"EVOLVING A WOMEN-SENSITIVE POPULATION POLICY & PROGRAMME"

(Final Report)

Sponsored by

THE UNITED NATIONS FUND FOR POPULATION ACTIVITIES

By

Institute of Social Studies Trust
5, Deen Dayal Upadhyay Marg
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PREFACE

The Institute of Social Studies Trust undertook a project titled "Evolving a Woman-Sensitive Population Policy through Consultations with Rural Women in India" between June 1993 and March 1995 under the sponsorship of the United Nations Fund for Population Activities. The aim of the project has been twofold. To understand the needs, perceptions and the constraints faced by the women of India, especially those from the poorer strata of society, in exercising control over their fertility, constituted the first aim. While, the second was to attempt to design a woman-sensitive population policy that will adequately reflect such needs, perceptions and constraints. Towards achieving these objectives, a series of meetings, discussions and interviews with hundreds of women spread across the country were held over two phases. During the first phase of the project, seven non-governmental organizations were selected to hold discussions with poor women in the respective locations of their operation. These were Mahila Haat in the U.P.(Hills), Banwasi Sewa Ashram in the U.P.(Plains), the Indian Institute of Education in Maharastra,the Trust for Reaching the Unreached in Gujarat, Rural Women's Social Education Centre in Tamil Nadu, Kasturba Gandhi National Memorial Trust in Madhya Pradesh and Bijapur District Women's Multipurpose Co-operative Society Ltd. in Karnataka. Between them, the seven NGOs had consulted about 2000 women in fifty villages on a broad range of issues affecting their lives, including the issue of fertility control.The reports from these seven NGOs are compiled in the First Phase Report titled "Listening to Women" submitted by ISST to the United Nations Fund for Population Activities in March 1994.

In the second phase of the project, an attempt was made to probe a little deeper into some of the grey areas which could not be adequately explored in the first phase because of the open-ended nature of the dialogue. A structured questionnaire was designed at ISST and fielded at four locations in the country,two each from rural and urban areas, with the help of four local NGOs with access to poor local women. These were Mahila Haat in the Kumaon Hills region of the U.P. (rural), 'Rupantar' in the Chhattisgarh region of Madhya Pradesh (rural),'MARG' in a slum in R.K.Puram, Delhi (urban), and 'Sampark' in the slums of Koramangala and Rajendra Nagar in Bangalore, Karnataka (urban).About eight hundred women and two hundred men from these four locations were interviewed on a range of issues such as health status of the family, with special reference to reproductive health of the women, unwanted pregnancies, contraceptive awareness and use, abortions, and sexual negotiations within the family. A qualitative assessment of the information generated by the survey and focus group discussions in the survey locations brings out in sharp focus the nature of the constraints under which the women have to make choices. The policy implications of the study that feed into the design of the prescribed woman-centered and woman-sensitive population policy, are solidly founded on the knowledge and understanding gained in the process of continued dialogue and interactions with the women who

have confided in us, within the framework of the structured questionnaire, focus group discussions and in informal personal interviews. This final report of the project takes an overview of the project activities and achievements in relation to the stated objectives with special emphasis on the second phase.

ISST is very grateful to the United Nations Fund for Population Activities for sponsoring this important project. We would also like to express our deep appreciation to all partnering non-governmental organizations in both phases of the project which have readily agreed to enter into this collaborative venture with us, to elicit the frequently unarticulated fears , constraints and problems that poor women face in our society in the exercise of choice in reproductive matters. Any population policy or programme that aspires to be sensitive to women's concerns, must take into account these factors in the design and implementation of such policies.

31 March, 1995

Swapna Mukhopadhyay
Director
Institute of Social
- Studies Trust

TABLE OF CONTENTS

I. INTRODUCTION

India has officially pursued a family planning programme for over four decades now, being the first developing country, indeed the first country ever, to have done so. The programme was initiated in 1952, in the aftermath of the First Five Year Plan, and has been pursued with a fair amount of zeal and financial investments from the latter half of the Sixties. Since then an enormous amount of research effort has gone into the collection and analysis of data on the fertility behaviour of the population and its proximate determinants.

The presumed goal of the official population policy has been to bring down the rate of growth of population to acceptable levels. This is reflected in the government's family planning programme, which has from the beginning been centered around fertility control. While over the years the scope of the programme has been expanded to bring in other related issues like maternal and child health, the centre of focus has continued to be one of fertility regulation. Whether or not the policy has been "successful" even in terms of this narrowly defined criterion, is a contentious issue. Opinions have ranged from those that have described the programme as being a "dismal failure" to those that have ascribed the secular fall in overall TFR since the early Seventies, --- from 5.2 to 1970-72 to about 3.7 in 1990-92, --- primarily to official efforts at family planning.

Differences of opinion on the efficacy and desirability of official population policy measures at controlling fertility is only one of the many contentious issues. Few areas of public policy in India have been so emotionally surcharged and marked by such diversities of opinions as the debates on population policy. Such debates had attained a significantly heightened pitch with the entry, within the last decade or so, of women's organizations in the arena of public discourse on population policy.

Women's movement in India has been critical of the target-oriented and top down character of official policy and the insensitive, often invasive nature of the fertility control measures adopted. It has been critical of the technocratic approach inherent in official policy of regulating aggregate fertility levels by manipulations of circumstances affecting women's reproductive lives at the micro level. It has questioned the violations of human dignity and reproductive rights of women by an uninformed and ill-equipped health care delivery system. The perceived insensitivity of the programme design, from the conceptualization stage down to implementation at the ground level, had at one point created a situation where it seemed that no meaningful dialogues could be pursued between the women's groups on the one hand and the officialdom on the other.

Yet once the dust settles it becomes clear there are areas of convergence that need to be explored and strengthened, that while the starting points and the thrust of emphasis might still be different, there are common concerns emerging in the debate which

need to be built upon. Among these, the necessity for providing the wherewithal of fertility control to those women who need it, whenever they need it, and in whichever manner serving the "unmet need" is
comes out as a clear point of convergence. By and large access to contraception that is non-coercive, backed by full information and associated health care facilities, is emerging as the core of the area of convergence.

The perceived difference in the emphasis and orientation between the two approaches is centered around the manner in which the issue of fertility regulation is conceptualized and implemented. Given the bureaucratic, hierarchical programmatic structure of government planning and policy implementing agencies, population policy, like other policies, is the primarily the concern of one or the other of the ministries ---- health and family planning in this case. Of necessity, it is dissociated from other intervening concerns to a certain extent by the very structure of the top-down, non-integrated nature of functioning of line ministries, whereas the way women's organizations would like to see the issue of fertility regulation is quite different. They would like to see it as one of the many issues that need to be addressed in women's lives in a co-ordinated and integrated manner.

The basic premise on which this line of thinking is founded centers around the low status and disempowerment of women in Indian society. Lack of power in controlling fertility is a symptom of this low status. To address fertility control in isolation from the circumstances that generate such powerlessness would be like treating the symptom in isolation from the causes that generate it. The primary objective, it is argued, should be to raise women's status. Affirmative programmes to ensure this must be done in a co-ordinated fashion along all the dimensions of women's empowerment - social, economic and political. As has been demonstrated, reduction in fertility is very likely to emerge as a secondary effect of such empowerment. However, from a feminist perspective, such reduction in fertility is looked upon as a second level objective. More important is to be able to provide the basic elements of an integrated policy of women's empowerment like primary health care, education, safe livelihood and basic human dignity within the family and in society.

However, it is perceived that as the process of social development takes root, a demand will emerge from the women themselves for effective control over their own fertility which is more informed, more practical, and non-violative of basic dignity. The government's population programme should be fully geared to service that demand.

In this stormy controversy on population between the philosophy behind the official programme and women's organizations in the country, the latter have sought to represent the views of the women of India who have been perceived to be on the receiving end of such programme. While many studies conducted in the last two decades have established that there is an urgent need to re-orient the official programme to make it much more sensitive, much more user-

friendly, and much less bureaucratic, The analysis and policy prescription have been largely based on perceptions of the analysts. Voices of women who have been actually affected by governmental programmes, or are potential target groups have been filtered, as it were, through the perception of the NGOs seeking to represent them. One of the primary purposes of this study have been to cut through such filtering to bring out the perceived needs and constraints of the poor women to whom the official programme is primarily targeted. What emerges from the dialogue with such women, in group discussions and through our survey, is a scenario of very low self-esteem that women seem to suffer from, along with a sense of isolation and lack of control. There is indeed an evidence of significant 'unmet need' but this is not always articulated as such : More often than not such need is only perceived but not translated into a demand. A complex range of factors - cultural, social and behavioral - intervene to keep them confined an unarticulated state. We also discovered the persistence of significant degrees of the balancing acts that women have to perform continuously, between values and premises developed through gender-socialization processes on the one hand and problems of survival on the other. The results of such balancing are evident from the seemingly inconsistent answers we received from many of the women interviewed ---- in matters concerning the issues of unwanted pregnancies or of abortion. All this serves to highlight the complex web of constraints most of these women operate under.

In terms of policy, it suggests that by merely addressing the service component, one will not be able to reach these women : the perception that an integrated approach to improvement in women's status is necessary, happens to be true, even for the limited goal of fertility reduction. It is not enough to be non-coercive and non-invasive. A population policy that is woman-sensitive must be based on the understanding of the social and cultural constraints of Indian women and should be designed to address questions of fertility control in the context of these larger issues.

II. NATURE OF REPRODUCTIVE CHOICE : AREAS OF CONCERN

As mentioned earlier the project was structured into two phases. In Phase I, a series of consultations were carried out with rural women with the help of seven rural-based voluntary organizations. These organizations had reasonably large mass base but more importantly, familiarity with the local poor women, and broadly represented the four regions of the country namely the North, East, West and the South. In Phase II an attempt was made to probe deeper into some grey areas to put together the elements of a "Women Sensitive and friendly Family Planning Strategy".

The findings that emerged from the consultations of phase I are broadly as follows :

Non functional and inaccessible Health Services and unhappiness
with the Government Family Planning programme were cited as major problems and the necessity of decent functional health services, access to correct health information and health education were expressed by the women during the consultations.

There was dissatisfaction with unemployment, poverty, lack of water facilities, sanitation and other basic infrastructural facilities. These problems appeared to overshadow questions on fertility regulation (cf, pg 2, `Listening to Women', Report of the First Phase, ISST/ UNFPA, 1994).

The above to a large extent reflect the current concerns that are being debated in the Population and Development debate. Clearly to arrive at a Family Planning Strategy which is women sensitive and friendly, one needs to probe deeper into the lives, beliefs and perception of poor women burdened down by economic and social pressures which have perhaps been internalized in such a fashion that they are not perceived as pressures at all. Phase I, was characterized by individual and group discussions centered around issues like Health needs, reproductive rights, contraception etc., which were held on the basis of open ended checklists prepared by the respective groups. Questions related to reproductive choice : ie., perceptions of Choice, ability to exercise choice and the material conditions that influence this ability were not discussed in great detail. Since, we felt these to be equally important issues that needed to be understood and addressed by a "Women sensitive and friendly Family planning Strategy", Phase II of the project, sought to address these issues in an in-depth manner, before one put together necessary elements of the strategy itself.

In Phase II of the project, information was collected on various parameters of `Reproductive Choice' through a structured questionnaire and focus group discussions. Also some action programmes were initiated in the survey locations. To be able to get rich and regionally diverse information, four Non-Governmental organizations from different parts of the country were invited to

participate in the project. The organizations that participated were (1) MARG from New Delhi, (2) SAMPARK from Bangalore, Karnataka, (3) RUPANTAR (Disha Trust) from Raipur, Madhya Pradesh, and, (4) MAHILA HAAT from Kumaon, Uttar Pradesh. These organizations were dealing with women's issues through their other activities. They did not necessarily specialize in the area of women's health, but had intentions of taking up issues of women's health at some point in future.

As stated above Phase II sought to gain an understanding on the issue of `Reproductive Choice' as perceived by women and incorporate these perceptions and needs in the `Women Friendly Family Planning Strategy'. This we thought would be best addressed under given constraints by conducting a survey using a standardized questionnaire. Towards this end, a questionnaire was designed at ISST, New Delhi. The questionnaire was designed such that it would yield a rich combination of both objective and qualitative information, although the stress was more in obtaining qualitative information. It was fielded in four locations in the country, namely two urban (New Delhi & Bangalore) and two rural (Raipur district in Madhya Pradesh & the Kumaon hills of Uttar Pradesh). The results from the four locations were presented and discussed in a two-day workshop held in Delhi in February 1995, Which was attended by representatives from the four participating NGO's including field surveyors from all the four locations, experts on Population, Development and Community health matters and ISST researchers. The small action programmes that were being conducted in the four locations by the NGO's as a part of this project were also described and discussed [Cf.appendices I & II for the reports and the questionnaire].

The main purpose of conducting the survey was to acquire a deeper understanding of the perceptions and constraints of poor women in matters of reproduction. Some of the issues we sought to explore were as follows :

(i) Reproductive Choice :

Some of the questions we hoped to address pertain to the issue of women's control over their own bodies within the context of her social situation. This is different from the thrust of the current debate on `Reproductive Choice' which essentially involves the nature of choice between the alternative contraceptives. Issues sought to be explored were of the following kind :

* Does the question / notion of choice at all exist in the harsh reality of a poor women's life ?

* If choice exists then what is the nature of such choice in deciding the number of children and when she would like to have them?

* The extent to which she is able to negotiate sexual relations with her partner.

(ii) Unwanted pregnancy:

Related to the issue of choice is the question of Unwanted Pregnancy. FHS (Family Health Survey) studies in the early sixties had found evidence that a large percentage of currently pregnant women did evidence that a large percentage of currently pregnant women did not want to be pregnant in the first place. We sought to unravel the issue of incidence and nature of such Unwanted Pregnancies, by trying to explore questions like :

* Does the notion of an `Unwanted Pregnancy' really exist especially in a culture where rearing of children continues to be viewed as the primary purpose of a woman's life ?

* If women do express that a certain pregnancy is unwanted, what are the reasons attributed to this feeling?

* What do women do in case an `Unwanted Pregnancy' does indeed occur ? Do they continue with the pregnancy or take some conscious action about it ?

* Who and what conditions influence their decisions on what they would decide to do in case of an `Unwanted Pregnancy'?

(iii) Abortion :

Abortion is another question related directly to the earlier questions. What are women's feelings on the issue of Abortion? How do they place themselves in relation to other women in the community regarding this issue? How deeply do they reflect prevalent notions of rightness and wrongness of having an `Induced Abortion'? These issues were addressed through questions like :

* What are the options available to them in case they do opt for an abortion? How well aware are they of existing methods and facilities ?

* What conditions, and people influence decisions on whether or not to have an abortion?

* What is the extent of awareness on existing legal provisions on abortion ?

(iv) Sexual Negotiations within the Family :

Within the existing patriarchal family system, a woman's voice often goes unheard, and there are clear delineations of a woman's duty towards her partner and his family. By the time a girl is married she has by and large internalized recognized norms of behaviour that are expected of her. As a direct offshoot of this we were interested in understanding how women negotiate space for themselves, if any, in the relationship with their partners/families. Hence there was an effort to probe the existing notions of women's duties towards their partners especially in the domain of Sexual relations.In this context we tried to explore the following issues :

* How prevalent is the incidence of `forced sex' within marriage ?

* How does the family react in case she refuses to have sex with her partner?. Can she depend upon the family for some support if she makes such a decision?

* Does her partner abide by the prevalent religious norms regarding sexual contact on religious and other occasions?

* Is there any cognizable link between perceived sexual oppression and `unwanted pregnancies' and the manner in which women articulate this?

(v) Family Planning :

We investigated family planning practices or their absence within the context of women's life situations, their health status in general and reproductive health in particular. The symbolic as well as the substantive importance of reproductive health in the area of population policy makes it a necessary area of discourse. Some of the questions we thought that could be addressed in this context were:

* Awareness of existing methods and perceptions of usefulness vis-a-vis actual use of contraceptive methods.

* What are the most commonly used measures of family planning ?, Which of the partners uses any chosen method and why so?

* Do women experience health complications on use of contraception and what do they do in this situation?

(vi) Men's Perceptions:

We tried to probe the perceptions of men on a number of issues. Responses were sought regarding their own and their spouses duties towards each other and what their reactions would be in case they felt that the wife failed to do her duties. This we felt, was important for bringing out the contradictions between men's and women's perceptions, in order that we get some insight about the objective reality of women's lives, within which they have to make decisions and choices. Among other things, men were questioned on :

* The extent to which they were informed about their family's health problems.

* Use of contraceptives and their perceptions on contraception induced health problems.

* Their views on Abortion and how would they react in case the wife expressed a desire to have one.

III. ARTICULATION OF PERCEPTIONS: FINDINGS OF A SURVEY

It was felt that by studying the answers obtained from this set of interrelated questions, and analyzing the contradictions and inconsistencies that may be present, we will be better equipped to appreciate the life situation of poor women on respect to reproductive needs and the parameters of the choice they exercise in matters of reproduction.

(A) Methodology:

(i) Designing & Translation of the questionnaire

A draft questionnaire was prepared and discussed thoroughly at a three day workshop at ISST from 15th to 17th July, 1994. The Workshop was attended by representatives of the four NGO's selected to conduct the survey, as well as several experts in the area of women's health. The necessary changes and corrections suggested at the workshop were incorporated and a revised version of the questionnaire was evolved at the end of the day. The final version (see appendix II) was then translated into Hindi and Kannada before being fielded in the selected locations. The Hindi translation was done at ISST staff in Delhi in association with NGO representatives to incorporate necessary changes in local dialects. Assistance from ISST's Bangalore office was provided for the Kannada translation to be used by the Karnataka based NGO.

Training of investigators

As an outcome of discussions held at the workshop, the respective NGO's were requested to conduct a brief training/sensitization exercise with the field investigators so as to familiarize themselves with the questionnaire. Also we felt that it was necessary that a set of guidelines should be kept in one's mind while conducting the survey. The guidelines were as follows:

- Not to ask leading questions if could be avoided. Allow the interviewee to respond and suggest options only when really necessary.
- To the extent possible the schedule was to be fielded by a pair of investigators.
- The ordering of the questions could be interchanged depending upon the need, so that the flow of conversation is not interrupted unnecessarily.

The sample size was 200 women and 50 men for each of the four locations, hence, the total sample to be covered was 800 women and 100 men. Selection of survey sites and method of sampling was left to the respective organizations involved in collecting the information.

The study itself was conducted in two stages : The first stage involved fielding of the questionnaires (for details of the questionnaire check appendix I), while the second stage consisted of focus group discussions, covering a range of issues for example., Infertility, incentives offered by the government run Family Planning Program, domestic violence, care seeking behaviour of the communities, issues related to Abortion, perceptions on the duties and responsibilities of men & women etc.,. These discussions were to be held for men and women separately.

Analysis of the information collected from the four study areas was done at ISST, New Delhi. While the organizations involved in the study were required to give a report summarizing the understanding evolved from the study (for the NGO reports see appendix I). Along with the report a brief write-up giving information on the action programmes initiated by the NGO's in their respective locations where the study was held was also to be submitted to ISST.

At the end of the survey and after the initiation of the action programmes, a workshop was held for two days from the 22nd to 23rd February, 1995 at ISST, Delhi. At this workshop the results from the survey were discussed. The representatives of the participating NGO's presented their respective reports, and the field personnel involved in the survey and action programmes, spoke of their experiences and impressions on their interactions with the communities. Suggestions given by the invited experts on Population, Development and Community health have been incorporated in the Family Planning strategy that has evolved from the survey.

(B) A Profile of the Survey Locations :

The Survey was conducted at four locations, viz. Delhi, Bangalore, Kumaon Hills and Raipur district. The first two were urban locations and the latter two were rural.

(i) Delhi

In Delhi the survey was carried out in the Ambedkar Nagar basti, R. K. Puram, Sector I. It is an urban slum with a population of 3000 persons. All the inhabitants of the basti were encroachers and, thus, the land or their jhuggis were not owned by them. The basti is dominated by the Scheduled Castes. Most of the women interviewed were illiterate. Among the literates, the minimum level of education was upto class 5, while the maximum was upto class 10.

In the employment sector, the Scheduled Castes generally work as 'Safai Karamcharis ? Approximately, 25% of the women in the basti worked as 'Jamadars' in residential complexes. About 20-30% of the working population (both men and women) were daily wagers. 5% of the working men were vendors, fruit sellers, vegetable sellers, or were selling sweets / eggs/ pakoras on the road side. About 8% fall in the expenditure bracket of Rs. 500-1000; 30% in Rs. 1000-2000; 55% in Rs. 2000-300; and 7% in Rs.3000-5000.

(ii) Bangalore

In Bangalore, the survey was carried out in three urban slums. These three slums were selected from an initial list of seven.

The sum in Koramangala comprises of three settlements, Laxman -Rao Nagar, Rajendra Nagar and Ambedkar Nagar, with a total population of 40,000.

These settlements are located in the midst of a high-income residential suburb in the South - West of Bangalore city. Thus, the slum supplies much cheap labor services like domestic labor, laundry, small tradesmen and vendors, etc. to this suburb.

The origin of the slum dwellers here is roughly 50% from Tamilnadu, 40% from rural Karnataka and 10% from Andhra Pradesh.

The settlement in Rajagopal Gardens has a total population of 10,000 in about 400 houses and 100 hutments. It is located very close to the major market in the city and this characterizes the employment pattern with a large number of people being vegetable / flower vendors. Others were engaged in construction labor. The inhabitants are mostly out State migrants, with 70% of the population coming from Tamil Nadu.

The third settlement in Okkalipuram is a cluster of many small groups of hutments, with a total population of 500 in 100 built houses. Many of those with permanent employment are working in the municipal corporation office or in government factories. A number of women work in garment factories within the city. 40% of the women are not in activities that produce cash income. Again, as many 90% of the women are illiterate.

(iii) Kumaon Hills, Uttar Pradesh

The hilly region in the north of Uttar Pradesh is called Kumaon. At present, the Kumaon circle comprises of three districts, viz., Pithoragarh, Almora and Nainital.

A major part of Kumaon is mountainous, but the southern part which is called Bhabar and Terai is flat.

There are both joint and nuclear families primarily Hindu, the Scheduled Castes and forward castes.

Women have mostly studied upto the primary level (class V) and are unpaid family workers.

Everyone has land and a house as this is a necessity to survive the cold climate of the hilly area.

(iv) Raipur District, Madhya Pradesh

In Raipur District, the survey was carried out in the Kurud and Dharseewa blocks. 129 households were interviewed which involved 222 women and so men.

The population is, on the whole, highly tribalized. The area presents a contract in richness and poverty great richness of natural resources, and great impoverishment of its rural masses. It is rich in mineral resources because of which there has been rapid industrialization.

There is widespread poverty, poor access to protected drinking water, poor communication facilities, and an attenuated health service infrastructure.

Over 40% of the people are classified in government statistics as living below the poverty line.

(C) Summary of Findings :

A qualitative analysis was made on the basis of responses from the women from the four different locations. The purpose was to be able to piece together a picture of the commonalities and differences in perceptions and problems faced by women in the four different locations.

(i) Salient points of the social & demographic profiles and availability of infrastructural facilities in the different locations:

* In the urban locations of Bangalore and New Delhi the households were largely of a nuclear nature, while in the rural locations of Madhya Pradesh and Kumaon hills, a mixed picture emerged with a predominance of joint households in some locations.

* The urban samples were predominantly Scheduled Castes , while in the Kumaon sample Forward Castes predominated. The Madhya Pradesh sample was a mixture of tribals and non-tribals, Other Backward Castes and Scheduled Castes.

* On the basis of the reported income levels,it was found that most households from the other locations fell below the national poverty line. We also collected information on asset ownership. The Delhi sample was an exception wherein a large percentage of households owned several items of durable consumption.

* Most of the women from the four locations were illiterate, the exception being the Kumaon sample, where a majority of women had been educated upto the third and fourth standards. Men

were relatively better educated than women in all the four areas. There was a fair sprinkling of high school qualified men in the urban samples.

* Work Status of the men varied somewhat across the four locations. Government service was fairly common in the case of Delhi and Kumaon hills, while casual labour, low-earning self employment and agricultural work was fairly extensive in the case of Bangalore, Delhi and Chattisgarh area of Madhya Pradesh.

* With the exception of the Kumaon sample where almost everyone owned a small piece of land, most of the households were land less.

* Infrastructural facilities relating to basic services were reportedly the worst in the Kumaon hills, followed by Madhya Pradesh. The urban areas fared much better in terms of availability of mechanized transport, primary & secondary school facilities, access to the Primary Health centre and second level referral services. Poor quality drinking water was reported as a serious problem in both the rural samples, whereas in the urban slums of Bangalore there was a problem of availability of water. Sanitation facilities were abysmal, or not available at all, in all the four locations. Availability of Health services differed in the four areas, the Kumaon hills being the worst affected.

* In the area of provision of health services, the rural areas were worse off than their urban counterparts. In the rural areas services were either not available at all, or when available, were grossly inadequate. The urban areas were much better serviced both by government as well as private medical care facilities. Generally, the people surveyed were critical about the poor functioning of government health services. This appears to be because of the expectation that it is the government that is responsible for the provision and maintenance of health services.

(ii) Salient points of Care seeking behaviour of the households :

* In all the four locations there was a marked tendency to report illnesses of children and men much more than those of the women.

* When an illness is not perceived to be a serious one the trend in the urban areas is that as a first step government services are sought, but having to cope with long queues and also buying the medicines, they tend to use small private clinics to save time, since they have to buy the medication in any case. (Here it can be supposed that cash money is more easily available in the urban areas). In the rural areas though, home remedies are attempted first, only when the illness becomes serious do they seek the services of the primary health cen-

tre. This is because of poor physical access (poor road and transport facilities, also the nearest available Primary Health centre can be quite far off).

* If an illness is perceived to be serious, and requires prolonged treatment normally only the government services are sought, because these services are free and the families cannot afford costly treatment especially on a prolonged basis.

* The most commonly cited combination of reasons for not seeking care were lack of money and time and perceptions that the ill nesses were not serious enough or that the illness would get cured on its own.

(iii) Salient Points that emerged on Women's health : The findings can be broadly divided under the following headings :-

(a) Pregnancy related information
(b) Women's reproductive health indicators
(c) Contraception
(d) Induced abortion

(a) Pregnancy Related Information:

This section seeks to give an overview of information related to age at marriage, average number of pregnancies, ante-natal care, deliveries, miscarriages, abortions and child deaths.

* The average age at marriage for women in all the locations ranged from 14 years in the lower limit to 19 years as the upper limit. Relatively the age at marriage for women was higher in the case of the Kumaon sample population.

* The average number of pregnancies among women from all the sample populations was around 4 per woman. Majority of the women had not had any kind of ante-natal care and did not feel that it was necessary either. Very few women reported health complications or problems during the pregnancies.

* Among all the four groups majority of the women had the deliveries in their marital homes this is against the normal understanding that most of the deliveries take place in the natal homes. In case of the urban sample the explanation could lie in the fact that they are largely a migrant population. No reasonable explanation is possible in case of the rural samples with the information available, but it is an interesting finding and needs to be looked into. The deliveries were mostly conducted by untrained dai's, but some had their deliveries at the local government facility, and this feature was more so in the case of the urban locations.

* Most of the reported miscarriages had occurred during the first three months of pregnancy, the exception being the Kumaon sample, wherein more than two-thirds of the reported miscarriages occurred during the second trimester.

* A negligible proportion of the women reported ever having an induced abortion.

* An interesting feature regarding child deaths was that the urban samples reported fairly high proportion of child mortality. While this was not the case in the rural samples, this may be due to under-reporting. This needs further investigation.

(b) Women's Reproductive Health Indicators :

This section seeks to give an overview on women's reproductive health. It needs to be stated here that since we were more interested in the perceptions of illness, specially gynecological and related problems the indicators used were a combination of symptoms and generalized problems (they are not clinical categories in a strict sense).

* This section of the questionnaire threw up interesting contrasts among the four locations. There was clearly no distinction in the reporting of illnesses along urban and rural lines. In the urban sample from Delhi and the rural sample from the Kumaon, women did report that they were suffering from a combination of symptoms or conditions (see appendix - II, Table III.b, for the symptoms). The Kumaoni women where the most vocal in expressing their problems, followed by women from the Delhi sample. In contrast there was practically no reporting of any illness/symptoms by the women from rural Madhya Pradesh.

* Majority of the women also said that they had been experiencing these problems for the past year, and felt that these were persistent problems. When asked about the seriousness of these problems the answers were very hazy, in fact very few reported these problems as being serious.

* A sizable proportion of women reported that they were suffering from menstrual problems. A small percentage of the women complained about prolapse. Combinations of giddiness and tiredness seem to be all too common among these women. Interestingly women did report about problems of white discharge too.

* In the urban samples sizable proportion of women did seek medical help for the problems they had reported. But they expressed unhappiness at the treatment they had received. The basis of the complaint seems to be that they were not cured of the problem for which they sought treatment, and the problem kept recurring.

(c) Contraception :

This section seeks to give an overview of issues relating to awareness of contraception methods, notions of their usefulness, extent of use, who makes the decision regarding use or non-use and complications experienced by women on use.

* Awareness of various methods of contraception was extensive in the urban samples, especially the Sample from New Delhi. The kumaoni women also exhibited high levels of awareness, whereas in the sample of Madhya Pradesh awareness levels were very low. High levels of awareness in the urban samples could be due to the fact that there is greater access to the visual and audio media (largely Television and Radio). In the urban samples a small minority of women reported total ignorance, this proportion was much higher in the case of rural sample from Madhya Pradesh.

* Uniformly in all the samples, the women felt that contraception was useful but this was not reflected in the actual use of any methods of Family planning. In fact in all the samples more than two-thirds of the women did not use any method at all. Interestingly, a minuscule proportion of the women had tried a combination of methods. Among those women who had adopted Family planning measures, tubectomies were the most common and they were done on completion of the preferred family size. Even among those who had used IUD's (mainly Copper-T) discontinuing of the method was quite high because they had experienced excessive bleeding.

* The main reasons why women thought that contraception is useful are (1) They are necessary to limit family size, (2) Useful for the purpose of spacing child births, (3) And the belief that too many pregnancies can cause health problems for the women.

* The decision to use family planning measures was mainly a joint affair between the women and their partners, the only exception being the Sample from New Delhi wherein, a majority of women users had decided on their own to use whatever method they had adopted.

* Preference for tubectomies could be attributed to the following reasons : (a) Health complications due to use of other methods and lack of proper information on the side effects of the contraceptives (for example, this might explain why in the case of usage of Copper-T, the associated normal initial bleeding might be taken as a sign of complication, leading to its discontinuity). (b) Given the hardships that these women face in their day to day situations, tubectomy which is normally a single shot affair, might be the easiest measure to choose. (c) Tubectomies are opted for normally on completion of the preferred family size, making it easier for the woman

to take this decision and probably with support from the family too.

* Reported incidence of complications due to contraceptive use is fairly high and this picture was uniform in all the four locations. The reported complications are mainly (1) Persistent Abdominal pain, (2) Persistent Back pain, (3) Excessive bleeding and (4) Weakness.

* The picture that emerged about women seeking treatment for complications resulting from contraceptive use is that in the urban samples large number of women did seek medical treatment, while, this was not so in the rural areas. This is to a great extent the reflection of availability of health care services as well the poor functioning of the `follow up' component of the Family planning program in the rural areas.

* Among the non-users, the common reasons given for not adopting any measure are as follows : (1) The women never felt the need to use contraceptives, (2) Some felt that it was immoral and not correct to use contraception, (3) Some of them had not conceived as yet or wanted some more children hence are not using any method now, but intended to use in the future.

(d) Induced Abortion :

This section gives a brief overview of the incidence of Induced abortion, and the perceptions / attitudes of women towards Induced abortion.

* A really negligible proportion of the women reported that they had ever had an induced abortion. But majority of them said that they knew of other women who had opted for induced abortions.

* The impression that we got from the survey was that there are a lot of inconsistencies in the opinions of the women regarding the issue of induced abortion in general. Personally they had distanced themselves from the whole issue, but were quite vocal about their opinions when it was about other women in the community. Uniformly in all the four locations, women said that the incidence of women who opt for an abortion and those who continue with the pregnancy when it is not wanted, are almost equal.

* There were some women who said that they would advise a friend to opt for an abortion, only under special circumstances. But most of the women felt that it was morally wrong and that children are God's gifts, hence they would never advise anyone to have an abortion even if the pregnancy is not wanted.

* Knowledge and awareness of legal provisions under the MTP Act was practically non-existent. But in the case of Kumaoni women there was some amount of openness and consistency about the appropriateness of having an abortion under varied circum-

stances.

* The circumstances under which women felt that having an abortion would be appropriate are as follows: (1) If the woman already has too many children, (2) If the pregnancy was out of wedlock, (3) If the pregnancy was due to rape or incest, (4) A very small proportion said that they would advise it if the woman's health was at risk or (5) In the likelihood of another girl baby. It needs to be mentioned here that when questioned about the circumstances under which abortion was appropriate, a significant proportion of women felt that there could never be an appropriate situation in which abortion should be taken recourse to.

(iv). Salient points that emerged on the issue of sexual relations :

This section seeks to give a broad picture about the nature of control that women have over their minds and bodies. It was felt that probing a little about the sexual relations between the women and their partners, with a focus on the ability to say no to sexual relations and also perceptions of unwanted pregnancy as related to their bodies would give us some idea about the kind and nature of control that women can exercise in their personal lives. The following are the salient points that emerged on probing :

This was as expected a very difficult area to probe, but the inconsistencies in the responses of the women are telling and give us some idea about the oppression in their lives. Uniformly across all locations there was evidence (as expressed by women) of coercive sex. And it can be said that women in general cannot and do not refuse when the partner insists on sex.

* The inconsistencies come up in a number of ways. Women would say that they can say 'no' to their husbands, but then follow it up by saying that he would get angry and abusive. The abuse can be of a verbal nature, and sometimes be followed by physical violence.

* Majority of the women do not think that it is `proper' to say no to their husbands, or refuse to have sex. Yet many admit to having refused, and consequently being threatened, abused and beaten up.

* The inconsistencies were more in the urban samples, especially the one from Delhi. The responses of the Kumaoni women were more straightforward and consistent, while majority of the women from the Madhya Pradesh sample did not speak on this issue at all.

* There were expressions of isolation as well. When asked whether the respective families would support the women if they disagreed with their husbands, majority of the women did not think that they could approach anybody in the family at all. Clearly, in case of nuclear families this question of seeking

support does not arise at all. Mostly women said that disagreements normally ended up with the wife giving in. They also said that they do not like to make an issue of the whole thing because it would lead to very embarrassing situations for them.

* A very small proportion of the women did express that at some point in their lives there were pregnancies which were unwanted, but there was no discernible link between perceived sexual oppression and the pregnancies which they felt were unwanted.

* To get some idea about the control exercised by the women in a situation of being confronted with an unwanted pregnancy, the women were asked about the course of action they had undertaken in this situation. We found that most of them reported to have continued with the pregnancy and took no action about terminating it. But, some of them did try to abort the pregnancy and report it as well. However they were largely unsuccesful. Either they were advised against having one on the grounds that they were too weak or that the method they had tried did not achieve the desired result. Very few actually reported that they went ahead and had an MTP.

(v) Salient features that emerged from the Men's section:

A small section of the questionnaire was canvassed for men from the families from which the women were interviewed, the aim was two-fold, firstly we wanted to get men's views on issues affecting women's lives and secondly to cross check the men's responses against those of the women from the same families. Interesting features emerged from the men's answers, especially when these are mapped against the responses of the women from the same families.

* Generally, men feel they have harder life as compared to the women as we have to go out to earn living for the family's sustenance. This is so even in families where women are engaged in work outside the home. When questioned about serious ailments in the family, men tend to report their own problems much more frequently. This appears to be less a reflection of objections state of affairs and more of perceptions, as can be seen from responses to probing questions on women's health.

* One of the striking features that comes out from our analysis of the men's responses is the abysmal state of awareness they have abut the health status of their wives. The ignorance was more pronounced in case of reproductive health. Alarmingly large numbers of men from all the survey locations were unaware of reproductive health problems that their wives have been suffering from. For many couples, the number f pregnancies reported by the husband and the wife did not tally. Same could be said about miscarriages-carriages induced abortion. Men did not appear to remember the maternal history of their wives. Most men interviewed were currently not using any contraceptive device. A very large percentage had never used any. A small percentage had undergone vasectomies. Many of

the men expressed concern about the side effects of contraceptive used for themselves, while a significantly smaller percentage expressed similar concern for their wives.

* Most men said that they will not allow their wives to terminate an unwanted pregnancy. The only exception was the Delhi Sample, where the men seemed to knew all the politically correct answers. A review of these questionnaires reveal a plethora of contradictions that need to be analyzed in greater detail.

* There are strongly held news about the duties of men and women among the men. Gender-roles are very clearly defined, with the commonly held belief that strong sanctions are required, and justified for erring wives. Here again, the Delhi men by and large, appear to be different, although the veracity of their statements needs to be looked into. There are known cases of violent and abusive husbands in this sample who have come out with politically correct answers.

* It would be blatantly wrong to suggest that all the men come out as abusive and violent monsters. There are significant differences even within each sample. However, the general picture that emerges from the men's responses is one of ignorance of, and hence insensitivity towards the problems that women live with health problems being only one of them.

IV. ACTION PROGRAMMES

The idea of weaving in small action programmes in the design of the project emerged in the process of designing the second phase. Strictly speaking, action programmes they were originally not conceived as constituent components of the project. However, it seemed blatantly unfair to us that women whom we expect to spend valuable time in answering questions on such wide-ranging issues, sometimes on intimate details of their private lives, would do so with no assurance of any tangible & direct benefit on their side from this interaction. Therefore, the idea of small action programmes that would respond directly to perceived or articulated needs that emerge during the course of the dialogues with the women in the four survey locations, was built into the project design.

One of the criteria that was used in the selection of NGOs was their proven record of access to poor women. None of the four NGOs were involved in the area of health at the time the survey was initiated, the simple reason being that we intentionally chose them so as to have unbiased responses from the field in the area of health status & health service delivery. Involvement in the dialogue with the local population on these issues has now given these already established NGOs a clear opportunity to expand their horizon & their activities in these areas as well. This, we feel is a move in the right direction, as we have argued that in order to be effective, reproductive needs have to be integrated within the overall life situations of women.

Given the shortage of time and resources, no grand plans could be designed. However, ground work has been initiated in all four locations. All four NGOs had felt the need to begin health awareness camps in the four locations. All the four groups have held group discussions on these and related issues. Several other kinds of activities are being planned. What is important is that the process has been initiated, and it will continue. What follows is a set of reports from the four locations where these programmes are currently under way.

(i). MARG (Delhi : Urban)

The project on reproductive health and reproductive choice taken up by us from ISST was an interesting exercise of learning and un-learning. On February 22 and 23,1995, in a meeting organized by ISST, we got the opportunity to share our findings with the house and invite suggestions on the action plan for future.

While carrying out the research in the Ambedkar Nagar basti, Sector I, R.K. Puram, we found that there was already an NGO called ASHA working in the basti on health-related issues. This NGO had set up a dispensary in the basti; they had organized some basti women to form a Mahila Mandal and also helped these women to set up a creche for the children of working parents. Some Aaganwadi workers are also a regular feature in the basti. On the other hand,

however, there are certain problems such as that of water and sanitation, which dissuade people from joining for a common cause, as there are constant fights between neighbours over water, toilets and drainage system. To add to this is the internal politics of the basti with 15 men acting as the `Pradhans'.

In a situation like this, we felt that the first and foremost task should be to link up with the local NGO. So we met Dr. Kiran Martin, the Executive Director of ASHA. Dr. Martin was most willing to interact with MARG in future. She is keen to work with NGOs that can provide vital inputs into their activities such as understanding the social problems and evolving mechanisms to tackle these problems with people's participation.

Thus both MARG and ASHA consented on holding a workshop in the basti on alcoholism. We also contacted Alarippu, another NGO in Delhi, to find out if they had a street play on alcoholism and whether they would be willing to perform in the basti. Alarippu readily agreed to do so and they have invited us to look through some of their scripts and work out the terms.

The idea of this workshop was discussed in the February meeting with all present. A suggestion that came up for the action programme was to get people from the basti to set up hand pumps for themselves with their own expertise, as it would solve the water problem to a great extent. This, however, is a long-term programme, though it certainly is a good idea and can be worked upon in future. Presently, we are concentrating on interacting with the people continuously, sharing our findings with them and organizing the workshop on alcoholism.

While working out the possibilities of a day-long workshop in March, it was realized that the month of March was not a good period for it because : (a) the children have their exams and the mothers would not leave them to attend the workshop; (b) with festivals like Mahashivratri, Eid, and Holi, a lot of attention is diverted to them. Some families have gone to their villages to celebrate Holi; (c) as women have to queue up for water, both morning and evening, it will not be possible to have a day-long workshop. We have, therefore, decided to have a series of small workshops of short duration, on alcoholism and related problems.

A series of street plays will be performed in the basti on different days and on different issues. For this, another NGO called Shakti Shalini has been contacted. The women in Shakti Shalini have prepared some street plays on domestic violence. Further, they enthusiastically said that they can also prepare one on alcoholism.

Initiation of the above mentioned activities has already begun.

(ii). SAMPARK (Bangalore, Urban)

The, action plans conceived by Sampark, include a range of intervention ideas. While there is clarity on the details of some immediate and small steps; the contour of some others are expected to evolve with further community discussion. Following is a brief elaboration of the conceived action plans :

1. Follow up on the study :

Sampark is committed to sharing the study findings with the women, and exploring its understanding and implications with them through a workshop/s. It is obvious, for example, that if the women realized how they have been conditioned to ignore many reproductive health disorders as part of life, and how rampant these are, and the toll it takes in totality, they would like to know how to treat or prevent these. Apart from sharing study results on incidence of, say, backaches and leucorrhoea, we could carry educative material and solutions from local health traditions and use a variety of processes to trigger application of such learning by the women themselves.

This will be a process of mutual learning and exploration and lead to various domains, say, even of gender sensitization or the political economy of health services. For Sampark, it will be an entry point into direct field work as well as field testing and development of training material and tools.

A one-day workshop by Gangamma (Mahila Samakhya) could be a good anchor-point midway through this process. Summarizing the study report into a one/two page flier (local language) for community use will be a creative challenge.

This work can be done in all the three slum sites.

2. Income-generation programmes :

Many ideas have been tossed up as a natural result of interaction between Sampark's full-time staff and women looking for sources of additional income. Sampark will be glad to carry forward this process and assist in IGP project formulation.

Financial support for IGP initiation and implementation may be undertaken by Sampark only in Koramangala slum where we intend a long-term presence. In other areas, if support from partner NGOs or through other means can be organized, Sampark will remain committed to assisting this process. Since not only technical selection of IGP activity, but social and attitudinal inputs are necessary for a sustainable IGP, discussion of details is not feasible at this stage.

One-day awareness camps on entrepreneurship or income-generating opportunities will be conducted as part of this plan, inviting representatives to any central venue.

3. Other financial participation :

If the process orientation of the first two 'action plans' does not gain adequate momentum and produce tangible output in the two sites other than Koramangala, Sampark will consider an appropriate financial contribution to an existing institution or forum (not affiliated to any political party) at an appropriate stage.

(iii). RUPANTAR (Chhattisgarh, Madhya Pradesh : rural)

Almost from the time we began to canvass the questionnaire, the women began to express an interest in knowing more about their reproductive health. This was coupled with, what appeared to us, almost total unawareness of physiology and reproductive processes. The community also appeared to hold some general misconceptions on reproductive matters. For example, it seemed to be assumed, on the basis of the report of several women, that the most fertile period in the women's reproductive cycle was the few days following menstruation.

The idea of holding small workshops in which to disseminate information and hold discussions on the health and well-being of women and children was conceived together with the Mahila Mandals of Banjari and Maroud. By mutual agreement it was decided that Vijiya, who is a trained community worker, would conduct small workshops with the women (respondents and others) in each of the villages. Since this was our first effort of the kind in this area, we did not want to make the attempt too didactic, and made efforts to make the sessions as participatory as possible.

This series began in October itself, and the last such workshop took place at Banjari on December 26, 1994. The average number of participating women in these workshops has been around 35. A rough syllabus for these sessions was worked out by Vijiya and Ilina, and was as follows :

* Menstruation and the recognition of normal and abnormal menses.
* White discharge, normal and abnormal, prevention and treatment.
* Back and low back pain, useful exercises in coping with these.
* Anemia, its recognition and women's nutrition in general as well as during lactation and pregnancy.
* Urinary tract problems.
* Depression.
* Pregnancy, growth of the fetus, necessary tests and immunization for the mother and child.
* Birth control and choice of methods.

* Child nutrition and child health.

The emphasis shifted among these themes marginally in the different workshops, depending on the response of the participants. For example, in the workshop at Maroud, the recognition and treatment of anaemia took centre-stage, whereas at Banjari, the focus was much more on low back pain in women, and the management of diarrhoea in small children.

We made a small attempt to evaluate the workshops with a sample of the women in three villages (Banjari, Maroud, and Bagoud). On the whole, the response was that it was a worthwhile exercise, but that more such inputs, on a regular basis, were needed, if these sessions were to be effective.

(iv) Mahila Haat (Kumaon, U. P : rural)

Mahila Haat's Action programme seeks to respond to health concerns expressed by women in the survey conducted in the months of August and September, 1994. The two locations where the action programme is being carried out, are, Daniya and Thal, both villages located in the Pithoragarh district of Kumaon, Uttar - pradesh.

Among the many important issues raised in the survey the one which stands out the most, is the way they perceive their own problems. Internalization is to the extent that they no longer perceive them to be problems at all, but as inconveniences that must be lived with. After reviewing the survey data, several health concerns emerged, which we intend to address through a series of Health education workshops.

The Action program consists of a series of seven workshops with a group of thirty women as the participants. Facilitation of workshops is being done by members of both ISST, Delhi and Mahila Haat.

The focus of the first two workshops is to have open-ended discussions on women's status and how her Health status is directly affected by her status in society. This exercise is mainly to link these issues in the women's minds.

These two workshops commence with a few games aimed at breaking the ice, to build trust among the participants and familiarize themselves with each other. The aim is also to evolve a tapestry in which every woman weaves in threads of her own self and her ideas to make their experiences a collective one, in which they can identify with each other.

The rest of the workshops directly address the health concerns that emerged from the survey.

The focus of one of the workshops is how poor nutrition can lead to anemia and irregular periods. With the help of a series of flash cards that tell a story, women come to know of what consti-

tutes a balanced diet.

Another workshop deals with ante-natal and post-natal care: how to assess a safe and unsafe pregnancy, required health care during pregnancy, breastfeeding practices and the importance of colostrum, nutrition during and after pregnancy, etc. These are addressed in several ways, including voice plays.

Similarly other workshops address issues of vaginal discharge (what is normal and what is not), prolapse of the uterus, methods of birth control, and menstruation (beliefs surrounding menstruation, how it occurs, hygiene during the menstruation, etc.).

The workshops are currently in progress. The topic of the gender roles and women's position in society currently being addressed, has generated a lot of interest among the participants and resulting in animated discussions. The women have been asked to list the health problems(in addition to the ones listed in the survey) that they feel are most acute and that they need information on. Accordingly the upcoming workshops will be tailored to their unique concerns and needs.

V. EVOLVING A WOMAN-SENSITIVE POPULATION POLICY

The fundamental premise on which a woman-sensitive population policy is based is that it is responsive to women's needs and that it is non- coercive, non-invasive and non- violative of the basic human dignity of women. If any of these conditions are violated,the policy, ipso facto, ceases to be woman-sensitive.

Starting from this basic premise, the task of designing such a policy must begin with the job of understanding the viewpoints and constraints of the women to whom such policy is targeted. In our efforts to do this we had interacted, through partnership with various NGOs, with hundreds of poor women through out India in two phases. This was done in focus group discussions and through a sample survey using a structured questionnaire.

In the survey locations we had found evidence of women's powerlessness in reproductive matters. This is manifest in matters of sexual negotiations with the husband marked as they are with significant incidence of abuse and violence on refusal. We found little effective control over the spacing of births and on unwanted pregnancies. Abortion was found to be a taboo subject with most women admitting of its presence on a significant scale as a birth control device, but less than one in a hundred admitting to have taken recourse to it themselves.

Proponents of a non-coercive, woman-sensitive population policy who also feel the need for regulating the rate of growth of population at the macro level,have often talked about targeting of official contraceptive services to those groups who are in need of such services but for one reason or another do not have the requisite access.In other words, one concentrates one's efforts in servicing the "unmet need". However the scenario that emerges from our dialogues with poor women suggests that the issue is not that simple. Very often such an unmet need is not even consciously perceived as a need, leave alone being articulated in the language of effective demand. A large percentage of women interviewed in our survey were aware of one or more methods of birth control - a finding corroborated by recent results from the National Family Health Survey as well. However only a small fraction of these actually practice any form of contraception, and most explained this behaviour by stating that they have not felt the need for it. They would not admit to characterizing any of their own pregnancies as unwanted, while proclaiming at the same time that contraceptives are useful for curbing unwanted pregnancies, that too many children are an economic burden and are ruinous for women's health, and that generally many women - other women, not themselves - take resort to abortion as a birth-control device.

The seeming inconsistencies and contradictions only reflect the complex realities of the women's lives. Bearing and rearing of children is still perceived to be the primary purpose of a woman's life, not merely by men, but also by the women. Son preference is still very strong among the sample population we surveyed, and high

infant mortality is still very much a fact of life for the Indian poor. Coupled with lack of effective control over sexual matters, early marriages and general insensitivity of the males in the family to women's problems and constraints, it is little wonder that an unmet need for contraception does not surface in the form of an articulated demand. Poverty, domestic violence and indifferent health status of the women exacerbate the general sense of powerlessness.

A woman-sensitive population policy must take cognizance of these realities of women's lives. It must build in mechanisms to counter the feelings of isolation, address the high incidence of domestic violence and abuse of women and lack of control over reproductive matters experienced by individual women.One of the ways in which this can be ensured is by linking up with existing neighborhood women's groups. Encouraging group solidarity by highlighting commonalities in women's life experiences has been used for conscientization purposes extensively , and successfully by many women's NGOs in the country in diverse contexts.Such groups can be utilized as forums for awareness and information dissemination in a number of inter-related areas, including family planning and health related matters.

Our findings suggest that while official policy has succeeded to a large extent in spreading the knowledge on contraceptive methods,such knowledge has been incomplete and has not been properly internalized. The policy has been unable to make a significant dent in gender-sensitization processes in the target population which, in the ultimate analysis, will determine the contours of reproductive choice for the women. While women do feel the pressures, these are rarely perceived or articulated in the language of 'power' or 'control', -- pressures that were revealed by them in the many contradictions that emerged in their conversations with us. Permeating all of it is the pervasive evidence of private bearing of social ailments.Domestic violence is borne in the silence and isolation of individual homes.Unwanted pregnancies for the individual woman is not perceived as such, for such things are oftentimes outside the boundaries of individual choice sets, where for one reason or another, pregnancies 'just happen'.

Our interactions with the women also revealed the low level of self-esteem that poor women live with. Women generally tend to ignore their own health problems until these become serious. In matters of reproductive health, a general feeling of modesty often prevents them from accessing even the existing facilities, however meagre. Group interactions on such issues are likely to bring about awareness about the commonality of problems and effect the transformation of unarticulated needs into articulated demands.

The recent 73rd and 74th Amendments to the Indian Constitution which provide for one-third reservation for women in all elected local bodies have opened up exciting new opportunities in this respect. These structures can be accessed in innovative ways to tie up with neighborhood women's groups.

A related issue that needs to be highlighted is the manner in

which reproductive matters are perceived by the women within the context of their life situations. The general concerns voiced by the women from the field in both phases of the project have rarely concentrated on the issue of fertility control in isolation from other major concerns of their lives. The dialogues held with women's group have brought out in clear relief the fact that regulation of their fertility is not something that they can even think about in isolation from other issues - like secure and adequate livelihood, like the need for water and sanitation, like having access to proper health care facilities.

Similar concerns have been voiced by women's organizations for a long time. Bureaucratic lines of control may have their own history and logic of hierarchy. Women's lives and experiences need not fit such structures. Indeed they rarely would. Empowerment is essentially an integrated multi-dimensional category. Unco-ordinated and hierarchical programme design and implementation is unlikely to be an efficient mechanism for the requisite changes. While it may be pointless to talk about a population policy that encompasses virtually all aspects of a woman's life, as some have suggested, it stands to reason that because of the integrated nature of all dimensions of women's empowerment in the realm of experience, and their essential interdependence, no population policy worth its name can ignore such interlinkages.

In operational terms, this means two things : One, that no single line ministry can hope to deal with all the complex realities of a woman's life that will affect her reproductive behaviour; and two, that ceteris paribus, a policy that recognizes the essential inter- relationships of different dimensions will necessarily be more efficient. A decentralized system of local governance, in which decisions can be taken in an integrated manner at the local level therefore, logically speaking, has much better potential of delivering the goods. The Panchayati Raj institutions can be accessed precisely for such purposes.Clearly, the recent amendments to the Constitution have set the stage for opportunities that urgently need to be tapped.

The basic objective of this project had been to integrate into the design of a national population policy, the voices of women to whom the policy is targeted. We had sought to do this by exploring and expanding on the areas of convergence that have emerged in the recent debates on population policy in the country, by integrating the needs, perceptions and constraints of the women themselves. The gender sensitivity of any policy depends on the extent to which such integration can be affected successfully at the ground level.

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APPENDIX. I

Ia. Report from MARG (Delhi - Urban)

Ib. Report from SAMPARK (Karnataka, Bangalore - Urban)

Ic. Report from RUPANTAR (Madhya Pradesh, Raipur - Rural)

Id Report from MAHILA HAAT (Uttar Pradesh, Kumaon Hills - Rural)

A REPORT FROM MARG ON THE SURVEY IN A DELHI SLUM

A small survey in the Ambedkar Nagar Basti, R. K. Puram, Sector I, New Delhi, was an effort towards understanding of the perception of the people in the Basti in general and of women in particular, on issues like general health, contraception, etc., which could then in the wider exercise of forming a women sensitive policy.

As the exercise was undertaken by MARG from ISST, the sample size and duration for the survey was decided in a workshop reorganized by ISST itself.

No male heads could be questioned as they were either not available, or when available, were disinterested in answering themselves and expressed their willingness to have any of the women in the family interviewed.

With this came the problem of interviewing the men. Though with a target of 50 men, we have been able to interview 51 male respondents, the problems involved need a mention. To being with, we realized that the men could either be met in the evening or early mornings. Later, one also realized that evenings was not a good time to speak to them as most of them were found drunk. Lack of street lighting further added to the problem because the men had to be called out of their jhuggis as the women would be preparing dinner inside, or feeding a child etc.

Getting reliable answers was in general quite a tough job. The concept of age and time in terms of hours, months or years, does not exit amongst the people here. Thus, even to arrive at approximates was a tough task for the researcher. Among most in the basti, people first get into a matrimonial alliance called `gona'. After the `gona' the girl and the boy , do not however live together. Normally it is only when the girl attains puberty, that she is sent to spend the rest of her life with her husband. For most women marriage meant `gona'.This custom of marriage created further complications for the researcher in trying to access the age at marriage.

Social and demographic characteristics of the household

The notion of family for most of the people in the basti is a group of people related to each other by blood, through the male descendants.

The resident population in the basti are encroachers dominated by the Scheduled Castes . Brahmins & Thakurs are negligible in their presence. A very small proportion were Muslims.

Women were mainly illiterate. Also, there are a lot of illiterate men. Amongst the literates, the minimum level of education is upto 5th class(primary education), while maximum is 10th

class(secondary education). Not even 1% of the literates have gone upto the level of higher secondary education. Graduation is simply out of question. To note, children in most families go to school, though the parents did complain about the lack of interest in the children for studies, especially so in the higher classes such as beyond 5th standard.

In the employment sector, the Scheduled Castes generally work as `Safai Karamcharis'. In fact, in the two Sulabh Sauchalayas that exist for public convenience, the Karamcharis are not from the basti, but outsiders, who stay within the Sulabh Sauchalaya's compound. Both men and women work as Government employed `Safai Karamcharis, though number of women in such Government jobs is negligent. Roughly 25% of the women in the basti go out for work, most of them are working in residential complexes as `Jamadars'. About 20-30% of the working population (both men and women) are daily wagers. 5% of the working population of men are vendors, selling fruit, vegetables, sweets, eggs and pakoras on the road-side. Muslim men and women from the forward castes, however, do not go out for work.

As far as basic services are concerned, people generally seem to be satisfied with what they have, exceptions being water, electricity and toilet facilities. In fact,regarding these exceptions also, people are not dissatisfied as such, though they do have problems such as lack of water sources which leads to large queues often resulting in fights. Mostly people find the water clean, safe and hygienic, and therefore drink it as it is. Even when they get chlorine tablets for cleaning the water, they often don't use them. For those who do use these chemicals in the water, they do so as long as they are getting the tablets.

Lack of proper toilet facilities is one of the major problems that the women in the basti face. The Sulabh Sauchalayas are poorly managed. One also had a first hand experience to supplement the dissatisfaction expressed by the basti women. Most women therefore go to a nearby park which is also referred to as jungle or nallah, and thus become vulnerable to the increasing crimes against women.

There is no PHC in the basti, but, there is a dispensary run by an NGO by the name Asha Clinic/Dispensary/Asha Dispensary.

Television sets, music systems and coolers are commonly found . Table fans used as ceiling fans in houses with pucca roofs can also be found. A lot of people have bicycles, used by men who go out to work.

Very few Scheduled Caste households have agricultural land in the villages, the land being a few bighas only, which is generally tilled by agricultural laborers who use non-mechanized implements. There are a couple of Scheduled Caste families who are into piggery and also sell pork.

Roughly 8% fall in the expenditure bracket of Rs. 500/-; 30% in Rs. 1,000/- to 2000/-; 55% in Rs. 2,000/- to 3,000/-; 7% in Rs.3,000/- to 5,000/-.

General health profile of the household:

About 75% of the women interviewed said that someone or the other in the family fell ill during the last month, though for a short duration, common illnesses being cold/cough, fever, malaria, influenza, diarrhoea, dysentery and eye flu. Generally, almost everybody had seasonal illnesses, which the women feel is quite common, though children are more prone to them.

Amongst the serious illnesses within the last year, as reported by about 40% of the women interviewed, the common ones were tuberculosis and typhoid. Some of the other ailments thought of as serious were jaundice, polio, appendicitis, gastroenteritis and injuries.

In most cases, the treatment is sought immediately or within 2-3 days. About 50% go to private practitioners and 50% to Government hospitals, though preference seems to be more in favour of private practitioners, even if they cannot afford it, as most of them said.

Also, where people have sought treatment in a Government hospital, level of satisfaction has gone down, and one does find people finally landing up at private clinics.

Mainly for brief ailments that they seek treatment from a private practitioner. for major illness, they mostly go to a Government hospital.

For most serious illness, it is seen that often advice is taken from more than one person. For treatment some of the common places are Dr. Kapoor's Clinic in Munirka; R.K Puram, Sector IV, Dispensary; NDMC Hospital, Moti Bagh; Safdarjung Hospital; AIIMS; Ram Manohar Lohia Hospital; T. B. Hospital Mehrauli and Asha Clinic or its Ekta Vihar branch (Dr. Kiran). Not many in the basti are presently happy with Asha Clinic as firstly they need a card for which Rs. 4/- is charged per person, and, moreover, for most medicines they have to go to Ekta Vihar where again they have to, at times, pay for it.

Reproductive history and health profile of women:

The average age at the time of marriage (not matrimonial alliance termed as `gona') for girls lies between 12 to 15 years, while for boys it is between 15 to 18 years. However, one does find a change in the trend, which indicates that now girls get married only after completion of 15 years, and boys on completion of 17 or 18 years. In about 90% of the cases, we found that the women had conceived their first child while in the age group of 15 to 18 years.

The number of children in 80% of the cases varies from 3 to 5. Such families do not want more and have undergone tubectomy; about 20% want more children. The common reasons in most of the cases who want more children are infant mortality and quest for a male child.

About 25% of the women have had miscarriages for reasons not known to them.

The incidence of infant mortality is high. Children have died in about 55% to 60% of the cases. Most children who died were between the age group of 3 months to 2 years.

Almost 90% of the women have had their deliveries in their marital home (either village or in the current dwelling place). Deliveries in such cases have been done mostly by local dais who have gained perfection through experience and do not have any formal training. There are very few cases where the deliveries have been done by trained dais . In some cases, women have gone to Government hospitals where the delivery has been done either by the nurse or the lady doctor.

80% of the women did not have ante-natal care during pregnancy. Very few have complained of health problems during pregnancies. Those who have complained have mentioned abdominal pain and/or weakness for which no medical help has been sought either because they did not think it to be necessary or because no help was easily available.

Infertility is not uncommon in the basti. Most of the childless couples have sought treatment, both medical and spiritual. In most of these cases, medically they have been told that nothing is wrong with either spouse. Women with no children do feel insecure though in almost all such cases, their husbands have provided moral support despite pressure from parents and relatives. In one of the cases, the couple said that they tried to adopt a child but were unable to do so as they were told that they did not have enough resources to take care of the well-being of the child. One also found women who have taken on the responsibility of bringing up a relative's child, without any legal adoption as such.

White discharge, backache, irregular cycles and anemia-related symptoms were the most commonly reported problems.

Medical assistance for white discharge has been sought by a number of women suffering from it, though they are not satisfied as it has a temporary effect. Mostly medical assistance in such cases has been sought from `hakims' and often treatment for reported problems is not sought either because they don't have enough money or because they feel shy. Generally, all anemia-related problems are neglected by both the women and their spouses/families.

Surprisingly, a lot of women talked about their reproductive health problems though with an expectation that they would also be provided medicines to cure these problems. Infact some of them before answering the section asked if they would be provided any medical assistance if they disclosed their problems.

Contraception

While a number of women discussed their reproductive health

problems without much hesitation, the issue of contraception seemed to be a taboo. At the very outset, women would say that they have not used any contraceptives as if it was something immoral, something really bad. Even when they were asked whether they have heard about contraceptive methods being used to prevent pregnancies, the answer quite often was "we have never used anything".

Further, vasectomy, tubectomy, abortion, and abstinence are not thought of as methods of contraception. Thus even if a woman had undergone tubectomy, she would say we have never used any contraceptive method. However, only on specifically asking about each and every method did we come to know that 90% of the women had heard about vasectomy, tubectomy, Nirodh, Copper-T, Mala-D, 3 or 5 years injection and abortion. About 40% had heard about the rhythm technique, though their concept was all wrong, as they believed that one should not indulge in sex for fifteen days after the completion of the menstrual cycle. We did come across a few women who said that hot cooked mixture of jaggery, ajwain (a kind of aromatic seed, also called henbane), and dry ginger can help prevent pregnancies.

People who had televisions had heard about Family Planning and hence contraceptives. They were definitely found to be more aware than those who did not have T.V. sets in their jhuggi. 90% women had heard about Nirodh, Copper-T, Mala-D, and other such methods through televisions. The other main sources have been neighbours and health workers of Asha Dispensary run by an NGO in the basti itself.

About 70% of the women think contraceptives are useful to limit family size. Of these, 3% to 5% women also felt contraceptives were useful for spacing. Though a lot of women said that contraceptives are useful, very few actually had adopted any of the methods. Most men have not made use of any contraceptive method at all. The reasons why women who have not used contraception despite large family size are mainly (a) husbands dissuaded them; (b) they are unsure of the methods like oral contraceptives and injectionables; (c) some are not physically fit to use Copper-T and some are anaemic and therefore not fit to undergo tubectomy; (d) lot of women also said that there is a natural gap between their pregnancies and so they do not feel the need to use contraceptives; (e) most women felt sick at the thought of using contraceptives.

As far as abstinence is concerned, it is just a way of life for the people in the basti. Though in the respondent's answers as noted in the questionnaires there is no specific reference to this aspect, one thought it must be mentioned in the report as most women said that they hardly indulge in sex too often for various reasons, some of them being - (a) husband comes back so drunk that he is in no state to do anything except shout and yell at everybody in the family; (b) lack of privacy as there are grown up children also sleeping in the same room; (c) either both spouse or any of them keeps fasts at least two days in a week; (d) women's menstrual cycle is one time when most couples do not have intercourse at all; (e) some men and women who were working in Government hospitals have odd duty hours and therefore they rarely got a chance; (f)

abstinence for one or two months after a woman delivers.

The decision regarding contraception was in a large percentage that of the man. In one or two cases the wife has secretly undergone tubectomy.

Women who tried Copper-T, got it removed after some time due to heavy bleeding and weakness. Couple of women who had used Mala-D stopped the use as often they would get pregnant if they missed a day or two, either because they would forget or would run out of stock and would not have enough money to immediately buy a new stock of pills.

Regarding complications on use of any contraceptive method, most women felt that their husbands should avoid vasectomy as it leads to enormous weakness, and if they feel weak they will not be able to go out for work and provide for the family. Further, most women who had undergone tubectomy did not seem to have any problems thereafter (at least, they did not report any complications after tubectomy). It was mostly women who had used Copper-T (which is a small percentage), who complained of excessive bleeding, backache, weakness and discharge after the use of the contraceptive.

To sum up, there is a `felt need' that dissemination of accurate information about availability, use procedures and providing such information would undoubtedly be a step towards the efforts being made to sensitize people, make them aware and help them change their attitudes.

Sexual Relations

For most of couples sexual intercourse is not an everyday phenomenon as they often have to abstain for reasons not in their control. Therefore, according to 80% of the women, when they have the opportunity, sexual intercourse is by consent. This consent, however, does not always include their willingness and in that case women do say `no' to their husbands. Saying `no' has no great significance for most of these women as usually the husband would accept refusal grudgingly or when the husband got angry the woman would give in. Moreover, getting angry does not include being abusive, though it does stretch from the husband not speaking to his wife for sometime or cursing his luck, to the husband not eating at home for a day or so. Quite a few respondents said that their husbands would get abusive when refused, and they would often then have to give in to avoid further quarrels which can be heard by others in the family or neighbours. In about 10% cases wife battering is common. The husband would often get violent on refusal. These are largely cases where they often get violent on refusal. These are largely cases where the men are alcoholics. Usually when a woman is menstruating the men would either abstain themselves or accept refusal. Abstinence is quite common on religious occasions like puja or fasts.

25% of the women interviewed have given contradictory responses. About 20% women who have abusive or violent partners have

said they never had an unwanted pregnancy. The rest 5% are those women who have first said that their husband would accept refusal and have later mentioned that they have had unwanted pregnancies which were a result of husband's insistence.

On the whole, women's notions of unwanted pregnancies found base in various reasons such as (a) non-usage of contraceptive methods; (b) already an infant being breast-fed; (c) health problems; (d) already sufficient number of children; (e) too much additional expense; (f) husband's careless and violent attitude towards life in general and his wife in particular. Women who attempt abortions do so with indigenous methods. Only few have actually gone to hospitals or private practitioners, and that too in the later stages of the pregnancy when they have been refused by the doctors. It definitely needs to be emphasized that unwanted pregnancy does not in any way connote that the women were unhappy with it or for that matter absolutely indifferent. For most of the women it only means that they would have been happier without it.

To sum up, though women have heard of contraceptives that can be used temporarily if required, the act of actually using them does not fall within the mental framework of people in the basti. Further, saying `no' to one's husband does not really empower women in any way. In such a situation questions of range of options available to women has no significance at all.

Induced Abortion

Induced abortion is not a common occurrence. Only about 10% women who had an unwanted pregnancy have used some or the other method to induce abortion. Of these 10% women, half of them consulted a doctor and then went in for a modern DNC or injectables and/or tablets recommended by the doctor. The other half took some pills from a local chemist/shop either on their own or as advised by their friends/dai/ANM. In any case, trying pills from local chemists is the first step taken by women who want to get rid of pregnancy, and consulting a doctor for it is the last and final move.

Women who have taken pills with a doctor's prescription/recommendation registered no complications. Women seem to have no idea about the medication. Largely women who have taken measures for an abortion have done so within the first three months of pregnancy.

DNCs have been sought in consultation with the husbands before doing so, while one woman has been secretive about it. In general, most of the women who have sought a doctor's advice have informed their husbands about the step taken either prior to it or later. Interestingly, in the case of most women who have not consulted a doctor, the husband has also not been informed about the step taken.

Further, for a modern DNC. of the 4 cases we have, 3 used a Government facility which was free of cost, while 1 went to a private doctor and paid Rs. 450/- for it. There is also a case

where a woman went to a private doctor, who successfully used some injectables to induced abortion on a payment of Rs. 500/-. In another case a woman took a capsule and two tablets on a private practitioner's recommendation, which had cost her Rs. 25/- only.

The general information on what is the normal course of action taken by women in the basti in case of an unwanted pregnancy, varies. However, women who have tried to abort any of their pregnancies have also said that women in the basti who do not want a child usually try for an abortion. Also, lot of these women have in general heard of quite a few women going in for an abortion these days. On the whole, the women respondents were not willing to reveal information on what other women, both inside and outside the basti, do when they do not want a child, especially so in the context of abortion. One got a stereotyped answer - " what do we know about others" or no response at all.

Most respondents who had heard of women going in for an abortion said that abortion is usually sought in the following situations :-

(a) Already too many children to add to the family's economic burden.
(b) To space children (concept of spacing comes in only when a woman has an infant being breast-fed and she again gets pregnant).

Lot of the women who have themselves taken steps to induce abortion would also advice their friends to do so, if they do not want a child. For most of these women it is appropriate to go in for an abortion if a person has too many children already. Generally speaking, a large percentage of the respondents are not responsive on the issue of abortion as it is basically a moral and / or religious issue for them. For those who are against abortion as they feel it is a sin and morally a wrong act, the advice is definitely `no'.

Though some women feel that abortion is the only way out in case of pregnancies out of extra-marital or pre-matrital relations, they outrightly condemn such acts.

Going to dais for an abortion is simply out of question. General preference in such a situation is either for a Government facility or a private clinic depending on one's financial position as well as personal preferences.

Law on induced abortion and its legality, and legal rights of women relating to abortion are all alien concepts for the basti women. Evidently, abortion is sought rarely only when one is in deep trouble and is definitely not considered to be a birth control measure.

Questionnaire for men

To begin with, one finds a contradiction on some points between what the women have said and what has specifically been

answered by men, for example, on age, level of literacy, and number of people fallen ill within last month/year. However, no specific reason can be ascribed to this.

Of the 51 men interviewed, 14 feel that women are more prone to illness, 13 feel they cannot say, while another 13 of them did not respond. Only 9 men said that men are more prone to illness. Of the remaining two, for one of them children are more prone and for the other, men and women are equally prone to illness. To note, all men have answered the questionnaire with their own respective families in mind and have not said what they generally feel. In other words, they would relate all the queries to their personal life and then answer, for example, where a woman is doing both outside and household work, her husband is reported to have said that women are therefore more prone to illness.

Most men who feel women are prone to illness attribute it to their being overburdened with work and quite an extent to their being genetically weaker. For a few the answers vary, depending a lot on the particular problems faced by their wife.

On the other hand, the two main reasons attributed to men being more prone to illness are burden of work, and an alcohol and drug related problem. Economic responsibilities of men is yet another answer given by some of them.

Most men are of the opinion that both men and women have an equally harder life and have not really been able to specify the reason for it though some feel that both men and women have their respective duties and responsibilities to fulfil, for example, one respondent said that while he goes out to work, his wife has household chores to attend to. A fair percentage, however, said that women have a harder life than men, either because they feel as women are now going out to work they have to take care of both household and job responsibilities , or because they feel that men have fixed duty hours while women have no hours of work. Interestingly, not many men who feel women are prone to illness due to overburden of work, also feel that therefore women have a harder life. Men tend to be very self-centered in their responses eg. - a man who is jobless at the moment while his wife goes out to work feels that temporarily his wife has a harder life, or for that matter a man who works overtime although acknowledges the fact that house work is not an easy task also feels that he has a harder life for the fact that he works overtime also.

Yet another contradiction comes up on the answer to the number of times a man's wife has been pregnant. Such a contradiction can be found in 45% of the response received from the male respondents.

In about 20% of the cases, men have not revealed information mainly on miscarriage or death of a child. Of these, there is one case where a man has said that his wife got pregnant once which culminated in live birth, though in reality the couple faced the problem of infertility. On an analysis of information collected from women and their husbands, one finds that about 8% women have also tried to hide information on miscarriages.

Moreover, where information from both men and their female counterparts is available, one finds that in 6% cases women have not been able to provide a proper count of their pregnancies while in about 12% cases the men have given a wrong count. It is quite important to mention that these are also cases where a woman has had 5 or more pregnancies.

One of the findings also reveals that while women have not talked about their health problems during any pregnancy, in some cases their male counterparts have said that they took their wife to the PHC/Doctor (private)/ANM/Dai for any health problems during pregnancy.

On contraception, 43% of the men interviewed said that neither they nor their wife used any contraceptive methods. While 21.6% of them said that only they have used contraceptive methods, another 21.6% said that only their wife has been the one to have used them. In 7% of the response from male respondents, both men and women are the users. The reasons for such usage varies from individual to individual.

Most men are found to be users of condoms, while some have undergone vasectomy. On the other hand, most women are found to have undergone tubectomy as reported by their male couterparts. Quite a few of them have been reported to be users of Copper - T. From an analysis of the men's questionnaire, the ratio between number of men who have undergone vasectomy and number of women who have undergone tubectomy is 4:10.

The information on contraception collected from both men and their female counterparts generally tallies except in some cases where a man has said that both he and his wife have used contraceptives. No specific reasons can, however, be attributed to this.

Men who have used condoms are satisfied with the existing process or supply. Largely they have got condoms either from the local dispensary called `Asha Dispensary' or from a chemist's shop. Where men have undergone vasectomy they have not been able to give their opinion on the supply of contraceptives as they feel they have not used any. This shows that as for women, for men also, vasectomy is not conceived of as a contraceptive, but only as a method to stop having more children forever. We may conclude that contraceptive is therefore conceived of as something of temporary usage. For vasectomy, men have either gone to a Government hospital or a private clinic. Where women are reported to have undergone tubectomy, they have been taken for it by their male counterpart. On the whole, satisfaction is expressed by men on the supply of contraceptives.

About 78% of the male respondents feel that contraception is a responsibility of both husband and wife, while only about 12% feel that it is primarily the husband's responsibility. Another 10% either feel they cannot say anything on the issue or have given no response.

On the question of health problems for men (if any), arising out of use of contraceptives, 39% male respondents have said that there can be no such problems for them, while 6% of them feel that contraceptive can cause health problems for them, such as infections through the rubber/latex used in condoms, gastric problems on use of condoms, skin allergy, fever and weakness on undergoing vasectomy. 51% said they could not answer and another 4% gave no response.

Similarly, 35% of the male respondents feel that contraceptives cannot cause any health problems for the women, like abdominal pain, constipation, backaches, menstrual problems and breathing problem. Further, where 49% men said that they could not say whether women can suffer health problems on use of contraceptives, 20% did not respond to the question.

Though women have not really answered the issue of abortion well, men seem to be more open about it. 53% of the male respondents would allow their wife to go for an MTP in case of an unwanted pregnancy, about 24% would not allow for an abortion at all, about 10% will let their wife do what she can and 4% will resist termination under some conditions. For about 10% of the male respondents, the question of abortion has no meaning as the couple faces the problem of infertility.

There are very few (about 9%) cases where women, as reported by their husbands, have undergone an abortion. With a fairly large percentage of men answering in favour of an MTP, in not many cases have their women actually gone for one. As has been seen earlier also, not many women are in favour of an induced abortion.

Most men could not say anything on the danger involved (if any) in induced abortions. However, about 30% of male respondents, of whom many are in favour of an MTP, feel that an induced abortion can be dangerous as it can lead to menstrual problems and weakness and in that case a woman may even die. While approximately 15% male respondents do not see any danger in an induced abortion, the rest (which is a large number in itself), feel that they cannot answer as the family has not experienced any such cases.

None of the male respondents are aware of any legislation on MTP or on legal rights of women relating to abortion. Neither do they know of any nearby facility which can be used to induce abortion. Women, however, seem to be more aware, at least about the facilities that can be used for an abortion. However, while women have the knowledge on abortion, whatever little it may be, the decision to go in for one cannot be taken without the man's consent.

Finally, we addressed the issue of what a man feels are the duties of a man/woman towards his/her family. Most men look at themselves as the providers, and, therefore, they feel they have a

duty to provide for the family and take care of well-being of all in the family. As expected, the stereotyped answer to what the men feel are the duties of a woman was bearing and rearing children, looking after the husband's, and, ofcourse, pleasing the husband.

Though a lot of men said they would initially persuade their respective wives to change their attitudes and would wait for sometime, some said that as a second step they would send the woman back to her parent's house and finally divorce her if things do not change. Quite a few also said that they would only persuade the woman and take on all the responsibilities. Here one would like to specifically point out that a number of male respondents posed to be good Samaritans , though in reality they are found to be either mentally or physically abusing their wives. In one of the cases where the researcher had to intervene when a woman was being beaten by her husband,one finds a major contradiction in his attitude when interviewed by a male researcher. Interestingly, he said he would first persuade her, wait till the children grow up and then go in for separation if the situation did not improve. He further added that he preferred not to get into quarrels as it would affect the children's career, and hence would avoid going against his wife's wishes. To note, he is an alcoholic, and fights between the husband and the wife are a common occurrence, known to all.

Another interesting point is that while some men have expressed complete trust in their wife and said that the woman is co-operative, there are some others who have quite modestly said that they would punish their wife and beat her if she neglects her duties towards her family.

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A REPORT FROM SAMPARK ON THE SURVEY IN BANGALORE

1. This is a report on the study on Women's Reproductive Health that was conducted between October '94 to January ' 95 in Bangalore by Sampark, as part of a study coordinated by ISST in four centres of India.

2. The methodology involved site selection as the first step, when three slums were chosen out of an initial list of seven. The investigators were selected and taken through a set of mock interviews. They were also provided training in data collection for the purpose of the study. Then initial contact was made, respondents interviewed. Supervision involved some analysis, midstream reflection, and gaining some insights into the results that were already coming through. The survey was complemented by conducting group discussions in each slum with the purpose of validating data collected, insights gained, and arriving at some action plans following the research effort.

3. As in any research, the major dilemma facing the staff was how one justifies enquiry of this nature without having any control over final implications of the project, specially at field level. We hope that when the outcome of the entire study is collated, the voices of the women respondents will be heard and acted upon by those who claim to make policy on their behalf.

4. The findings have been summarised under three categories:

   A. LIFE IN THE SLUMS.

   B. HEALTH PROBLEMS AND EXISTING SERVICES: IMPRESSIONS .

   C. REPRODUCTIVE HEALTH : REALITIES OF CHOICES.

Major Findings

* Gender discrimination related to health exists in the form of nutrition priorities-the men are usually entitled to eat first. Children are fed next, and the women eat last.

* There is no gender discrimination in sending young children to primary school. Literacy is perceived as important to survival in the city, and boys and girls are all sent to primary school. However, both boys and girls generally dropout after primary school to join in economic activities: few children reach tenth grade.

* Except for the poorest families, dowry is an expected and institutionalised part of the marriage transaction. As a broad generalisation, it is valid that sons are more preferred, and that not having a daughter can be accepted more easily than not having a single son.

* Many women and men state that one of the duties of the wife is to please or satisfy the husband, failing which she can be punished. No corresponding expectation of the husband exists.

* The high incidence of induced abortion is borne out from figures given by the health providers. This is related to the whole reality regarding contraception beliefs and practices: sterilisation, in most cases of the women, is almost the only form of contraception practiced. Clearly, conception and contraception are entirely the woman's problem.

* Domestic violence is an accepted fact of life. Three issues are the most common trigger points for husbands abusing their wives: sexual relations, improper money spending by the husbands, and alcoholism among the men.

* The stigma attached to infertility is not forbidding; neverthe less, a second wife is socially sanctioned.

Background of the Project

ISST conceived of the project as an intensive and qualitative study to be conducted in four geographically dispersed locations, and requested Sampark to take it up in Bangalore slums. Although we have not been involved directly in research activities so far, we accepted this project for several reasons. In the main, there is an urgency about looking closely and non-statistically at field realities, in light of the structural changes the economy is going through. The market is being made more powerful as a deciding factor, and women are on the peripheries of markets. All aspects of their life - from economics of IG for them, to health related issues, which largely depend on government polices and support, are obviously getting affected. The issue is too basic for an organisation with gender concerns to ignore. It also is hoped that the project would affect policy-making for women; which we will be glad to be part of.

Methodology: slum selection and initiation

Site Selection:

The study proposed to cover four centres - two urban and two rural. In Bangalore, Sampark was expected to focus on urban slums. Since the study intended to look closely at people's own perceptions on health and reproductive choice issues, it was desired that the selected target group should not have been exposed to special education/extension or services in this field.

As Sampark does not directly work with any community, we had to select the target community from amongst projects of partner NGOs. We listed the following criteria:

1. Partner NGOs' philosophy and programmes should not encompass health/reproduction issues, or be liable to bias this study other-

wise.

2. The slum community should be representative of the majority of slums in the city and not atypical in any way.

3. The rapport established by partner NGO should be adequate to generate response on the sensitive questions.

4. There should be adequate possibility of further work with the communities, either directly or through assistance to partner organizations.

We looked at seven possible locations through three partner NGOs. We finally shortlisted three slums (see # ** for characteristics).

Initial Contact :

The initial contact was made in the form of an informally arranged meeting with community leaders in the slums, through the field staff of partner NGOs. We explained very carefully the nature of the research project and our motives for carrying out this study on sensitive topics. Among other things, we explained that we did not believe that the current family planning programme of the government was an adequate response to all the health and reproductive choice needs of the people, as a stand on this was often explicitly asked and, everywhere, the people's fear seemed to be that all studies on the topic are inadequately sensitive to their viewpoint and result in more of the same programmes. We also explained that permission from both the community leaders and the people to be interviewed was necessary for us to proceed with the study, and if they were discomfited with any aspect, we would not go ahead. A copy of the translated questionnaire (without organisation names) was left with a suitable and responsible person in each case, for their consideration before permission was granted.

Subsequently, a women's meeting was called with the same purpose and detailed explanation and discussion conducted.

Thereafter, house to house canvassing was done, using a paid volunteer from the slum or the fieldworker from the NGO as a guide.

Selection of respondents:

There was no purposive selection of respondents. However, no strict procedure was followed to generate a random sample. In the first group discussions with the communities, some women expressed fears or reservations about collaborating in such a project. It was also experienced from the beginning that a few respondents might drop out when sensitive issues were broached. Thus, respondent availability during the hours of our visit and their voluntary collaboration became the main criterion for their inclusion.

We have collected statistics on the composition of the sample frames(total slum population) and, while completion is awaited, we do not except significant variance in composition of the respondents along usual demographic variables such as income, caste,

religion, education etc. from the frame.

Selection of investigators:

Sampark had one female and two male staff capable of canvassing this survey and wished to deploy several more female investigators on this project. We tried several means to recruit investigators: advertising, word-of-mouth to social science institutions and other NGOs, approaching the women's study unit of a local women's college, but although a few people initially displayed interest, we got only one investigator who stayed with the project. So, a team of two plus two did the entire study.

Questionnaire translation:

Sampark's inhouse team translated the questionnaire into Tamil, the predominant language in the slum population, and a regular volunteer at Sampark translated it into Kannada, the other major language. Both translations were vetted by experts: the Tamil version by a language teacher from Valley School, and the Kannada version by Revati Lakshmanan.

Mock runs :

The translated questionnaires were dummy-tested at staff's houses or with friends before field studies commenced. A guided trial run was also conducted during staff training.

Training of investigators :

A formal half-day training session with trips to investigators and a detailed dummy run was conducted before commencement of field canvassing. This was conducted by Revati Lakshmanan, Shashikala and Raghav.

Supervision :

The first few visits were accompanied and supervised closely by Shashikala or Raghav. Subsequently, a daily oral report on field visits and examination of the filled questionnaires was done by Raghav.

Mid-stream reflection :

After about 40 questionnaires were filled in, the investigators were asked to compile the resultant information and analyse trends and also share experiences, responses and feelings generated by the work. This was also structured through a one-hour presentation to Revati and Shashikala. Apart from ironing out any glitches in the canvassing procedures, the exercise was an important step in cementing the quality of the fieldwork, boosting investigator morale through in consolidation of the investigative team's conceptual

grasp of the study dimensions, obtaining a measure of their own response to the survey and a stocktaking of initial data trends and whether it fitted the team's qualitative impressions from the field exercises.

Group discussions :

Shashikala accompanied our two-member women's team on the first group discussion in each location. Subsequent visits were made by this team alone. A briefing and debriefing followed each visit and the exercise was carried out in a serious and purposive manner by restricting the size of the group to not more than ten, in some cases including purposively few respondents known from individual interviews to be willing to respond to the more sensitive topics included.

The purpose of group discussions was three fold, first and foremost, the intention was to share with a group of slum women and men, the tentative results of the survey, based on the understanding that had been formulated by the field researches. The group discussion would provide feedback to the people interviewed, as well as provide an opportunity for validation of the insights developed. Secondly there was also an effort to get views on aspects of their lives, according to the checklist formulated, which are reported below. Finally, there was yet another intention, which was to bring up alternatives for action that Sampark and other intervening NGOs could take up for benefit of the slum women.

Limitations :

As in any research, the major question dilemma facing the staff was how one justifies enquiry of this nature without having any control over final implications of the project, specially at field level.

Ability to address issues which affect day to day life in the slums and of the women was limited.

Despite all this, cooperation from the women, local leaders,was forthcoming.

Even within what is essentially a research project, the effort from ISST and Sampark has been not only to collect information for use outside the field area, which is in itself a valid exercise in this case, given the potential for influencing policy, but the effort has been to generate a meaningful debate on these issues among the women, the NGOs who work with them, to involve local leaders in the process, as well as for Sampark staff to get sensitized to some of these issues, and to be able to respond to them in a useful way.

Findings :

A. LIFE IN THE SLUMS :

<u>KORAMANGALA</u>

The Koramangala slum is three settlements, with a total population

of 40,000, divided roughly between them as:

Laxman Rao Nagar : 22 year-old; 1200 hutments + 900 houses;
Rajendra Nagar : 18 year-old; 3000 hutments + 2400 houses;
Ambedkar Nagar : 8 year-old; 1200 hutments + 700 houses;

The word hutment denotes a squatter dwelling of rough bamboo or pole frame and cloth/plastic walls and dung plastered floor, with a floor area of 50 to 200 square feet, the word house denotes a brickwalled structure of 150 - 400 feet with tin/asbestos or tile roofing.

These settlements are located in the midst of a high-income residential suburb in the South-West of Bangalore city with direct road access to the commercial hub. Thus, the slum supplies much cheap labour services as domestic labour, laundry, small tradesmen and vendors, etc. to this suburb. Yet, perhaps because it is a relatively young settlement, it suffers an abysmal lack of amenities.

The 4000 house structures are built on the basis of a 20 year lease from the municipal corporation, the remaining settlers have no titles.

Some structures are owner-resident, while others are 'rented' : this may even apply to hutments where a 'fee' has to be paid to some local leaders before a piece of land is encroached/build upon. A rent of Rs. 100 to Rs. 400 is the range. A recent entrant into the area is Sharadama, 56, a widow from Chickpet who first joined her elder son at Mysore. It turned out their neighbor at Chickpet was the owner of a small house in this slum and Sharadamma rented it for Rs. 250 a month so as not to depend on her elder son. She now lives with her younger unmarried son but is looking for a job so as to be able to fend for herself. She has about 150 square feet divided into a living and a cooking space by brick wall and a cloth partitioned verandah; with access to her landlord's toilet unit outside. Her landlord's house is 225 Sq. ft., but they have a small dugwell attached, a rare privilege.

About 10% of households have a TV set, around 10% a radio, and 20% will have a bicycle, usually to conduct a business from.

The origin of the people is roughly :

Tamil Nadu	: 50%
Karnataka rural	: 40%
Andhra Pradesh	: 10%

There are about 40% Hindu families, 30% Muslim and 30% Christian.

In terms of nature of employment, the rough breakup is:

Casual (manual) labour (construction sites, etc.)	: 25%
Self-employment (vending, agarbatti making, mason)	: 45%
Temporarily wage employed	: 25%
Permanent wage employment	: 5%

Roughly 50% of the women earn cash incomes. There are 15 agarbatti deposits, each providing work to about 500 women. The work is piecerated and women do about 2-3 bundles a day, for about 300 days in a year, earning Rs. 3000 to 4000 per year.

As much as 90% of the women are illiterate.

The facilities existing in and around the slum include:
Drinking water : Is seriously scarce, with most people paying 25p. per pot to private water sources in the neighbourhood. There are tap connections, one to a lane of 50 households, in one end of the slum, but only a single borewell at the other. Both are erratic and insufficient to serve the population. The households have a system of door-to-door collection whenever the borewell (handpump) is to be repaired, but the reason for very frequent breakdowns is not clear.

Sanitation : Except for two ill-maintained toilet blocks, there is no provision for sanitation. The sewage lines are just open channels created in the lanes between the hutments.

Schools : There are insufficient - one is run by the municipal corporation and is free, there are two other fee-charging private schools. There is an urdu school run by the mosque and an English medium school run by the church.

Health care: There is no government hospital or health care centre in the vicinity; the two nearest PHCs are at Adugodi and Austin Town, both atleast 4Km, away.

Transport , communication, etc. : Being in the midst of Koramangala, adequate facilities exist.

The following formal and informal fora are active in the area:
There is an unregistered 'Social Welfare Association' affiliated to the major opposition party which is attempting to solve civic problems such as settlement rights, sanitation etc. Religious and political fora exist: there is a church,a Hindu association, and political units of major parties. The St. Johns Hospital has a subsidised outreach service addressing a portion of the slum, with visits by doctors and a nominal charge of Rs. 2/- per consultation.

The slum is part of the Uttarhalli constituency represented by BJP MLA Mr. Sriniwas, who is not a local resident.

RAJAGOPAL GARDENS
The Rajagopal Gardens has a total population of 10,000, in about 400 houses and 1000 hutments.

The settlement is located very close to the major market in the city and this characterises the employment pattern with a large number of people being vendors of vegetables and flowers, and many women engaged in flower garland tying. Others are engaged in construction labour.

Rent for a hutment would be in the range of Rs. 80 - 300.

About 20% of households have T.V/radio, and 20% have a bicycle, usually to conduct a business from. About 20% of the households use pushcarts, some owned and some hired.

The origin of the people is roughly :

Tamil Nadu	: 70%
Karnataka rural	: 20%
Andhra Pradesh	: 10%

There are about 60% Hindu families and 40% Muslim, very few belonging to any other religion.

In terms of nature of employment, the rough breakup is :

Casual (manual) labour (construction sites, etc.)	: 25%
Self-employment (vending, agarbatti making, mason)	: 60%
Temporarily wage employed	: 10%
Permanent wage employment	: 5%

Almost all women earn cash incomes, from garland tying or agarbatti making, in their spare time. Again, as much as 90% of the women are illiterate.

The facilities existing in and around the slum include:

Drinking water: Is available through municipal taps but inadequate.

Sanitation: No toilet blocks exist, and there is no provision for sanitation. The sewage lines are just open channels created in the lanes between the hutments.

Schools and PHC : Are located very close and are adequate, although the quality of services is not satisfactory.

Transport, communication, etc. : Being close to a major market and bus terminus, adequate facilities exist.

The following formal and informal fora are active in the area :

The voluntary agency Seva-in-Action has a volunteer who is in regular contact and health and disability assessment camps have been conducted, while discussions on primary education and income generating activity for women have been taken up. There is a government anganwadi whose teacher is resourceful and cooperates with SIA initiatives and also assisted us considerably in our survey. Two religious groupings with their own regular activities are existent around a local masjid and an Annamma temple.

OKKALIPURAM:

Okkalipuram is a large cluster of many small groups of hutments, of which we studied the LaxmanRao Nagar, Srirampuram settlement. This is a relatively well laid out settlement of about 500 population in 100 built houses, which came up 10 years ago. The land belongs to

the municipal corporation.

The relative prosperity of this settlement can be gauged from the fact that it could easily pass for a middle-income area if sanitation existed.

About 20% of households have s TV set, around 20% a radio, and 40% a bicycle.

The origin of the people is roughly:

Karnataka rural	: 50%
Andhra Pradesh	: 40%
Tamil Nadu	: 10%

About 90% of the families are Hindu and 5% each, Muslim and Christian.

In terms of nature of employment, the rough breakup is :

Casual (manual) labour (construction sites, etc.)	: 15%
Self-employment (vending, agarbatti making, mason)	: 40%
Temporarily wage employed	: 5%
Permanent wage employment	: 40%

Many of those with permanent employment are working in the municipal corporation office or in government factories. A number of women work in garment factories within the city. Many of the self-employed men sell small goods from the pavements. A large number of women roll agarbattis in their spare time, yet 40% of the women are not in activities that produce cash income. Again, as much as 90% of the women are illiterate.

The facilities existing in and around the slum include:

Drinking water: Is abundantly available, on tap 24hrs.

Sanitation: There is a block of toilets which is maintained and used by residents but this is inadequate. Again, the sewage lines are just open channels created in the lanes between the hutments. This is particularly a serious health hazard during the rainy season as the roads are waterlogged and the drains overflow, the area being low-lying.

Schools and Health care: There are available nearby. Apart from the government PHC, there is a corporation hospital and also a Family Planning Center run by the Lions Club. There is a government-run Anganwadi.

Transport, Communication, etc. :

Being centrally located in the city, adequate connections exist.

This is the only slum (of the three we studied) which has organised fora representing them in the body politic. The Federation of slum dwellers, affiliated to the national apex body, actively linked

with advocacy groups such as SPARC, is located here with the President being a resident of this slum. There is a women's counterpart wing with savings and income-generating activities called Mahila Milan, which is spread over several city slums, whose main office bearers also belong to Okkalipura.

B. Health problems and existing services: impressions

There appear to be a few distinct patterns worth noting. The first is that in all the urban settlements, awareness of health status is high and seeking of medical assistance is frequent. Second, certain biases exist - the health of the male adult and of young children is highly valued and spend upon, while the women may not seek treatment or seek free treatment if possible : this distinction is seen as valid and reasonable done by both the men and women, men having primary status as the family heads. Third, the perception is strong that many health problems of women are so routine as to be ignored and even not recognised; many women initially reported no reproductive health problems, but on probing, we found they were often suffering from illness like backache and leucorrhoea.

There are patterns in health-seeking behaviour: the government services are least trusted. The primary reason is the attitude of the staff, and the need to bribe. A routinely vocalised response is that the bribes needed to be paid in government hospitals for sterilisation operations more than offset the incentives the government pays to the respondents; similarly, considerable sums have to be spent on operations and deliveries, to obtain legitimate services such as a bed or wash facilities. The inadequacy of facilities or services is only the second reason, and this is of course aided by the perception that the higher charges and the indiscriminate use of injections and other irrational medication by private practitioners indicates a better quality of care. There is certainly a need to provide an inexpensive and rational health service to the urban poor.

Most deliveries take place in hospitals.

REPRODUCTIVE HEALTH: REALITIES OF CHOICES

Specific forms and intensity of gender discriminations

Nutrition : In the majority of cases, the men are entitled to eat first. Normally, the children are fed next, and the women eat last. There are some exceptions: in some cases, children are reported to be fed as and when required; and Bylamma, 23, Koramangala, reports that she doesn't wait for her husband to eat as she is breastfeeding her small child.

Education : There is no gender discrimination in sending young children to primary school. Literacy is perceived as important to survival in the city and boys and girls are all sent to primary school. An interesting report from a few mothers in Koramangala was that they felt it was all the more important to educate their

girls as they face a higher brunt of responsibility later in life; however, both boys and girls generally dropout after primary school to join in economic activities: few children reach tenth grade.

Dowry : Except for the poorest families, dowry is an expected part of
the marriage transaction. Expectations of the groom's family are not explicitly discussed but indirectly communicated. An interesting case is of Parveentai, 26, of Koramangala, who was married 10 years ago. She says that no dowry was expected or paid at that time, but that it has now become a normal expectation. Two women narrated incidents from their families of dowry related harassment: one woman lost her sister to burning and a case has been registered with the police. One woman's daughter has returned to stay with her because of dowry harassment.

Son preference : Parveen Tai prefers a girl child, although her own experience has been difficult: she returned to her parents because she was insulted and ill-treated for not conceiving. Her husband married again, but lost the second wife and child. He then came to take her back from her parents, they have seen doctors who have given them hope of conceiving. This may be one example of a woman who prefers a daughter, but we found others too. Yet, as a broad generalisation, it is valid that sons are more preferred, and that not having a daughter can be accepted more easily than not having a single son.

Property rights : The only property that women are entitled to is what they receive at the time of marriage. When we interviewed one woman with four daughters, she said that she will find one son-in-law who will stay with them, but not divide the property between her daughters: only give them the due dowry. Even widows have to depend on their sons, not have any property to live by.

Duties of husbands and wives: Many women and men state that one of the duties of the wife is to please or satisfy the husband, failing which she can be punished. No corresponding expectation of the husband exists.

Duties and incidents of abortion : In group discussions on abortion, the statements made were similar to those made during individual interviews: that it was largely immoral, certainly harmful to the woman's health, and resorted to only as a last measure if the mother's health was threatened.

It does seem that the real incidence of induced abortion is much higher than reported by respondents, going by the response of the health providers.

Use and awareness of contraception methods: The high incidence of induced abortion is borne out from figures given by the PHC doctor to whom the residents of Rajagopal Gardensgo to. This is related to the whole reality regarding contraception belief and practices: the only form of contraception practiced is sterilisation; only a

few women from Okkalipura reported use of condoms by their men. Clearly, conception and contraception are entirely the women's problem.

Incentives for sterilisation: There are reported cases of failed sterilisations and post-operative complications, and there is a fear that the quality of care at the government centres is very poor. A normal practice is for the women to have a tubectomy immediately following delivery, as then the risk of a repeat exposure to surgery is avoided. This also sometimes allows a woman to choose sterilisation without her husband's knowledge or prior permission.

A uniformly heard statement is that bribes to be paid at the government hospital more than offset the incentives offered. Whether this is true in substance or not, it does communicate strongly about the fear, distrust and disgust the government facilities evoke in these users.

Domestic violence: This is an accepted fact of life. Three issues are the most common trigger points for husbands abusing their wives:

Sexual relations
Improper money spending by the husbands
Alcholism among men

Women accept being unequal to their husbands and the submissiveness in the large is the main means they use to reduce escalation of conflicts.

Infertility: Four cases of infertility came to our notice during the course of the survey. There was a separation in only one of these cases, where subsequently, reconciliation has occurred. In all the other three cases, the husband has not, harassed the wife, although pressure or harassment from the husbands family may occur. Thus, the stigma attached to infertility is not forbidding, nevertheless, a second wife is socially sanctioned. We were unable to draw further conclusions from such a small sample.

Rukmini, 34, Okkalipura, had not conceived for 10 years now. The couple did not worry for the first 4 years, then she and later her husband consulted a doctor and were treated successfully. She now has a six-month old son, at whose birth they weighed coins equal to his weight and gifted to their family temple.

Parveen Tai's case has been reported in the section on son preference. Although she was rejected by her husband for not conceiving, he has now taken her back.

One woman from Koramangala, 40 years of age, is only now pregnant. Her husband has another wife too but supports both of them. He has otherwise been kind to her. He is a tender coconut-seller, she used to roll agarbattis but has now discontinued this.

Another woman, whose husband is a construction site worker, has not conceived for thirteen years. She faces teasing when her in-laws visit. But her husband, whom we met, has no bitterness towards his wife - he says, " it is all God's will"

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A REPORT FROM RUPANTER ON THE RAIPUR DISTRICT IN MADHYA PRADESH

General backdrop

The ISST questionnaire on family reproductive health was canvassed in the Kurud and Dharseewa blocks of Raipur district between August and October, 1994. Apart from this, the service providers' questionnaire was administered to providers in the government system and to providers of traditional maternity services(dais).

The questionnaire was canvassed in three parts, an initial household survey to register the households and identify female and male respondents.

Except in the rural areas surrounding Raipur town, the response to the questionnaire was good, and by large people were cooperative. Around Raipur however, and perhaps because this was a new area for us, the response was more guarded, although never actually hostile.

A few observations are in order. In general, it was felt that women were reluctant to talk openly about their sexual relations, problems therein etc. In part, this is to be explained by the fact that women other than the respondents were generally present during the administration of the questionnaire in most places, and the form of the survey was rather like a group discussion with the focus shifting from one to other women. Men were never present during the canvassing of the women-specific section, and by and large interest was sustained because it was a group process.

The other sections which drew guarded responses were the sections on unwanted pregnancy and abortion. Here too, the feeling of the surveyors(Durga, Vijiya, Saraswathi) was that, the women were not comfortable and not very open. Reasons could be that in the Chattisgarh area, elective abortion was socially unacceptable although post partum sterilization was known and used, and the categorization of a pregnancy that had taken place as `unwanted' was an alien concept.

Basic Background of the study area :

Kurud block, where the survey was conducted, is quite typical of the plains of Chhattisgarh. Chhattisgarh is the name given collectively to the seven easternmost districts of Madhya Pradesh, viz Rajnandgaon, Durg, Raipur, Bastar, Bilaspur, Raigarh and Surguja . Culturally, and linguistically, the region forms a fairly homogeneous whole, although outlying areas in Bastar, Surguja and Raigarh display heterogeneous characteristics. In terms of physical terrain, the region comprises of a central plain in the valleys of the rivers Mahanadi and Shivnath, known as the rice bowl of Madhya

Pradesh (so named as it traditionally grew some of the best rice in the state), bounded by the Satpura and Maikal ranges to the west, north and south, and the age old Gondwana plateau to the south.

Before proceeding further, certain basic demographic characteristics of the region may be worth keeping in mind. The 1991 census of population gives us the following demographic profile:

District	Area (km)	Population	Sex ratio	Literacy rates
Surguja	22.3	20,82930	964	24.00%
Bilaspur	19.9	37,96553	993	28.06%
Raigarh	12.9	17,24420	1006	34.00%
Rajnandgaon	11.1	14,39524	1020	36.00%
Durg	8.9	23,98497	980	47.00%
Raipur	21.3	39,02609	1007	39.14%
Bastar	39.1	22,70472	1003	20.00%

The population is, on the whole, highly tribalized. The proportion of Scheduled Tribes to total population in these districts is as follows:

Surguja	54.8%
Bilaspur	23.4%
Raigarh	48.5%
Rajnandgaon	25.4%
Durg	12.6%
Raipur	18.6%
Bastar	67.8%

In addition the following districts have á high proportion of population belonging to the Scheduled Castes:

Durg	11.8%
Raipur	13.8%
Bilaspur	17.3%
Raigarh	10.7%
Rajnandgaon	9.4%

Chhattisgarh presents a contrast in richness and poverty; great richness of natural resources, and great impoverishment of its rural masses. Of Madhya Pradesh's total forest area of 155414.39 sq. km, 44537.41 sq. km or 28.65% lies within the borders of

Chhattisgarh. Some of the best C. P. Teak and other timber is produced within this area. The area is also rich in mineral resources. In 1989-90, 45.56% of the total mineral revenues (mines royalties of the state of Madhya Pradesh was contributed by the Chhattisgarh districts. Based on these resources, the region has seen, in the post independence years , rapid heavy industrialization, and is earmarked for further industrial growth.

Most of the agricultural land in the rural areas is single crop monsoon fed land. The percentage of area under irrigation is very small.For the area as a whole, only 12% of the cultivated area is irrigated. Within the area, Raipur district (35%) and Durg (33%) have a relatively higher cultivated area under irrigation, whereas Bastar and Raigarh have only 1% and 3% of their cultivated areas under irrigation respectively. (Source: Sandarbh Chhattisgarh, 1993)

Rapid industrial growth has led to the diversion of much of the irrigation water for industry, the most notable examples being the diversion of the Tandula and Kharkhara reservoir resources to the Bhilai Steel Plant.

Communications,and the coverage of the Public Distribution System, of health and educational services continues to be extremely poor especially in the outlying areas. As a result of this and of poor water supply and living conditions, parts of Bastar are known to suffer every year from epidemics of gastro enteritis and bloody dysentry that claim many lives each year.

Health status of the sample population:

Health data pertaining specially to this region are not available. However, the overall health picture is similar to what one observes from other parts of rural India. And is compounded by the problems of widespread poverty, poor access to protected drinking water, poorly developed communications facilities, and an attenuated health service infrastructure.

Over 40% of the people are classified in government statistics as living below the poverty line, and is borne out by high rates (again over 40%) of infant and childhood malnutrition. This is accompanied by high rates of childhood diarrhoea and acute respiratory infections, leading to high rates of infant and under-5 mortality.

Health problems of women, particularly those associated with reproduction are extremely common, leading to high rates of maternal mortality. Rural surveys in similar population groups in a contiguous area of Maharashtra have received high rates of female reproductive tract morbidity. (Source: SEARCH, Gadchiroli)

Chhattisgarh is one of the major foci of sickle cell anaemia in the world. This congenital disease is common in Chhattisgarhi

caste / tribe groups such as Sahus, Kurmis, Satnamis and Gonds. Very high rates of infectious disease exist in this area. Malaria is endemic, and chloroquine resistant falciparum malaria has been identified in the area around Raipur. Epidemics of water related illnesses such as gastro enteritis , dysentry and typhoid are an annual feature. Tuberculosis is very common, and the area is known to have high prevalence rates for leprosy.

Recent features in the health landscape include pollution related respiratory illness in the urban area around Bhilai and Korba. Rapid social change associated with high rates of displacement from land due to industrialization and high rates of unemployment have led to phenomena such as large scale seasonal migration which have compounded the problems outlined above.

Issues that are especially to be kept in mind:

Gender issues: The position of girls and women in Chhattisgarh

The position of women in Chhattisgarh society deserves special attention. Unlike in many other parts of India, women here do not use purdah and take full and equal part in public production. This is the case in agriculture, minor forestry and in the unauthorized sectors/contractual establishments in industries. In the more sophisticated industries however, women have not found a place because of so called skill disabilities. Wage discriminations however, do exist in agriculture and unauthorized industry.

Relations between the sexes in Chhattisgarh are a little different from those commonly previling in northern India. Chhattisgarh women are vocal and outspoken, and the society as a whole does not practice very strict norms of monogamy. Although women are free to enter into or leave marital relations with relative freedom, (second and subsequent marriages are socially sanctioned through a simple exchange of bangles : the 'churi' system) they do suffer from discrimination in their personal lives according to traditional legal systems. For example, child custody on mother's remarriage passes to the father and the mother is assumed to have no rights over the children. The average age at first marriage is low, and even today stands at around 14 years for women. Child marriages are known to take place. There is a lot of variation with regard to equality in marital relations, wife beating is known, and fairly widespread. Dowry is uncommon in the native Chhattisgarh population. In-migrants from other parts of India have introduced the practice of dowry in the region, and violence related to dowry is becoming well known in the urban areas.

In rural areas there is a strong prevailing faith in magic and witchcraft. For example in the Jharkhand area, women are supposed to possess supernatural powers which they use to harm others. An elaborate system of identification and persecution of witches who are called Tonhis exists. In a secular perspective, it is possible to recognize all of these as ways of establishing social control over women,. NGO work in Chhattisgarh has thus, found it relatively easy to mobilize women for public programmes,

but breaking the particular nuances of women's cultural oppression in this region has been an uphill task.

Infertility in this society is generally attributed to the women, and the commonly accepted solution to the problem is for the male spouse to remarry. In such cases the first wife is not necessarily abandoned. In some cases two wives of one man are known to coexist in relative stability for long years, often until the end of their relative lifespans. In other cases, the infertile marriage breaks up, and both the husband and the wife are known to have taken the initiative in such cases.

Health care seeking behavior of men and women in the community:

It is common in Chhattisgarh for people to maintain very high standards of personal hygiene and to keep their homes scrupulously clean. However, as has been pointed out above, infectious diseases are common due to structural and infrastructural factors. What do men and women do in such circumstances ?

The coverage of government health services in the area is poor. According to statistics for 1986-87 (the latest available), the number of persons served per health centre in the districts of the region are as follows:

Raipur	405119
Durg	185033
Rajnandgaon	93718
Bilasspur	115566
Raigarh	69097
Surguja	64037
Bastar	51954

It will be seen that the load on government health services even within the region is highest in Raipur. The southern parts of Raipur district, where communications are poorer, are worse served than the areas closer to the district headquarter.

The problems in rural areas is compounded by the fact that in Madhya Pradesh, Government doctors are officially allowed to do private practice since there is no system of paying them a non-practicing allowance. In practice this means, that the health staff use their positions and the official facilities that exist to further their own incomes, and in the rural areas there is virtually no health care to be had except on payment.

Over large parts of rural Raipur, the only effective health cover is offered by an army of RMPs (registered medical practitioners), who acquire a government registration on the basis of some training they may have had with a senior in the field that has enabled them to pass the rudimentary test qualifying for a registration. The RMPs practice a mixture of allopathy, ayurveda and hocus pocus, and make handsome earnings. Raipur district has a fairly good private medical service run by missionaries. There are three hospitals at Dhamtari, Baitalpur and Tilda run by the church

that provides quality medical care of fairly high technical standard. However, these facilities are expensive and beyond the reach of poor people.

The health care seeking behaviour of the population is conditioned by these objective realities. There is an understandable tendency to put off a visit to a health professional as long as it can be avoided. When such a visit becomes necessary, people do not readily distinguish between the relative merits or demerits of a qualified doctor, an RMP, or a health assistant. All of these cost money, and all of these are loosely referred to under the generic name of 'daktar'. There is little prima facie evidence of obvious and blatant sex preference in seeking health care. However, pregnancies are generally managed at home, with little ante natal care, and deliveries are conducted by dais in the village. From the records of the Tilda Mission hospital, we could see that there was a marked seasonality in hospital attendance. Peak agricultural seasons like July (sowing) and October - November (harvesting) were lean periods of attendance, and illnesses and deliveries were brought to hospital in these periods, only when the distress was acute.

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A REPORT FROM **MAHILA HAAT** ON THE SURVEY IN THE KUMAON HILLS

The hill region in the north of the state of Uttar Pradesh is known as Kumaon. It lies between latitude 28 51 'N and 30 49'N. It is divided into eleven administrative circles, out of which two, the Kumaon and Garhwal, fall in the mountainous region. Kumaon and Garhwal together comprise the region of Uttarakhand. At present the Kumaon circle comprises three districts, Pithoragarh, Almora and Nainital. The Kumaon circle also forms part of the international boundary of India; in the north the snow-clad mountains connect it to Tibet, while to the east the Kali River forms the dividing line between India and Nepal. To the west of Kumaon is Garhwal, while to the south is Ruhelkhand.

The major part of Kumaon is mountainous, while the southern part which is known as the 'Bhabar' and 'Terai' is flat. On one side,there are soaring snowcapped peaks, on the other, large rolling plains. The mountain ranges slope from north to south, and as one moves south, the slope gradually give way to the plains. There are fast flowing rivers in these mountains, on both sides of which are terraced fields cut into the mountain side. Once these rivers flow into the valleys they are bordered by cliffs on both sides.

Based on geographical and climatic factors, Kumaon can be divided into three main parts :

1. Area situated between 750 m to 1250 m above sea level.

   In this hilly region predominantly the land is irrigated with the help of water available from small canals and streams. Most of the area is left as wasteland where dry crops are grown.

2. Area situated between 1250 m to 1850 m above sea level.

   Fruit are grown in the upper area of these ranges by Jhuming Cultivation System.

3. Area above the 1850 m sea level which boasts of some of the World famous highest mountain ranges like Naina Devi (7822 m), Trishul(1725 m) and NandaKot (6865 m) which are snow-clad peak.

   Pinder, Sarju, Ramganga, Gomati, Kosi, Ganga and Sabal etc are some of the important rivers of this area. Most of these rivers originate from the mountains of above 1859 m height. The river Pinder originated from the world famous Pindari glacier which is very beautiful from tourism point of view.

   <u>Climate and Rainfall :</u> The climate is not uniform in all places since the geographical conditions vary according to the height of the area. Usually we find hot climate in the vallies

and cold climate in the mountain area. Generally the rainfall is around 1189 mm in this region.

Kumaon at a glance :

-	Division	1	
-	Districts	3	
-	Area in Sq Mts	21035	Sq. mt
-	Pithoragarh	8856	''
-	Almora	5385	''
-	Nainital	6794	''
-	Population (1991)	29,38,697	
-	Pithoragarh	5,57,148	
-	Nainital	8,24,134	
-	Tehsil	19	
-	Blocks	41	
-	Villages	7238	
-	Markets / Towns	31	
-	Corporations	8	
-	Military Cantonments	3	
-	Indicated area(12,3)	15	

Objectives of the Study :

Today, developmental programmes involve a lot of planning in an effort to improve the social conditions as well as standard of living of women. However, women are not participating either in the planning or in the implementation of such developmental programmes. It becomes important to know and understand their opinion about such programmes.

As of now, the way policies related to population and family welfare have been implemented, it seems that their objectives are being narrowed down. Family welfare should not just aim at reduction of child birth, but also raise t living standards and make women economically independent. Hence our health ministry could add health care services at the time of child birth, general health care services and health education in areas like nutritious diet etc to these programmes. There is a need for total change in the family welfare policies, plans and methods of their implementation.

For successful implementation of the programmes, there is a need to know people's opinion and past experience: to know and understand the facilities available in villages, main difficulties faced and their solutions(if any).

Rationable for Selection of Villages for Survey

1. Keeping various factors in mind only a few villages were selected from the areas where Mahila Haat is working at present.

2. Distance of the villages : Since the distance of the village from the district headquarter determines the health

services available to the villagers, villages situated at different ranges were considered for the study.

3. Diversity of the village population : People from different castes and communities have been chosen as samples as each community has its own traditional practices and customs which influence their health.

4. Different Sections of the Society : Both men and women of different age groups were selected as sample. Doctors, midwives and nurses were also involved in the discussions related to health issues, and more time was given for discussion with women than men.

Jageshwar, Danya, Shahkande, Almora and Panwanaula etc from Almora district, and, Thal and other nearby villages from Pithoragarh district were selected for the survey.

Health Care Facilities in Almora District

In Almora district, only the Government hospital provides health services. There are many non governmental organisations but they do not work in health related areas. Few organisations apart from being involved in their own work keep homeopathic medicines which are used to treat minor diseases.

Gramin Uthan Samiti of Kapkot and Lakshmi Ashram of Kausani are organisations working for women's development. Lakshmi Ashram had a dispensary through which homeopathic and Ayurvedic medicines were given to villages for ailments. But people were neither given medicines nor any information for ailments or problems related to child birth.

Another organisation called "Sahabhagi Gramin Vikas". They also works on health related issues such as organising awareness camps, workshops etc. in this area.

Available Health Care Services in the Region

1. Govt. hospital at district head quarters
2. P H C and M H C at block level
3. 40 to 50 dispensaries in each block.

The Govt. health services structure is not able to provide adequate services in the villages. There are two reasons for this. The regional health centres are situated atleast 15 to 20 Kms from the village in the hilly areas. Hence it is difficult to take the patients to the hospital. In certain areas though the hospital is within the reach of the people either the doctor will not be there or medicines and other basic facilities such as for blood tests, injections, delivery etc are not available.

Discussions with women

1. Discrimination between male and female child :

It is a common practice that women giving birth to a male child are respected and cared for, and the occasion is celebrated with joy and gaiety. Usually more money is spent on the health care and education of a male child.

Discrimination in rearing of male child and female child is gradually reducing, but is not completely absent.

Discussions with women in Panwanaula brought forth the fact that even though they love their daughters, they want a son for varied and well-documented reasons. One woman, for instance, had five daughters and was pregnant again because she wanted a son.

2. Property Rights :

Women know that they do not have any right in their parental property after their marriage. A girl who is not married has full rights on her parental property but the property is not legally transferred to her. She can have a house to stay or land for cultivation but she does not have any right to sell that property.

Similarly the life of a widow also depends upon the views and thinking of her family members. Some do stay with their in-laws, while house some return to their parents'. She maintains her life at both the places but the right to sell the property is neither given to her by the family members nor does she ask for it.

Health :

Women pay less attention to their own health as they feel that it is of no importance. The health of their husbands and sons is very important. If they have minor ailments they do not get treatment at all; if the ailment becomes serious they go for treatment to the nearest centre. However, in the health centres, there will neither be a doctor nor proper medical facilities. Hence they do not show any interest in going to these health centres. If the disease has to be treated properly they have to go to either district head quarters or even to far away cities.

Pregnancy and Postnatal period :

During pregnancy and after delivery, women do not take any special care of their health. If they have cow or buffallo in their houses, women are given milk after delivery, but they have restricted diet. Certain foods are not given to them especially if they gave birth to a male child. Green vegetables are not given to

the mothers as they feed their children because of the belief that green vegetables upset the mother's stomach. Similarly, fruit and vegetables which are considered cold are not used and chilies and fried things are also not given. These restrictions are observed for the sake of the child's health. Due to this restricted diet the mother's food intake is limited and she becomes weak and anaemic. It appears that with the help of education, the restrictions on diet are reducing.

Due to the difficult geographical conditions, there is no provision for bathrooms and toilets, and women have to face many problems. They have to go to a river to take bath after delivery which can cause health problems.

On one hand, they do not get balanced diet, and on the other hand, the hard life and the physical work they do together leads to untimely aging. In Kumaon, the Bhotia women do not observe any restriction in their diet and the mothers are given meat, eggs, etc because of which they are healthier than other women.

5. Post natal diseases :

They do not take much care regarding problems which occur after the delivery. They believe that every woman has some problems after the delivery. Some of the common health problems among them are, pain in the back and joints, indigestion and swelling in the uterus etc. In many cases the uterus comes out after the delivery but they do not reveal it due to hesitation and shyness. Sometimes there is heavy bleeding or pus because of uterus indisposition. Women think that there is no household treatment and medicine for this problem. Very often there is swelling around nipples and boils in the breasts of feeding mothers. Besides these problems, 90% of women have white discharge and worms in the stomach.

6. Sexual Intercourse :

Women said, when asked in confidence, that neither is their willingness taken care of nor any importance is given to their health conditions. If any woman refuses her husband, it leads to dispute and quarrel. At times, women's health gets spoilt due to forcible intercourse after abortion and operation.

7. Delivery :

Usually delivery is performed in the marital house only. Sometimes A N M or experienced elderly women or experienced dai is called for delivery. Otherwise, women give birth to a child themselves without anybody's help.

Women do get fruit, vegetables and milk only if these are available in their homes. So, it seems that if a family has all the facilities then there will be definite improvement in its health.

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APPENDIX. II

QUESTIONNAIRE

**Household Identity No. .....*

INSTRUCTIONS

1. If there are more than one answers, please write all the codes.
2. Female household heads to be questioned :

   [Sections : I, II, III, IV, V, VI & VIII]
3. Other women of the household to be questioned :

   [Sections : III, IV, V, VI & VIII]
4. Male household heads to be questioned :

   [Sections : I, VII & VIII]
5. Other males to be questioned :

   [Section : VII & VIII]
6. In a male-headed household one female respondent preferably the leading lady to be asked

   [Section : II]

   in addition to sections listed under (3) above.
7. Household : Defined as group of people having a common kitchen.
8. Household Head : Whoever is perceived by Household members as the head.

* : All households interviewed should be serially numbered.

Name of Investigator(s)	:
Name of the Village\town\city	:
Taluk/Block	:
District	:
Survey Conducted On (Date)	:
Survey Conducted By	:
Supervised By	:

Individual Serial No: .....

SECTION I : SOCIAL AND DEMOGRAPHIC CHARACTERISTICS OF THE HOUSEHOLD :

	<code>		Ans
I. 1 Household type	1-	Joint	
	2-	Nuclear	
	3-	Other (Specify)	
I. 2 Religion :	1-	Hindu	
	2-	Muslim	
	3-	Christian	
	4-	Jain	
	5-	Buddhist	
	6-	Sikh	
	7-	Other (Specify)	
I. 3 Caste :	1-	SC	Specify
	2-	ST	
	3-	OBC	
	4-	Forward Caste	
	5-	Others	

I.4 PARTICULARS ON HOUSEHOLD MEMBERS:

Sl.No. of the household Member	Name	Head/ Relation to the head of Household	Age	Sex	Marital status *	Education **	Work Status ***	Sector of work ****
							Primary/ Secondary	
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								

* ** *** ****

1- Unmarried
2- Married
3- Widowed
4- Divorced
5- Separated
6- Deserted
7- Married, but husband is away for most of year
8- Common law marriage
9- Others

1- Totally Illiterate
2- No schooling but can read & write
3- Primary
4- Middle School
5- Secondary School
6- Graduate & Above

1- Self-employed
2- Wage worker
3- Casual Labour
4- Salaried
5- Non-worker
6- Unpaid family worker

Sector of work:
1- Agriculture
2- Cottage Ind.
3- Other Ind.
4- Trade
5- Services
6- Others

Note : The Sl.No. given to a household member will be used for further references.

I.5 ACCESS TO BASIC SERVICES:

The Basic Services	Code A	Code B	Code C
I.5.1 Mechanised Transport			
I.5.2 Primary School			
I.5.3 Secondary School			
I.5.4 PHC/MCH			
I.5.5 Drinking Water			
I.5.6 Electricity			
I.5.7 Metalled Road			
I.5.8 Post Office			
I.5.9 Police Station			
I.5.10 Any Other			

Code A

1- Availing & satisfied
2- Availing but not satisfied
3- Available but not availing due to problems
4- Not available

Code B

Usual problems :
1- Corruption
2- High charges
3- Incompetent staff
4- Too far
5- Poor management
6- Any Other(specify)
7- No problems

Code C

Distance:
1- Within 1km.
2- 1-3 Kms.
3- 3-5 Kms.
4- 5+ Kms.

1.6	<Code>	Ans
I.6.1 Drinking Water Source	1- Tap 2- Well 3- Tubewell 4- Pond/River 5- Naula 6- Any other	
I.6.2 Do you think that the water that you use for drinking is:	1- Adequate in supply always 2- Inadequate in supply 3- Adequate only in season 4- Others _____	
I.6.3 What do you think about the quality of drinking water?	1- It is safe & hygienic 2- Unsafe & Unhygienic	

	<Code>	Ans
I.6.4 If water is unsafe, do you take any precaution.	1- Boiling before drinking 2- Consume after filtering 3- Use some chemicals for cleaning the water 4- Any other method 5- Drink as it is	
I.7 Toilet facility	1- Western 2- Indian with Flush system 3- Indian without Flush system 4- Use the fields 5- Soak Pits 6- Any other _____	

I.8 ECONOMIC CHARACTERISTICS OF THE HOUSEHOLD:-

	<Code>	Ans
I.8.1 Does the HEAD of the Household own the house?	1- Yes 2- No	
I.8.2 Land Ownership: Total Land owned by the household (In acres)	1- No Land 2- <1 3- 1-2 4- 2-5 5- 5&above(specify)	
I.8.3 Ownership of Livestock	Pigs Bullocks Cows Buffaloes Sheep Goat Poultry Rabbits Others	
I.8.4 Other Assets owned	Agricultural Implements (specify) 1- Mechanized 2- Non-Mechanized	Consumer Durables <Code> 1- Television 2- Radio 3- Bicycle 4- Scooter 5- Car 6- Bullock cart
Others(Specify)	_____	

	<Code>	Ans
I.9 Estimated Monthly expenditure of the household last month?	Expenditure Group 1- < - 500 2- 500 - 1000 3- 1000 - 2000 4- 2000 - 3000 5- 3000 - 5000 6- 5000 & above	
I.9.1 Is it normal expenditure?	1- Yes 2- No	
I.9.2 If no, what is the normal monthly expenditure?	Expenditure Group 1- < - 500 2- 500 - 1000 3- 1000 - 2000 4- 2000 - 3000 5- 3000 - 5000 6- 5000 & above	

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Household Serial No.: .....
Individual Serial No.: .....

SECTION II : GENERAL HEALTH PROFILE OF THE HOUSEHOLD

Ask the following questions to one woman in the household	<Code>	Ans
II.1.1 Have you or any other member in your household been ill during the last month? Now ask II.2 to II.4.6 & record in Table II.1.1	1- Yes 2- No 3- Can't say 4- No response	
II.1.2 Have you or any other member in your household been seriously ill within the last year? Now ask II.2 to II.4.6 & record in Table II.1.2	1- Yes 2- No 3- Can't say 4- No response	
II.2 What type of ailment is this?	1- Tuberculosis 2- Cold/Cough 3- Malaria 4- Influenza 5- Typhoid 6- Chicken pox 7- Dysentry 8- Diarrhoea 9- Diptheria 10- Gastro-enteritis 11- Food poisoning 12- Jaundice 13- Bronchitis 14- Anaemia 15- Fever 16- Tetanus 17- Pneumonia 18- Injuries 19- Others (specify)	
II.3 For how long has this ailment lasted?	1- For one week 2- For one month 3- For one year 4- > one year 5- Other	
II.4 Was any treatment sought for it?	1- Yes 3- Can't say 2- No 4- No response	
II.4.1 If no,ask: why did you not seek treatment?	1- No money 2- No time 3- No medical facility 4- Don't consider serious enoug 5- Will get cured naturally 6- Loss of day's wages 7- Nobody to take care of Children 8- Fall ill regularly 9- Others (specify)	

	<Code>	Ans
II.4.2 If yes to II.1 ask: II.4.2 When was treatment sought?	1- Immediately after the problem started 2- Few days after the problem started 3- When the situation became very serious 4- Others	
II.4.3 Where were you treated?	1- Local health practices 2- PHC 3- Subcentre 4- Private clinic 5- Home remedies 6- Community Health Worker 7- Pharmacist 8- Spiritual 9- Others (specify)	
II.4.3(i) Why here? Specify.		
II.4.4 Whose decision was it to seek treatment?	1- My own 2- My spouse 3- Elder family member 4- ANM/LHV 5- PHC doctor 6- Other	
II.4.5 Were you satisfied with the treatment?	1- Yes 2- No 3- Can't say 4- No response	
II.4.6 If no, why do you feel disatisfied? Please record this answer below:		
II.4.7 Has anybody visited you from the Government Health Service in the last three months	1- Yes 2- No	
II.4.7.1 If yes, for what purpose?		

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Household Serial No.: .....
Individual Serial No: .....

SECTION III : REPRODUCTIVE HISTORY AND HEALTH PROFILE OF WOMEN

III.1 What was your age when you were married? _____Years / Don't know

III.2 Your husband's age when you were married? _____Years / Don't know

III.3 How many children do you have now? Total = Male... ; Female.....

III.4 Do you want to have any more?If yes, Total = Male... ; Female.....

III.5 Have any of them died? If so, how many? .....

III.6 How many times have you been pregnant? .....

(Questions III.6.1 to III.6.13 may be repeated for each of the pregnancies the woman has had and recorded in Table IIIA)

	<Code>	Answer
III.6.1 How old were you at the time you were pregnant for the first (the second, or the third) time?	1- < 15yrs 2- 15 - 18 yrs 3- 18 - 21 yrs 4- 21 - 24 yrs 5- 24 - 27 yrs 6- 27 - 30 yrs 7- 30 - 35 yrs 8- 35 & above	
III.6.2 What was the outcome of this pregnancy?	1- Livebirth 2- Stillbirth 3- Miscarriage 4- Induced abortion 5- Currently pregnant	
III.6.2.1 If it is a miscarriage, in which month of pregnancy did it happen?	1- 0-3 months 2- 3-6 months 3- 6 mths & above	
III.6.2.2 Why did it happen?	1- Domestic Violence 2- Husband's insistence on sex 3- Hard manuallabour 4- Do not know 5- Others (specify)	
III.6.3 If 1,2 or 3, where did delivery take place?	1- Natal home 2- Marital home 3- PHC 4- Govt Hospt 5- Pvt Hospt 6- Pvt poly-clinic 7- Subcentre 8- Others(specify)	

	<Code>	Ans
III.6.4 Who conducted the delivery?	1- Trained Dai 2- Untrained Dai 3- ANM 4- Lady doctor 5- Male doctor 6- Relative 7- Neighbour 8- Others(specify)	
III.6.5 What was the sex of the baby?	1- Female 2- Male 3- Don't Know	
III.6.6 Is the child is still alive?	1- Yes 2- No	
III.6.7 If no, at what age did the child die?	1- < 1 month 2- (1-6 mths) 3- (6-12 mths) 4- (1-2 yrs) 5- (2-6 yrs) 6- (6-14 yrs) 7- (14 &above)	
III.6.8 Did you have routine health care during this pregnancy?	1- Yes 2- No 3- No response	
III.6.9 Did you have any health problem during this pregnancy?	1- Yes 2-No	
III.6.10 If so, what?	Specify	
III.6.11 Did you seek medical help?	1- Yes 2- No	
III.6.12 If yes, where from?	1- PHC 2- Local health practitioner 3- Subcentre 4- Local Dai 5- ANM/LHV 6- Others (specify)	
III.6.13 If no, why not?	1-Did not think it was serious 2- Lady doctor not available. 3- Health facility far off. 4- Did not have enough money. 5- Husband/family did not think it was a serious problem.	

III.6.13 (contd...)

<Code>	Ans
6- Would have interferred with my housework	
7- Nobody to take care of children	
8- Loss of wages	
9- Normally use home remedies	
10- Previous experience of health facility not good	
11- Others (specify)	

III.7 WOMEN'S HEALTH PROBLEMS

The answers to the questions in this section to be recorded in Table IIIB. (** List of symptoms given in Table IIIB).

		<Code>	Ans
III.7.1	Do you currently have this problem	1- Yes 2- No 3- Dont't know 4- No response	
III.7.2	If yes, did you have it within the last year?	1- Yes 2- No	
III.7.3	Has it been persistent?	1- Yes 2- No	
III.7.4	Was it serious?	1- Yes 2- No	
III.7.5	If Yes, did you seek medical help?	1- Yes 2- No	
III.7.6	If yes, What kind of medical help did you seek?	1- PHC/Sub-centre 2- Pvt facility 3- Local dai 4- Others (specify)	
III.7.7	What was your experience of the help you recieved	1- Good 2- Bad (specify) 3- Dont know 4- Others, (specify)	
III.7.8	If no, why did you not seek medical help?	1- did not think it was serious 2- lady doctor not available 3- Health facility far off 4- Did not have enough money	

III.7.8 (Contd ...)

<Code>		Ans
5-	Husband/family did not think it was a serious problem	
6-	would have interferred with my housework	
7-	Nobody to take care of the children	
8-	Would have lost wages	
9-	normally use home remedies	
10-	Previous experience of the health facility not good	
11-	Others (specy)	

III.8 INFERTILITY

If a woman has not conceived within three years of marriage and she or her husband have not been using contraception, as her the following questions to elicit:

III.8.1 Her reasons for infertility : for e.g. her own inability/husband's inability/any others. (please elaborate)

III.8.2 Reactions to infertility : Her own/husband's/in-laws/others. (please elaborate)

III.8.3 Has she or her husband done anything about it? : for e.g. seeking advice from a doctor/or visited temples etc. (please elaborate)

III.8.4 If any medical checkups been done? Please find out on whom it was done : her/her husband/both and where?

III.8.5 Please find out have the facilities in local PHC's/subcentres been utilized?

III.8.6 Probe on the issue of insecurity/does she feel insecure about it?/does she fear desertion by her husband etc (please elaborate)

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Household Serial No.: .....
Individual Serial No: .....

SECTION IV : CONTRACEPTION

	<Code>	Ans
IV.1 What methods do you know of that can be used to prevent yourself from getting pregnant If answer is 1, stop Otherwise continue	1- None at all 2- Vasectomy 3- Condom 4- Tubectomy 5- Copper T 6- Oral pills 7- Injectable 8- Abortion 9- Abstinence 10-Withdrawal 11-Rhythm 12-Indigenous drugs (specify) 13-Implantables 14-Others (specify) _____ _____	
IV.1.1 How do you know this?	1- Through radio/television/cinema 2- Through a friend 3- ANM/LHV told me 4- PHC doctor told me 5- Husband told me 6- Learnt from neighbours 7- Other family members 8- Village groups 9- Others (Specify) _____ _____	
IV.2 Do you think they are useful?	1- Yes 3- Can't say 2- No 4- No response	
IV.2.1 If yes, why?	1- Since contraceptives are necessary to limit family size 2- To space children right 3- Because too many pregnancies cause health problems 4- Others (specify) _____ _____ _____	
IV.3 Have you or your husband ever taken any kind of measures to prevent pregnancy? If yes, go to IV.4 else ask IV.3.1	1- Yes 2- No	

	<Code>	Ans
IV.3.1 Why have you not taken any such measures?	1- It is immoral 2- Never felt the need for it 3- It is unnatural 4- It results in further complications 5- No time for it 6- Don't have enough information 7- Afraid of using it 8- Others (elaborate) _____ _____ _____	
IV.4 If yes, could you say what this is?	1- Vasectomy 2- Condom 3- Tubectomy 4- Copper T 5- Oral pills 6- Injectable 7- Abortion 8- Abstinence 9- Withdrawal 10- Rhythm 11- Indigenous drugs (specify) 12- Indigenous methods (specify) 13- Implantables 14- Others_____	
IV.4.1 If it was an implantable or an injectable, was any medical checkup done, and did they enquire about your medical history, and were you tested if you were pregnant or not?	1- Yes 2- No	
IV.4.2 Why have you chosen this method over others?	(please elaborate):	
IV.4.3 Whose decision was it to use this?	1- My own 2- My husband's 3- PHC doctor 4- ANM/LHV 5- Others (specify) _____	
IV.4.4 Have you ever had complications/problems arising our of contraceptive use?	1- Yes 2- No	

	<Code>	Ans
IV.4.4.1 If yes, what complictions?	1- Excessive bleeding 2- Weakness 3- Discharge 4- Infections 5- Abdominal Pain 6- Back pain 7- Others _____	
IV.4.4.2 Did you have these symptoms immediately before using this contraceptive/device?	1- Yes 2- No	
IV.4.4.3 Did you seek treatment for these complications before or after contraceptive use?	1- Yes 2- No	
IV.4.4.4 If not, why did you not seek treatment?	1- No money 2- No time 3- No medical facility 4- Not serious enough complication 5- Will get cured on its own 6- Others _____ _____ _____	

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Household Serial No.: .....
Individual Serial No: .....

SECTION V : SEXUAL RELATIONS

	<Code>	Ans
V.1 Can you say no to your husband?	1- Yes 2- No 3- Sometimes 4- Never thought about it 5- No response	
V.2 Do you ever say no to your husband?	1- Yes 2- No 3- Sometimes 4- No response	
V.3 Do you think it is proper to say no to him?	1- Yes 2- No 3- Sometimes 4- No response	
V.4 What if you are sick or tired or unwilling to have sex for any reason, would you still be unwilling to say 'no'?	1- Yes 2- No 3- Sometimes	
V.5 If or when you do say no, how does your husband react or how would you expect him to react?	1- Would get angry/abusive 2- Would get violent 3- Would accept refusal 4- Other (specify) _____ _____ _____	
V.5.1 When you are menstruating and do not want sex with you husband, how does he react?		
V.5.2 If and when you refuse to have sex because of cultural or religious reasons how does he react?		
V.6 If you are coerced into it would others in the family object to the coercion?	1- Yes 2- No	
V.7 Is there any pregnancy with which you were unhappy?	1- Yes 2- No 3- Can't say 4- No response	
V.7.1 Which pregnancy is it?		

	<Code>	Ans
V.7.2 Why were you unhappy with this pregnancy?	1- Too much additional work 2- Too much additional expense 3- Health problems 4- Others (specify) _____ _____	
V.7.3 Did you take any action on it? If so, what?	1- Continued pregnancy with no action 2- Had an abortion 3- Tried to terminate but failed 4- Others (specify) _____ _____ _____ _____	

V.8 To those women who are indifferent or unhappy with one or more pregnancies, probe the issue further by asking questions like:

If you were unhappy/indifferent, why did you get pregnant in the first place? Why did you not take some action?

This is to elicit information/perceptions on the range of options they feel they have in these matters. The substance of their answers may be written in a paragraph below after the interview is over.

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Household Serial No.: .....
Individual Serial No. .....

SECTION VI : INDUCED ABORTION

If interviewee herself has had an abortion, ask VI.1 and VI.2

If interviewee herself has not had an abortion, go straight to VI.2

Questions VI.1.3 to VI.1.13 to be asked for the last abortion the woman had. If more than one please find our whether the pattern differs. If yes, write on a separate sheet of paper.

	<Code>	Answer
VI.1 VI.1.1 Is having an abortion quite common occurrence in this area?	1- Yes 2- No 3- Don't know	
VI.1.2 From your reproductive history it seems that you have had induced abortions. How many you have had?	1- One 2- Two 3- Three or more	
VI.1.3 In which month of pregnancy did you have and induced abortion?	1- 0-3mths 2- 4-6mths 3- >6 mths	
VI.1.4 Was it an easy decision?	1- Yes 2- No 3- Cant say 4- No response 5- Others (specify) _____ _____	
VI.1.5 Did you discuss this or take advice from any other person before deciding to have an abortion?	1- Yes 2- No 3- No response	
VI.1.5.1 If yes, who was this person(s)?	1- Husband 2- Mother-in-law 3- Other relative 4- Friend 5- PHC doctor 6- ANM/LHV 7- Dai 8- Others(specify) _____	
VI.1.5.2 If answer is not Husband, Please ask does your husband know about it?	1- Yes 2- No 3- No response 4- Others (specify) _____	

	<Code>	Answer
VI.1.6 To whom did you go to for the abortion	1- Trained Dai 2- Untrained Dai 3- Private Doctor 4- PHC Doctor 5- ANM/LHV 6- An older women in the house 7- Neighbour 8- Others (specify)	
VI.1.7 Where was the abortion done?	1- Natal home 2- Marital home 3- In the PHC/Subcenter 4- In a private clinic 5- In the home of the dai 6- Other (specify) _____	
VI.1.8 Why did you go where you did?	1- More privacy 2- Only affordable option 3- Safer & more hygienic 4- More comfortable with 5- Not aware of any other choice 6- Aware but no other choice 7- Husband said so 8- Others (specify) _____ _____	
VI.1.9 What kind of method was used to induce abortion?	1- Vaginal herbs/roots 2- Vaginal insertion of foreign bodies 3- Oral indigenous 4- Modern-oral; 5- Modern DNC 6- Injectable 7- Massage 8- Others (specify) _____ _____	
VI.1.10 Were you charged a fee for the abortion?	1- Yes 2- No 3- No response 4- Don't know	
VI.1.10.1 If yes, how much was this?	Cash: _____ Kind : _____	
VI.1.11 Did any complication occur at time of abortion or afterwards? If yes, go to VI.1.12	1- Yes 2- No	

	<Code>	Answer
VI.1.12 VI.1.12.1 If yes, what kind of complication?	Describe:	
VI.1.12.2 Did you seek treatment for it? If yes, go to VI.1.12.5	1- Yes 3- No response 2- No	
VI.1.12.3 If no, why did you not seek treatment?	1- Do not want others finding out 2- Couldn't afford time & expense 3- No one willing to treat me 4- Did not consider serious enough 5- No treatement available nearby 6- Others (specify) _____ _____ _____	
VI.1.12.4 If did not seek treatment, what happened to complication?		
VI.1.12.5 If you did seek treatment, who treated you for the complication?	1- Trained Dai 2- Untrained Dai 3- Private Doctor 4- PHC Doctor 5- ANM/LHV 6- An older women in the house 7- Neighbour 8- Others (specify)	
VI.1.12.5.1 What kind of treatment?	Describe :	
VI.1.12.5.2 Do you feel satisfied with the treatment received?	1- Yes 2- No	
VI.1.12.5.3 If no,why do you feel disatisfied?		

	<Code>	Answer
VI.2.1 When a pregnant woman in your village/locality doesn't want to have a child which course does she usually follow?	1- Continues pregnancy 2- Tries for an abortion 3- Others (specify) _____ _____	
VI.2.2 VI.2.2.1 Are there many women seeking abortions?	1- Many 3- No response 2- Few 4- Don't know	
VI.2.2.2 For what purpose is it mostly sought?	1- For controlling family size 2- To space children 3- When pregnant out of wedlock 4- In case of rape 5- In case of incest 6- To preserve the mother's health if she is at risk 7- When the child will be a girl 8- Don't know 9- Others (specify) _____ _____	
VI.2.2.3 To whom do these women go to get the abortion done?	1- Trained Dai 2- Untrained Dai 3- Private Doctor 4- PHC Doctor 5- ANM/LHV 6- An older women in the house 7- Neighbour 8- Others (specify)	
VI.2.3 If you had a friend who had an unwanted pregnancy would you advise her to opt for an abortion?	1- Yes 2- No 3- No response 4- Don't know	
VI.2.3.1 If not, what are your reasons for not doing so?	1- Not safe/dangerous to health 2- God's gift & should not be done 3- Morally a wrong act 4- Facility is unavailable 5- Would feel guilty 6- Others (specify) _____	
VI.2.3.2 In what situation do you think it may be appropriate for a woman to go for an abortion?	1- In case of rape 2- In case of incest 3- Pregnancy out of wedlock 4- Mother's health seriously at risk 5- Too many children already 6- Likelihood of another girl 7- Never 8- Others (specify) _____	

	<Code>	Answer
VI.2.3.3 In case there is an appropriate situation, to whom and why would you advice a woman to go?		
VI.2.4 Till which month do you feel an abortion can be performed safely?	1- Upto 3rd month 2- Upto 5th month 3- >5th month ok 4- Any time during pregnancy 5- Don't know	
VI.2.5 Try to extract the state of awareness about the legal rights of women relating to abortion by addressing their knowledge on laws of induced abortion and its legality		

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Household Serial No.: .....
Individual Serial No : .....

SECTION VII : QUESTIONNAIRE FOR MEN

Name	:
Age	:
Status of marriage	:
Education	:
Occupation	:

	<Code>	Ans
VII.1 Has anybody been ill in your family within the last month?	1- Yes 2- No 3- Can't Say 4- No response	
VII.1.1 If yes, who are they?	Please list serial no. of house hold members	
VII.1.2 Has it been serious?	1- Yes 2- No	
VII.2 Has anybody been seriously ill in your household within the last year?	1- Yes 2- No 3- Can't say 4- No response	
VII.2.1 If yes, who are they?	Please list serial no. of house hold members	
VII.2.2 What has been the nature of their illness?	(Please specify)	
VII.3 Who are more to illness?	1- Men 3- Can't say 2- Women 4- No response	
VII.3.1 If the answer is men, why so?	1- Burden of work 2- economic responsibilities 3- Alcohol, drug related problems 4- Any other	

	<Code>	Ans
VII.3.2 If the answer is women, why so?	1- Overburdened with work 2- Women are genetically weaker 3- Too many pregnancies 4- Gender discrimination within the family 5- Any other	
VII.3.3 Who has the harder life?	1- Man 4- No response 2- Woman 5- Equally hard 3- Can't say	
VII.3.4 Why so?	(Please specify)	

if it is a married man, please ask questions VII.4 to VII.11

	<Code>	Ans
VII.4 How many time has your wife been pregnant?	(write in Numbers)	
VII.5 Pregnancies culminated in.	1- Live births 2- Still births 3- Miscarriages 4- Abortions	
VII.6 Has she had any health problems during these pregnancies?	1- Yes 2- No 3- Don't know 4- No response	
VII.6.1 If yes, then give brief detail of the problem.	(Write in Words) _____ _____	
VII.7 Were you involved in any way in taking care of the problem?	1- Did you take her to the PHC/Doctor ANM/Dai 2- Called any of the above 3- Asked the elderly women to take care 4- Other (Specify)	
VII.8 Have your or your wife ever used any contraceptive method?	1- Yes 2- No 3- Don't know 4- No response	

	<Code>	Ans
VII.8.1 If yes, then? VII.8.1.1 what method has been used by you?	1- Vasectomy 2- Condom 3- Abstinence 4- Withdrawal 5- Rhythm 6- Indigenous methods 7- Others 8- None	
VII.8.1.2 what method has been used by your wife	1- Tubectomy(operation) 2- IUD(loop, or Copper-T) 3- Oral Pills 4- Injectibles 5- Indigenous method (specify) : _____ _____ 6- Any other 7- None	
VII.8.1.3 Why is it that you or your wife as the case may be is the one to have used the contraceptive & why not the other	(Answer to be qualitative)	
VII.9 If you have used any contraceptive, from where did you get it?	1- PHC 2- Male Health Worker 3- From the shop(non-medical 4- Local Dispensary 5- Other (Specify)	
VII.10 If your wife uses contraceptives where does she get her supply of contraceptives?	1- You get it for her 2- Herself from the PHC 3- From some other women 4- Any other source (Specify)	
VII.11 Your opinion about the supply of Contraceptive(s):	1- Satisfied with the existing process of supply 2- Unaware of any process of supply of contraceptives 3- Never used/felt the need, hence not bothered 4- Not satisfied ; Need to have a better supply system	

	<Code>	Ans
VII.12 Do you think contraception is primarily the responsibility of the husband/wife?	1- Husband 5- Both 2- Wife 3- Can't say 4- No response	
VII.13 In your judgement can contraceptives cause health problems for you?	1- Yes 2- No 3- Can't say 4- No response	
VII.13.1 If yes, then what?	(Specify) : _____ _____	
VII.14 In your judgement can contraceptive cause health problems for your wife?	1- Yes 2- No 3- Can't say 4- No response	
VII.14.1 If yes, then what?	(Specify) : _____	
VII.15 If your wife gets pregnant & doesn't want to have the child what would you do?	1- Will go for the MTP 2- Let her do what she can 3- Will resist termination under some conditions 4- Will not allow her to go for an abortion 5- Other (Specify)	
VII.16 Has your wife had any induced abortion?	1- Yes 2- No 3- Can't say 4- No response 5- Not applicable for unmarried men	
VII.16.1 Do you think she would confide in you if she wants to have an induced abortion?	1- Yes 2- No 3- Can't say 4- No response 5- Not applicable to unmarried men	
VII.16.2 Can it be dangerous to have an induced abortion?	1- Yes 2- No 3- Can't say 4- No response	
VII.16.2.1 If yes,under what conditions can it be dangerous?	(Specify): _____ _____	

	<Code>	Ans
VII.16.3 Are there facilities nearby which can be used to have an ind. abor?	1- Yes 2- No 3- Can't say 4- No response	
VII.17 Try to extract the state of awareness about the legal rights of women relating to abortion by addressing their knowledge on laws of induced abortion and its legality		
VII.18 What in your view is the husband's duty towards wife/family?	1- Provide for economically 2- Protection 3- Well-being 4- Others	
VII.18.1 What in your view is the wife's duty towards the husband/family?	1- Bearing & rearing the children 2- Looking after the household 3- Pleasing the husband 4- Others (Specify)	
VII.18.2 If your wife does not do her duty, how would you react?	1- Persuade her 2- Reprimand her 3- Punish her 4- Other (Specify)	

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Household Serial No.: .....
Individual Serial No : .....

SECTION VIII : ACTION FOR THE FUTURE

	<Code>	Ans
VIII.1 What in your view are the major problems you are facing?	1- No jobs 2- Irregular and tool little income 3- Lack of schools 4- Lack of basic health facilities 5- Lack of water 6- Lack of sanitation 5- Too many children 6- Alcohol and drug related problems 7- Lack of fuelwood 8- Anti social activities 9- Others _____ _____ _____	
VIII.2 What in your opinion is the major health probem of women in this locality?		
VIII.3 Are you aware of any assistance that the govt. provides to combat these problems?	1- Yes 2- No	
VIII.3.1 If yes, what kind of assistance is this?		
VIII.4 Do voluntary organizations/NGOs provide any kind of assistance?	1- Yes 2- No 3- Don't know	
VIII.5 VIII.5.1 If yes, what kind of assistance is this?		
VIII.5.2 How can it be improved upon?		

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INTERVIEWER'S REPORT

	Code	Ans.
1. Reliability of answers:	1- Mostly reliable 2- Partially reliable 3- Mostly unrealiable	
2. Extent of co-operation:	1- Good 2- Moderate 3- Poor	

3. Any other comments:

TABLE - II.1.1

Serial no. of member of household	Type of Ailment (II.2)	Ailment for how long (II.3)	Treatment sought (II.4)	If no, why? * (II.4.1)	If yes, when? (II.4.2)	Where? (II.4.3)	Whose decision/ advice (II.4.4)	Satis-fied? (II.4.5)	If Dis-satisfied Why ? ** (II.4.6)	Visit from GHC (II.4.7)	Purpose of Visit *** (II.4.7.1)
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											
11.											
12.											
13.											
14.											
15.											

* (II.4.1) : _____

** (II.4.6) : _____

*** (II.4.7.1): _____

T A B L E - II.1.2

Serial no. of member of household	Type of Ailment (II.2)	Ailment for how long (II.3)	Treatment sought (II.4)	If no, why? * (II.4.1)	If yes, when? (II.4.2)	Where? (II.4.3)	Whose decision/ advice (II.4.4)	Satis-fied? ** (II.4.5)
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								

* (II.4.1) : _____

** (II.4.5) : _____

Table III A (Section III)

Sl.No. of pregnancies	Age at Conception (III.6.1)	Outcome of pregnancy (III.6.2)	If miscarriage, when (III.6.2(i)	Why did it happen (III.6.2(ii)	Place of delivery (III.6.3	Person doing delivery (III.6.4)	Sex of the Baby (III.6.5)	Child Alive (III.6.6)	If no, age of death (III.6.7)	Routine Health Care (III.6.8)	Health problem (III.6.9)	Specifics of the problem * (III.6.10)	Medical help sought? (III.6.11)	Where from? (III.6.12)	If not, why not? (III.6.13
1.															
2.															
3.															
4.															
5.															
6.															
7.															
8.															
9.															
10.															

* (III.6.10) Please elaborate:_____

TABLE III B
Women's Health Problems

Symptoms	Do you currently have this (III.7.1)	Did you have it within the last year (III.7.2)	Has it been persistent (III.7.3)	Was it serious (III.7.4)	If yes, did you seek medical help (III.7.5)	What kind? (III.7.6)	Experience of help received (III.7.7)	If not, why not (III.7.8)
1. Vaginal Discharge								
2. Tiredness/ Paleness								
3. Breathlessness								
4. Genital Rashes/ Itching/ Ulceration								
5. Backache								
6. Abdominal Pain								
7. Vaginal- Bleeding								
8. Giddiness								
9. Obstretical- Problem(s)								
10. Burning/ Micturation								
11. Prolapse								
12. Incontinence								
13. Menstrual problems								
14. Pain during intercourse								