵ were asked if they wanted to have any more children, and if so how soon. Six percent of the respondents explained that they could not get pregnant (either because they were sterilized or were infecund). Excluding those, fully three-quarters of the women expressed a preference to control their fertility. 47 percent of the women said they did not want any more children and 30 percent wanted a child later. This information, in conjunction with the information on use of family planning methods becomes the basis of calculation of unmet need. As shown on table 3.4, fertility preferences vary by age, education, and current fertility.

- Younger women are more likely to desire another child. Among those young women who would like to control their fertility, they are more likely to have a need for spacing than for limiting. However, even by the age 25, over 50 percent were ready to stop childbearing.
- Fertility preferences are directly correlated with family size. A higher proportion of those with one or two children expressed a desire for spacing, while the majority of those with three or more children mentioned a desire to limit. Having three children seems to be a cut-off point for a majority of respondents.
- Fertility preferences did not vary much by educational status. However, as will be shown later in the multivariate analysis, education does impact on whether a woman is defined to have unmet need.
- Urban or rural residency status seems to impact the desire to limit the family size. Urban women were more likely to say they did not want another child.
- The age of the youngest child was also found to be significant. It was found that if the age of the youngest child was either less than or equal to one, the woman was more likely to have unmet need for spacing (see table 3.5).

⁵ Throughout this report, 'respondents' refer to the 799 married women interviewed for the study. When the data are from the male survey, that will be specified.

Table 3.4 Desire for another child
(% across)

	Total	Desire for another child		
		Want soon	Want later	Do not want
N =	755*	24%	30%	47%
Age				
15-24 years	254	37	49	15
25-34 years	337	21	25	54
35-44 years	164	8	10	82
Education				
Illiterate	470	25	31	44
Up to primary	84	24	26	50
Above primary	201	20	27	53
Residence				
Urban	151	18	22	60
Rural	604	25	32	43
Number of living children				
None	80	100	-	-
1	115	34	61	5
2	151	15	52	33
3	170	12	25	62
4	104	5	22	73
5 or more	65	5	8	88

Excluding all women who said that they cannot get pregnant

Table 3 5 Unmet Need by Age of the Youngest Child
(% down)

youngest child's age	Total	Unmet need DHS definition		Total	Unmet need SRI definition	
		Spacing	Limiting		Spacing	Limiting
N =	254 [#]	133	121	438 [#]	201	237
<=1 years	57%	68	45	60	73	49
>1-4 years	27%	26	27	26	21	30
5-10 years	14%	5	23	13	6	18
11-23 years	2%	-	5	2	-	3

women defined to have unmet need

FERTILITY PREFERENCES OF PREGNANT AND AMENORRHEIC WOMEN

The fertility preferences of the currently pregnant women and those with post-partum amenorrhea can be studied either in terms of their recent or current pregnancy or their future fertility intentions. In the calculation of unmet need according to the standard DHS definition, only the wantedness of the recent/current pregnancy is taken into consideration. However, these women's future fertility preferences may be different. The research team compared the past and future fertility preferences for these women. As table 3 6 reveals, there were a few pregnant/amenorrheic women from the DHS unmet need category who expressed a desire for another child soon. Their need status should change from unmet need to no need. There were also women in

the no need category with reference to their current or last pregnancy who would be classified as having unmet need in terms of their future fertility preferences This supports the argument that the future fertility preference should also be taken into consideration while calculating unmet need

Table 3 6 Future Fertility Preference by Unmet Need (DHS definition)
% across

	Total	Desire for another child		
		Want soon	Want later	Do not want
Base				
Unmet need - DHS	254	4	39	57
Met need	228	3	23	74
No need	273	59	27	14

STRENGTH OF FERTILITY PREFERENCES

Analysis of the in-depth interviews revealed that women with an expressed desire for either limiting or spacing their births were not all equally motivated to try to control their fertility as the following quotes illustrate

I don't feel like using anything, it is too bothersome and then (there are) all those problems Woman with unmet need for spacing, Sitapur

I have no problem I am the only daughter in law in the family There are enough people to look after the children if they are born Woman with unmet need for limiting, Agra

(If I get pregnant again, I) will have to get the cleaning done (referring to abortion) , there is no other way Woman with unmet need for limiting, Agra

Among the women who would like to control their fertility, the motivation to contracept is influenced by both the extent of health, social and economic difficulties they would face if they had another pregnancy and child, and the difficulties they perceive in using a method of family planning Women have to make a choice between what presents the larger difficulty -- another child or use of contraception The reality in Uttar Pradesh is that the latter is often more difficult Table 3 7 shows that 24 percent of the women agreed that the following statement "It is easier for me to have another child than to use family planning methods" Women with the least educated husbands as well as the youngest and poorest were most likely to agree

Table 3 7 Statements On Family Planning By Need Status

It is easier for me to have another child than to use family planning methods		
	N	% agreeing
Total	799	24
ages 15-24	256	33
ages 25-34	351	23
ages 35-44	192	16
SEC 1 (least poor)	107	10
SEC 2	188	18
SEC 3	275	23
SEC 4 (poorest)	229	37
Illiterate husband	215	37
Husband – primary education	40	28
Husband – primary to 9 years	261	24
Husband – over 9 years education	283	14

Insights from the qualitative study highlight that in many cases, women had very limited control over their reproductive lives, including use of family planning. Responses from both men and women indicate that husbands' wishes take precedence regarding family size and the outcome of unexpected pregnancies. However, women did not necessarily consider this unfair. Some felt that it was the husband's right to decide since he was the one who ultimately provided for the family.

If women were to act only in accordance with their own reactions to an unexpected pregnancy, a few would resort to abortion, often referred to in local parlance as 'cleaning'. These women felt that the "*only course available* (in the case of an unexpected pregnancy) *was abortion*."

Nonetheless, most women said that if a pregnancy was to be terminated, the husband was the person who would take that decision.

Similar views were expressed by most of the men who were interviewed. A few, who were clearly in a minority, felt that the decision on whether or not to abort an unwanted pregnancy ultimately rested with the woman. In general, however, abortion was not seen as an acceptable course of action except in the most extreme cases, and it is not seen as a proxy for use of contraceptives or as an alternative form of family planning. Most women, if faced with an unexpected pregnancy, would keep the baby, rather than resort to abortion.

To examine this issue quantitatively, data from the survey were used to construct a motivation scale based on responses to a hypothetical question about how the respondent would react if she became pregnant. Twenty percent of the women (n=755)⁶ mentioned that they would be miserable if they found themselves pregnant and would opt for an abortion (see table 3 8). On the other end of the scale, 36 percent of the women said that they would quite happy in the event of a pregnancy. Predictably, the vast majority of women who desired a child soon, i.e., within the next two years, would be happy with another pregnancy. Among the spacers and limiters, a higher

⁶ This was not asked to women who said they could not have any more children.

proportion of the latter group said that they would be miserable and would not adjust. Thus, the motivation to limit is stronger than the motivation to space.

Table 3.8 Motivation to Avoid a Pregnancy by Fertility Preference
% down

Reaction to pregnancy	Intentions about another child			
	Total	Want soon	Want later	Do not want
N =	755*	178	224	353
Would not be unhappy with one more	36%	81	37	13
Would be unhappy but not miserable	16%	5	20	19
Would be miserable but will adjust	28%	12	34	32
Would be miserable and will abort	20%	3	9	36

* Excluding women who said that they cannot get pregnant

Analysis of the motivation scale and unmet need status shows that the majority of those with unmet need would adjust to another pregnancy, even if they would be miserable (see table 3.9). Many of those who said they would opt for an abortion are classified as having met need (40 percent for the DHS definition and 46 percent for the SRI definition). This suggests that only when a woman is absolutely certain that she does not want another child will she adopt a form of contraception.⁷ Until such time, however, she does nothing and adapts to unwelcome pregnancies.

Table 3.9 Motivation Scale by Need Status
% down

Reaction to pregnancy	Total	DHS definition			SRI definition		
		No need	Met need	Unmet need	No need	Met need	Unmet need
N =	799	287	258	254	207	154	438
Would not be unhappy with one more	35%	62	16	24	72	12	26
Would be unhappy but not miserable	15%	11	14	22	4	11	22
Miserable but will adjust	28%	21	30	35	17	31	33
Miserable and will abort	22%	7	40	19	7	46	20

The motivation of women with unmet need for spacing or limiting was also analyzed (see table 3.10). Across these two categories, motivation was higher for limiters. This holds true for both definitions of unmet need. While only about a tenth of the women with unmet need for spacing would terminate an unexpected pregnancy, nearly 30 percent of the women with unmet need for limiting gave this answer.

⁷ Female sterilization is the most commonly used modern method, and often the only one available to women, thus they do not have a wide range of options for spacing their births. Family planning is seen as a permanent choice.

**Table 3 10 Motivation Scale by Limiting or Spacing Status
(% down)**

	Unmet need DHS definition			Unmet need SRI definition		
	Total	For spacing	For limiting	Total	For spacing	For limiting
N =	254 [#]	133	121	438 [#]	201	237
Would not be unhappy with one more	24%	29	17	26%	37	16
Would be unhappy but not miserable	22%	23	22	22%	18	25
Miserable but will adjust	35%	38	32	33%	35	31
Miserable and will abort	19%	11	29	20%	10	28

Women with unmet need

THE NUMBER AND GENDER OF CHILDREN

Many studies have shown that the preference for sons is very strong in the Indian context, and this shapes the fertility desires of men and women. In the qualitative phase of this study, responses to a question on the ideal/preferred number of children ranged from two children to “as many as you can feed.” Three to four children seemed to be the ideal number, with many favoring two sons and one daughter. Earlier studies have shown the need for two sons and indicated that if several daughters were born in this quest for sons they were considered an unfortunate but expected by-product. Now people seem to be setting an upper limit on the number of daughters. Although this study did not examine sex-selective abortion, there is at least anecdotal evidence in India that people were using it to achieve their desired sex-composition.

The older generation appeared somewhat less rigid about the number of children that a couple should have. However, they clarified that the number of children did not matter as long as they were all (or mostly) sons.

“I would like a large family, as many as granted by God, but only sons.”

“There can be any number of sons but not many daughters.”

Data from the quantitative phase indicate that, irrespective of the number of children a respondent had, the prospect of one more birth was very attractive for those with no sons, one son or two sons. Significantly fewer women with a dominant number of sons desired another child.

Table 3 11 Number of Sons and Desire for Another Child

	Number of respondents	Percent wanting another child
One child	115	95%
No sons	61	97
1 son	54	93
Two children	151	67
No sons	34	82
One son	71	72
Two sons	46	48
Three children	170	38
No sons	14	100
One son	51	43
Two sons	79	25
Three sons	26	31
Four children	104	27
No sons	2	100
One son	27	44
Two sons	40	23
Three sons	25	20
Four sons	10	-
No. of sons Vs. No of daughters		
Sons < daughters	250	59
Sons = daughters	210	67
Sons > daughters	295	38

Women were asked if they agreed with the following statement A woman should not use family planning before she has had two sons Nearly three-quarters of the women agreed, and as table 3 12 shows, there was very little variation by age, SEC or husbands education, although the poorest women were slightly more likely to agree and those with well-educated husbands slightly less likely

Table 3.12 Agreement with Statement on Use of Family Planning and Number of Sons

A woman should not use family planning methods before she has had two sons	N	% agreeing
Total	799	73%
ages 15-24	256	75
ages 25-34	351	73
ages 35-44	192	72
SEC 1 (least poor)	107	63
SEC 2	188	72
SEC 3	275	72
SEC 4 (poorest)	229	80
Illiterate husband	215	81
Husband - primary education	40	75
Husband - primary to 9 years education	261	73
Husband - over 9 years education	283	68

4. CONTRACEPTION

Women cannot effectively act on their fertility preferences without knowledge that it is possible to control their fertility, correct understanding about specific methods, and knowledge about where to obtain services. In both the qualitative and quantitative phases of this study women were asked how much they knew about family planning and where they obtained that information. The results, presented below, highlight the crucial need for more and better knowledge about the range of family planning methods available as well as side effects from particular methods and how to deal with them. The data also show that more creative communications activities are needed because people rely more on (uninformed) traditional networks for their information than on formal sources, including health providers and the media. This chapter also presents data on women's current use of and future intentions to use family planning.

KNOWLEDGE OF FAMILY PLANNING

During the in-depth interviews, women mentioned a range of modern temporary contraceptive methods including oral contraceptive pills, intra-uterine devices and condoms. For many of these women, awareness did not progress beyond "have heard about it". Natural methods were mentioned by a few women. "The local doctor provides the herb but he does not reveal its name". Many women also mentioned female sterilization. In fact, some of the respondents were aware only of the operation as a contraceptive method. Usually they had learned about sterilization from a local health functionary.

I am village woman, I neither know anything nor have I done anything. The 'behani' (madam) came she asked about these things. She asked whether I would get operated to stop further children. She said that I have two sons and two daughters which is more than enough. It is better to have a small family, one can look after the children properly education, clothing, food. If one has a lot of money and land then a large family is okay. Female/ Agra

I have heard that operation of the stomach is done, both big and small. Operation is done to the ladies. Female /Sitapur

There was considerable awareness among the mothers-in-law of the IUD and sterilization⁸. Mothers-in-law also mentioned post-partum amenorrhea as a natural method of contraception.

Male respondents seemed to prefer natural methods such as periodic abstinence and withdrawal. Among modern methods, awareness was largely limited to condoms (Nirodh) and oral contraceptive pills. However, the men were very concerned about what they term "the harmful side effects" of these methods.

⁸ Today's mothers-in-law were probably in their early reproductive years in the mid-1970s, which are the years branded by the "sterilization excesses" of the Emergency. Their high knowledge of the operation is therefore not surprising.

In the quantitative study, respondents were asked whether they were aware of particular methods of family planning. Responses were first solicited spontaneously, and then by prompting. Although 67 percent of the women said they were aware of family planning, only 37 percent of the women could spontaneously name a specific method. Yet, when prompted, the proportion of women who were aware of at least one specific family planning method jumped to almost 100 percent. The methods women were most aware of were the pill, female sterilization (regular), male sterilization and condom (see table 4.1). Awareness of contraceptive methods was also high among the men interviewed. There was almost universal awareness among men regarding male methods such as condoms (97 percent), and male sterilization (97 percent). Men were less aware of female methods, particularly those less commonly used in UP like the IUD and injectables. Men were somewhat more aware than women of traditional methods.

Table 4.1 Awareness of Family Planning Methods among Women & Men
% down

	Total	
	Women*	Men*
Total mention		
N=	799	199
MODERN METHODS		
IUD/Copper T	64%	47%
Injectables	66	46
Oral Pills	84	88
Condoms	75	97
Male sterilization	79	97
Female sterilization (regular)	82	76
Female sterilization (laparoscopy)	64	63
TRADITIONAL METHODS		
Abstain now and then from sex	44	54
Sex during safe periods	35	53
Not specified	1	-

* The percent of the total who mentioned being aware of the method

Further analysis revealed that women from the highest socio-economic class, SEC 1, were more likely to be aware of all methods than those from the lowest socio-economic group, particularly for the IUD, condoms and laparoscopic sterilization (see table 4.2)

Table 4.2 Women's Awareness of Methods by SEC
% down

	Total	SEC			
		1 (least poor)	2	3	4 (poorest)
N =	799	107	188	275	229
Modern methods					
IUD/Copper T	64%	94	74	64	43
Injectables	66	75	73	63	60
Oral pills	84	97	92	81	75
Condoms	75	97	85	74	59
Male sterilization	79	92	80	78	73
Female sterilization	82	94	82	86	73
Female sterilization (Laparoscopy)	64	86	76	60	47
Traditional Methods					
Abstain now and then from sex	44	45	49	48	35
Withdrawal	31	46	36	31	18
Sex during safe periods	35	53	41	34	22
NS	1	-	-	2	2

Among the men, the number of respondents from the upper SEC was too small to make an effective comparison across the socio-economic categories. However, analysis of awareness across men's educational groups (a proxy for SEC), showed that awareness of many of the contraception methods, but particularly the IUD and oral contraceptive pill, was directly related to education.

Awareness also varies by need status (see table 4.3). A significantly higher proportion of women from the met need category were aware of most of the methods compared to those with unmet need (using either definition). Women with no need were less likely to mention individual methods than unmet-need women. Awareness is high, with little variation across need groups of female sterilization, not surprising given the emphasis the family planning program in UP has placed on the operation. Equal proportions of women from the met and unmet need categories mentioned injectables, a method not currently available. The research team believe that this represents hearsay (as in "heard that there is some injection that can prevent pregnancy") rather than any real awareness of injectable contraceptives.

Table 4 3 Awareness of FP methods by Need Status
(% down)

All	Total	DHS definition			SRI definition		
		No need	Met need	Unmet need	No need	Met need	Unmet need
Modern methods							
N =	799	287	258	254	207	154	438
IUD/Copper	64%	48	84	62	55	88	60
Injectables	66	66	67	65	65	66	66
Oral pills	84	78	93	81	78	95	83
Condoms	75	65	88	74	58	91	73
Male sterilization	79	72	87	78	74	90	77
Female sterilization (regular)	82	80	87	80	81	86	82
Female sterilization (Laparoscopy)	64	51	79	62	54	84	61
Traditional Methods							
Abstain now and then from sex	44	39	52	43	38	46	47
Withdrawal	31	27	43	21	28	53	24
Sex during safe periods	35	24	57	24	29	57	30
Not specified	1	2	-	1	3	-	1

In the survey, a set of statements regarding how to use modern family planning methods was presented to the respondents, who were asked whether they agreed or disagreed with each statement. While correct knowledge did not seem to vary with age, better knowledge seemed to be directly related to higher SEC and educational status of both the husband and wife (see tables 4 4 and 4 5). A higher proportion of respondents from the upper SECs and educational groups gave the correct response to two of the three sentences. In general, people do not seem to know what to do if a woman forgets to take a pill. This is not too surprising considering how low pill use is in the study site.

Table 4 4 Knowledge of How to Use the Pill and IUD by SEC and Age
% down

All	Total	SEC				Age of Respondent		
		1	2	3	4	15-24	25-34	35-44
N =	799	107	188	275	229	256	351	192
There is no need to have oral pills daily if the husband is out of town								
Correct answer	43%	51	55	43	31	45	44	40
If a woman misses having oral pill on one day she can have two pills the next day								
Correct answer	24%	22	29	24	21	27	23	22
Copper T is inserted once in every three years								
Correct answer	47%	72	56	46	30	37	52	52

Table 4 5 Knowledge of How to Use the Pill and IUD by Education
% down

	Total	Education of Respondent			Education of Husband			
		Illiterate	Up to primary	Above Primary	Illiterate	Primary	Primary to 9 yrs.	9 yrs +
N =	799	490	90	219	215	40	261	283
There is no need to have oral pills daily if the husband is out of town								
Correct answer	43%	38	50	53	32	43	47	49
If a woman misses having oral pill on one day she can have two pills the next day								
Correct answer	24%	24	26	25	21	25	25	25
Copper T is inserted once in every three years								
Correct answer	47%	36	60	68	29	38	47	63

Based on these data, a four-point scale was developed. Each correct answer was scored as one point. Responses according to need status revealed that the women with a met need had better knowledge of modern contraceptive methods than women with unmet need or women with no need (see table 4 6)

Table 4 6 Knowledge Score by Need Status
% down

	Total	DHS definition			SRI definition		
		No need	Met need	Unmet need	No need	Met need	Unmet need
N =	799	287	258	254	207	154	438
No knowledge	32%	40	15	39	39	12	35
1	33%	28	36	35	28	37	34
2	24%	22	32	19	22	33	22
Excellent knowledge	11%	10	16	8	12	18	9
Mean score	1.15	1.01	1.50	0.94	1.06	1.56	1.04

SOURCE OF AWARENESS

A vast majority of the respondents who were aware of at least one method -- 74 percent of the women (n=790) and 78 percent of the men (n=199) -- had heard about contraceptive methods from informal sources (see tables 4 7 and 4 8). For the women, government hospitals were the most widely mentioned source among the formal sources of information (29 percent). Auxiliary Nurse Midwives (ANMs), who are key field-level functionaries for the family planning program, received very low mention (9 percent). A substantially higher proportion of the men mentioned formal sources, including ANMs. For both men and women, the responses also indicate that communication through mass media channels has had very limited impact.

Women with met need were more likely to mention they had learned about family planning from their husbands, formal sources and TV. Among those classified using the SRI definition, women

with met need were less likely to mention village ladies In general, those with no need and unmet need were similar in their responses

Table 4.7 Women's Sources of Information about Family Planning
(% down)

	Total	DHS definition			SRI definition		
		No need	Met need	Unmet need	No need	Met need	Unmet need
N=	790*	280	258	252	201	154	435
INFORMAL SOURCES							
Ladies in village	74	75	73	73	73	68	76
Husband	29	24	41	23	22	42	28
Sister-in-law/ Brother-in-law	28	27	30	26	25	33	27
Parents/Others at parents house	18	18	18	19	18	18	18
Mother-in-law	15	16	15	12	14	14	15
Neighbor	11	10	11	14	11	12	11
Friends	6	5	6	6	6	7	6
FORMAL SOURCES							
Govt hospital	29	24	37	27	29	36	27
Doctor/nurse	19	13	27	19	14	29	18
ANM	9	6	11	12	7	15	8
AWW	3	3	4	2	3	5	2
MASS MEDIA							
Radio	16	13	14	22	15	12	18
TV	11	8	17	9	10	21	9
Books	4	2	7	2	3	10	2
* Award of at least one method The percentages add up to more than 100 since respondents gave multiple responses							

Table 4 8 Men's Sources of Information about Family Planning
% down

N=	199
Informal Sources	
Villagers/acquaintances	78%
Wife	16
Brother-in-law/ Sister-in-law	4
Neighbor	7
Formal sources	
Doctor/nurse/hospital	59
ANM	30
Medical store	3
Mass Media	
Radio	16
TV	7
Books	10
Newspapers	2
Self/own experience	25
# The percentages add up to more than 100 since respondents gave multiple responses	

The above findings have important implications for service delivery. The family planning program positions the ANM as the key field-level worker for information, education, and communication (IEC) activities as well as provision of methods. However, these findings indicate that women are not reporting having received information from ANMs, perhaps their role needs to be reexamined. One possible explanation for the very high mention of informal sources of information is a lack of access to the formal channels of communication. However, it is also possible that there is a greater level of comfort, and hence greater interaction with, informal networks of the people, which makes it possible to discuss issues such as family planning freely.

PROBLEMS ASSOCIATED WITH FAMILY PLANNING METHODS

Problems associated with contraceptive methods -- both actual side effects and rumored problems -- function as major barriers to use. During the in-depth interviews, questions were asked to try to understand the problems from the respondents' point of view. The analysis shows that many people fear methods. Beliefs about side-effects based on hearsay, conjecture and actual experience contributed to a negative picture about contraceptives in general. It almost seemed as if negative reports about contraception spread faster and were more believable than positive stories or successful results. Below are the results presented method by method.

IUD/Copper T Stories about the harmful effects of the Copper T were common. One of the respondents mentioned that she had heard of a case where the loop had "*become rotten inside the body*" and consequently had to be surgically removed. Another spoke of a copper T moving higher up into a woman's abdomen causing her grievous harm. Based on her personal experience, one woman reported that she had to give up using the Copper T since her husband found penetration difficult. The most common complaints about the Copper T were bleeding and pain. Some of the respondents had to seek medical care when side effects became severe.

I started having excessive bleeding. My sister-in-law took me to the doctor. I had to take five injections before the bleeding stopped.

Women mentioned similar side effects in the follow-up survey. 46 percent mentioned bleeding and 36 percent mentioned various kinds of pain in the body (see table 4.9)⁹

⁹ In the survey, people were asked about the problems with the method they said they were most aware of.

Table 4.9 Problems Associated with Copper T

	% mentioning the problem
N	114
Bleeding	46%
Stomach pain	18
Pain in the legs and back	18
If copper T rises up, will have to get operated/may cause death	11
Harmful for health	10
Causes heat in the body	7
Causes swelling	6
Weakness	7
Undesired weight gain	4
Nausea/giddiness	3
No problems	6
Don't know/can't say	21

** The percentages add to more than 100 since multiple responses were recorded

From the six men who said Copper T was the method they were most aware of, two reported swelling as the main problem with the method, while three of them felt that there were no problems with the method. No response was elicited from one of the men.

Oral Pills Many people mentioned that pills cause heat in the body. This is considered a serious problem in traditional Indian medicine. A few respondents felt that despite the heat people could take pills depending on their particular constitutions.

Pills do not suit everyone. They produce heat in the body. Only people with cold tendency can take them. Anyway a doctor has to be consulted before starting the pills. The doctor would be able to say whether the person has a hot tendency or a cold tendency. Male/Agra

Pills were considered to be very strong and hence to have harmful consequences. Many of the respondents, both men and women, reported that weakness was a definite side effect. Other respondents mentioned vomiting and giddiness. At least a few of the respondents expressed the need to consume special food to counter the 'strength of the tablet'. This belief contributed to the non-use, since the special diet required was considered too expensive.

And the tablet, Mala D, is there. Once my bhabhi had taken Mala D then she was so weak that glucose was given to her, so we have fear and don't take these. If Mala D is taken then ¼ 1 kg milk is required daily in the morning and evening and in addition to this apple and other dry fruits are required. We cannot afford all this and so don't use these pills. It is good to take the medicine but diet is also required such as if there may be fever then at once the medicine is to be brought. Female/Sitapur

A few women mentioned bleeding as a worrisome side effect, and others mentioned problems such as lack of availability and the difficulty of having to take the pill every day. These women were worried about the risk of conception if even one pill was missed.

In the survey, 199 women said they were most aware of the pill, they mentioned similar problems to those identified in the in-depth interviews. More than a third of them mentioned that the pill caused heat in the body. However, an even greater percentage said they didn't know what the problems were. More details are provided in table 4.10.

Table 4.10 Problems Associated with Pills
(% down)

N=	199
Causes heat in the body	34%
Harmful for health	14
Bleeding	9
Stomach pain	5
Vomiting	4
Feel faint	3
Doubt efficacy	3
Don't know/can't say	38
None	7

**Percentages add to more than 100 since multiple responses were recorded

Condom In the in-depth interviews, men mentioned lack sexual pleasure as the main problem with condoms. A few of the men said they had given up using condoms for this reason. One of the respondents also mentioned that his wife complained of pain whenever he used condoms.

Most women did not report any problems with condoms. However, a few considered them to be harmful for both men and women. They were convinced that condoms made men weak. Some women also feared that a ruptured condom would result in conception. Others worried about condoms rupturing during intercourse, entering the wife's stomach, and leading to her death.

If it bursts and goes into the wife's stomach, it will kill her Female /Sitapur

Nirodh may make my husband weak and moreover it bursts Female /Sitapur

One of the women from the urban area of Agra explained that the condom was one of the easiest methods available for contraception.

There is no problem it is easy to use, no problem in disposing also since the sweeper comes to take garbage Female/ Agra

During the quantitative phase, one-quarter of the women respondents who had mentioned condoms as the method they were most aware of (n=90), reported that the major problem was rupturing. Forty-one percent said there were no problems with condoms, and another 31 percent

were unaware of any problems. Among the problems mentioned by men, about one-fifth mentioned breakage as the main problem.

Female Sterilization Apprehension about the side effects of sterilization was mentioned by quite a few respondents during the in-depth interviews, including a variety of problems such as swelling or pain in the stomach, and other gastric problems.

My jethani got operation done but she had to suffer a lot after that. When she coughs there is the risk of stitches breaking. Female /Sitapur

Following is a quote from a woman with unmet need for limiting. The only method she was aware of was female sterilization. Although she was sure she did not want any more children, she refused to get the operation. Her knowledge of side effects was based on the experience of a close relative.

I don't want to go for an operation. There are many diseases due to operation and that is why I don't want to get myself operated. My younger sister-in-law's sister started suffering from gastric problems and some other problems after she got herself operated. She has become a patient after the operation. Female /Sitapur

Weight gain as a consequence of sterilization was seen as a problem by few of the women. However, none of the respondents had experienced this problem themselves. Those who reported this had either heard about it from others or were reporting what they knew about their sisters or sisters-in-law.

My sister-in-law has become very fat after her operation, that is a major problem. She feels that it would have been better if she had not undergone the operation and instead had eaten medicines. The flaw in tablet is if you forget to eat you may conceive but operation is permanent. Yes that is the advantage. Female/Sitapur

One of the women who had been sterilized reported loss of interest in sex as a problem she had to cope with ever since her operation. A few women mentioned fear of conception after the sterilization operation. The respondents had heard about such instances and were convinced about the validity of the information. In the quantitative phase of the study, with reference to female sterilization, no single problem emerged as the most important problem. Details are given in table 4.11.

**Table 4 11 Problems Associated with Female Sterilization
(percent down)**

Female sterilization		Laparoscopy	
Regular			
N=	146	N=	126
Stomach pain	16%	Pain in the legs/back	17%
Weakness	11	Gas trouble in the stomach	15
Gas trouble in the stomach	14	Harmful for health	14
Pin in the legs and back	10	Doubt efficacy	8
Causes heat in the body	7	Causes heat in the body	7
Undesired weight gain	6	Undesired weight gain	7
Cannot lift weight	3	Weakness	9
Causes swelling	3	Cannot lift weight	6
Don't know/can't say	45	None	18
None	4	Don't know/can't say	15

** The percentages add to more than 100 since multiple responses were recorded

Vasectomy as a contraceptive option did not seem to find favor with either men or women. There was a general fear about the debilitating consequences of vasectomy. After the operation, it was believed that a person had to give up physical exertion altogether. It was believed that a man as the earning member of the household could not afford to opt for vasectomy. In fact, there were a few cases where the wife had advised her husband against opting for vasectomy.

USE OF METHODS

All non-pregnant women (n=687) were asked whether they were currently using any method of family planning. The majority of them (62 percent) were not. Use was highest among the least poor, oldest and best educated groups.

**Table 4 12 Current Use of Family Planning Method
% across**

	Total number	Currently using a method	
		Yes	No
N =	687*	38%	62%
SEC			
1 (least poor)	93	62	38
2	162	39	61
3	233	39	61
4 (poorest)	199	23	77
Age			
15-24	202	20	80
25-34	308	43	57
35-44	177	49	51
Education			
Illiterate	417	28	72
Up to primary	79	43	57
> primary	191	57	43

*All non-pregnant women

Almost half the women using a method (47 percent) were relying on a traditional method, and traditional method use was higher in the poorest, youngest and least educated groups (see table 4.13). Most of the women using traditional methods were relying on periodic abstinence, yet few of them had correct information on when in the menstrual cycle they should avoid sexual intercourse. Among the users, nearly two-thirds said they were using to stop childbearing. Of that group, 39 percent were using a permanent method, 24 percent were using modern temporary methods and 38 percent were using traditional methods. Twenty-three percent were using a method to space, three-quarters of them were using traditional methods. These data show that even those women who are trying to control their fertility are at significant risk of unintended pregnancy.

Table 4.13 Use of Family Planning by Key Characteristics
% across

	Number	Method being used		
		Modern		Traditional
		Temporary	Permanent	
N =	258*	21%	32%	47%
SEC				
1 (least poor)	5 7	30	30	40
2	63	30	30	40
3	91	18	30	53
4 (poorest)	47	6	40	53
Age				
15-24	39	18	0	82
25-34	133	28	26	46
35-44	86	13	55	33
Education – Women				
Illiterate	117	10	33	56
Up to primary	34	27	24	50
> primary	107	32	33	36
- Husband				
Illiterate	45	7	38	56
Up to primary	8	13	50	36
Primary-9 yrs	82	17	29	54
> 9 yrs Of school	123	30	30	40

* Women currently using a method

INTENTION TO USE CONTRACEPTION

Respondents were asked if they planned to use (or continue using) any family planning method in the future. Twenty-seven percent said they did not intend to, 18 percent said they would continue to use and 55 percent said they would start using or would switch methods (see Table 4.14). A significant proportion of women who said they would like to control their fertility, but are currently not doing so said they had no intention of using a method in the future. Thirty-four percent of those with unmet need by the DHS definition (n=254) and 29 percent of those with unmet need by the SRI definition (n=438). These women either face what they perceive to be

insurmountable barriers to achieving their fertility preferences or they have little motivation to act on them Six percent of those with unmet need by the SRI definition (n=438) mentioned that they would continue to use the method they were currently using -- all the women (n=26) were users of traditional methods and 24 them were satisfied with the traditional methods that they were using

Table 4.14 Future Intention to Use Contraceptives by Need Status
(% down)

	Total	DHS definition			SRI definition		
		No need	Met need	Unmet need	No need	Met need	Unmet need
N =	799	287	258	254	207	154	438
Not use any method at all	27%	43	4	34	41	5	29
Continue using method	18%	NA	55	NA	44	21	6
Start using any/new method but unsure when	34%	44	24	33	7	9	35
Start using any/new method within 1- 2 yrs.	21%	13	16	34	8	66	31

Responses from current users (n=258) showed that the majority of the women currently using either a temporary modern or traditional method wanted to start using another method in the future (see table 4 15) These women were asked about the method they wanted to switch to 57 percent of the women who were currently using a modern temporary method wanted to use a permanent method in the future and 37 percent mentioned they would like to start using another temporary method All current users of traditional methods who desired to switch said that they would opt for a modern method, about half permanent and half temporary These findings show the importance of making available the information that would enable users to select other suitable methods if they so desire

Table 4 15 Future Intention of Current Users regarding Continuing Use
% down

	Total	Modern methods		Traditional
		Temporary	Permanent	
Base #	258	55	82	121
Not use any method at all	4%	2	4	5
Start using any/new method but unsure when	24%	38	7	30
Start using any/new method within or after two years, after 1 year	16%	16	5	24
Continue using method	55%	44	84	41

All current users of family planning methods

5. REPRODUCTIVE HEALTH

This chapter presents data on the kinds of reproductive health problems women had experienced and whether they sought treatment for these problems. The results show that while many women do seek treatment for severe pregnancy-related problems, they often do not for other gynecological problems. Women's reproductive health status can influence use of contraception, particularly if they perceive a relationship between poor health status and family planning.

GYNECOLOGICAL PROBLEMS

During the qualitative phase of the study, women reported a range of gynecological problems, particularly white discharge. While some spoke of suffering from white discharge themselves, many others reported that they knew women who had suffered or were suffering from the problem. Although most of the women were not clear about the cause of white discharge, almost everyone believed that it led to other health problems. Women felt that it caused their energy to drain away, leading to severe weakness and lethargy. It was also associated with pain in the legs and body. Very few women had sought treatment for white discharge, and in cases where the women had reported treatment, it was limited to that which was locally available. One of the informants had reported using some medicine that had not provided any relief. She was convinced that only expensive medicines, which she could not afford, could cure the problem of white discharge.

This white water yes, it happens to me also, this disease, I have it very frequently. I did not taken any treatment for it. I told everyone but they did not get any medicine. I told my mother also, but even she did not buy any medicine. Female /Sitapur

The medicine does not give me any relief. the low-priced, normal medicines are not effective in this, but then we do not have so much money. We cannot buy the expensive medicines. I have heard that high priced medicine is used for this. Female /Sitapur

Although some of the men interviewed in the qualitative phase of the study mentioned being aware of their wives' gynecological problems, they were not able to specify any particular problems except bleeding and excessive pain in the abdomen. Bleeding during pregnancy was seen as a problem to be taken seriously by women and their husbands. Almost all the informants who reported bleeding during pregnancy also reported having sought medical help.

One-and-a-half months before her delivery she had excessive bleeding. The medicine man of the village gave some indigenous herbal medicine, and asked her to take it with sugar solution. She got well in ten days. Male /Agra

In one of the cases, bleeding during pregnancy resulted in miscarriage.

I noticed some spotting, and later on bleeding started I told my sister-in-law, she took me to the doctor We have to go to Runakta to consult a doctor She gave me medicines to stop the bleeding, it wouldn't stop, so she said that I would have to get the 'cleaning' done (referring to abortion) because the child had got spoiled. Female/Agra

Some respondents also mentioned menstrual problems Excessive or irregular bleeding, accompanied by pain, were problems common to many of the women interviewed A few of the women reported having had periods twice a month However, missed periods, common to many of the women, were not perceived of as a problem

Problems related to use of family planning methods, particularly post-operative complications such as excessive bleeding and pain, were mentioned by some of the women It was felt that such complications left the women very weak and thin A few women mentioned problems such as irritation in the vagina, difficulty in urination, miscarriage and the problem of 'stones ' Most of the women who reported one or more of these problems had not consulted any medical source for treatment In fact, even husbands were not informed unless the problem assumed serious dimensions There seemed to be a sense of embarrassment or shame in having such problems Mothers-in-law or sisters-in-law were the only people consulted in most cases

The providers of medical care whom the women did go to were not necessarily qualified medical practitioners the '*medicine man,*' *the compounder of the hospital,*' '*the man who distributes medicines in the hospital*' and the anganwadi worker were mentioned as the sources consulted for treatment Use of homeopathic medicines and home remedies such as lime-juice were also mentioned by few of the women

In the quantitative stage of the research, respondents were queried about their reproductive health The women were asked a series of questions on whether they had suffered from any menstrual problems such as irregular bleeding, short menstrual cycle, or heavy bleeding in the three months preceding the date of interview The proportion of women who affirmed having had such problems during that time period was very small, ranging from 6 to 8 percent One limitation of this question was that it referred to a very short time span

Fourteen percent of the women said they had suffered from white discharge since their last menstrual period Table 5.1 lists the problems those women associated with white discharge

Table 5.1 Problems Associated with White Discharge

N =	109*
Itching and irritation in the vaginal areas	59%
Bad odor with the discharge	65%
Severe abdominal pain	80%
Fever with discharge	49%

* Women who suffered from discharge since their last period

PROBLEMS RELATED TO PREGNANCY AND DELIVERY

Respondents were asked about the problems that they had faced during their pregnancies or deliveries. While a majority of the women said that they had not faced any problems, 38 percent said that they had. The majority of men -- a larger majority than for the women -- also reported there had been no problems either during pregnancy or delivery (see table 5 2)

Table 5 2 Problems During Pregnancy and Delivery
% down

	Women	Men
N =	799	199
Yes, only during pregnancy	19	11
Yes, only during delivery	12	7
Yes, during both	7	5
No problems in either	56	69
Not specified	7	8

All the women who mentioned having had problems during delivery and/or pregnancy (n=302) were asked to specify the nature of those problems. Going into premature labor was mentioned by the highest proportion of women (40 percent). Pain and prolonged labor were each mentioned by 20 percent. Women mentioned a variety of other problems, as detailed in table 5 3

Table 5 3 Problems during Pregnancy and Delivery
% down

	Total
N =	302*
Pain in the stomach started a few days before the delivery	40
Pain in the legs/hands/body	20
Long delay between start of labor & birth of child	20
Nausea/vomiting, giddiness and weakness	17
Injection had to be given to induce labor	13
Blood & water started coming/water started after 6 months	13
Frequent diarrhea/ related problems/ stomach infection	12
Swelling in the body	11
Difficulty in movement	10
Frequent fever	7
Fell unconscious	6
Night blindness	2

* All women who had mentioned having had delivery/pregnancy related problems

** The percentages add up to more than 100 since multiple responses were recorded

These respondents were then asked if they had sought treatment. The majority of the women (60 percent) said that they had done so. However, differences emerged across educational and SEC status. A much higher proportion of women with some schooling and from the higher two SECs had sought treatment compared to the illiterate and poorest women (see table 5 4). Among the men who reported that their wives had had problems in course of their pregnancies or deliveries, 80 percent (n=45) affirmed that they had sought treatment.

Table 5.4 Was Treatment Sought for Pregnancy/Delivery Problems?
% down

	Total	SEC				Education of respondent		
		1	2	3	4	Illiterate	Up to primary	Above Primary
N =	302*	43	71	103	85	178	40	84
No	40%	28	21	46	57	52	28	23
Yes	60%	72	79	54	44	48	73	77

*Women who mentioned pregnancy/delivery problems

The vast majority of women (80 percent) sought treatment for pregnancy- and delivery-related complications from medical sources outside the village. Only 4 percent of the women mentioned non-medical sources. More than half of the women who had not sought treatment (n= 122) explained that they had consulted a health worker when she had come for a home visit, thus they felt there was no need to approach anyone else (see table 5.5). Problems of access in terms of distance, absence of source in the village, inability to afford treatment, and transportation were also mentioned by small proportions of women.

Table 5.5 Reasons for Not Seeking Treatment for Pregnancy/Delivery Problems
% down

N =	122*
Had consulted health worker when he/she came home	57
No need	10
No source in village	10
Nobody to take me	9
Source too far away	7
People said it will become all right on its own	6
Expensive to go to source outside village	4
Source in village is expensive	3
No source for commuting till there/no body to accompany	3

* All women who had faced problems during pregnancy/delivery, but had not approached any source for treatment. Percentages add to more than 100 since multiple responses were recorded.

6 WOMEN'S AUTONOMY AND INTER-SPOUSAL COMMUNICATION

The in-depth interviews revealed that women had little autonomy to take decisions that concerned them, outside of the kitchen. A newly married girl might not even have that degree of autonomy, since she would be seen as an assistant to her mother-in-law. Nor did they have the freedom to travel outside their homes or villages to do necessary errands without permission and/or an escort. The study examined quantitatively the effect that decisionmaking authority (or lack thereof) and low mobility had on unmet need for family planning. Intra-family communications were also examined to see if women felt they could discuss family planning issues with their spouses, a necessary component to being able to obtain services in the Indian context.

DECISIONMAKING

The qualitative phase examined the process of decisionmaking in the family. The objective was to understand the nature and extent of the role of women have in decisions. The data show that in most cases, one of the male members of the family was the main decisionmaker. In a few cases, a mother-in-law assumed that role, as the eldest member in the family. Responsibility for the daily management of the household, especially in terms of carrying out domestic chores, lay primarily with the daughter-in-law. As a young wife in the family, a woman's opinion was not often solicited nor given much importance.

My father looks after everything in the household since he is the head of the household. He takes care of the expenditure. I get my own things, everything else is handled by my father. My mother is also consulted whenever required. My wife is usually not consulted.
Male/Sitapur

The pattern in nuclear families¹⁰ was slightly different from that in joint or extended families. In nuclear families, the couple had more decisionmaking autonomy. Whenever major decisions were to be made, the extended family might or might not be consulted. Joint decisionmaking by the husband and wife was more common in such cases, although in all cases the husband had the veto power. Decisions about running the household were normally left to the wife.

I go to the market. My wife tells me about the household things to be bought -- food, clothes for the children, and so on. To purchase a big thing I take the decision. If there is any need to consult the wife about it I do, otherwise I don't. There are so many problems for which I don't take her opinion. And if there is any difference in opinion then my decision would be final. Male/Agra

The follow-up survey assessed the extent to which women were consulted on a range of issues, such as food to be cooked for the day and marriages in the family and major expenses. The data show that the majority of women were involved in decisionmaking, not independently but with

¹⁰ Nuclear families here include couples who shared the residence with their extended or joint family but maintained a separate kitchen.

other members of the family (see table 6 1) Women had autonomy only in the kitchen and were least involved in decisions having to do with how money was to be spent

Table 6.1 Percent of Women Consulted on Decisions
% across

N =799	Not even consulted	Only consulted	Help in deciding with others	Decides on ones own	Others	NS
Food to be cooked	1%	1%	26%	72%	-	
Education of child	4	8	66	12	11	
Health treatment of child	2	4	63	21	-	11
Marriage in the house	20	17	51	3	-	-
Household purchases	22	13	61	4	-	-
Amount to be spend on food	37	12	47	4	-	-

Men were also asked if they consulted their wives on issues pertaining to the household In general, men reported very high levels of consultation, with older and urban men slightly more likely to report that they did so (see table 6 2) There appears to be a gap between perceptions of the extent of consultation reported by men and women, with men more likely to report consultation

Table 6 2 Percent of Men who Consulted their Wives on Household Decisions
% down

	Total	Age			Residence	
		15-24	25-34	35-44	Urban	Rural
N =	199	27	82	90	40	159
Household expenditure	91%	78	89	97	93	91
Family Planning	80%	67	79	86	88	79
Child Care	84%	37	88	96	93	82

Using the data presented in table 6 3, a decisionmaking scale was constructed Each of the respondent was given a score of between 0 (not even consulted) and 5 (decides on ones own) for each of the six kinds of decisions, which were not all equally weighted ¹¹ Each respondent's scores for the six decisions were then summed, and the respondents were grouped into five categories where '1' reflects the bottom end of the scale -- low decisionmaking power -- and '5' reflects the top end -- high decisionmaking power The distribution along the scale does not follow a "normal" curve there is a steady increase in proportions up to a score of 4 and then an

¹¹ Weights for the decisionmaking scale

Statement	Weight
Food to be cooked	1
Education of child	3
Treatment of ill child	2
Marriage in the household	3
Household purchases	4
Amount of money to be spent on the food	4

abrupt dip (see table 6 3) Data are also presented by age and SEC Age was an important predictor of better decisionmaking power Young women had substantially lower scores However, there was little variation by SEC or education (data not presented) Thus, the quantitative data do not reflect the same low degree of decisionmaking authority that was highlighted in the analysis of the in-depth interviews How decisions are made in the household and how people's opinions are weighted is a complex process that was probably not captured by this simple scale

Table 6 3 Decisionmaking Scale by Age and SEC
% down

	Total	Age			SEC			
		15-24	25-34	35-44	1	2	3	4
N =	799	256	351	192	107	188	275	229
1 (lowest)	9%	19	6	3	6	9	11	10
2	19%	25	16	15	20	21	16	20
3	23%	27	22	19	20	21	25	23
4	46%	29	52	57	48	46	44	47
5 (highest)	4%	-	4	6	8	3	4	
Mean	3.2	2.4	3.3	3.5	3.4	3.1	3.1	3.1

Nonetheless, there appears to be a relationship between the decisionmaking scale and need status The highest mean scores were found among women with met need and the lowest among women with no need It is difficult for women to use family planning in UP – those with met need are probably able to do so because they have gained decisionmaking authority by virtue of the number of children they have had or age Women in the unmet need group are older than those in no need, and this probably explains the difference between those two groups

Table 6 4 Decisionmaking Scale by Need Status
% down

	Total	Need status					
		DHS			SRI		
		No need	Met need	Unmet need	No need	Met need	Unmet need
N =	799	287	258	254	207	154	438
1 (lowest)	9%	19	3	6	22	5	5
2	19%	22	14	21	23	13	19
3	23%	24	19	24	21	19	25
4	46%	33	57	48	30	58	49
5 (highest)	4%	3	7	1	4	6	3
Mean	3.2	2.8	3.5	3.2	2.7	3.5	3.3

MOBILITY

The in-depth interviews highlighted the importance of independent mobility to being able to fully access contraceptive services Even if a woman had a co-operative family atmosphere in terms of using contraception, the need to seek permission and/or be escorted to go out of the house was nonetheless a barrier In the follow-up survey, women were asked about the freedom they had to

carry out a range of activities outside of their homes. Mobility within the village was clearly better than mobility outside the village, and there seemed to be greater mobility to go for medical care (either illness care or immunization) than for other kinds activities such as going to the village shop (see table 6 5)

Table 6.5 Women's mobility
(in percent)

N=799	Proportion who said they could go alone
To the village shop to buy things	16 %
To the market outside village to buy things	7 %
To the medical center within the village	31 %
To the medical center outside the village	14 %
To take child for immunization	23 %
To maternal home	17 %

The husbands' views on whether permission would be needed for these activities further reinforces these points (see table 6 6). Although more men felt that their wives were free to go to the village grocer than did the women, that the majority felt that their wives did, indeed, need to take permission for such activities.

Table 6 6 Men's attitudes on Women Mobility
% across

Whether wives need permission to				
N= 199	Yes	No	Others	NS*
Go to the village shop to buy things	77%	23%	-	-
Go to the market outside village to buy things	94	6	-	-
Go to the medical center within the village	53	25	11	11
Go to the medical center outside the village	89	11	-	-
Take child for immunization	67	22	2	9
Go to maternal home	97	4	-	-

* Not specified

These data were also used to create a mobility scale in which a score of '1' indicates a low degree of independent mobility and a score of '3' indicates a high degree of independent mobility. The scale did not reflect much variability among the sample, and in general women score relatively low. Older women had slightly higher scores and SEC showed a shallow U-shaped distribution. Women in the poorest household probably have to move outside their villages out of economic necessity. The result for the higher SEC group is contradictory with data that showed that wives with highly educated husbands had lower scores. The data also showed almost no variation by need status. Again, this simple scale probably does not reflect the complexity of women's autonomy and freedom of movement.

Table 6.7 Mobility Scale by Age and SEC
% down

	Total	Age			SEC			
		15-24	25-34	35-44	1	2	3	4
N =	799	256	351	192	107	188	275	229
1 (low)	38%	57	33	23	30	52	37	33
2	48%	37	53	55	49	43	50	51
3 (high)	14%	6	14	22	22	6	13	17
Mean score	1.76	1.49	1.81	1.99	1.94	1.56	1.76	1.86

COMMUNICATION BETWEEN SPOUSES

Analysis of the in-depth interview data showed that while most husbands and wives did not report difficulty talking to their spouses, they mainly talked about their children's needs -- their education and future -- household needs, and financial issues. Communication was often minimal and focused.

No what is there to discuss with him? Nothing. If there is anything to be asked then I do that. Female/Agra

Some women mentioned difficulty in communicating with their spouses. In one case, a woman expressed her inability to convince her husband about the problems she had to face.

If I tell him, what is the use? My husband says 'don't tell me all this'. He does what his mother wants him to do. They don't even provide me with enough clothes. Now I don't tell him anything. Female/Agra

Most men and women reported that any direct discussion about family planning took place only between husband and wife. Those few women who mentioned having discussed spacing issues with their husbands claimed that there were no major differences between them on the issue. They also believed that spacing was essentially an issue that concerned only the husband and wife. Mothers-in-law also said that couples did not confide in them or ask their advice on matters related to family planning. However, the interviews did seem to suggest that the mothers-in-law played an indirect role through the influence they exerted on their sons. Some of the men seemed to agree with this; they believed that other members of their family should have a say in the number and gender distribution of their children. One of the men mentioned that he had approached his mother to know whether she had any objections to the couple adopting contraception.

Data from the survey revealed that whether or not women and men discussed family planning, the women did not feel they should use a method in secret. They were asked if they agreed with this statement: "A woman can use a family planning method without telling her husband." Only 19 percent agreed, with almost no variation across age, SEC or need groups, although women with met need were slightly more likely to agree as were older and less poor women.

Table 6.8 Secret Use of Family Planning

A woman can use FP methods without telling her husband		
	N	% who agreed
Total	799	19%
Need status (SRI definition)		
No need	207	16
Met need	154	23
Unmet need	438	19
ages 15-24		
ages 25-34	256	17
ages 35-44	351	18
SEC 1 (least poor)		
SEC 2	107	26
SEC 3	188	17
SEC 4 (poorest)	275	17
	229	21

SEXUAL AUTONOMY

The qualitative research revealed that women were not sure if they had a right to initiate sex with their husbands, sex in marriage was seen more for the fulfillment of the men's desires. Women's sexual fulfillment was given secondary importance, if it was considered at all. The responses revealed that men almost always initiated sex.

If I felt like, I never told him Female/Sitapur

No, a woman has to control her feelings, it is up to the husband. Female/Agra

A few men mentioned that if a wife refused sex on account of the children, then the husband had to understand.

Sometimes when the youngest child cries and she (wife) refuses then she is right it is only because of time, if the child gets up then she (child) may get scared. Male/Agra

To examine the relationship between sexual behavior and use of family planning, the study examined the degree of sexual autonomy that a woman had in her relationship with her husband, with the hypothesis that in the absence of freedom, it would be more difficult for a woman to adopt user-dependent contraception.

Sexual initiative -- the percentage of times sex was initiated by the husband -- was used as a measure of sexual autonomy, even though the research team accepts that this is probably a fairly modern indicator. A high score might not reflect women's sexual repression but does indicate certain inhibition, disinterest or other negative/ indifferent attitudes. The data show that while men took the initiatives more than 80 percent of the time, women with met need were slightly more likely to do so than the others. Thus, women who had their fertility under control also had a more open and equal sexual relationship than the others. On a similar note, women were asked to respond to a question on their feelings when they think of sex with their husbands. The majority

of women responded that they thought sex was pleasant. However, more than one woman in four had a negative reaction to the idea. This reaction did not differ significantly by unmet need status.

7. VIOLENCE

The qualitative data revealed that sadly many of the women interviewed had experienced domestic violence, and that this violence, or fear of violence, affected their ability to adopt contraception. This stands to reason, since contraception in the Indian context requires co-operation and dialogue between spouses and freedom for a woman to express her views and assert her rights. The latter can be easily crushed by violence. Physical violence can diminish a woman's confidence in asserting herself. In the face of the likelihood of being hit or slapped, a woman would need courage to talk about something as personal as family planning. Even verbal or psychological abuse could inhibit a woman from speaking up, from expressing her views. Repeated experience of physical, sexual or verbal violence could badly shatter a woman's self esteem to the extent that she might begin to believe that her views or needs or health are not really important. It is important to recollect here that the average rural Indian woman would have been married as a teenager to a man she had never met before and would have abruptly entered a strange family, positioned by tradition at the lowest rung of the power hierarchy. If experiences of violence or abuse are added to this, the effect can substantially impact a woman's ability to act on her fertility preferences.

The incidence of sexual coercion in marriage, of a husband resorting to force to make the wife comply with his wishes, emerged as a fairly common reality in the lives of these women.

It has not happened to me so I do not know but if anyone denies the husband for sex then he does it forcefully I have heard of so many cases Female/Sitapur

Responses from many women seemed to indicate that sexual needs and demands in marriage were not always worked out amicably between husband and wife. A few cases were reported where the husband had sulked and refused food. Many of the women reported that their husbands showed anger and irritation when their demand for sex was refused for some reason or the other.

Sometimes I refuse, but he does not agree Female/Sitapur

If you object, who will stop? Female/Agra

Everything happened after quarreling (referring to the first time husband had sex with her after marriage) I refuse, he does not agree he still does it Female/Agra

Sometimes I refuse previously he used to get angry, now he understands my problem Previously he used to get angry if I go to sleep Female/Sitapur

To follow-up on the extent of violence and its relationship, women were asked if they had ever been beaten, why they had been beaten and how they expected their husbands to behave in certain circumstances. Thirty percent of the women said they had been beaten by their husbands (see

table 7 1) Youth, illiteracy and low socio-economic standard increased the odds that a woman would say her husband had beaten her

Table 7.1 Experienced beating by husband
In percent

	N	Yes
Total	799	30%
Age		
15-24	256	34
25-34	351	30
35-44	192	24
SEC		
1 (least poor)	107	20
2	188	26
3	275	32
4 (poorest)	229	35
Education of respondent		
Illiterate	490	34
Up to primary	90	39
Above primary	219	17
Education of husband		
Illiterate	215	35
Up to primary	40	35
Primary to 9 years	261	33
9 years +	283	22
Residence		
Urban	160	27
Rural	639	30

Women who said they had been beaten were asked to specify why One-third of the women who had been beaten said it was due to answering back Almost a third said it was for refusing sex or not listening to their husband's wishes The other responses reveal that the women were (and recognized that they were) sometimes handy victims of the other stresses and problems that husbands faced outside the house

Table 7 2 Reason for being beaten by husband
In percent

	Total
N =	237*
When I answer him back	36%
When I refuse sex/do not listen to his wishes	30
When I do not cook properly	10
When I answer back to my mother-in-law	10
When I scold/beat the children	7
When there is some tension in the house	4
When in-laws provoke him	2
When he is drunk	2
If I talk of going to maternal house	1

*All women who reported been beaten by husband

Being beaten is the extreme expression of anger. Women were also asked to give a range of responses as to how their husbands would react to a set of situations and what they would prefer their husbands' reactions to be. These data are presented in table 7.3. There is a kind of divide in the table after the first three items. Above that divide, women report that their husbands are more likely to have an angry reaction, and that they would prefer an understanding one. Below the divide, husbands are more likely to react the way their wives would prefer. If 'gets angry' combines verbal abuse and physical abuse, then behaviors that invite the greatest anger are as follows:

- answering back to her husband
- answering back to her mother-in-law
- cooking food badly
- refusing to have sex
- suggesting a particular form of contraception

Not wanting more children and expressing a desire to visit her mother's home do not appear to arouse anger. Not surprisingly, there is little variation in how women would like their husbands to react -- that their side of the story be heard and that their point of view or problems be understood.

**Table 7.3 Husbands' Reactions to Seven Situations
And Wives Desired Reactions**

		% across							
N = 799		Gets angry	Gets upset	Slaps or hits	Gets annoyed	Listens	Under - stands	Never answers	Others
1 Food is badly cook by wife									
Husbands reaction		33	19	7	1	26	8	7	1
What is desired		9	4	-	1	43	37	4	2
2 Wife answers back to her mother-in-law									
Husbands reaction		41	21	8	1	5	4	7	15
What is desired		6	3	1	-	21	48	7	13
3 Wife answers back to her husband									
Husbands reaction		40	21	20	-	6	3	7	4
What is desired		9	1	1	-	29	50	-	9
4 When wife asks to go to maternal home									
Husbands reaction		12	13	1	1	66	7	-	3
What is desired		-	-	-	-	66	31	-	2
5 When wife tells her husband that she does not want any more children									
Husbands reaction		5	4	-	-	52	29	-	9
What is desired		1	-	-	-	30	64	1	5
6 When wife suggests use of some particular method of family planning									
Husbands reaction		16	4	1	1	40	25	1	15
What is desired		5	-	-	1	25	59	1	10
7 When wife refuses to have sex									
Husbands reaction		23	16	8	-	35	16	-	2
What is desired		2	-	-	-	36	62	-	1

A violence scale was constructed using the seven situations presented in table 7 3 For each situation a score of between 1 and 6 was assigned as follows

- Slaps/hits 1
- Gets angry 2
- Gets upset/irritated/annoyed 3
- Gets embarrassed 4
- Listens to wife 5
- Talks with and understands wife 6
- Situation never arisen¹² 0 (treated as missing data)

The scores for each situation were summed, then each respondent was given an average score¹³ The scores were then grouped into two categories living in a more violent situation and living in a less violent situation This scale was then assessed according to women's family planning need status The analysis shows quite clearly that women with met need are less likely to live in violent situations Women with unmet need and no need are more similar, with no-need women the most likely to be living in the violent situations

Table 7 4 Violence Scale by Need Status
% down

	Total	Unmet need - DHS			Unmet need-SRI		
		No need	Met need	Unmet need	No need	Met need	Unmet need
Total	799	287	258	254	207	154	438
Living in more violent situation	32%	42	16	36	39	17	33
Living in less violent situation	67%	56	84	63	59	83	65
Non-committal*	1%	2	0	2	2	-	2

* Gives a response that "the situation has never arisen" in 4 or more situations

¹² These responses were such as 'this has never happened in my life' 'I don't know' 'I never quarrel with my mother in law etc It is possible that these women are in effect not willing to disclose the true situation

¹³ Situation has not arisen was not included in the scoring and averaging The few women who gave that answer for four or more situations were labeled 'non-committal' See Annex 1 for more detail

8 **MULTIVARIATE ANALYSIS**

OF UNMET NEED

The data presented in the chapters above highlighted one-by-one variables that appeared to influence women's fertility preferences and their ability to act on those preferences. This chapter assesses the relative importance of those variables using a multivariate technique -- logistic regression -- to determine which of the variables has a statistically significant relationship with unmet need status. The results are structured to show which variables will decrease the odds that a woman is defined to have unmet need. The analysis was done for both two definitions of unmet need presented in Chapter 2, the standard DHS definition and the definition recommended by the research team after analysis of the qualitative and quantitative data. The pool of women included in the analysis are all women in the study sample from Sitapur who said they would prefer to avoid a pregnancy at the present time (i.e. both spacers and limiters).

The model presented on table 8.1 below was derived during an analytic process to develop the model with the best explanatory power. The following variables were tested:

- 1 Age. It was assumed that unmet need would be higher among those from the younger category.
- 2 SEC. It was hypothesized that women in higher SEC groups would be less likely to have unmet need.
- 3 Residence. It was assumed that rural women would be more likely to have unmet need.
- 4 Education of respondent and education of spouse. It was hypothesized that literate women and those whose spouses had more education would be less likely to have unmet need.
- 5 Knowledge of modern methods of family planning. Better knowledge was assumed to reduce the odds of being classified as unmet need.
- 6 Decisionmaking power. The hypothesis was that more involvement in household decisions would reduce the likelihood of being classified as having unmet need.
- 7 Mobility. It was hypothesized that the higher the mobility, the lower the likelihood of unmet need.
- 8 Experience of violence. It was hypothesized that those living in less violent households would be less likely to be classified as unmet need.
- 9 Motivation to achieve fertility preferences. The hypothesis was that those with the highest motivation (would abort in case of unexpected pregnancy) would be less likely to have unmet need.
- 10 Relationship between actual and ideal family size. The hypothesis was that women whose actual family size exceeded their ideal family size would be less likely to have unmet need.
- 11 Number of sons. It was hypothesized that those having more than two sons would be less likely to have unmet need.

A forward selection process was used to obtain the final model. During that process the following variables were dropped because they were not significant:

- a SEC. Despite the fact that differences in SEC were highlighted in many of the bivariate tables, it did not prove to have significance in the multivariate analysis. Eighty-seven percent of the

sample population fell in the lowest two groups, thus overall the variable did not have much variability or explanatory power

- b Decisionmaking scale Regression showed that as one moved from the groups with lowest involvement in decisionmaking , “not even consulted,” to the highest, “decides on ones own,” the likelihood of being in the met need increased, as hypothesized However, the variable was not considered for the final model since the significance level was low
- c Mobility scale This variable was also dropped for the same reason although the direction was as hypothesized
- d Residence of the respondent Almost 80 percent of the sample was from the rural areas and so the variability quite limited Hence this independent variable was not considered
- e Number of sons For testing the hypothesis on the number of sons, a four point scale was constructed, in the following manner
 - No son 1
 - 1 son 2
 - 2 sons 3
 - More than 2 sons 4

The significance of this scale in the model was low, hence this variable was not considered for the final model The regression results revealed that going from no sons to more than two sons, the likelihood of having unmet need increased, contrary to the hypothesized effect

The variables included for the final model are age, education of respondent, education of spouse, motivation scale (motivation to avoid unintended pregnancy), difference between the actual and the ideal number of children, knowledge of modern methods of family planning, and violence scale Beginning with the analysis of the odds of being defined to have unmet need using the definition recommended by the research team, 8 1 table shows that among women who say they would prefer to avoid a pregnancy, three-quarters can be defined to have unmet need This means that the vast majority of women in UP who would prefer to avoid a pregnancy are in fact at significant risk of an unintended pregnancy, either because they are not using any method of family planning, they are using a method incorrectly (mainly incorrect use of periodic abstinence), they are using a highly ineffective method (folk method), or they are dissatisfied with their current method However, the regression analysis shows several factors that reduce the odds that a woman would be classified as having unmet need¹⁴

- Women in their mid-20s, 30s, and 40s who would like to avoid a pregnancy are less likely than younger women to be classified as having unmet need
- Literate women are less likely to have unmet need (this variable has the highest degree of significance in this model)
- Women whose husbands are highly educated are less likely to have unmet need
- Women who say they would seek an abortion if they became pregnant are less likely to have unmet need
- Women whose actual number of children is greater than the number they say is ideal have lower odds of being classified as having unmet need

¹⁴ For each of the variables, the odds ratios are compared to the reference category specified with a “1” on the table

- Women with correct knowledge of both the pill and the copper T are less likely to have unmet need
- Women living in less violent situations are less likely to have unmet need compared to women living in more violent situations (significant at the 90 percent level)

The model correctly predicted the unmet need classification of the women in 76.8 percent of the cases and was highly significant

It is interesting to compare the analysis using the researchers' recommended definition of unmet need with the standard DHS classification. Using the standard DHS classification about half the women who say they would prefer to avoid a pregnancy can be said to have unmet need and half to have met need. The principle difference between the two models is that women who say they are using any method of family planning, even incorrect use of periodic abstinence, are classified by DHS as having met need.¹⁵ While in general the same variables are significant and reduce the odds of being classified as having unmet need (with the exception of husband's education), there are differences in the size of the coefficients and in the degree of significance.¹⁶ For example, older women in the "DHS" model have an odds ratio of .5467 at a significance level of .067 while for the "SRI" model the coefficient is .3050 at a higher degree of significance (.0013). The violence scale is another example. For the "DHS" model the odds ratio is .4325 at a highly significant level (.0003), while in the "SRI" model the coefficient is .6275 and the significance somewhat lower, at .0792. This analysis suggests that the "DHS" unmet need group includes women who are unable to take even the smallest steps toward addressing their desire to avoid a pregnancy (for example because they live in more violent households), or are young wives who have little skill at expressing, much less acting on, their preferences. In the "SRI" group, more women have tried to act on their preferences but most still do not have the knowledge, skills or autonomy to do so effectively. This group is also more diverse, thus the age, and education variables are more highly significant.

¹⁵ The standard approach focuses strictly on the use or nonuse of family planning methods not the results of family planning behavior (or non-behavior) – that is avoiding or having an unintended pregnancy

¹⁶ The overall predictive power of the "DHS" model is somewhat less – the model correctly predicted 69.3% of the unmet need classifications

Regression Models

DETERMINANTS OF UNMET NEED	DHS definition (Unmet need = 250) (Met need = 258)		SRI definition (Unmet need = 431) (Met need = 154)	
	Odds ratio	Significance	Odds ratio	Significance
Variable				
AGE				
15-24(r)	1			
25-34	5095**	0181	4378**	0128
35-44	5467*	0637	3050*	0013
EDUCATION OF RESPONDENT				
Illiterate(r)	1			
Literate	6439**	0466	4503*	0007
EDUCATION OF HUSBAND				
-Illiterate to HSC/SSC(r)	1			
-Some college but not grad- grad/PG-professional	8032	3885	6028**	0427
MOTIVATION SCALE				
-Not unhappy to miserable but will adjust (r)	1			
-Miserable will not adjust	6008**	0290	5861**	0218
DIFFERENCE BETWEEN IDEAL & TOTAL NO OF CHILDREN				
-Ideal is same as actual(r)	1			
-Ideal is more than actual	1 0636	8105	1 0027	9923
-Ideal is less than actual	6383*	0832	5592**	0270
Knowledge of FP methods				
Oral pills				
False(r)	1			
-Correct answer	5040***	0037	5999**	0327
Copper-T				
False(r)	1			
-Correct answer	4373***	0001	4687*	0011
VIOLENCE SCALE				
-Living in more violent situation (r)	1			
-Living in less violent situation	4325***	0003	6275***	0792
-2 Log Likelihood	600 419		549 612	
Goodness of Fit	510 487		599 211	
Model Chi-square	103 693		124 807	
df	10		10	
Significance	0000		0000	
% of correct prediction	69.3%***		76.8%***	
(r) - Reference category				

* significant at the 90 percent level

** significant at the 95 percent level

*** significant at the 99 percent level

9 CONCLUSIONS AND RECOMMENDATIONS

The major findings from this study are that

- Nearly three-quarters of the women in Sitapur expressed a preference for controlling their fertility yet more than half of them (54.8 percent) have unmet need, using the definition recommended by the research team. These women are at significant risk of unintended pregnancy. Young women are more likely to have unmet need, as are illiterate women or women whose husbands are poorly educated.
- Women face significant barriers that make it difficult for them to achieve their reproductive preferences, including poor knowledge and understanding of family planning methods, a strong bias for boys, and the experience of intrafamily violence. Decisionmaking autonomy did not emerge from this study as a significant factor.
- Women who express a preference to control their fertility are not all equally motivated to take the steps necessary to achieve their preferences. The multivariate analysis showed that unmet need is correlated with the strength of a woman's motivation to avoid a pregnancy. It is also correlated with having exceeded the woman's view of ideal family size. Thus, only women who would find another birth very difficult, for a whole range of reasons, are able to act on their fertility preferences.

These findings suggest a set of policy and programmatic recommendations

- **Education clearly makes a difference.** Expanding opportunities for girls to attend school and for women to become literate might reduce women's risk of having an unintended pregnancy, and, of course, education makes sense for many other reasons.
- **The reproductive health and family planning needs of younger women and those in the poorest SEC groups need to be better addressed.** Programs need to recognize the constraints that a young bride faces in the Indian context and to provide better information about and access to spacing methods. The use of temporary methods was more common (though still rare) among the upper SEC groups and educated women. Eighty percent of the youngest women and 77 percent of the women from the lowest SEC were not using any method of family planning. There is an urgent need to reach out to these women and mold the program to fit their needs.
- **Programs need to reach out to the less motivated women.** Women who belonged to supportive, economically comfortable families tended to be less motivated to act on their stated preference to avoid pregnancy than others. These women failed to contracept simply because the barriers were higher than their motivation. The data showed that a woman had to be more than just motivated -- she had to be fairly desperate about preventing pregnancy -- before she would go out and do something about it. Grass-root workers need to reach out to

women so that the barriers to the use of family planning become lower. The goal is to make use of contraception as easy or easier than having another pregnancy or another child.

- **Creative communication activities are essential** The study found that for most women interpersonal communication, rather than mass media or health professionals is the main route by which they received information on contraception. One possible explanation is lack of access to formal channels of communication. However, it is also possible that there is a greater level of comfort, and hence greater interaction, with the informal networks that make it possible for them to discuss sensitive issues such as family planning freely. Findings suggest that IEC activities should be designed with grass root involvement, for example, local volunteers who could be trained to provide necessary guidance to the villagers regarding family planning methods and related issues. Another issue that needs to be creatively addressed is the strong son preference. There is a need for communication aimed at changing this mindset, since the change is likely to be slow, it is important that communication begin soon and continue to address this at all times.
- **Teaching women the correct information about family planning clearly makes a difference** Fear of contraception methods was definitely a deterrent to their adoption. Beliefs about side-effects based on hearsay and conjecture as well as actual experience contributed to a negative picture about contraceptives in general. In fact, it almost seems as if rumors of negative reports about contraception spread faster and are more easily acceptable than positive stories or successful results. While this study does not address this directly, the researchers believe that mass media communication is probably viewed with distrust while personal networks are seen to be more reliable. Thus, the first recommendation here would be for more creative and regular use of interpersonal communication methods. It is important that these be both credible and inter-active, so that doubts and problems can be addressed quickly. The second recommendation would be for the use of mass media more to reinforce messages and to create awareness than to try to persuade people to adopt new behaviors.
- **Intrafamily violence is a feature of women's lives that urgently needs to be addressed** This analysis shows that living in a violent household affects women's ability to act effectively on their fertility preferences. Programs that address the roots of violence might reduce women's risk of having an unintended pregnancy and, of course -- like literacy programs -- make sense for many other reasons. Social conditioning and natural reticence make domestic violence an issue that most people prefer to avoid. The status of women, their lifelong conditioning, and their lack of options also make this an issue they feel they cannot do anything about. Women need some forum where they may talk about violence and learn ways of handling the situation. Some alternatives are street theater, local women's groups, training grassroots workers to offer counseling and to recognize symptoms of violence. Broad-based programs are also needed to address the roots of violence, such as poverty, unemployment, and use of alcohol.

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Annex Details on the SEC Grid, Decisionmaking Scale, and Violence Scale

SEC Grid	Education								
	Occupation		Illiterate	Literate no formal education	School up to 4 yrs	School 5-9 yrs	HSC/SC	Some college but not graduate	Grad/post graduate-general
	Code	1	2	3	4	5	6	7	8
Unskilled workers	1	E2	E2	E2	E1	D	D	D	D
Skilled workers	2	E2	E1	E1	D	C	C	B2	B2
Petty traders	3	E2	D	D	D	C	C	B2	B2
Shop Owners	4	D	D	D	C	B2	B1	A2	A2
Business men/ industrialist with no of employees	none	5	D	C	C	B2	B1	A2	A2
	1-9	6	C	B2	B2	B2	B1	A2	A1
	10+	7	B1	B1	B1	A2	A2	A1	A1
Self employed professional	8	D	D	D	D	B2	B1	A2	A1
Clerical/salesmen	9	D	D	D	D	C	B2	B1	B1
Supervisory level	A	D	D	D	C	C	B2	B1	A2
Officers/executive-junior	B	C	C	C	C	B2	B1	A2	A2
Officers/ Executives-Middle/ Senior	C	B1	B1	B1	B1	B1	A2	A1	A1

The education and occupation of the chief wage earner of the family is taken into consideration for arriving at the SEC of the family. The information is plotted in the above grid to arrive at the SEC. In the ICRW report the SECs have been noted in numbers A1-E2 in the above grid stand for SEC 1-8 AS follows

- A1-SEC 1
- A2-SEC 2
- B1-SEC 3
- B2-SEC 4
- C-SEC 5

- D-SEC 6
- E1-SEC 7
- E2-SEC 8

In this report

- SEC 1 = A1-B2
- SEC2 = C
- SEC3 = D
- SEC4 = E1,E2

DECISIONMAKING SCALE

Women were asked to comment on how much they participated in seven kinds of household decisions. Each situation was weighted according to how important it was to the household. The statements and the weights are as follows:

Statement	Weight
Food to be cooked	1
Education of child	3
Treatment of ill child	2
Marriage in the household	3
Household purchases	4
Amount of money to be spent on the food	4

The responses were scored as follows:

Response	Score
Not even consulted	0
Only consulted	1
Help in deciding with others	2
Decides on one's own	3

Accordingly, each respondent was given a weighted score. The maximum possible score was 51 and the minimum was '0'. The scores were grouped in the following manner to make a five-point scale:

0-10	1 (not even consulted)
11-20	2
21-30	3
31-40	4
41-51	5 (decides on one's own)

VIOLENCE SCALE

The following seven possible situations were presented in the survey, and women were asked how their husband would react. These were all given equal weights.

Situations

- When the food is cooked badly
- When wife answers back to the mother in law
- When wife answers back to the husband
- When wife asks to go to her maternal home
- When wife tells husband that she does not want any more children
- When wife suggests use of a particular family planning method
- When wife refuses to have sex

The following were the possible responses and the score given to each response

- Slaps/hits 1
- Gets angry 2
- Gets upset/irritated/annoyed 3
- Gets embarrassed 4
- Listens to wife 5
- Talks with and understands wife 6
- Situation never arisen¹⁷ 0 (treated as a missing value)

If a respondent scored '0' in four or more situations, then she has been put in a separate category. There are 11 such women in the data.

For the other respondents, an average score was calculated on the basis of the situations in which she did not score 0. For example, if a respondent is getting scores of 1,4,0,3,2,0, and 1 in the 1st, 2nd, and 7th situation respectively, then her average score will be $(1+4+3+2+1)/5 = 2.2$. Similarly if the respondent is getting scores of 2,3,4,5,6,0 and 1 in 1st, 2nd and 7th situation, then her average score will be $(2+3+4+5+6+1)/6 = 3.5$.

A three point scale was made by grouping the respondents in the following manner

Score 1-3	49	Living in a more violent situation (1)
Score 3	5-6	Living in less violent situation (2)
Separate category		Situation never arisen in 4 or more statements

¹⁷ These responses were such as "this has never happened in my life", "I don't know", "I never quarrel with my mother in law" etc. It is possible that these women are in effect not willing to disclose the true situation. The responses sought to convince that such a situation has not happened with her and so she would not know how her husband would react.