

Attitudes Towards Male and Female Sterilization in Uttar Pradesh

Sponsored by :
AVSC International
New Delhi



Centre for Operations Research and Training
402, Woodland Apartment, Race Course
Vadodara 390 007
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F O R E W O R D

THE Government of Uttar Pradesh, with financial and technical assistance from USAID, has been trying to strengthen the family welfare programme. Under this initiative, efforts are being made to increase the accessibility and quality and promotion of family planning services. The programme is being implemented by the State Innovation in Family Planning Service Agency (SIFPSA).

To achieve the objectives, various innovative approaches are being adopted, in which both NGOs as well as public clinics are being involved. One of the initiatives is to revamp the availability and provision of vasectomy and increase in trained male and female doctors. AVSC International which has been promoting safe and effective techniques of sterilization all over the world has been helping SIFPSA/UP Government in training doctors to conduct Non-scalpel Vasectomy (NSV) and Minilaprotomy.

In order to get the feedback on the perceptions and performance from the community for these methods as well as the opinion of providers in promotion of male sterilization using the improved method. AVSC International commissioned Centre for Operations Research and Training (CORT), to do a study in the districts of Almora and Gorakhpur among the community members as well as among the providers on their perception and performance. This report details out the findings from the study. The study also included the health seeking behaviour of both males and females in regard to their reproductive health problems in particular.

We are thankful to AVSC International to have commissioned CORT to do the study. We are also thankful to the Government officials and doctors for their willing cooperation and help to the visiting research team without which, CORT could not have been able to complete the study.

Mr. Nayan Kumar, Manager (Field Operations), and Ms. Nupur Mukherjee formed the study team under the guidance of Dr. Sandhya Barge, Associate Director.

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Baroda

S Rajagopal
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EXECUTIVE SUMMARY

This study was funded by AVSC International and conducted by the Centre for Operations Research and Training (CORT) under the auspices of the State Innovations in Family Planning Services Agency (SIFPSA). Its objectives are:

To address these issues a study was conducted in two districts in Uttar Pradesh—Almora and Gorakhpur. From each district, two primary health centres (PHCs) were randomly selected; and 334 randomly selected adults (166 men and 168 women) from 28 villages were interviewed with the help of a semi-structured questionnaire. Apart from the sample survey, eight focus group discussions, four each for men and women, were also organized to collect

Study Objectives

- ✓ to assess the community's awareness, knowledge and attitude about various family planning methods, especially minilaparotomy and non-scalpel vasectomy (NSV),
- ✓ to find out people's preferences and choices of contraceptives,
- ✓ to understand the community's preference regarding the sex of the provider for reproductive health (RH) care,
- ✓ to assess the preferred season for undergoing sterilization,
- ✓ to obtain the views of health providers regarding male and female sterilization; and
- ✓ to assess the awareness and knowledge of the providers about minilaparotomy and NSV.

qualitative information on the subjects under investigation. In addition 30 health providers— seven doctors and 23 paramedical staff of the PHCs—were also interviewed.

The study showed that knowledge of family planning methods was universal and almost all the respondents were aware of at least two modern terminal methods and two modern non-terminal methods of contraception. However, knowledge of non-scalpel vasectomy (NSV) and minilaparotomy was low and was reported by only 15 and 34 per cent of the respondents, respectively. Both the methods were relatively better known in Almora (22 and 52 per cent, respectively) than in Gorakhpur (8 and 17 per cent, respectively). Men were significantly more aware about various family planning methods than women in Almora district. In Gorakhpur, it was the reverse—i.e., women were more aware than men.

In general, both men and women believed that female sterilization was easy to perform, and had fewer chances of complications and failure than vasectomy. This indicates that people had major misconceptions about vasectomy, which could be a reason for the non-acceptance of male sterilization.

When the respondents were told about NSV and asked whether they felt that the community would accept the method, about two-thirds answered in the affirmative. They saw the two main advantages of the method as non-use of incision or stitches and the low chances of infection. Similarly, the respondents felt that minilaparotomy has high chances of acceptance as it requires a small incision and has few side effects.

The respondents felt that the acceptability both NSV and minilaparotomy would increase substantially if these methods were made available at the PHC level and were conducted by the doctors posted at the PHC. This would reduce their dependence on visiting teams of doctors from district hospitals who were often not very regular. In addition the services would be easily accessible and could be availed of whenever they wanted. It would also cost less to commute to the PHC, and it would be easier for the family members to attend on them.

Detailed probing about the process of conducting the three female sterilizations—abdominal tubectomy, laparoscopy and minilaparotomy—revealed that most of the respondents, particularly men, had only a vague knowledge of the process. Women's knowledge was relatively better. The three methods were compared with respect to the simplicity of the operation, chances of complications, type of anaesthesia required, mean hours of recovery after the operation, and the number of days of rest required after sterilization. The findings showed that a substantial proportion of the respondents (25 to 50 per cent) had several misunderstandings about the methods which needs the attention of

Main Findings: Family Planning

- ✓ Knowledge of modern family planning methods is universal.
- ✓ Around 15-30 per cent of the respondents knew about NSV and minilaparotomy.
- ✓ Chances of acceptance of NSV and minilap were high if services were available at PHCs.
- ✓ Misconceptions about vasectomy existed.
- ✓ Female sterilization was considered simpler, safer and more effective than vasectomy.
- ✓ Minilap was considered the best method of sterilization.
- ✓ Winter (October-February) was considered ideal for sterilization.
- ✓ More men than women support the reintroduction of vasectomy.
- ✓ It was acceptable for male doctors to conduct female sterilization.

programme managers. For instance, 12-14 per cent of the respondents said that laparoscopy and minilaparotomy were done under general anesthesia and 15-33 per cent believed that these methods had high chances of complications.

Minilaparotomy was considered relatively simpler and safer among the methods of female sterilization. Only 15 per cent of the respondents felt that the method had a high chance of complications compared to 33 per cent in the case of laparoscopy and as high as 71 per cent in the case of abdominal tubectomy.

Both men and women felt that vasectomy had several side effects; it makes men physically as well as sexually weak. It was interesting to note that while the majority of men (81 per cent) favoured fresh effort to promote vasectomy, only a limited proportion of women (43 per cent) did so. Individual counselling by doctors and health workers was considered the most effective method to popularize vasectomy.

Probing on the preferred season for sterilization revealed that almost all respondents (98 per cent) favoured the winter months, i.e., October to March, for sterilization. The main reasons for this preference were the belief that during winter the chances of infection are fewer (75 per cent), stitches dry up quickly (23 per cent) and during winter both men and women have relatively less work—both at home and on the farm. Interestingly, these preferences and beliefs were also supported by the health workers.

About half the respondents said that there was a time lag between the decision to adopt sterilization and actually undergoing the operation. Some important reasons are waiting for the camp (which are mainly held in winter), getting mentally prepared, family circumstances, consultation with the doctor and overcoming fear of the operation.

The study revealed that men (73 to 79 per cent) and women (95 to 96 per cent) felt that women should be operated on by a doctor of the same sex. However, men were relatively more open than women. It is important to note that the majority of both men and women felt that if female doctors were not available, male doctors could perform the operation on women.

The health workers also, confirmed that although women prefer female doctors, they rarely refuse to undergo sterilization by male doctors. This observation was supported by the answers given by respondents regarding reproductive health care.

About one-third of the men and only 5 per cent of the women respondents said that the sex of the doctor for treatment of reproductive

health problem made no difference. However, further probing showed that only 4 per cent of the men and 25 per cent of the women were adamant that a female health care provider is a must for reproductive health care. The remainder felt that if female doctors were not available or if the situation required it, women could be examined and treated by male doctors. The analysis clearly showed that the majority of the men gave higher weightage to the experience and specialization of the doctor rather than the sex of the provider for the treatment of women's reproductive health problems.

An analysis of reproductive health problems showed that about 66 per cent of the women and 23 per cent of the men reported symptoms of reproductive morbidities. In the case of women, vaginal discharge (39 per cent), lower back pain (32 per cent) menstrual problems (29 per cent) and lower abdominal pain (21 per cent) were frequently mentioned. A smaller proportion reported a burning sensation during urination (13 per cent) and vaginal itching (7 per cent). On the average, each woman reported two symptoms of reproductive health problems.

Main Findings: Reproductive Health

- ✓ Two-third of the women reported one or more symptoms of reproductive tract infections (RTIs).
- ✓ Three-fourths of the women sought medical treatment.
- ✓ About half the women sought help from private clinics.
- ✓ About half the women consulted male doctors.
- ✓ Women preferred female doctors for RH treatment, but were ready to accept a male doctor if a female doctor was not available.
- ✓ Men felt the sex of the provider made no difference. Experience and specialization were more important.
- ✓ 23 per cent of the men reported sexual health problems. Only 50 per cent sought treatment.

In the case of males, white discharge in urine, scrotal swelling and burning during urination were the frequently reported complaints of reproductive health (7 to 9 per cent). Two-thirds of the respondents who reported reproductive health problems had also sought medical treatment. It is important to note that almost half the women who reported reproductive health problems were treated by male doctors.

Interviews with health workers revealed that their perceptions about the methods were similar to those of community members. This shows that the workers were members of the same community and shared similar attitudes and value systems.

It is important to point out that health workers did not have precise knowledge about NSV or minilaparotomy. As in the case of community

members, most felt that if services for NSV and minilaparotomy were introduced at the PHC level, the acceptance of these methods would substantially increase.

The workers felt that since at present, the males were not interested in vasectomy, they had no option but to promote tubectomy. According to the workers, if they did not concentrate on women or continued targeting males for vasectomy, they would not be able to get any sterilization cases or meet their assigned family planning targets.

From the Horse's Mouth

Male Sterilization

"People generally have a fear regarding operations that there will be a big cut causing loss of blood and many stitches need to be given. As there is no need for cuts and stitches in this technique (NSV), surely this will be adopted by the people."

"A number of vasectomy cases have failed in the past. This causes serious embarrassment for the couple in the community and tension in the family. Due to these reasons, men now avoid getting operated. They do not want to take a chance."

"It is not in our hands. We have to think about family members also. His [meaning her husband's] mother will never want her son to get operated as something might happen to him [meaning his health might be adversely affected]."

"In our area, it is the females who get operated. None of the males accept vasectomy. We cannot even think of such a thing. What if something happens to our men [meaning husbands]? It will come on our head [meaning women will be blamed] so it is better than we ourselves get operated."

"Both men and women should be made to understand that by having a vasectomy one does not lose one's manhood. It also does not make men weak or affect their earnings adversely. Advice from doctors will be more believed."

"Women remain inside the house. Even if they do not work, it will not affect the family's earnings. But men have to go out and work. If they get operated and become weak then who will earn? How will the family run [means be supported]?"

"In the village everyone is involved in daily farm work. To spend time going to far-off place is difficult. Even when you go sometimes doctors may not be available. If the facility is

available in nearby places [PHCs] and it does not cause hinderance in work, then surely more people will accept the method." (FGD, males, Dwarpar, Gorakhpur)

"Men have to work hard and do heavy labour. After an operation, men become weak and unfit for heavy work. Hence, men will not accept the method even if the facility is available at PHCs." (FGD, female, Gorakhpur)

"In this method [minilap], there is a small cut and so only a few stitches are required. Thus, this method causes less post-operative problem." (Woman informant, Almora)

Preferred Season

"In summer the chances of a wound getting infected are high where as in winter such chances are very low."

"During winter, there is less farm work and it is possible for the women to rest after an operation."

"In our homes, we do not have electricity. During summer, there is no fan. Due to the heat one cannot rest by lying down inside the room or avoid taking a bath. Hence it is difficult for a woman to rest after the operation in summer. Such exposure also leads to infection."

Sex of the Provider

"A woman's operation should be done by a lady doctor only." (Female informant, Gorakhpur)

"If there is an urgent need for the woman to get operated, then one has to let whichever doctor is available do the operation; whether male or female". (Female informant, Gorakhpur)

"It does not matter whether the doctor is a male or a female; only the doctor should be skillful so that there is no chance of failure". (Male informant, Almora)

"It makes no difference if the doctor is male or female. In towns there are many male doctors who specialize in treating women's deceases; only they can treat women. They also conduct deliveries. What is the harm in approaching such doctors?" (Male informant, Gorakhpur)

"We will prefer to go to the doctor who is better, whether male or female. It makes no difference whether the doctor is male or female". (Male informant)

"If the problem is serious or unbearable, then we will go to a male doctor. However, if the problem is not so serious and there is no khatra [risk] to life, we will wait for a lady doctor".

(Female informant, Gorakhpur)

"If we start counselling men to adopt sterilization, they will not adopt the method and, in the bargain, the couple will not adopt sterilization at all. It is in the interest of the woman and also ours that atleast some method of sterilization be adopted. So we advise female sterilization". (ANM)

Chapter 1

Introduction

Background

The Government of Uttar Pradesh, with financial and technical assistance from USAID, is currently trying to strengthen its family welfare programme. Through this initiative, efforts are being made to increase the accessibility and quality of family planning services. The project is being implemented by State Innovations in Family Planning Service Agency (SIFPSA).

Increasing access to quality family planning services is the top priority of SIFPSA. To achieve this objective, various innovative approaches are being used that involve both NGOs and public clinics. One initiative is to revamp the availability and provision of vasectomy services and increase the number of trained male and female doctors who could conduct minilaparotomy and laparoscopy sterilizations. With adequate numbers of trained male and female doctors, sterilization services could be provided at static clinics such as block PHCs year round, without depending on a visiting team from the district headquarters.

AVSC International, which has been promoting safe and effective sterilization techniques all over the world for years, is helping SIFPSA/the Government of Uttar Pradesh to train doctors in non-scalpel vasectomy (NSV) and minilaparotomy. It has been realized that very few women doctors are available to serve in rural areas. Unless male doctors provide sterilization services, it is not possible to build up the capabilities of the PHCs to provide tubectomy services round the year on demand. To some extent, the same is true of integrating reproductive health services at the PHC level.

However, some programme managers as well as providers have expressed a concern that community members may not accept male doctors for conducting tubectomy or providing reproductive health services. Similarly, doubts have been expressed about the revival of vasectomy acceptance even if it is repackaged and offered as a new technique in the form of NSV. Some providers also do not believe that the availability of sterilization services round the year would make a

major difference in acceptance of sterilization, as the community, due to various beliefs, prefers the winter season for operations and avoids the summer or the rainy season.

However, little authentic information is available on how men and women feel about these issues. Are they aware of different sterilization techniques? What are their perceptions about and preferences among these methods? Will they accept the services if they are provided by male doctors? Given the programmatic importance and policy relevance of these questions, particularly in expanding contraceptive choice, AVSC International (AVSCI) decided to carry out a diagnostic study to answer these questions. The responsibility the study was entrusted to Centre for Operations Research and Training (CORT), a multi-disciplinary research organization with its headquarters at Vadodara and branch offices in Delhi, Lucknow and Patna.

Objectives of the Study

The broad objectives of the present study were to:

- assess the awareness, knowledge and attitude of the community about various family planning methods, particularly, minilaparotomy and non-scalpel vasectomy,
- identify people's preferences and choices of contraceptives,
- understand the community's preference regarding the sex of the provider for reproductive health care of men and women,
- assess people's preferred season for undergoing sterilization,
- study the health providers' view—on male and female sterilization; and
- assess the awareness and knowledge of the providers about minilaparotomy and NSV.

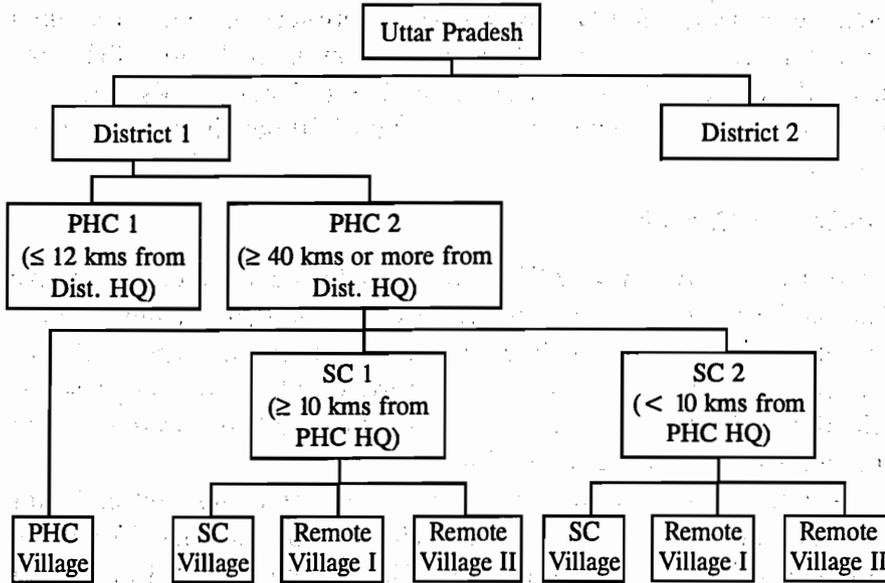
Study Area

Almora and Gorakhpur districts were selected by AVSC International for the study. In these districts acceptance of minilaparotomy and vasectomy is relatively higher than in other districts of Uttar Pradesh.

Two block PHCs were selected from each district. One was selected at random from PHCs that were 12 km from their district headquarters. The second PHC was selected from PHCs that were more than 40 km from their district headquarters. In each selected PHC, three villages were selected—the PHC village, one sub-centre village within 10 km of the block PHC. Under each sub-centre, two remote villages with no public health facility were selected.

In total, 14 villages in each district were selected for the study. The selection procedure is outlined in Figure 1.1.

Figure 1.1 : Schematic Diagram of the Sample Design



Methodology

To meet the objectives of the study, both quantitative and qualitative approaches were adopted. These included:

- a sample survey of recently married men and women,
- interviews with doctors and other health providers in the selected PHCs,
- focus group discussions with men and women from the community.

The following sections briefly describe each study tool used for data collection.

Quantitative Methods

Community Survey: From each of the 14 selected villages, 16 recently married people (8 men and 8 women) were randomly selected and interviewed. To compensate for refusal or non-availability of the respondents, a few additional samples were allocated in each village. Thus, at the end of the survey a total of 334 interviews—14 interviews more than planned—were conducted. Of these 334 interviewees, 166

were males and 168 females. The interviews were conducted with the help of a semi-structured questionnaire. The questionnaire was translated from English into Hindi, the language used in Uttar Pradesh and was pre-tested before being used in the field.

Interviews with Health Providers: A pre-tested, semi-structured questionnaire was used to collect information. In each block PHC, the medical officer and other health providers (ANMs, LHVs and male health workers) were interviewed. A total of 30 health providers were interviewed.

Qualitative Methods

Focus Group Discussions: FGDs were conducted to collect qualitative data on the perceptions and preferences of community members about various family planning methods and their opinions on the possibility of reviving vasectomy. The FGDs were carried out by two senior social scientists of CORT. Guidelines for conducting the FGDs were prepared and pre-tested before being used in the field.

In all, 16 FGDs were conducted—eight for males and eight for females. There were 6-7 people in each FGD; 56 men and 53 women participated in the discussions. Two FGDs were conducted in each of the four PHC villages; from each block PHC, one remote village was chosen and two FGDs conducted.

Chapter 2

Profile of the Respondents

This chapter describes the characteristics of the respondents in the quantitative survey. Only features that may influence their knowledge, attitudes and practice (KAP) of contraceptive use have been discussed here.

Characteristics of the Respondents

The average ages of the male and female respondents in both Almora and Gorakhpur districts were 36 years and 31 years, respectively. A much higher percentage of the women respondents (43 per cent) compared to the men (6 per cent) were illiterate and only a small proportion (14 per cent) had received formal education. The situation was worse in Gorakhpur where 63 per cent of the women were illiterate compared to 24 per cent in Almora. The main occupations were cultivation (22 per cent) followed by service (11 per cent). Most of the females (81 per cent) were housewives and a small proportion were involved in cultivation or worked as agricultural labourers (Table 2.1).

In both districts, (Almora and Gorakhpur) most of the respondents (more than 97 per cent) were Hindus and three-fifths were living in joint families. However, the proportion of respondents living in nuclear families was significantly higher in Almora (47 per cent) than in Gorakhpur (34 per cent). As a result, the average family size was larger in Gorakhpur (8.9 per household) than in Almora (6.2 per household). The average monthly income per household reported was Rs 3,005 in Almora and Rs 3,082 in Gorakhpur (Table 2.1). Although the average family income is almost the same, due to the different size of the average family, the per capita incomes differed (Rs 485 in Almora versus Rs 346 per month in Gorakhpur).

Family Size

Almost half of the respondents (45 per cent) had four or more living children. The overall family size was large in Gorakhpur, where 52 per cent of the respondents had four or more children compared to 37 per cent from Almora district. The mean living number of children for

Table 2.1: Background Characteristics of the Respondents*(Percentage)*

Respondents	Almora			Gorakhpur			All		
	Males	Females	All	Males	Females	All	Males	Females	All
Age (in years)									
20-24	5	24	15	9	22	16	7	23	15
25-29	11	20	16	16	21	19	14	21	17
30-34	19	22	20	18	22	20	18	22	20
35-39	19	18	18	27	18	22	23	18	21
40-44	30	12	21	17	13	15	24	12	18
45+	16	4	10	13	4	8	14	4	9
Mean age (in yrs)	37	31	34	35	31	33	36	31	34
Educational qualifications									
Illiterate	4	24	14	7	63	35	6	43	25
Literate but no formal education	6	28	17	13	8	10	10	18	14
Class 1-5	12	16	14	11	8	9	11	12	11
Class 6-8	21	17	19	14	7	11	17	12	14
Class 9-12	25	7	16	24	6	15	25	7	16
Class 11-12	16	5	10	14	5	9	15	5	10
College education	16	3	10	17	3	11	16	3	10
Occupation									
Cultivator	24	15	19	50	—	25	37	7	22
Service	36	—	18	9	1	5	22	1	11
Agriculture labourer	5	6	5	14	7	10	10	6	8
Petty/small-scale business	23	—	11	13	1	7	18	1	9
Skilled worker	6	—	3	6	3	5	6	2	4
Unskilled worker/labourer	6	1	4	8	4	6	7	2	5
Housewife	—	78	40	—	84	42	—	81	41
Monthly household Income (Rs)									
Upto 1000	11	—	6	7	6	9	3	6	
1001-2000	29	28	29	32	38	34	30	33	31
2001-3000	25	17	34	29	34	32	27	39	33
3001-4000	11	43	17	17	8	13	15	15	15
4001+	24	6	14	15	14	19	10	15	
Ave. monthly income (in Rs)	3069	2943	3005	3079	3086	3082	3074	3015	3044
SD	1595	996	1322	1635	2461	2080	1611	1881	1750
Religion/Caste									
High caste Hindu	50	60	44	28	18	23	39	39	39
Other backward caste/Hindu	19	6	12	38	40	39	29	23	26
Scheduled caste	31	36	33	32	30	31	31	32	32
Muslim	—	—	—	2	12	7	1	6	3
Type of family									
Nuclear	42	52	47	36	32	34	39	42	40
Joint	58	48	53	64	68	66	61	58	60
Ave. family size	6.7	5.7	6.2	9.7	8.2	8.9	8.2	6.9	7.6
SD	2.7	2.2	2.5	4.6	6.2	5.5	4.0	4.9	4.5
Total number of respondents	80	83	163	86	85	171	166	168	334

Gorakhpur and Almora districts was 3.5 and 3.1, respectively. Fifty per cent of the respondents had a child below the age of four.

Table 2.2: Number of Living Children and Desire for Additional Children

(Percentage)

	<i>Almora</i>	<i>Gorakhpur</i>	<i>Males</i>	<i>Females</i>	<i>All</i>
Total living children					
0	5	4	4	5	5
1	9	9	9	9	9
2	22	15	20	17	18
3	26	20	22	25	23
4	23	28	26	25	26
5+	14	24	19	19	19
Mean no. of children	3.1	3.5	3.2	3.3	3.3
Mean no. of living sons	1.5	1.8	1.7	1.7	1.7
Mean no. of living daughters	1.5	1.7	1.5	1.6	1.6
Age of youngest child (years)					
< 4	46	54	49	51	50
5+	49	42	47	44	45
Current pregnant	8	9	5	13	9
Desired additional children	17	26	20	24	22
Time when child is desired					
Within 2 years	6	6	5	7	6
After 2 years	10	17	13	15	14
Depends on God	1	3	2	2	2
Total number of respondents	16	171	166	168	334

While only 5 per cent of the men reported that their wives were pregnant, 13 per cent of the women interviewed reported that they were pregnant. This indicates either intentional under-reporting of pregnancy by men or lack of awareness because their wife's pregnancy was in the early stages (Table 2.2)

Desire for Children: Nearly one-fifth of the respondents expressed a desire for another child and most of them wanted a child after 2 years. The proportion of respondents who wanted another child was 17 per cent in Almora compared to 26 per cent in Gorakhpur (Table 2.2). The difference in the two districts can be attributed to the male respondents—only 12 per cent of the men in Almora compared to 26 per cent in Gorakhpur wanted at least one more child.

Chapter 3

Awareness, Knowledge and Beliefs about Family Planning Methods

Awareness of Contraceptive Methods

To assess awareness about contraceptive methods, respondents were asked "Do you know or have you heard of any method that is used by married couples to delay or prevent pregnancy?" Those who answered in the affirmative were asked to name the methods. All the methods that they spontaneously mentioned were marked in the questionnaire. Subsequently, the methods they had not mentioned were read out one by one and they were asked whether they knew or had heard about the method. Table 3.1 gives the combined results of spontaneous and probed answers.

Table 3.1: Awareness of Contraceptive Methods

(Percentage)

Family Planning Methods	Almora	Gorakhpur	All
Vasectomy	100	99	99
Tubectomy	93	99	96
Laparoscopy	69**	90	80
Minilaparotomy	52**	17	34
Non-scalpel vasectomy	22**	8	15
Condom	99	98	98
Oral contraceptive pills	98	96	97
Loop/Intra-uterine Devices (IUD)	84	86	85
Safe period	80	77	79
Injectables	58	60	59
Withdrawal	55	59	57
Foam tablets	33	25	29
Total no. of respondents	163	171	334

** Significant at 1% level

Among the terminal methods, almost all of the respondents both in Almora and Gorakhpur were aware of vasectomy, tubectomy and laparoscopy. Similarly, awareness about intra-uterine devices (IUDs), condoms and oral contraceptive pills (OCPs) was universal. Less

known methods were non-scalped vasectomy (NSV) (15 per cent), minilaparotomy (34 per cent), injectables (59 per cent) and foam tablets (29 per cent) (Table 3.1). There was a statistically significant differences in the awareness of NSV, laparoscopy and minilaparotomy between the two districts.

A comparison of the two districts shows that laparoscopy was less known in Almora (69 per cent) than in Gorakhpur (90 per cent) but minilaparotomy were reported by a much higher proportion in Almora (52 per cent) than Gorakhpur (17 per cent). This difference in awareness is perhaps due to the fact that in Almora minilaparotomy is used for female sterilization, whereas in Gorakhpur laparoscopy is more commonly used (Table 3.1).

A comparison of the responses by sex revealed that in Almora awareness of all the methods (except for minilaparotomy and injectable) was higher among the men than among the women. In contrast, awareness of all the methods in Gorakhpur was higher among women than men. The difference was statistically significant in the case of minilaparotomy in Almora (21 per cent of males vs. 81 per cent of females) and injectables in Gorakhpur (45 per cent among males vs. 75 per cent among females).

Table 3.2: Number of Contraceptive Methods Known to Respondents

(Percentage)

No. of methods know	Almora			Gorakhpur			All		
	Males	Females	All	Males	Females	All	Males	Females	All
Modern terminal methods									
Two methods	14	19	17	12	8	10	13	14	13
Three	61	27	44	66	76	71	64	51	58
Four	18	37	27	16	11	14	17	24	20
All	7	17	12	6	5	5	6	11	9
Mean no. of methods	3.2	3.5	3.4	3.2	3.1	3.1	3.2	3.3	3.2
Modern non-terminal methods									
None	1	-	1	2	-	1	2	-	1
One	1	-	1	3	1	2	2	1	1
Two	9	12	10	5	1	3	7	7	7
Three	24	29	26	42	26	34	33	27	30
Four	33	45	39	33	54	43	32	49	41
All	32	14	23	15	18	17	24	16	20
Mean no. of methods	3.8	3.6	3.7	3.4	3.9	3.7	3.6	3.7	3.7
Total number of respondents	80	83	163	86	85	171	166	168	334

The higher awareness of family planning methods among men in Almora than in Gorakhpur indicate that men in Almora are more involved in contraception than men in Gorakhpur.

Table 3.2 shows that most of the respondents (87 per cent) were aware of at least three modern terminal methods of contraception, and nine out of 10 respondents were aware of at least three modern non-terminal methods. In other words, awareness of modern contraceptives was almost universal in both districts. The percentage of women who knew a greater number of modern terminal methods was higher in Almora (54 per cent) than in Gorakhpur (16 per cent).

The data, however, also shows that only about one-fifth of the respondents were aware of all the methods, which indicates that there is scope to enhance awareness and choice of contraceptive methods. Further, the significant differences in the awareness of men and women in the two districts (with higher awareness among men in Almora and among women in Gorakhpur, despite the higher proportion of illiterates) points to the need for location—specific strategies that ensure equal access to contraceptive information.

Awareness of Male and Female Sterilization Methods

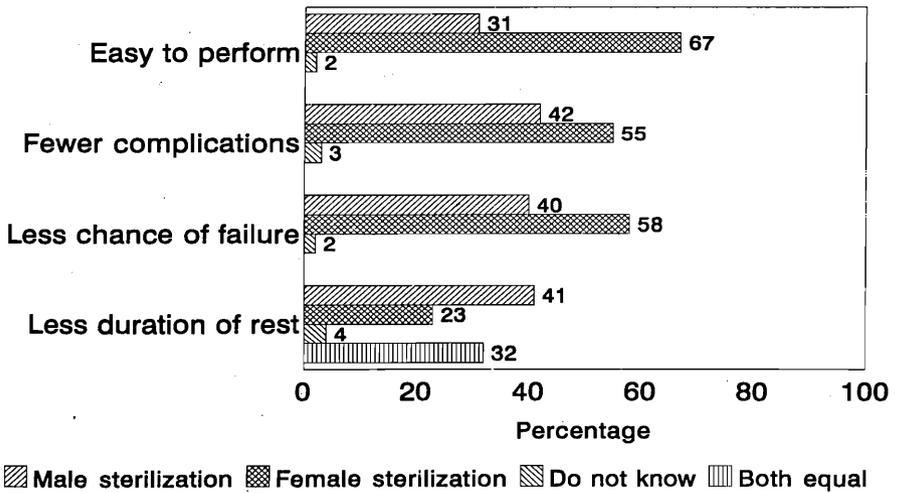
To understand why couples prefer female sterilization and why few adopt vasectomy, it is essential to study the perceptions of men and women towards different sterilization methods. Generally, a method is preferred on the basis of accessibility, its perceived effectiveness, safety, and side effects (if any). Cost does not play a major role as most of the contraceptives are available free of cost from public clinics.

The present study assessed people's perceptions about male and female sterilization in terms of the following attributes:

- is easy to perform,
- has fewer chances of complications,
- has lower chances of failure,
- requires less rest from work.

As can be seen from Figure 3.1, on the four criteria two-thirds of the respondents felt that female sterilization was easy to perform (67 per cent), has fewer chances of complications (55 per cent) and has fewer possibilities of failure (58 per cent). However, a higher proportion of the respondents (41 per cent) felt that male sterilization required a shorter duration of rest, about one-fifth felt that female sterilization needed a shorter rest period, and the remaining one-third felt that both types of sterilization required equal duration of rest (Appendix A).

Figure 3.1: Perception of Respondents about Male/Female Sterilization



This analysis clearly identifies misconceptions about the safety and efficacy of vasectomy; people perceive it as holding higher chances of complications and failure. It is interesting that these beliefs were common to both men and women. In fact, a substantially higher proportion (76 per cent) of the women as against men (58 per cent) believed that female sterilization is easier to perform than vasectomy ($p < 0.01$). Regarding complications and chances of failure, a slightly larger proportion of men than women evaluated female sterilization more positively than male sterilization (Appendix A).

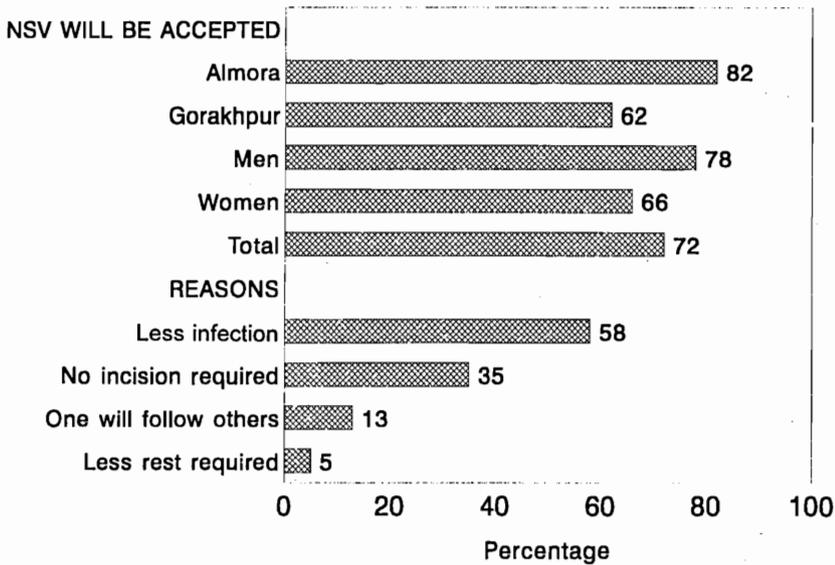
There are also major misconceptions about the number of days men and women have to rest after the operation. In the case of vasectomy, the average number of days mentioned by men was 31 and by females 35 (Appendix A). During the FGDs, both men and women repeatedly mentioned that men, who are the bread winners of the family cannot afford such a long rest, whereas women, who generally remain at home, could do so.

These community perceptions help explain the low incidence of male sterilization.

Perceptions about Non-scalpel Vasectomy: Respondents' awareness and perceptions of NSV were assessed in both districts. Overall, about one-fifth (22 per cent) of the respondents from Almora and about one-tenth (8 per cent) in Gorakhpur were aware of NSV (Table 3.1). The method was explained to respondents who were not aware of NSV: "NSV is a new method of male sterilization. The new technique does not

require any incision and, hence, there are no stitches. It is as effective as any other sterilization method." If the respondents had any questions about the method, they were answered. Finally, the respondents were asked whether they thought NSV would be accepted by the people.

Figure 3.2: Perceived Chances of Acceptance of NSV



At Almora a significantly ($p < 0.01$) higher proportion of men (94 per cent) than women (70 per cent) felt that NSV would be accepted. However, in Gorakhpur a lower but almost equal proportion (61 per cent) of both men and women believed it would be accepted. The main reasons given for the possible acceptance of NSV were that an incision is not required (35 per cent) and, hence, presumably there would be fewer post—operative complications (71 per cent in Almora and 45 per cent in Gorakhpur). A small percentage (5 per cent) also felt that with NSV the duration of rest would be shorter (Figure 3.2).

About 13 per cent (17 per cent in Almora and 8 per cent in Gorakhpur; 22 per cent men and 4 per cent women) did not give a specific reason but felt that once people start accepting the new method, many others would follow their example. About 13 per cent of the women and 8 per cent of the men from both the districts were against NSV as it involved sterilization. They said that this weakened men and they were unable to do hard labour.

FGDs with both men and women confirmed these views. Most respondents were in favour of NSV primarily because no incision was

required and, hence, subsequent problems of infection or delayed healing were less likely. In the words of Mehta, a male informant from Almora:

"People generally have a fear regarding operations that there will be a big cut causing loss of blood and many stitches will need to be given. Since in this technique [NSV] there is no need for cuts and stitches, surely this will be adopted by the people."

Ramesh from Gorakhpur had similar views:

"A man, even after the operation, will be able to continue doing his routine work. Since there will be no stitches, there will be very little chance of sepsis, which is very convenient for people. The method sounds easy and does not require stitches. I feel many men may accept it."

A male from Almora said:

"If there is no adverse effect after its acceptance, we will also accept it."

Some of the men from Almora favoured the promotion of vasectomy, particularly NSV. As it was observed from FGD that:

"Problems occur only when one does heavy and laborious work and there is a danger of the stitches breaking. Jobs like picking up heavy things, filling water, having to walk 2-5 kms into the forest to fetch grass and firewood should not be done for some time after the operation. Generally, these jobs are done by women, so men should accept sterilization."

Many respondents said:

"People follow each other once they were convinced of the safety and effectiveness of NSV, its acceptance would increase."

While many people were optimistic about the acceptance of NSV, some were apprehensive about adopting the method since they had no idea about its effectiveness or the process involved.

Expressing the general misgivings of the people, Savitridevi, aged 40, from Gorakhpur district said:

"Men have to work very hard. After the operation, they may become weak, hence, they will not get operated."

Ramdulari, aged 27 and the mother of two children, said:

“Men are the ones who have to earn and feed the family. The Poori Zimmedari (entire responsibility) of the family rests on them. Now, if a man after the operation becomes weak, who will look after the family?”

Table 3.3: Will Availability of NSV Services at PHCs Increase its Acceptance?
(Percentage)

	Almora	Gorakhpur	Males	Females	All
Yes	83	70	85	67	76
No	4	10	7	7	7
Difficult to say	13	20	8	26	17
Reasons for increased acceptance*					
Easy access/shorter commuting time	78	69	69	79	74
Less expensive	24	9	18	15	16
Known doctor at PHC	9	8	15	2	9
More people will get to know about the method	4	3	5	2	4
Other irrelevant reasons	7	9	17	1	9
Total respondents	163	171	166	168	334

* Percentages total more than 100 because of multiple responses.

When asked whether the availability of NSV facilities at the PHC would affect its acceptability, nearly two-thirds (85 per cent men, 67 per cent women) answered in the affirmative (Table 3.3). The main reasons given were easy access and proximity to the home, which meant that commuting to the PHCs and taking care of patients would be relatively simple (74 per cent). Some of the respondents rightly felt that it would be less expensive. Other reasons given were that the doctors would be known to them and people would get to know about NSV.

FGDs also supported these views. In the words of different respondents:

“In the village, everyone is involved daily in farm work. To spend time going to a far—off place is difficult. Even when you go, sometimes doctors may not be available. If the facility is available near by and it does not hinder our work, surely more people will accept the method.” (from FGD males, Gorakhpur)

"One can walk down to the clinic and need not spend money and time in travel. Also, other family members can go and attend to him." (from FGD for females, Almora)

"If the facility is available near by, more people will come to know about the method. Its acceptance will increase." (from FGD for males, Almora)

A small proportion of the people (7 per cent) who did not feel that acceptance of vasectomy would increase even with the availability of NSV at PHCs gave reasons such as people's lack of faith in government services, fear that the vasectomy would fail, and fear that men would become weak and unfit for hard work after the vasectomy. Expressing their views, one FGD participant said:

"Men have to work hard and do heavy labour. After the operation, men become weak and unfit for heavy work. Hence, men will not accept the method even if the facility is available at the PHCs." (from FGD for female, Gorakhpur)

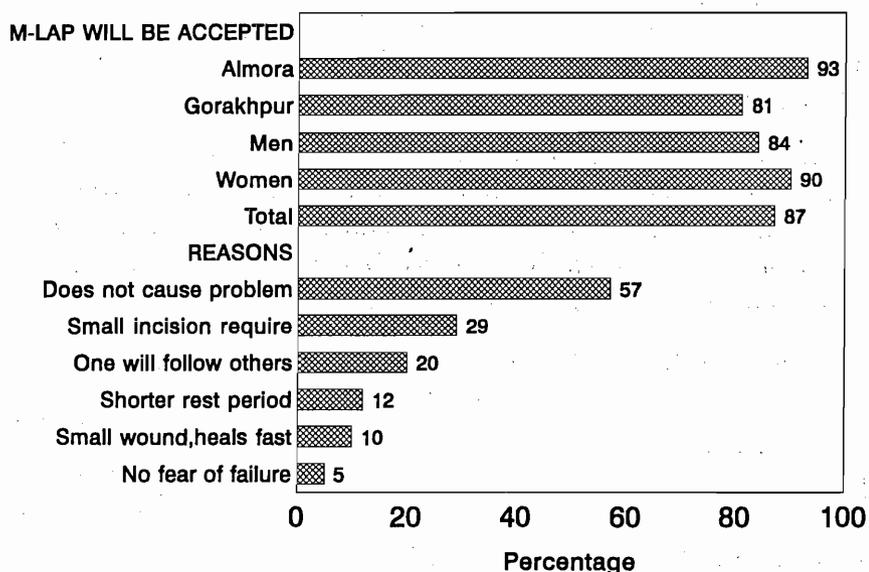
"Even if male sterilization is available at the PHC, it will take a long time for people to become aware of it and accept the method. First, the people have to be educated and convinced about its safety and effectiveness. I do not think the PHC workers will do that. They are all useless." (from FGD for males, Gorakhpur)

Some males gave non-committal answers, such as:

"If one feels the need for the male operation and he is willing, then he will accept it." (from FGD for males, Gorakhpur)

Awareness and Perceptions of Minilaparotomy

The percentage of respondents who had heard of minilaparotomy was 52 per cent in Almora district but only 17 per cent in Gorakhpur. One reason for the limited awareness in Gorakhpur could be that laparoscopy was more popular in Gorakhpur. The second reason could be the way the question was framed which was "There is a new method of female sterilization called minilaparotomy [*chota chirawala operation*]. Have you heard of this method?" Calling minilaparotomy a 'new method' might have confused the respondents because, according to the doctors, minilaparotomy was commonly used in Gorakhpur. However, this fact did not emerge from the respondents, answers.

Figure 3.3: Perceived Acceptance of Minilaparotomy

When minilaparotomy (*chota chirawala operation*) was explained to them, the majority of the respondents (87 per cent) felt that this method if easily available would be accepted by the people (Figure 3.3). The perceived reasons for its acceptance were that the method does not cause problems after the operation (57 per cent) and the incision is small (29 per cent).

In the words of Laxmidevi, a woman from Almora district:

"In this method, there will be a small cut and, so, few stitches will be required. Thus, this method will cause fewer post-operative problems."

Similar views were expressed by Phulmati, a woman from Gorakhpur district:

"If the method requires only a small cut and only two instead of five stitches are given, the pain will naturally be less. In such a case, a woman may prefer this method." (from FGD for females, Hawalbaugh, Almora)

"If in this method the pain and problems are less than the bada chira wala operation [tubectomy], then women will definitely accept this method." (from FGD for male, Takula, Almora)

"As this method is less likely to cause problems [because of the fewer stitches], women will not have to worry about post-

operative complications." (from FGD for females, Deurbir, Gorakhpur)

Comments by Pushpa, a woman from Almora district, highlight the role of husbands. She observed:

"If the method is simple and effective, then definitely it will be accepted by women. However, it is men who get their women [meaning wives] operated. If the mard [husband] himself is convinced that this method is better, he will get his wife operated or convince her to accept this method."

Table 3.4: Reasons for Increased Acceptance of Minilaparotomy if Available at PHC

Reasons	(Percentage)		
	Males	Females	All
Increased acceptance of minilaparotomy	85	86	85
Reasons for possible increase in acceptance*			
Proximity cases commuting time for patient and caretakers	60	83	72
Less expensive	15	26	21
Doctor will be known and easily available	10	5	7
People will come to know about the method	7	4	5
Other irrelevant reasons	23	3	13
Total number of respondents	166	168	334

*Percentage totals more than 100 because of multiple responses.

Most of the respondents (85 per cent) felt that minilaparotomy would be accepted more if the service was made available at PHCs. The main reason was easy to access the method (72 per cent, of which 83 per cent were women and 60 per cent were men). Another 21 per cent (26 per cent women and 15 per cent men) felt that availability of the service at PHCs would reduce the expenses incurred. Several other reasons were given, such as acquaintance with and easy accessibility of doctors and increased awareness of the method (Table 3.4).

The following verbatim protocol typically expresses their views:

"Proximity to the village will facilitate commuting and will be helpful in taking care of patients."

"In our hilly region, if the facility is available nearby, the expense and time required to commute will be less. If the government provides such a facility here, women will definitely

accept this method [minilaparotomy].” (from FGD for males, Matela, Almora)

Knowledge about Various Methods of Female Sterilization

Awareness does not necessarily mean that the respondents have correct knowledge. So, in order to assess their knowledge, respondents were asked questions about the type of anaesthesia given, the site of the operation, the operation process, etc.

Respondents were considered to possess correct knowledge if they could correctly mention the site of operation on the body and the broad steps of the operation. If one or more facts were correct, it was categorized as ‘somewhat correct’ and the rest, were categorized as incorrect answers.

Abdominal Tubectomy: Overall, 6 per cent of the respondents had correct knowledge while 58 per cent had “somewhat correct knowledge,” 11 per cent had wrong information and the rest said

“do not know”.

More women than to men had correct knowledge about the method (Table 3.5).

A majority of the respondents (83 per cent) considered abdominal tubectomy a difficult operation to perform with higher chances of complications (71 per cent). Most (70 per cent) could correctly answer that general anaesthesia was required for abdominal tubectomy. However, more women (87 per cent) had correct knowledge about anaesthesia compared to men (54 per cent). On an average, women reported the need for about six days rest at the clinic after an abdominal tubectomy whereas men reported about one-and-half days. The mean days of rest required following abdominal tubectomy was reported as 41 days. The difference in the average number of days of rest given by men (38 days) and by women (45 days) was not statistically significant. There was a wide variation in the answers (Table 3.5).

Laparoscopy: Only 5 per cent of the respondents had accurate knowledge about laparoscopy, whereas 50 per cent had somewhat correct knowledge. A little over two-thirds of the respondents felt that laparoscopy was a simple operation (69 per cent). One-third of the respondents believed that laparoscopy had high chances of complications, while over half of them felt that it had low chances of complications. Men and women had similar levels of knowledge about laparoscopy (Table 3.5).

Table 3.5: Knowledge about Abdominal Tubectomy, Laparoscopy and Minilaparotomy*(Percentage)*

<i>Knowledge</i>	<i>Abdominal Tubectomy</i>			<i>Laparoscopy</i>			<i>Minilaparotomy</i>		
	<i>Males</i>	<i>Females</i>	<i>All</i>	<i>Males</i>	<i>Females</i>	<i>All</i>	<i>Males</i>	<i>Females</i>	<i>All</i>
Knowledge about the process of operation									
Correct	5	6	6	8	2	5	—	13	9
Somewhat correct	52	65	58	36	65	50	36	64	55
Wrong	10	13	11	18	11	15	3	5	4
Don't know	33	16	25	38	22	30	61	18	32
Ease of operation									
Simple	14	9	11	68	70	69	58	79	73
Difficult	79	87	83	16	22	19	14	12	12
Can't say	7	4	6	16	8	12	28	9	15
Chances of complications									
High	61	81	71	35	31	33	5	20	15
Low	24	14	19	48	58	53	50	54	53
No chance	10	2	6	1	2	1	6	16	12
Do not know	5	3	4	16	9	13	39	10	20
Type of anaesthesia given									
Local	38	9	24	68	72	70	64	78	74
General anaesthesia	54	87	70	14	13	14	14	12	12
Do not know	8	4	6	18	15	16	22	10	14
Mean hrs required after operation to stay in the clinic/centre									
	34.7	146.3	88.8	6.5	8.8	7.6	17.1	10.4	12.2
Minimum	1	1	1	1	1	1	1	1	1
Maximum	292	360	360	72	72	72	168	168	168
Mean days required after operation for rest									
	37.8	44.9	41.3	19.5	25.3	22.4	19.6	16.7	17.4
Minimum	1	3	1	1	1	1	4	3	3
Maximum	183	365	365	90	185	185	90	150	150
Total number of respondents	165	157	322	140	127	267	36	77	113

Minilaparotomy: Only 9 per cent could report correctly on minilaparotomy, while 55 per cent had somewhat correct knowledge. In general, knowledge about minilaparotomy was poor, and half or more respondents could not answer questions on the process, chances of complications, or the type of anaesthesia required. However, a relatively a higher proportion of women than men had correct knowledge (Table 3.5). Respondents from Almora were more knowledgeable than those in Gorakhpur.

Perceived Reasons for the Low Acceptance of Male Sterilization

To gain an insight into attitudes towards male sterilization, respondents were asked why the popularity/acceptance of vasectomy had declined.

Table 3.6: Perceived Reasons for the Low Acceptance of Vasectomy
(Percentage)

Reasons for lower acceptance*	Almora Gorakhpur Males Females All				
Men had to work hard	42	70	49	63	56
Causes weakness	36	53	42	46	44
Vasectomy failures cause family and social problems	35	6	22	19	20
Men have to go outside home	15	14	7	21	14
Female sterilization is easier	15	8	17	7	12
Vasectomy was never accepted willingly; it was forced	6	5	9	1	5
Provision of incentives has stopped	3	6	3	6	5
Female takes self-decision for getting sterilized	3	4	4	3	4
Fear of operation	7	–	6	1	3
Others**	16	14	17	11	15
Don't know	8	5	4	10	7
Total number of respondents	163	171	166	168	334

*Multiple responses.

**Men were negligent towards women's health, other methods available, women are more aware.

The main reasons given were that *men have to do hard work*, and that after vasectomy men become weak and, hence, unfit for hard labour. Another important reason was fear that the operation would fail, thereby causing serious family and social tensions (Table 3.6). About 14 per cent felt that men have to go outside home for work and, hence, cannot afford to stay at home and rest after the operation. A small proportion of respondents felt that vasectomy had declined because of the availability of other methods, particularly female sterilization, that are simpler and more effective.

An analysis by sex of the respondents did not show any major differences. This indicates that the majority of women also believe that vasectomy causes weakness and, thus, after a vasectomy, men cannot do hard work. These observations were also supported by the views expressed during FGDs. For instance, a woman from Gorakhpur district said:

"Women remain inside the house. Even if they do not work, it will not affect the family earning. But men have to go out and work. If they get operated and become weak, then who will earn? How will the family run [be supported]?"

Expressing a similar view, another woman commented:

"Men do not get operated because they have to earn and feed the family while women have to sit at home."

For men, failure of the method and its social consequences was a major concern and this was reflected repeatedly during all FGDs.

"A lot of vasectomy cases have failed in the past. This causes serious embarrassment for the couple in the community and tension in the family. Due to these reasons, men now avoid getting operated. They do not want to take a chance."

A male from Almora district said,

"Since a lot of male sterilizations have failed, men fear that if in their case the operation fails and the woman [wives] conceives again, then the wife will be stigmatized."

"Certain social beliefs also prevent men from adopting vasectomy. It is said that after undergoing male sterilization, men lose their sex drive or lose their manhood. Also many develop an inferiority complex [unme hinta ki bhavna aa jati hai]."

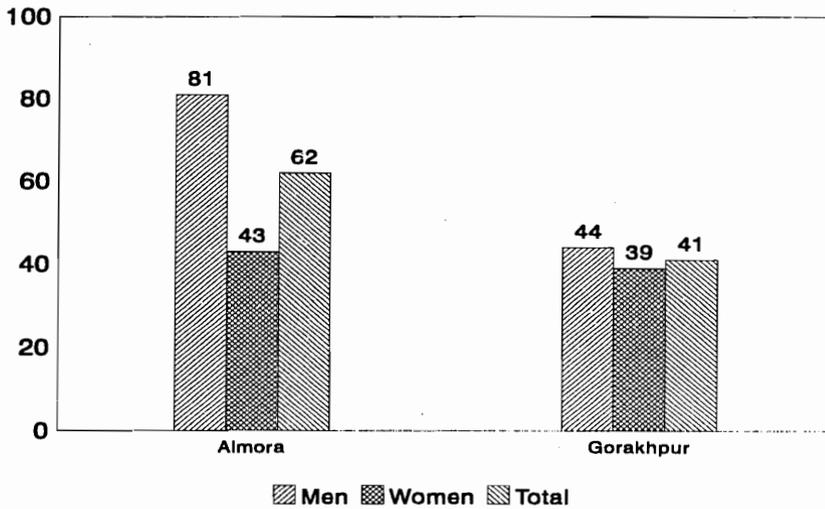
An interesting reason mentioned by a few women for non-acceptance of vasectomy was:

"After sterilization of the wife, if something happens to her [i.e., the wife dies] the man can marry again. But if a man gets sterilized, how can he marry and produce children to carry on the family name?"

Should Vasectomy be Promoted Again: The study shows that about half (52 per cent) the respondents were in favour of promoting vasectomy. The people of Almora (62 per cent) supported the promotion of vasectomy more than those from Gorakhpur (41 per cent). The percentage of men supporting the promotion of vasectomy in Almora district (81 per cent) was almost double that in Gorakhpur (44 per cent) (Figure 3.4). Interestingly, a higher percentage of males (62 per cent) compared to females (41 per cent) felt that vasectomy should be promoted. The difference by sex was more conspicuous in Almora (38 per cent points) than in Gorakhpur (5 percentage points).

The study revealed a deeprooted fear among women that vasectomy would weaken men and that they would not be able to do their normal work. According to them, it would mean that the family's income would be affected. Also, the women had an underlying fear that if such a thing happened, the women would be blamed for not undergoing the operation themselves and letting their husband take a 'risk'. Also, in a joint family, the woman's in-laws would not want their son to take a

Figure 3.4: Percentage Supporting Promotion of Vasectomy



risk an operation. The following protocol of one woman reflects their thinking:

“It is not in our hands. We have to think about family members also. His [the husband’s] mother will never want her son to get operated as something might happen to him [his health might be adversely affected].”

A woman from Gorakhpur district said:

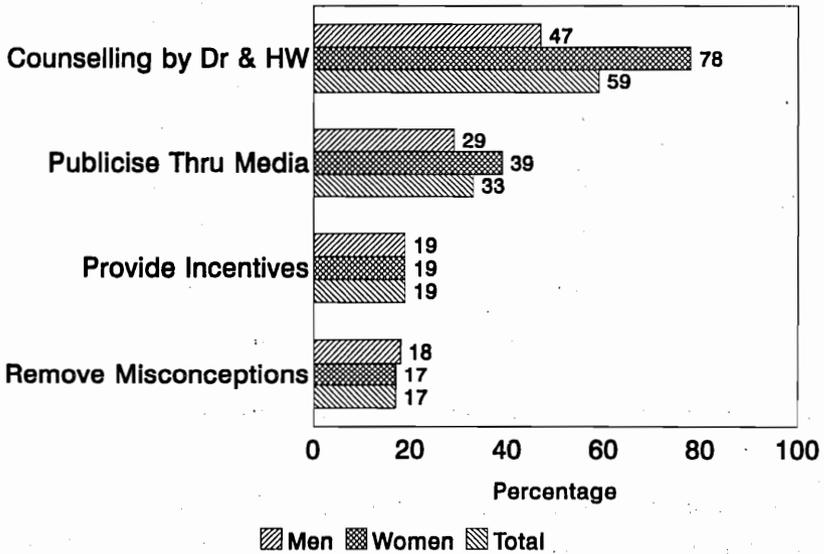
“In our area, it is the females who get operated. None of the males accept vasectomy. We cannot even think of such a thing. What if something happens to our men [husbands]. It will come on our head [we will be blamed] so it is better that we ourselves get operated.”

A young woman from Almora, the mother of one child, talked about the existing beliefs:

“People believe that a man’s life is more precious than a woman’s. In case something happens to a woman [that is, she dies], then the man can marry again and get another lady to look after the first ones’ children, but if something happens to the man during or after the operation, who will look after the wife and children? Due to these fears, women do not allow their husband to get operated.”

Steps Suggested for Promoting Vasectomy: The majority of those who were in favour of vasectomy (59 per cent) said that promotion of the method should be done personally by the PHC doctors and other health providers by talking directly to the people.

Figure 3.5: Suggested Steps to Promote Vasectomy



They felt that the words of doctors and health workers are taken more seriously and believed by the community members; if the health providers advise and reaffirm the safety and effectiveness of the method, the method may get slowly accepted. For this, a house-to-house educational effort is preferred. Other suggestions were to publicize the method through the media (33 per cent), provide incentives to acceptors (19 per cent), and remove misconceptions (17 per cent). While the response pattern in the two districts was similar, a much larger proportion of women (78 per cent) than men (47 per cent) emphasized a personalized house-to-house educational campaign by doctors and health workers (Figure 3.5). More women also emphasized an educational campaign through different media. The FGD revealed that the women were convinced that unless men are educated about the method and their misconceptions removed, the chances of increasing acceptance of vasectomy are remote.

Suggestions given in the FGD also support the above findings. Some comments follow:

“Both men and women should be made to understand that by having a vasectomy one does not lose one’s manhood. It also

does not make men weak or afflict their earnings adversely. Advice from doctors will be more readily believed.

“People should be told all about the new male operation [NSV], and about its advantages as well as disadvantages, if any.”

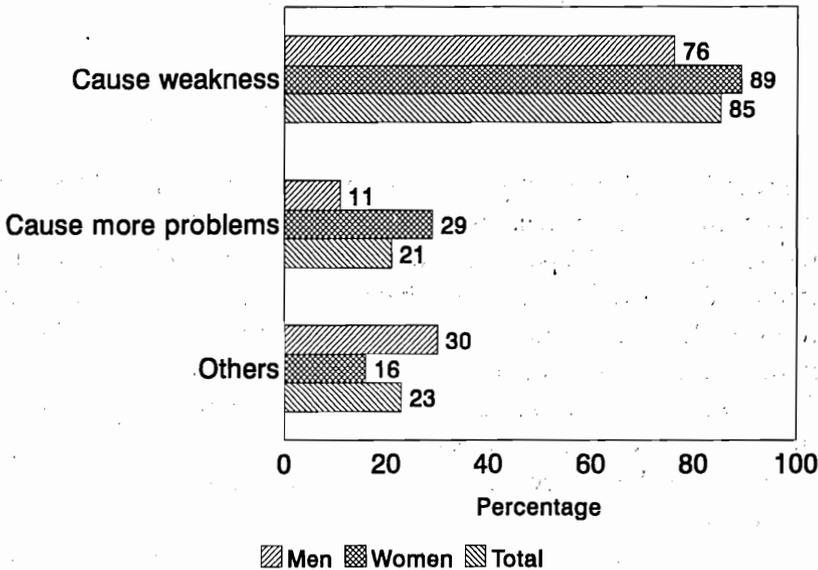
“Group meetings should be organized regularly in the villages where, during the question-answer session, all the doubts in the minds of the people regarding vasectomy can be cleared.”

“Women should also be told about the advantages of vasectomy because it is they who usually object to the men getting operated. They should be reassured that men will not become weak and it would not affect their earnings adversely.”

Yet others suggested giving monetary incentives:

“If the unemployed people are given some money, out of greed they may agree to be operated.”

Figure 3.6: Main Reasons for Opposing Vasectomy

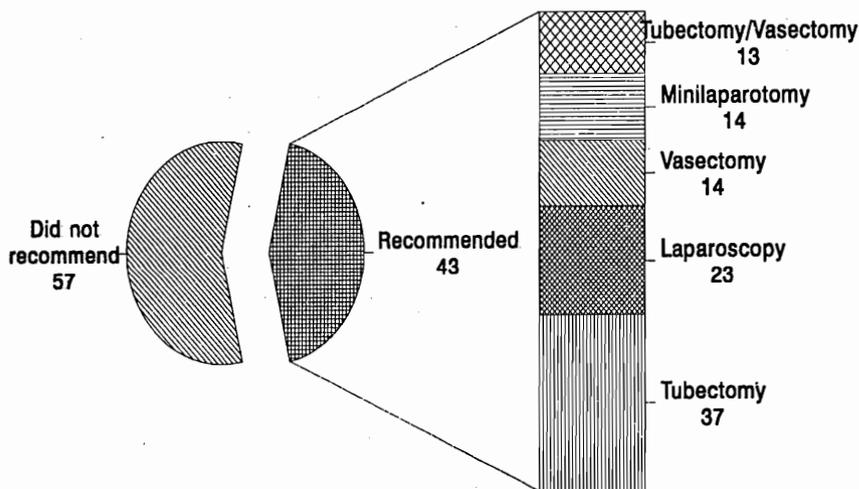


About half of the respondents (47 per cent; 37 per cent men and 57 per cent women) did not favour the promotion of vasectomy. They mainly believed that the method weakens men and they become unfit for hard work (85 per cent). Some of them (21 per cent) also believed that vasectomy causes more problems, e.g., sexual weakness and failure leading to family tension, than other sterilization methods (Figure 3.6).

Sterilization Methods Recommended

To gauge how much faith people had in sterilization methods or their belief in permanent methods of family planning, the respondents were asked whether they had ever recommended sterilization to their friends or relatives and, if so, which methods and whether male or female sterilization.

Figure 3.7: Percentage who Recommended Sterilization



It was found that slightly less than half the respondents (43 per cent) had recommended sterilization to others (Figure 3.7). Overall, a higher percentage of men (53 per cent) compared to women (34 per cent) had recommended sterilization to others. An analysis of the method recommended revealed that among the respondents who had recommended sterilization, most had favoured tubectomy (37 per cent), followed by laparoscopy (23 per cent), and vasectomy (14 per cent), and minilaparotomy (14 per cent). However, 13 per cent did not have any bias towards either vasectomy or tubectomy, and mentioned that they would recommend both.

The response pattern in the two districts showed some interesting variations. For instance, vasectomy was recommended more in Almora (41 per cent) than in Gorakhpur (14 per cent). Similarly, minilaparotomy was recommended by 25 per cent of the respondents in Almora but only 5 per cent did so in Gorakhpur.

The response pattern differed by sex, particularly in Almora. In both districts, vasectomy was recommended mainly by men (e.g., in Almora by 31 per cent men and 7 per cent women). Similarly, in Almora more

men recommended tubectomy (29 per cent as against 24 per cent by women). A much larger proportion of women recommended minilaparotomy (28 per cent) than men (3 per cent). A section of men and women did not show any particular preference either for vasectomy or tubectomy (29 per cent of the men and 7 per cent women). In Gorakhpur district except in the case of vasectomy, no significant difference in the response pattern was observed between the groups by sex.

The reasons given by the majority for not advising others about family planning methods although they themselves knew about it was that 'the need or the occasion did not arise' (68 per cent), lack of complete knowledge (13 per cent), not having adopted any method themselves (12 per cent) and 'people get offended' (10 per cent). No significant difference was observed in the response pattern between the two districts or between the sexes.

During FGDs when the same issues were raised, almost identical comments were made by the participants. It was felt that these issues are sensitive and unless the other persons ask themselves or have a close rapport, nobody would like to offer advice on his or her own. In the words of one of the FGD participants:

"We do not discuss topics like sterilization with others because they may get offended and it might lead to quarrels or bad feeling among people. However, if one has accepted some method herself and someone asks about it, then we can discuss it." (from FGD for females, Gorakhpur)

"How can we recommend sterilization to others when we ourselves have not adopted the method?" (from FGD for females, Almora)

Reasons for Recommending a Method of Sterilization: About 50 per cent of the respondents who had recommended sterilization were further asked about their preference among the various sterilization methods. Their answers are in Table 3.7.

The study reveals that the main reason for recommending any specific sterilization method was its perceived safety, simplicity and effectiveness (ranged between 37 and 58 per cent). An equally important reason was the perception of minimal side effects of the methods (33-57 per cent) (Table 3.7).

Personal experience was mentioned by 14-20 per cent of the respondents while easy accessibility or perceiving it as the only method

available was mentioned by 14-16 per cent of the respondents who had recommended female sterilization methods to others (Table 3.7).

Table 3.7: Reasons for Recommending a Particular Sterilization Method
(Percentage)

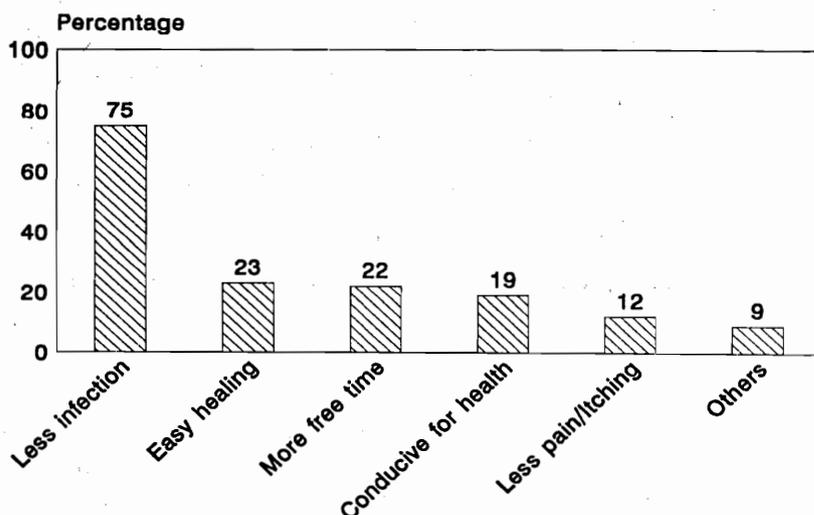
<i>Reasons*</i>	<i>Vasectomy</i>	<i>Tubectomy</i>	<i>Mini-laparoscopy</i>	<i>Vasectomy/Tubectomy</i>
Easy and effective	57	49	58	37
Does not cause any problems	33	38	57	16
Self-user of this method	14	14	20	5
Easily available	—	16	14	—
Others	26	6	8	5
Not specified	—	—	—	39
Total number of respondents	21	53	51	19

* Multiple responses.

Preferred Season/Months for Sterilization

One of the objectives of the study was to find out which seasons community members preferred for undergoing any of the sterilization operations and the reasons, if any, behind such preferences.

Figure 3.8: Reasons for Preferring Winter for Sterilization



Almost all the respondents (98 per cent), irrespective of district and sex of respondent preferred the winter season and the majority (91 per cent) said the months between October to March would be ideal for sterilization. The rest preferred the months from July-October. The

main reasons for preferring winter for sterilization was the general belief that, during winter, there are fewer chances of infection (75 per cent) and the stitches dry up quickly (23 per cent) (Figure 3.8).

About one-fifth also felt that during winter, there would be less farm work and hence it would be possible to rest after the operation. About 12 per cent also felt that pain and itching during winter would be less (Figure 3.8).

The response pattern in the two districts did not differ much except that the low work load during winter as a reason for preferring sterilization during that season was mainly mentioned by respondents from Almora (37 per cent; 34 per cent men and 40 per cent women) compared to Gorakhpur (7 per cent). The following are extracts from FGDs.

"During winter wounds do not get infected and stitches dry quickly."

"In summer the chances of a wound getting infected is high whereas in winter such chances are very low."

"During winter, farm work is less and it is possible for the women to rest after the operation."

"In winter it is possible to keep the wound covered so flies cannot infect the wound, while during summer one cannot keep the wound covered because of the warm weather, sweating, itching, etc., and hence flies sit on it and one is troubled by them. This also increases the chances of infection."

A couple also said:

"If one is in a hurry, then she can get operated on any month; but winter would be preferable."

Another reason given in both districts was:

"During this period, good vegetables and fruits are available. In general, winter months are conducive for good health as food gets digested easily."

According to one woman:

"During summer and the rainy season, we all are busy in farm work. All of us, including women, have to work hard in the fields. In winter the load of work is less, so one can get time to rest after the operation."

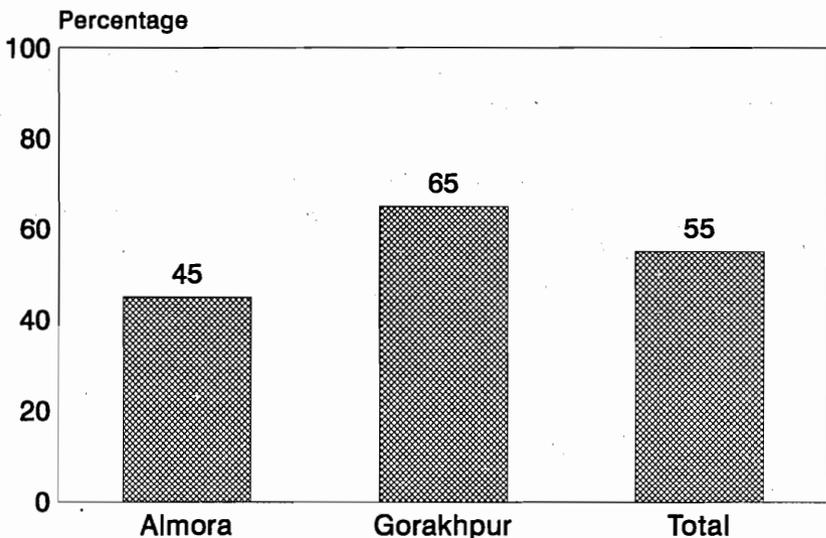
Another reason given by a woman in Gorakhpur was:

"In our homes, we do not have electricity. During summer, there is no fan. Due to the heat one cannot rest by lying down inside the room or avoid taking a bath. Hence, it is difficult for a woman to rest after the operation in summer. Such exposure also leads to infection."

Reported Time Lag Between Decision on Sterilization and Actual Operation

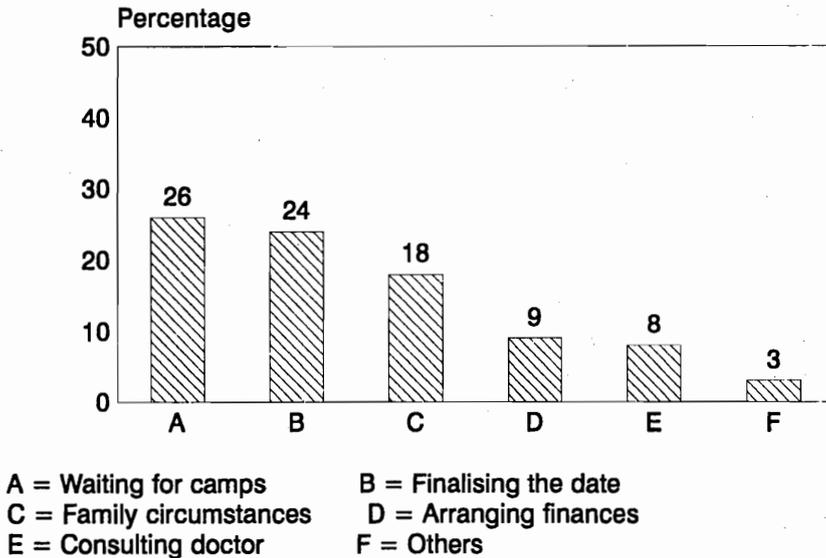
Another objective of the study was to understand whether the people adopt sterilization soon after they decide to accept the method or if there is a time lag between the decision and acceptance of the contra-ception. This is very important from the point of view of service delivery.

Figure 3.9: Agree that Time Lag Exists Between Decision to Adopt Sterilization and Actual Operation



About 55 per cent of the respondents (45 per cent in Almora, 65 per cent in Gorakhpur) reported a time lag between the decision taken for sterilization and the actual operation itself. A small percentage could not answer and expressed their ignorance on the matter (Figure 3.9).

Those who reported a time lag between the decision on sterilization and actual acceptance of the method were further probed and were asked to explain the reasons for the time lag. Their answers as well as informal discussions with other community members revealed that several factors operate simultaneously in causing the delay. One

Figure 3.10: Reasons for the Time Lag

important factor is the season. Almost one-fourth of the respondents reported that people by and large wait for the winter months when health camps are organized at the PHCs. An equal proportion of the respondents (24 per cent) said that even after deciding to get sterilized, people have to make arrangements and decide the exact date of the operation. A lot depended on the circumstances in the family (18 per cent), arranging money (9 per cent) and availability of doctors/workers for consultation prior to the operation (8 per cent) (Figure 3.10).

While no significant difference was observed between the sexes of the respondents, those reporting a time lag between the decision and execution of sterilization was significantly higher in Gorakhpur (65 per cent) than in Almora (45 per cent) (Figure 3.9). Situations that caused delays in getting operated as reported by the women were as follows:

“Often the decision for an operation is taken at the birth of a child, particularly if it is an unwanted one. But immediately after the decision one cannot rush for an operation. First, one has to wait for winter when health camps are held, discuss with others and make arrangements at home to look after the children. There are several other things also to be done.”

“Even after one makes up one’s mind to get operated, to decide the exact date of operation one has to see the situation in the family. If there is a marriage or religious ceremony scheduled

for the next month or two, then the woman will delay the operation since she will have to be involved in the function and its arrangements. There could be several other situations within the family which could delay sterilization." (from FGD for females, Gorakhpur)

"After deciding the date of the operation it is possible that the woman's child or someone else in the family may fall sick, or she herself may fall sick, or her husband may go somewhere and is busy; in all such cases, she has to postpone the operation. Then she will have to wait for the next camp to be organized to get operated. Often women themselves delay sterilization because of fear of the operation." (from FGD for females, Almora)

Other reasons for delay were:

"If the doctor of one's choice does not come for the operation, then people postpone the operation." (from FGD for females, Gorakhpur)

"If a lady doctor does not come for the operation on camp day, then some women may go back." (from FGD for males, Hawalbag, Almora)

"For a woman to get operated, she has to wait for a camp day. Only when a camp is organized, she can get operated whereas for a man he can go to the PHC any day and get operated."

Preferences about Sex of the Provider of Sterilization

A common belief among programme managers and policy makers of family planning in Uttar Pradesh is that LMOs are essential for conducting female sterilization. It is believed that if male doctors provide services, many women would not like to accept sterilization and it may even offend some people. However, there is a dearth of LMOs; there are fewer than one LMO for every five medical officers. Hence, as long as female sterilization is left solely in the hands of LMOs, access to these services will continue to be limited and only through a mobile team could it be taken to various sites. However, in many states such as Bihar and Gujarat, it has been reported that male doctors are actively involved in providing female sterilization services. This indicates that the same could be done in Uttar Pradesh to enhance the accessibility of sterilization services round the year. In the present study, an attempt was made to confirm these beliefs—to find out whether or not people are ready to get sterilization done by a doctor of the opposite sex, to check

how strong these preferences are, and whether there is scope to increase accessibility to sterilization services by training male doctors.

Table 3.8: Respondents' Opinion on Sex of the Doctor for Performing Family Planning Sterilization

(Percentage)

Respondents	Almora			Gorakhpur			All		
	Males	Females	All	Males	Females	All	Males	Females	All
Male sterilization should be performed by									
Male doctor only	64	95	80	82	95	89	73	95	84
Either male or female doctor	36**	5**	20	18	5	11	27**	5**	16
Female sterilization should perform by									
Female doctor only	70	95	83	88	96	92	79	96	88
Either male or female doctor	30**	4**	17*	12	4	8*	21**	4**	12
Total number of respondents	80	83	163	86	85	171	166	168	334

*Significantly different at 5% level

**Significantly different at 1% level

As expected, the majority of the respondents (84 per cent) preferred a male doctor for vasectomy and a lady doctor for female sterilization (88 per cent). However, it is interesting to note that for both male and female sterilization, men were relatively more open and were ready to accept doctors of the opposite sex for sterilization (Table 3.8).

For instance, 27 per cent of the men compared to 5 per cent of the women said that the sex of the provider did not matter much and, if necessary, they were amenable to the idea of getting sterilized by a lady doctor also. Similarly, in the case of female sterilization 21 per cent of the men and only 4 per cent women said that the sex of the doctor was not a consideration or criterion for accepting sterilization (Table 3.8).

Such openness was observed more in Almora than in Gorakhpur. For instance, in Almora the percentage of men ready to accept doctors of either sex to perform male and female sterilization was double (30-36 per cent) that in Gorakhpur (12-18 per cent) (Table 3.8). The difference between men and women and the difference between the districts was statistically significant ($p < .01$) and ($p < .05$), respectively. The following were the comments made by the participants in the FGD.

According to the women:

"A woman's operation should be done by a lady doctor only."

"A man cannot get sterilization done by a lady doctor. He will feel uncomfortable in front of a lady."

“If there is an urgent need for the woman to get operated, then one has to let whichever doctor is available do the operation—either male or female.”

A village woman, even if literate, has a lot of inhibitions; she will be hesitant to get her operation done by a male doctor.”
(from FGD for males, Almora)

However, some men said:

“It does not matter whether the doctor is a male or a female; the doctor should be skillful so that there is no chance of failure.”

“We have no objection to having our wives being operated by either a male or a female doctor. In fact it is preferable to be operated by a male doctor because usually they are more skillful compared to female doctors.”

The findings suggest that, with proper motivation, the percentage of people who would not attach a lot of importance to the sex of the doctor could be increased. The small proportion of people who are open to this idea could be used as catalysts to change the attitude of their community. Also, men could be motivated and used as advocates to convince their wives and other family members that there is nothing wrong in getting a woman sterilized by a male doctor. If this is successfully done, it could go a long way towards increasing the accessibility of minilaparotomy and other sterilization services for women.

Chapter 4

Awareness, Knowledge and Treatment Seeking Behaviour of Community Members for Reproductive Health Problem

Family planning is a part of reproductive health care and, hence, cannot be studied in isolation without taking into account various gynaecological and genital morbidities. The prevalence of reproductive tract infections (RTIs), in particular, play an important role in the acceptance and continuation of contraception. This can happen in two types of situations.

If a woman is already suffering from RTI problems and still adopts a contraceptive such as an IUD, the chances are high that the infection will become aggravated. A mild pre-existing infection could become acute and she would discontinue the use of the contraceptive. There is a high possibility that this experience would be wrongly interpreted by the client. She would believe that her infection was due to the IUD. Thus, a misconception would get rooted in the client's as well as other people's minds about IUDs, in general.

In another situation, a woman may have an RTI but remain asymptomatic. She may undergo sterilization or accept an IUD and subsequently, in the natural course of events, her infection may become acute. Again, the contraceptive adopted by the woman may be considered as being responsible for the infection. Finally, there is a real danger that if during the insertion of the IUD sterilized equipment is not used or the procedure for infection prevention is not properly maintained, women may get infected.

Hence, it is critical that the reproductive health of the woman should be taken into account before she adopts any contraceptive. For this, apart from the health providers, it is also important that the people themselves are aware of RTIs.

Awareness of RTIs

To assess the awareness and knowledge of the people about gynaecological morbidities, the respondents were asked to list the names or symptoms of common gynaecological morbidities (*zanani bemari*).

Table 4.1: Awareness about Gynaecological Morbidities*(Percentage)*

<i>Gynaecological problems</i>	<i>Almora</i>			<i>Gorakhpur</i>			<i>All</i>		
	<i>M</i>	<i>F</i>	<i>All</i>	<i>M</i>	<i>F</i>	<i>All</i>	<i>M</i>	<i>F</i>	<i>All</i>
	<i>S+P</i>	<i>S+P</i>	<i>S+P</i>	<i>S+P</i>	<i>S+P</i>	<i>S+P</i>	<i>S+P</i>	<i>S+P</i>	<i>S+P</i>
Menstrual problems like									
bleeding/pain/spotting	100	100	100	100	100	100	100	100	100
Discharge from the vagina	98	100	99	99	100	99	98	100	99
Lower abdominal pain	95	96	96	97	100	98	96	98	97
Low backache	86	100	93	94	99	97	90	99	95
Burning sensation while									
passing urine	91	98	95	91	95	93	91	96	94
Infertility	89	99	94	91	97	94	90	98	94
Itching in the vagina	75	96	86	93	95	94	84	96	90
Lump in the breast	74	96	85	67	95	81	71	96	83
Ulcer/bleeding sore in									
genital region	53	86	69	76	86	81	65	86	75
Mass/swelling out of									
the vagina	48	90	69	62	93	77	55	92	73
Leakage of urine/faeces									
from the vagina	50	78	64	64	75	70	57	77	67
Dyspareunia/post-coital									
bleeding	29	30	29	48	47	47	39	38	38
Total no. of respondents	80	83	163	86	85	171	166	168	334

S = Spontaneous, P = On probing, M=Male, F=Female.

Awareness about some of the common gynaecological morbidities such as menstrual disorders (100 per cent), leucorrhoea (white discharge) (99 per cent), lower abdominal pain (97 per cent) lower backache (95 per cent) burning micturition (94 per cent), and itching in the vagina (90 per cent) seemed to be fairly high among both male and female respondents in both districts. Certain other morbidities such as dyspareunia (38 per cent) and ulcerative or bleeding sores in genital regions (75 per cent), prolapse or mass coming out of vagina (73 per cent) and leakage of urine (67 per cent) were initially mentioned by less than 10 per cent of the respondents. However, on probing most of them reported having heard of these morbidities and their proportion varied between 38-100 per cent (Table 4.1).

Overall awareness of most of the disorders was above 70 per cent, except for dyspareunia which was 38 per cent and leakage of urine/faeces from the vagina (67 per cent) (Table 4.1).

Prevalence of Reproductive Health Morbidities

An analysis of the responses shows that three symptoms of reproductive disorders—viz., menstrual problems (*masik ki samassiyān*), vaginal discharge (*dhat*) and lower abdominal pain (*padu main dard*)—were frequently mentioned spontaneously by both men and women. On further probing, the names of diseases/symptoms which were not mentioned spontaneously were read out one by one and the respondents were asked whether they were aware of these symptoms. The majority affirmed their awareness. Leucorrhoea (discharge from the vagina) was reported by the maximum number of respondents (39 per cent), followed by lower backache (32 per cent) and menstrual disorders (29 per cent) (Table 4.2).

Table 4.2: Reproductive Health Problems of Women as Reported by Respondents (Percentage)

<i>RH problems</i>	<i>Almora</i>	<i>Gorakhpur</i>	<i>All</i>
% respondent/wife suffering at least one RH problem	70	61	66
Type of RH problem*			
Discharge from vagina	50	29	39
Low backache	33	31	32
Menstrual problems like bleeding/pain/spotting	26	33	29
Lower abdominal pain	17	25	21
Burning sensation while passing urine	13	14	13
Itching in vagina	7	7	7
Lump in the breast	3	4	3
Leakage of urine/faeces from vagina	2	2	2
Dyspareunia/Post-coital bleeding	1	—	1
Ulcer/bleeding sore in genital region	1	—	1
Mass/swelling out of vagina	2	1	1
Total number of respondents	163	171	334

*Multiple responses.

This pattern was nearly the same in both districts, except in the case of vaginal discharge which was reported by a higher proportion of the respondents of Almora (50 per cent) compared to those from Gorakhpur (29 per cent). Women with at least one reproductive health problem was reported by 70 per cent of the respondents from Almora compared to 61 per cent in Gorakhpur. As expected, more reproductive health problems were reported by women (74 per cent) than by the male respondents about their wives (57 per cent), perhaps indicating lack of male involvement in their wives' health problems or lack of communication and sharing between husbands and wives on issues related to reproductive

and sexual health. The mean no. of reproductive health problems reported by the respondent women was 2.3 (Table 4.3).

Table 4.3: Number of Reproductive Health Problems among Women as Reported by Respondents

<i>Number of RH problems</i>	<i>(Percentage)</i>		
	<i>Almora</i>	<i>Gorakhpur</i>	<i>All</i>
0	30	39	34
1	25	21	23
2	24	16	20
3+	21	24	23
Mean	2.2	2.3	2.3
Total number of respondents	163	171	334

Treatment Seeking Behaviour for Reproductive Health Morbidities

The analysis revealed that of those suffering from reproductive health morbidities, about two-thirds reported having sought treatment for at least one disorder. It is to be noted that in both the districts a much higher percentage of men (91-96 per cent) compared to women themselves (61-73 per cent) reported that their wives had sought treatment for gynaecological morbidities (Table 4.4).

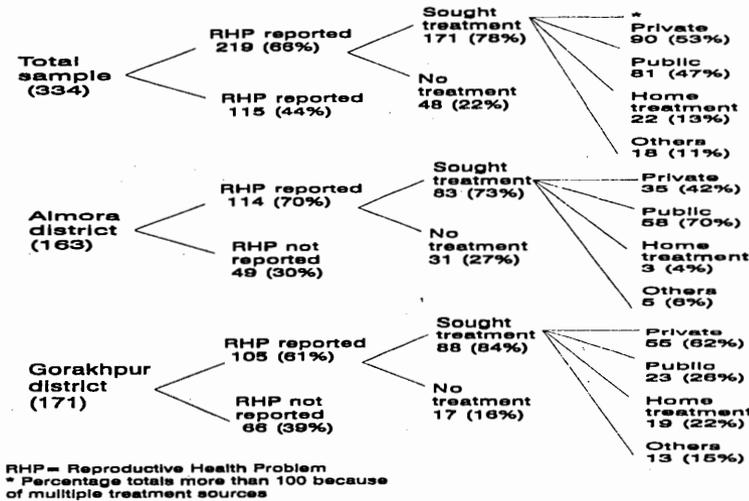
Table 4.4: Treatment for Reproductive Health Problems of Women as Reported by Respondents

<i>Source of treatments</i>	<i>(Percentage)</i>								
	<i>Almora</i>			<i>Gorakhpur</i>			<i>All</i>		
	<i>M</i>	<i>F</i>	<i>All</i>	<i>M</i>	<i>F</i>	<i>All</i>	<i>M</i>	<i>F</i>	<i>All</i>
% sought treatment for at least one problem	91**	61**	73	96**	73**	84	94**	66**	78
Source of treatment#									
Private doctor	31	29	30	66	450	52	49	34	41
PHC/CHC	38	17	25	12	4	8	24	11	14
District government hospital	20	13	16	6	11	9	13	12	12
Home treatment	2	3	3	8	27	18	5	14	10
ANM/SC	11	9	10	6	4	6	8	6	7
Pharmacy	—	3	2	8	4	6	4	3	4
Others	2	3	3	6	5	7	4	4	4
Respondents who had at least one RH problem	45	69	114	50	55	105	95	124	219

** $p < 0.01$. # Multiple responses. M=Male, F=Female.

In both districts, the difference in reporting treatment of reproductive health problems by men and women was statistically significant ($p < .01$). Such a difference in reporting by gender could be because of the ignorance of the men who presumed that their wives must have undergone treatment. Alternatively, Men may have given a socially desirable answer or purpose, i.e., their wives had received medical assistance rather than reveal the truth. Further in depth inquiry is required into this aspect.

Figure 4.1: Pattern of Health Seeking Behaviour of Women Suffering from Reproductive Health Problems



Source of Treatment: Half (53 per cent) of the respondents reported private doctors as the main source of treatment. Another 47 per cent used a public clinic (Figure 4.1) such as a sub-centre (9 per cent), primary health centre/community health centre (18 per cent) and district hospitals (15 per cent). A much higher percentage of the people in Almora district reported using public clinics (70 per cent) than in Gorakhpur district (26 per cent). This could be due to two reasons. Either the public services in Almora were more efficient or alternative health facilities such as private doctors, were not available in Almora district. It was also important to note that home treatment as well as other sources of treatment for reproductive health morbidities were reported much more frequently in Gorakhpur district (home 22 per cent, others 15 per cent) than in Almora (home 4 per cent, others 4 per cent). These figures show quite different patterns of health seeking behaviour in the two districts and, hence, need further investigation. A number of women from both the districts reported use of more than one source (Table 4.4).

Sex of the Provider: Inquiries into the sex of the doctor who provided treatment for reproductive health disorders reveals that in Almora a higher percentage of women had received treatment from a male doctor for their reproductive health ailments while at Gorakhpur the majority sought treatment from female doctors (Table 4.5). This could be due to the availability and accessibility of doctors in the two districts. In hilly regions where transportation is a serious problem, women cannot afford to be choosy and seek care from the most easily accessible source.

Table 4.5: Sex of Health Care Provider from Whom Medical Assistance was Sought

<i>Sex of the health care provider*</i>	<i>(Percentage)</i>								
	<i>Almora</i>			<i>Gorakhpur</i>			<i>All</i>		
	<i>M</i>	<i>F</i>	<i>All</i>	<i>M</i>	<i>F</i>	<i>All</i>	<i>M</i>	<i>F</i>	<i>All</i>
Male provider	66	64	65	54	28	42	60	46	53
Female provider	32	33	33	42	60	50	37	46	42
Home treatment	5	9	7	15	43	27	10	26	18
Respondents who sought treatment for atleast one reproductive health problem	41	42	83	48	40	88	89	82	171

* Multiple responses. M=Male, F=Female.

Further analysis by disease showed that in the case of menstrual problems and vaginal itching a significant number of women in Gorakhpur did not contact any doctor for treatment and relied on home medicines. Further, in both the districts, for treatment of vaginal itching a large proportion (50-55 per cent) consulted a female doctor. For other reproductive health diseases in Almora no preference was observed for sex of the provider, while in the case of Gorakhpur, for all diseases, a Female doctor was preferred.

All female respondents were asked whether they had undergone a vaginal examination. The analysis revealed that only half the women (49 per cent) had ever undergone an internal examination. About half of them had a PV examination only once, one-fourth, had been examined twice and the remainder had undergone an examination three or more times. The mean number of PV examinations per woman in Almora (mean=2.5) was 50 per cent higher than in Gorakhpur (mean=1.7) (Table 4.6).

Table 4.6: Women who had undergone Internal Examination
(Percentage)

<i>Frequency of internal Examination</i>	<i>Almora</i>	<i>Gorakhpur</i>	<i>All</i>
% reporting internal examination	52	47	49
Total number of women interviewed	(83)	(85)	(168)
No. of times		52	
1	42	60	26
2	33	21	10
3	4	15	8
4	12	4	4
More than 4 times	9	—	
Mean	2.5	1.7	2.1
Number of undergone an PV examination	43	40	83

Of the women who had undergone an internal examination, most had been examined by a female doctor (67 per cent) or a nurse (23 per cent). A small percentage (9-10 per cent) of them had been examined by a male doctor (Table 4.7).

Table 4.7: Person who Conducted Internal Examination*
(Percentage)

<i>Examined by</i>	<i>Almora</i>	<i>Gorakhpur</i>	<i>Total</i>
Female doctor	56	80	67
Nurse	35	10	23
Male doctor	9	2	6
Both male and female doctor	—	8	4
Total number of respondents	43	40	83

*Based on 83 women who reported internal examination.

Preferences Regarding the Sex of the Provider

To assess how far the community members are ready to allow treatment of female reproductive health problems by male doctors, respondents were asked whether they would approach only a female doctor or be ready to seek help from any doctor irrespective of sex for treatment of reproductive health ailments.

As expected, over four-fifths of the respondents showed a preference for a female doctor. It is interesting, however, to note that in both districts more men than women showed an openness to examination of the woman by doctors of either sex, if the necessity arose.

A significantly higher percentage of men than women said that either a male or a female doctor would be sought to treat reproductive health problems of their wives (Table 4.8).

Table 4.8: Opinion Regarding Sex of the Doctor for Treatment of Women's RH Problems

(Percentage)

Preferred Sex of Doctor	Almora			Gorakhpur			All		
	M	F	All	M	F	All	M	F	All
Preference of doctor									
Either by male or female doctor	35**	6**	20	31**	5**	18	33**	5**	19
Only female doctor	65	94	80	69	95	82	67	95	81
Acceptance of male doctor in case of non-availability of female doctor									
Yes	45	33	39	57	26	42	51	29	40
Depends on condition	17	31	24	7	49	28	12	41	26
No	3	30	17	5	20	12	4	25	15
Total number of respondents	80	83	163	86	85	171	166	168	334

** $p < 0.01$. M=Male, F=Female

Respondents who had shown a preference for female doctors were further questioned to understand whether they would go to a male doctor for treatment if a female doctor was not available. The analysis revealed that of the 81 per cent who had shown a preference for female doctors, half (40 per cent) were willing to be treated by a male doctor. Another 26 per cent said that it would depend on the condition and seriousness of the disease, while the 15 per cent said that they would not like to be treated by a male doctor at any cost (Table 4.8).

An analysis by sex of the respondents revealed that, out of the total sample of women only about one-fourth women were rigidly against getting treated for reproductive health problems by a male doctor. The remaining three-fourths were, in general, willing to be treated by a male doctor if a female doctor was not available (29 per cent) or if the condition of the sickness demanded it (41 per cent) (Figure 4.2).

It is encouraging that most of the men were relatively open about the sex of the doctor. About one-third felt that the sex of the provider was not important while half said that if female doctor was not available a male doctor could be consulted. Only 4 per cent were adamant that a female doctor was a must for reproductive health treatment of their

Figure 4.2: Preferred Sex of the Provider for Reproductive Health Care



MD, if LD not available
 Any sex
 Depends on condition
 Only Female doctor

wives. This is encouraging and should be taken seriously to enhance the accessibility of reproductive health services by training male doctors.

Out of the 50 respondents who strongly felt that only a female doctor should be consulted for reproductive health problems, 43 (86 per cent) were women and 7 (14 per cent) were men. The main reasons given by the people for non-acceptance of a male doctor was shyness (73 per cent) and communication being easier with a female doctor, especially for reproductive health problems (33 per cent).

Preference for the Sex of the Doctor in Different Situations

The respondents were further probed about their preference for male versus female doctors under certain conditions such as a female doctor versus an experienced male doctor, a female doctor versus a reputed male gynaecologist, a male doctor situated nearby versus a lady doctor located at distant place (20-25 m), a male doctor/who changed less than female doctor and a female doctor available only once or twice a week versus a male doctor who was always available.

Their responses show that the majority of the men gave higher weightage to experience and the doctor’s specialization than the sex of the provider for the treatment of women’s reproductive health problems. For instance 72 per cent of the men (89 percent in Almora and 57 per cent in Gorakhpur) said that between a female doctor in general practice and a male gynaecologist, they would prefer the latter for treatment of their wife’s reproductive health problems. Similarly, in situations where the female doctor is not easily accessible either because of the distance or less frequent visits to the clinic, the majority of men preferred to contact a male doctor for treatment if they are easily accessible and

Table 4.9: Preference for Male Vs Female Doctor for Treatment of Reproductive Health under Various Conditions

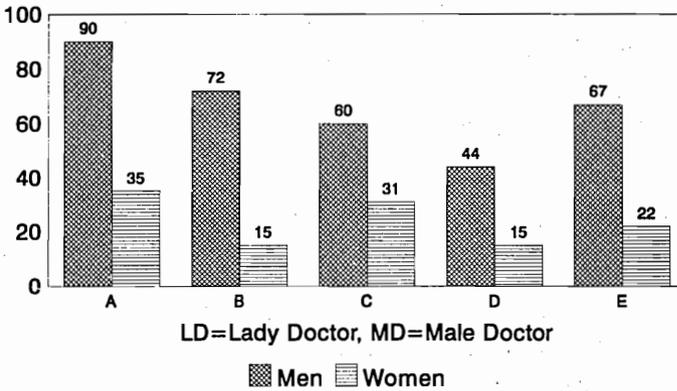
Preferences	(Percentage)								
	Almora			Gorakhpur			All		
	M	F	All	M	F	All	M	F	All
Sex of the health care provider*									
Male provider	66	64	65	54	28	42	60	46	53
A young female doctor vs experienced male doctor									
Male doctor	94	49	70	86	21	54	90	35	62
Female doctor	6	51	30	14	79	46	10	65	38
A female doctor vs a reputed male gynaecologist									
Male doctor	89	18	53	57	12	34	72	15	43
Female doctor	11	82	47	43	88	66	28	85	57
A female doctor located at a distance (20-25 kms) vs male doctor within the village/nearby place*									
Male doctor	61	41	51	58	21	40	60	31	45
Female doctor	39	54	47	42	79	60	40	67	54
A female doctor charging Rs 30/- vs a male doctor charging 15/-*									
Male doctor	53	18	35	36	12	24	44	15	29
Female doctor	46	81	64	63	88	45	55	84	70
A female doctor available only once or twice a week vs a male doctor always available									
Male doctor	69	31	40	66	13	40	67	22	45
Female doctor	30	65	48	34	87	60	32	76	54
Total number of respondents	80	83	163	86	85	171	166	168	334

*Percentages add to less more than 100 because of multiple responses, M=Male, F=Female.

regularly available (Table 4.9). However, if both male and female doctors were available and even if the female doctor charged more (Rs 30 versus Rs 15), the majority of men (55 per cent) especially in Gorakhpur (63 per cent), preferred female doctor for the treatment of women's reproductive health problems.

However, in most of the situations above, the majority of the women respondents preferred a female doctor to a male health provider. Only 15 to 30 per cent, depending on the situation, preferred a male doctor (Figure 4.3). Women in Almora were relatively more open to treatment by a male doctor than those from Gorakhpur (Table 4.9).

Figure 4.3: Percentage Men and Women Preferring Male Doctor in Different Situation



A = Young LD Vs Experience MD B = LD Vs Reputed Male Gynec
 C = LD 20-25 km Away Vs Village MD D = LD charging Rs. 30 Vs MD Rs. 15
 E = LD available twice a week Vs MD always available

The FGDs also reflected similar views. As one of the male participant in Gorakhpur district said:

“It makes no difference if the doctor is male or female. In towns there are many male doctors who have specialized in treating women’s diseases; only they can treat a woman. They also conduct deliveries. Where is the harm in approaching such doctors.”

Men being the main earners in families felt that if an equally qualified male doctor was available at a lower cost, they would prefer him to a female doctor who charges a higher fee. According to Ram Singh from Almora district:

“We would prefer a doctor who charges Rs 15. We would tell our wives to go to such a doctor but if she does not agree, then we have to spend Rs 30 and go to a lady doctor. In such matters we will do what they want.”

As noticed in the survey results, FGDs also revealed that the reputation and experience of a doctor was given higher weightage by men than the sex of the provider. Most of the participants in the FGDs agreed:

“We would prefer to go to the doctor who is better experienced, whether male or female. It makes no difference whether the doctor is male or female.”

However, FGDs with women clearly revealed that their first preference is always a female doctor, even if they have to wait for her or spend more on treatment from them. Male providers were acceptable only in cases of emergency or non-availability of lady doctors.

The general feeling was well expressed by Kunti Devi, one of the participants from Gorakhpur district:

“If the problem is serious or unbearable, then we will go to a male doctor. However, if the problem is not so serious and there is no Khatra [risk] to life, we will wait for a female doctor.”

Over all, the study indicates that while men were more concerned about experience, specialization and easy availability than the sex of the provider in choosing a doctor for reproductive health treatment, women's first concern was the sex of the provider. However, women were ready to accept male providers if a female doctor was not available. Infact, as the study reveals, almost half the women had undergone treatment with male providers for their reproductive health problems.

Chapter 5

Attitude of Health Providers Towards Family Planning Methods

Views of Health Providers

One of the objectives of the study was to understand the perceptions of the health functionaries and doctors of various family planning methods and their knowledge about the new techniques of male and female sterilization-NSV and minilaparotomy, respectively. The knowledge and attitudes of the health providers are crucial because their beliefs determine how they counsel and motivate clients to adopt contraception. Their beliefs, whether right or wrong are transmitted and perpetuated among the community.

Seven doctors and 23 health workers from each of the selected PHCs were interviewed. This included four LHVs and 15 ANMs and MPWs.

The profile analysis of the representative sample shows that all the health providers were below 42 years of age. The average age of doctors was 37 years and health workers 44 years. There were a larger number of women health workers whereas all the doctors interviewed were males. Most of the health workers were high-caste Hindus and only one of them was a Muslim. The educational qualifications of the health workers varied from class 8 to post-graduates. Most of them had work experience of five years or more and the majority had been working in their present PHC for at least two years (Appendix B).

Training Status

Training Received by Doctors in Sterilization Operations: Only three doctors reported having received training in family planning operations. Only one was trained in both vasectomy and minilaparotomy while the other two were trained only to conduct vasectomies. Five doctors had reported performing male sterilization, although only three of them had formal training. This is because any doctor with an MBBS degree is allowed to conduct vasectomies. Two of the doctors had conducted vasectomies in the recent past (three months earlier) while the remainder had not conducted any vasectomy operations for a long time (a year or more).

Training Received by Health Workers in Family Planning: Most of the health workers (21 out of 30) reported having undergone training in family planning in the past two years. The duration of training ranged between two days and eight or more days; one-third of the personnel had attended training for two days, one-third for three to seven days, and one-third for eight or more days. Barring three workers the other health workers felt that the training had been very useful.

Awareness and Knowledge about Non-scalpel Vasectomy and Minilaparotomy

To assess the knowledge about NSV, health providers were asked to explain the sterilization procedure, type of anaesthesia given, duration of rest required, and other details. Knowledge was considered correct if the respondent could correctly mention the operation site in the body and the basic broad steps of the operation. If any one or more facts about the method was given correctly, it was categorized as 'somewhat correct'. The rest were of the responses considered incorrect or wrong.

Non-scalpel Vasectomy (NSV)

Awareness: All seven doctors and 19 out of 23 paramedics interviewed had heard of NSV (Table 5.1).

Understanding the Process of NSV: The doctors and paramedics who had heard of NSV were asked to briefly describe the basic process of NSV. Responses to the open-ended questions were analyzed by trained NSV providers at AVSC. The analysis revealed that *not one* of the seven doctors, and only five of the 19 paramedics, were able to describe the procedure correctly. Three doctors and four paramedics were somewhat correct in their description, while four doctors and 10 paramedics had little or no correct knowledge of the procedure. In summary, of the 26 medical personnel interviewed who had heard of NSV, less than 20 per cent (none of whom were doctors) could correctly describe the procedure.

Some of the doctors gave correct but incomplete descriptions, while others described the procedure incorrectly. Three doctors and five paramedics were aware that NSV involved a small puncture, but thought that the vas was cut.

Minilaparotomy

Awareness: All seven doctors and 21 of the 23 paramedics interviewed had heard of minilaparotomy.

Table 5.1: Awareness and Knowledge of Non-scalpel Vasectomy/Minilaparotomy
(Number)

Knowledge	No scalpel vasectomy			Minilaparotomy		
	Functionaries			Functionaries		
	Doctors	Health	All	Doctors	Health	All
Aware about NSV and Minilaparotomy	7	19	26	7	21	28
Process of NSV and Minilaparotomy*						
Correct	0	5	5	0	1	1
Somewhat correct	3	4	7	3	5	8
Don't know	4	10	14	4	15	19
Performance of the operation*						
Easy	7	14	21	6	19	25
Difficult	—	4	4	1	2	3
Don't know	—	1	1	—	—	—
Chances of complications*						
High chances	—	1	1	1	—	1
Low chances	4	5	9	5	17	22
No chance	3	6	9	1	3	4
Don't know	—	7	7	—	1	1
Type of anaesthesia*						
Local	7	15	22	7	20	27
General	—	4	4	—	1	1
No. of hours required to stay in hospital following NSV and minilaparotomy*	1.6	1.8	1.7	16.0	15.3	15.5
Rest required after operation at home*						
No rest	4	4	8	1	2	3
Short rest	3	5	8	4	14	18
Long rest	—	5	5	2	1	3
Don't know	—	5	5	—	4	4
Total number of health functionaries	7	23	30	7	23	30

*Asked only of those aware of the method.

\$ For corresponding tables for Almora and Gorakhpur, see Appendix C.

Understanding the Process of Minilaparotomy: The medical personnels understanding of minilap was no better than of NSV. An analysis of the open-ended responses revealed that *none* of the seven doctors and only one of the 21 paramedics were able to describe the procedure correctly. Three doctors and five paramedics were somewhat correct in their description, while four doctors and 15 paramedics had little or no correct knowledge of the procedure. In summary, of the 28 medical personnel interviewed who had heard of minilaparotomy, *only one* could correctly describe the procedure.

Most of the medical personnel, including doctors, were either incorrect or unspecific about the site of the incision. Two doctors and eight paramedics believed that the correct incision site to be just below the navel. Only one of the paramedics and *none* of the doctors said that instruments, rather than fingers, should be used to take out the fallopian tube.

Attitude towards Male Sterilization

Reasons for Decline in Male Sterilization: To understand the perceptions regarding male sterilization, health providers were asked to list the reasons for the decline in the acceptance of vasectomy.

Table 5.2: Perceived Reasons for Decline of Male Sterilization and Suggestions how to Promote it

<i>Reasons and suggestions</i>	<i>(Number)</i>		
	<i>Functionaries</i>		
	<i>Doctors</i>	<i>Health</i>	<i>All</i>
Reasons for decline in acceptance of vasectomy in the past years*			
Men become weak/cannot do heavy work	2	13	15
Fear of loss of sexual desire	3	9	12
Fear of failure	1	10	11
Female sterilization is simple/easier	—	5	5
Vasectomy was never accepted; it was forced	2	1	3
Others	3	6	9
Vasectomy should be promoted	7	20	27
Suggestions to promote male sterilization*			
Counselling of males and females	7	13	20
Publicity should be greater through the mass media	5	13	18
Educate the community	6	8	14
Community should be involved in this programme	1	1	2
Total number of health providers	7	23	30

* Multiple responses.

Health providers related the beliefs of the people about male sterilization due to which men have stopped adopting vasectomy. Half of them reported the common notion in the community that men become weak after undergoing vasectomy and unfit for heavy work (15 out of 30) and that there is a loss of sexual desire/manhood (12 out of 30 which is 40 per cent). Another frequently mentioned reason was the fear of sexual failure (11 out of 30 which is 37 per cent) (Table 5.2).

Promotion of Vasectomy: When asked whether vasectomy should be promoted again, 20 out of the 30 health workers interviewed answered in the affirmative. The suggestions given for the promotion of vasectomy were counselling men and women to accept vasectomy (20), educate the community about the new technique of vasectomy (14), and publicize the information through the media (18).

The health providers were further asked whether they thought that the acceptance of vasectomy and female sterilization would increase if NSV and minilaparotomy facilities were made available at PHCs.

Table 5.3: Opinion of Health Providers about Acceptance of NSV

<i>Opinion of health providers</i>	<i>Functionaries</i>		
	<i>Doctors</i>	<i>Health</i>	<i>All</i>
Availability of NSV at PHCs will increase acceptance of vasectomy			
Yes	5	22	26
No	2	1	4
Reasons for increase in acceptance of vasectomy*			
Does not cause complications	4	20	24
Method does not require incision or stitches	3	11	14
Proximity to home	3	2	5
Shorter period of rest required	1	3	4
Less expensive	—	1	1
Others	1	4	5
Total number of health providers	7	23	30

* Multiple answers

Most of the doctors and health functionaries (26 out of 30; 86 per cent) felt that acceptance of vasectomy would increase with the availability of NSV at the PHCs. The main reasons mentioned were that NSV is not likely to cause complications (24 persons, which is 80 per cent) because the method does not require any incision (14 people or 47 per cent). Other reasons were lower expenses due to proximity to the home and shorter duration of rest required after the operation (Table 5.3).

Four respondents felt that there would be no increase even with the availability of NSV at the PHCs because of the perceived apprehension that vasectomy would cause loss of manhood, that wives would not allow their husbands to be operated, and that men cannot afford to stop working and take rest.

Table 5.4: Opinion about Minilaparotomy

<i>Opinion</i>	<i>Functionaries</i>		
	<i>Doctors</i>	<i>Health</i>	<i>All</i>
Availability of Minilaparotomy at the PHCs will increase acceptance of Minilaparotomy			
Yes	6	17	23
No	—	1	1
Already available	1	3	4
Don't know	—	2	2
Reasons for increase in acceptance of Minilaparotomy*			
Nearby availability of services	4	16	20
Method is easy with few complications	2	9	8
Shorter period of rest required	4	4	8
No chance of failure	1	3	5
Method is popular	1	4	5
Less expensive	1	2	3
Total number of health providers	7	23	30

*Asked only of those who said the acceptance of method would increase.

Regarding increase in female sterilization, most of the respondents (23 out of 30) felt that there would be an increase in the acceptance of minilaparotomy if it were made available at PHCs. The main perceived reasons for the increase in the acceptance of the method included accessibility (20 out of 30 which is 66 per cent), fewer complications (8 people or 27 per cent) shorter post-operative rest period (8 people or 27 per cent) fewer chance of failure (5 out of 30 which is 17 per cent) and that the method is already popular and well accepted (5 out of 30 which is 17 per cent) (Table 5.4).

The only reason given by the health worker who said that there would be no increase in female sterilization was that those who wanted to get sterilized would go wherever services were available, whether near or far.

Method Recommended for Sterilization

To gain insight into the attitudes and practices of the health workers about their work in promoting contraceptives, they were asked "If a couple wants to adopt sterilization, whom would you suggest to, undergoes the operation—the husband or the wife?"

Table 5.5: Methods Recommended for Sterilization

<i>Preferred sterilization method & its reasons</i>	<i>Functionaries</i>		
	<i>Doctors</i>	<i>Health</i>	<i>All</i>
While recommending sterilization to a couple, whom would you suggest gets operated?			
Male	7	12	19
Female	—	7	7
Either	—	4	4
Reasons for recommending sterilization to a male*			
Method is easy	7	10	17
Less rest required	3	11	14
Fewer complications/no side effects	4	6	10
No chance of failure/successful method	3	4	7
Others	—	1	1
Reasons for recommending sterilization to a female			
Easier to motivate	—	6	6
Vasectomy is not always successful it fails	—	2	2
Total number of health providers	7	23	30

* Asked only of those who mentioned male only. Asked only of those who recommended women only.

The majority of the health providers, including all the doctors (seven out of seven) and about half of the health functionaries (12 out of 23 which is 52 per cent) said that they would ask the man to get operated; the reasons given were that the method is easy with fewer complications and side effects. Another reason was that the duration of rest required would be less for male sterilization compared to female sterilization (Table 5.5).

Seven workers (out of 23) who said that they would advise the wife to get sterilized felt that women are easier to motivate while vasectomy was known for its failure. In the words of one ANM:

“We are more in touch with the women who come to us for antenatal checkups, etc. We have good rapport with them. So it is easier for us to counsel them to adopt sterilization. They trust us and are more likely to listen to us while in the case of men, we are not much in touch with them. In such a situation, it is a little awkward for us as well as for the men if we start talking to them about getting sterilized”

Kunti Bai, another ANM from Almora, said:

"We prefer to recommend female sterilization because there have been many cases of vasectomy failure. Suppose we convince a man to get operated and then the operation fails, we will get into a lot of trouble. It becomes difficult for us to enter that village again as the people become very antagonistic".

Laxmi, an ANM from Gorakhpur, who had another reason for promoting female sterilization, said:

"If we start counselling men to adopt sterilization, they will not adopt the method and in the bargain the couple will not adopt sterilization at all. It is in the interest of the woman and also ours that at least some method of sterilization is adopted. So we advise female sterilization".

Preferred Method Recommended for Male Sterilization: To understand the opinion of health providers about the effectiveness of the various methods of male and female sterilization they were asked about specific methods that they would advise a man or a woman to adopt for sterilization.

In the case of male sterilization, all except four mentioned NSV. The reasons were that the method is easy, has fewer chances of complications, requires a shorter duration of rest and there is no fear of failure (Table 5.6).

The reasons given for not recommending scalpel vasectomy was that it required an incision and, hence, stitches. Compared to NSV, the duration of rest required was longer, the method had chances of failure, and it was difficult to motivate people to accept this method.

Preferred Method of Female Sterilization: Among the different female sterilization methods, four out of seven doctors preferred laparoscopy, while health functionaries showed a preference for minilaparotomy (13 out of 23) followed by laparoscopy (7 out of 23).

The reasons given for preferring a particular technique were that the 'method is easy with fewer complications', it requires less rest, and the 'method is reliable with few chances of failure' (Table 5.7).

Table 5.6: Preferred Method of Male Sterilization

	<i>Doctors</i>	<i>Health Functionaries</i>	<i>All</i>
Method of male sterilization preferred for recommendation			
Vasectomy (Non scalpel)	7	19	26
Vasectomy (scalpel)	–	2	2
Depends	–	2	2
Reasons for recommending NSV*			
Fewer complications	7	16	23
Easy	4	13	17
Requires shorter duration of rest	4	6	10
No fear of failure/fully effective	1	6	7
New method	2	2	4
Easier to motivate people to accept	1	1	2
Less medicine required	1	–	1
Know only this method	–	1	1
Reasons for not recommending vasectomy*			
More complications/more stitches	5	18	23
Requires more time for rest	1	6	7
Chances of failure	–	5	5
Difficult to motivate	2	2	4
More medicine required	2	1	3
New method has to be promoted	–	1	1
Total number of health providers	7	23	30

*Multiple responses.

Table 5.7: Preferred Method of Female Sterilization

	<i>Male's</i>	<i>Females</i>	<i>All</i>
Method preferred for recommendation			
Minilaparotomy	1	13	14
Laparoscopy	4	7	11
Abdominal tubectomy	2	2	4
Depends	—	1	1
Reasons for recommending abdominal tubectomy*			
Fewer complications	2	1	3
No chance of failure	—	2	2
Reliable method/successful	1	1	2
Laparoscopy not available	—	—	1
Reasons for recommending laparoscopy*			
Easy	2	7	9
Fewer complications	2	5	7
Requires shorter duration of rest	2	1	3
Operation requires less time	—	3	3
Hospitalization not required	—	3	3
Reliable method	1	—	1
Easily available	1	—	1
Several operations can be done in a day	1	—	1
Economical for the govt.	1	—	1
Popular method	1	—	1
Reasons for recommending Minilaparotomy*			
Fewer complications	—	7	7
Required less amount of rest	1	5	6
Minor operation/fewer stitches	1	4	5
Easy	—	5	5
No chance of failure	1	2	3
Reliable/successful	—	3	3
Know only about this method	—	3	3
Total number of health providers	7	23	30

* Multiple replies; question was asked only to those who recommended the specific method.

Provider's Perceptions about Clients Preference for the Sex of the Doctors Providing Sterilization Services: Health providers were asked for their opinion about the people's preferences regarding the sex of the doctor and how this affected acceptance of sterilization services.

Most of the health providers (22 out of 30, which is 73 per cent) felt that women were open to male doctors conducting the sterilization operations. In their words:

“Women prefer to have a lady doctor operate but in case a lady doctor is not present, they are ready to be operated on by a male doctor because in both cases female health workers are present”.

“In very rare cases are patients known to refuse sterilization because the surgeon is a male. Usually they do not object to being operated by male surgeons”.

One doctor (out of seven) and six health workers (out of 23) felt that women would not be ready for sterilization if it was provided by a male doctor. According to them, the main reason for non-acceptance of services by women from male doctors was inhibition of the women, who feel awkward in the presence of males. Another reason was the “bad” behaviour of the male doctor, which was reported by one health functionary.

Chapter 6

Men's Health Seeking Behaviour

The Reproductive health care of men is an important aspect to be considered when the reproductive health of women is studied. As their reproductive health problems are closely related to each other and responsible for each other's well-being.

To assess the awareness and knowledge of people about the genital morbidities of men, they were asked to give the names or symptoms of any reproductive health morbidities that they knew or had heard of. White discharge in urine (63 per cent), burning in urine (40 per cent) and scrotal swelling (34 per cent) were more frequently mentioned spontaneously by men than diseases like sexual weakness or premature ejaculation (23 per cent), infertility (14 per cent), or sores in the genital area (14 per cent). However, all these percentages increased substantially when in-depth questions were asked. Awareness of these diseases for the total sample ranged between 72 per cent and 93 per cent.

Table 6.1: Awareness about Men's Reproductive Deceases/Problems

(Percentage)

RH problems	Almora			Gorakhpur			Total											
	M		F	M		F	M		F									
	S	S+P	S	S	S+P	S	S	S+P	S									
White discharge in urine	56	86	29	64	42	75	70	95	39	87	54	91	63	91	23	76	49	83
Burning in urine	35	94	16	82	25	88	45	98	25	99	35	98	40	90	20	91	30	93
Scrotal swelling	18	84	21	80	19	82	50	95	25	91	37	93	34	96	23	85	28	87
Sexual weakness/Premature ejaculation	25	86	1	48	13	67	21	88	7	66	14	77	23	87	4	57	14	72
Infertility	16	81	10	90	13	86	12	74	13	95	12	85	14	78	11	93	13	85
Sores in genital area	14	68	1	82	1	75	14	86	2	89	8	88	14	77	2	86	8	81
Total no. of respondents	80		83		163		86		85		171		166		168		334	

S=Spontaneous P=On probing.

Awareness was higher among the men (77 to 96 per cent) in both the districts compared to women (57 to 93 per cent). Overall, awareness was higher among the people of Gorakhpur (77 to 98 per cent) compared to those in Almora (67 to 88 per cent) (Table 6.1).

Genital Morbidities among Males

Around one-fourth of respondents (23 per cent) reported that either they or their spouse was suffering from genital problems.

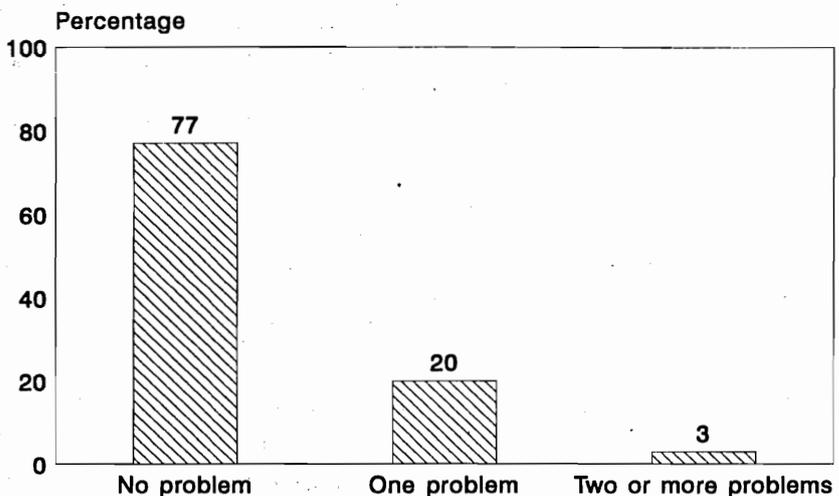
Table 6.2: Reproductive Health Problems of Men as Reported by Male and Female Respondents

RH problems	(Percentage)								
	Almora			Gorakhpur			All		
	M	F	All	M	F	All	M	F	All
% of respondents/husbands suffering from at least one RH problem	25	15	20	36	18	27	31**	16**	23
Type of Reproductive Health problems*									
White discharge in urine	15	8	12	6	7	6	10	8	9
Scrotal swelling	3	1	2	20	11	15	11	6	9
Burning in urine	9	5	7	11	5	8	10	5	7
Sexual weakness/premature ejaculation	1	1	1	1	-	1	1	1	1
Infertility	1	1	1	-	-	-	1	1	1
Sores in genital area	1	1	1	1	-	1	1	1	1
Total number of respondents	80	83	163	86	85	171	166	168	334

* Multiple responses. ** $p < 0.01$, M=Male, F=Female.

Table 6.2 shows that less than one-fourth (23 per cent) of the respondents reported at least one genital problem. Among those reporting

Figure 6.1: Percentage of Men Suffering from Reproductive Health Problems



an ailment, in Gorakhpur scrotal swelling was reported more frequently (15 per cent) while at Almora white discharge in the urine was mentioned by most respondents (12 per cent) (Table 6.2). Another decrease reported by about 7 to 8 per cent of the respondents was burning while passing urine. Multiple problems were reported by about 3 per cent of the respondents.

It may be noted that while 31 per cent of males reported at least one reproductive health problem, only 16 per cent of the females reported this of their spouses, ($p < 0.01$). This could be because the wives were not aware of their husbands problem or were not informed by their husbands. Some of the females described the problems thus:

“....white discharge in urine [dhat girta hai]...”

“.....burning in urine/hydrocele [pani bhar jata hai]....”.(Female, Hawalbaugh, Almora)

“.....[garmi hoti hai], it is like AIDS, it could have been transmitted through sexual intercourse, it is an itching sensation, which spreads and results in abscesses.....”.(Male, Almora)

“.....white discharge in urine, which may be the cause of weakness; night emission, swelling in penis, scrotal swelling, sores in the genital area.....”.(Male, Almora)

Treatment Seeking Behaviour: Treatment seeking behaviour varied greatly in both districts. While four-fifths of the men and slightly less than 58 per cent of the women in Almora reported that males sought treatment for the ailment, in Gorakhpur only 55 per cent of the men did so; and surprisingly 93 per cent of the women reported that their husbands had undergone treatment. However, since the sample size was very small, the data should be interpreted cautiously.

Again, the percentage of people with at least one problem being cured was very low (13 per cent). Though 93 per cent of the women in Gorakhpur reported that their husbands had sought treatment, only 7 per cent reported that their ailment had been cured. This may be due to the fact that of those seeking treatment, the majority (53 per cent) had sought home treatment. Other reasons could be incomplete treatment or reinfection due to unsafe sex. However, in this study, there is no data to answer these questions. An in-depth qualitative study is required to address these issues.

On the treatment seeking pattern of males, some of the females had this to say:

"men who have high tolerance to pain usually hide their problems."

"they do not understand the gravity of the problem and hope that they will be cured on their own in due course of time."

The reasons for males hiding their problems were brought out during in-depth interviews.

"They fear that society will look down upon them as condemn them of having a loose character..."

"They prefer to seek treatment secretly."

"Usually they seek a cure within their friend's circle, who have already experienced reproductive health problems recommend that the affected person use a certain ointment [tube]. When the affected person does not find the ointment effective he is forced to consult a doctor."(Male, Almora)

Source of Treatment

Of the respondents, 69 per cent mentioned that men do seek treatment for reproductive health ailments (Table 6.3). As mentioned by a male, they go to the PHC and if they are not cured, then they go elsewhere.

Table 6.3: Treatment for Male RH Problems as Reported by Respondent
(Percentage)

	Almora			Gorakhpur			All		
	M	F	All	M	F	All	M	F	All
% sought treatment for at least one problem	80	58	72	55	93	67	65	78	69
Source of treatment*									
Private doctor	80	58	31	19	7	15	25	15	22
District government hospital	25	17	22	10	20	13	16	19	17
PHC/CHC	30	8	22	13	7	11	20	7	15
Home treatment	5	—	3	3	53	26	2	30	17
Pharmacy	—	8	3	—	—	2	10	4	3
Others	10	8	9	13	13	4	4	11	6
Not reported	20	42	28	45	7	33	35	22	31
% reporting problem has been cured	5	17	9	19	7	15	14	11	13
Reasons for no treatment#									
Did not feel it necessary	5	17	9	19	7	15	14	11	13
Poverty	—	25	9	—	7	2	—	15	5
Getting better	—	—	—	—	7	2	—	4	1
Others	15	17	16	26	—	17	21	7	17
Respondents who had at least one RH problem	20	12	32	31	15	46	51	27	78

* Multiple response, M=Male, F=Female.

"They usually consult the PHC doctor. In case their problem continues to persist, they seek treatment elsewhere".

"Some persons end up going to quacks."

"Earlier people used to go to the Vaidh (a person who uses Ayurvedic system of medicine for treating deceases) for treatment but as the Vaidh presently has left the village, people go to the PHC doctor".

While 31 per cent of those with problems did not seek any treatment, only 13 per cent of those who had problems got cured, which is roughly 18 per cent of those who sought treatment.

Most men with reproductive health problems felt that it was not necessary to seek treatment (3 per cent); poverty (5 per cent) was cited as another reason.

Table 6.4: Respondents' Opinions on the Treatment of Men's Reproductive Health Problems

Opinion	(Percentage)								
	Almora			Gorakhpur			All		
	M	F	All	M	F	All	M	F	All
Respondents who feel that men seek treatment for their Reproductive Health problems	72	98	85	87	92	89	80	95	87
Respondents reporting men will allow a female doctor to examine their private parts if she is posted at the health centre	51	43	47	50	33	41	51	38	44
Total number of respondents	80	83	163	86	85	171	166	168	334

M=Male, F=Female.

Regarding the sex of the doctor to whom males would be willing to go for treatment, especially for reproductive health problems, 44 per cent mentioned that males would not mind their private parts being examined by a female doctor at the clinic. The following protocol confirms this view (Table 6.4).

"Men usually do not have inhibitions in seeking treatment from a lady doctor."

"Men will not go in for an internal examination by a lady doctor but may seek medication only."

“Men who are self-conscious and shy, plus those who can withstand their problem will return without acquiring any treatment from a lady doctor.”

“In the absence of a male doctor, the person may be forced to seek treatment from a lady doctor, as the person has no choice.”

“It varies from person to person. A more health conscious person will not bother if a doctor is male or a female as long as he is able to get proper treatment.”

Table 6.5: Incidence of Sex-related Problems and their Treatment Seeking Behaviour

Complaint/problems	Almora		Gorakhpur		All	
	Suffering	Treatment taken	Suffering	Treatment taken	Suffering	Treatment taken
% having at least one problem	37	21	69	14	54	17
Sexual Health Problems						
Ill effects of night emission	22	11	49	5	36	8
Pain in scrotum	19	9	15	3	17	6
Post-intercourse pain in the penis	6	1	8	3	7	2
Erection inadequate	1	1	12	3	7	2
Red urine	9	3	3	—	6	1
Marital strain due to sex problems	1	—	7	1	4	1
Genital/Groin itching	4	1	3	1	4	1
Inadequate libido	—	—	5	—	2	—
Anxiety about sex	—	—	3	—	2	—
Painful glands in groin	4	1	—	—	2	1
Purulents discharge from urethra	3	—	1	—	2	—
Obstruction in passing urine	3	—	2	—	2	—
Total	80	86	166			

One of the most common sexual health problems mentioned by about one-third of the men was the night emission. Men generally believed that semen is ‘power’ and its loss in the form of night emission would make them weak. Some also believed that eight drops of blood make one drop of semen and hence loss in the form of night emission has a bad effect on health. A few felt it could lead to weakening of vision. Seven per cent also reported pain in the penis after intercourse and inadequate erection. Another frequently reported sexual problem (17 per cent) was pain in the scrotum [*ga dukhare*] which could be due to STD infection. Some (6 per cent) reported red urine which could be due to several reasons, such as untreated gonorrhoea, or the effect of some drug. This problem was reported more frequently in Almora than

Gorakhpur. However, a comparison of the results from the two districts reveals that overall sexual health problems were reported more frequently in Gorakhpur district than Almora.

Overall, very few respondents sought any medical intervention. For instance, while 54 per cent of the men reported some problem, only 17 per cent had sought medical treatment. However, between the two districts a slightly higher proportion of men in Almora district who were suffering from sexual health problems had undergone treatment than those in Gorakhpur district. This difference was not statistically significant.

Appendix A

Awareness and Knowledge of Male and Female Sterilization

(Percentage)

	<i>Almora</i>			<i>Gorakhpur</i>			<i>All</i>		
	<i>M</i>	<i>F</i>	<i>All</i>	<i>M</i>	<i>F</i>	<i>All</i>	<i>M</i>	<i>F</i>	<i>All</i>
Easy to perform									
Male sterilization	58	30	44	26	12	17	41	21	31
Female sterilization	42	68	55	73	85	79	58	76	67
Don't know	—	2	1	1	3	2	1	3	2
Has fewer chances of complications									
Male sterilization	50	42	46	31	45	38	40	44	42
Female sterilization	50	48	49	66	53	60	58	51	55
Don't know	—	10	5	3	2				
Has fewer chances of failure									
Male sterilization	29	41	35	36	52	44	33	46	40
Female sterilization	71	54	63	62	47	54	66	51	58
Don't know	—	5	2	2	1	2	1	3	2
Requires shorter period of rest									
Male sterilization	58	24	40	46	35	41	52	30	41
Female sterilization	12	28	20	26	26	26	19	27	23
Equal	26	44	36	23	34	28	25	39	32
Don't know	4	4	4	5	5	5	4	4	4
Male sterilization									
Mean no. of days	20.0	22.8	21.4	36.2	45.6	40.5	28.3	34.3	31.3
Minimum	3	3	3	1	3	1	1	3	1
Maximum	90	90	90	99	99	99	99	99	99
Female sterilization									
Mean no. of days	30.3	21.0	25.5	39.7	46.8	43.3	35.2	34.0	34.6
Minimum	2	3	2	3	4	3	2	3	2
Maximum	99	60	99	99	99	99	99	99	99
Total number of respondents	80	83	163	86	85	171	166	168	334

M=Male, F=Female.

Appendix B

Background Characteristics of the Health Providers

(Number)

<i>Background Characteristics</i>	<i>Doctor</i>	<i>Health Functionaries</i>	<i>Total</i>
Age (in years)			
< 29	2	—	2
30-34	2	4	6
35-39	—	3	3
40-44	1	6	7
45-49	—	3	3
50+	2	7	9
Mean age (in yrs)	37.1	43.6	42.1
Sex			
Male	7	8	15
Female	—	15	15
Marital status			
Married	6	21	27
Unmarried	1	1	2
Widow/widower	—	—	1
Religion			
High-caste Hindu	5	15	20
Backward caste Hindu	1	3	4
Scheduled caste	—	1	1
Muslim	1	3	4
Others	—	1	1
Professional qualifications			
MBBS	5	—	5
MD/MS	1	—	1
LHV	—	4	4
ANM/FHW/MPW	—	15	15
Others	1	4	5
Educational qualification			
Class 8-10	—	2	2
Upto matriculation	—	10	10
Intermediate	—	6	6
Graduate and above	—	11	11
Years worked in a health department			
< 4	3	—	3
5-9	1	5	6
10-14	1	1	2
14+	2	17	19
Mean	8.4	20.2	17.4
Years worked in present centre			
< 1	4	—	4
2-4	2	6	8
5-9	1	6	7
9+	—	11	11
Mean (in years)	1.6	8.8	7.2
Total number of respondents	7	23	30

Appendix C

**Awareness of Doctors and Paramedics about the Process of NSV and
Minilaparotomy in Almora and Gorakhpur Districts**

<i>Awareness</i>	<i>Non-scalpel vasectomy</i>			<i>Minilaparotomy</i>		
	<i>Doctors</i>	<i>Paramedics</i>	<i>All</i>	<i>Doctors</i>	<i>Paramedics</i>	<i>All</i>
Almora Centre	(3)	(11)	(14)	(3)	(11)	(14)
Process of NSV & ML/LA						
Correct	—	2	2	—	—	—
Somewhat correct	2	3	5	1	1	2
Don't know correctly	1	6	7	2	10	12
Gorakhpur Centre	(4)	(8)	(12)	(4)	(10)	(14)
Process of NSV & ML/LA						
Correct	—	3	3	—	1	1
Somewhat correct	1	1	2	2		6
Don't know correctly	3	4	7	2	5	7

Figures in brackets refer to the number of doctors or health functionaries who responded.

ABOUT CORT

Centre for Operations Research and Training (CORT), established in 1991 is a policy oriented multidisciplinary social science research and training organization. It specializes in operations research in family planning and reproductive health. Other areas of expertise include child labour, sexual behaviour, AIDS/STD, health financing, rural and tribal development and women's issues.

CORT'S primary objective is to conduct studies that have immediate policy relevance and which contribute towards national development.

CORT collaborates both with national and international agencies in its research activities. A few selected collaborators includes Government of India (GOI), Indian Council of Medical Research (ICMR), Governments of Gujarat, Uttar Pradesh, Tamil Nadu etc., State Innovations in Family Planning Services Project Agency (SIFPSA), Family Planning Association of India (FPAI), The Ford Foundation, Population Council, International Labour Organization (ILO) Geneva, International Programme on the Elimination of Child Labour (IPEC) Delhi, World Health Organization (WHO) Geneva, United Nations Development Programme (UNDP), UNICEF, Population Action International, INTRAH, Rural Labour Association, Center for Women Studies M. S. University, etc.

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